STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

Earl Ray Tomblin
Governor

Michael J. Lewis, M.D., Ph.D.
Cabinet Secretary

June 4, 2012

Kwakou Butcher
HRSA Project Officer
5600 Fishers Lane
Rockville, MD 20857

Dear Mr. Butcher:

The Division of STD/HIV/Hepatitis (DSHH) is excited to provide you with a copy of the WV HIV/AIDS Comprehensive Plan/SCSN for 2013-2015. This document was developed in collaboration with the Statewide Coordinated Statement of Need (SCSN) workgroup. The DSHH is very appreciative of Jay Adams, Chair of the SCSN workgroup, and all of his efforts to produce the finalized Comprehensive Plan.

The planning process was a very positive experience for all parties involved. Participants worked diligently to develop a plan to provide quality services to PLWHA. The collaborative process allowed providers to develop a plan to provide guidance in planning HIV Care and treatment services in West Virginia.

The DSHH is extremely pleased with their contractual agreement with the AIDS Task Force of the Upper-Ohio Valley (ATF). ATF's implementation of the Ryan White Part B Program under the direction of Jay Adams has been instrumental in successfully providing HIV care and treatment services throughout the state. West Virginia's Comprehensive Plan supports the mission that all PLWHA who need HIV care and treatment services will receive the services and support that will prolong their lives.

Sincerely,

Loretta E. Haddy

Loretta E. Haddy, PhD, MA, MS
State Epidemiologist and Director
Office of Epidemiology and Prevention Services

Bureau for Public Health
Office of Epidemiology and Prevention Services
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WV Ryan White Part B Programs

JAY ADAMS, M.A.
HIV Care Coordinator

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June 4, 2012

Kwakou Butcher
HRSA Project Officer
5600 Fishers Lane
Rockville, MD 20857

Dear Mr. Butcher :

On behalf of the statewide WV HIV/AIDS Care and Treatment Comprehensive Planning Group, I am writing to express concurrence, to the Health Resource Service Administration (HRSA), for the WV 2012 - 2015 HIV / AIDS Care and Treatment Comprehensive Plan. The Planning Group fully supports the goals and objectives of the 2012 – 2015 Plan and the Statewide Coordinated Statement of Need (SCSN).

The 2012 – 2015 WV Comprehensive Plan was developed through a thorough planning process that ensured full participation by people living with HIV / AIDS, (PLWHA), and all of the Ryan White funded Parts in West Virginia. After extensive data collection and needs assessment in FY 2011, meetings were conducted in October, 2011 to develop the 2012-2015 Plan. The WV 2012 – 2015 Comprehensive Plan includes goals, objectives, strategies and appropriate timelines that will ensure that PLWHA are linked with quality HIV healthcare. The Plan includes a vision for helping West Virginia achieve the goals of the National HIV / AIDS Strategy and provides a blueprint for implementing healthcare reform through the Affordable Care Act.

As Chair of the Planning Group, I am pleased to convey the Group's support for the 2015 Comprehensive Plan that will fully support the state's mission, that all PLWHA in West Virginia who need HIV care and treatment services, will receive high quality services that support sustaining their lives.

If you have any questions about the WV Plan or our planning process, please feel free to contact me at 303-232-6822.

Sincerely,

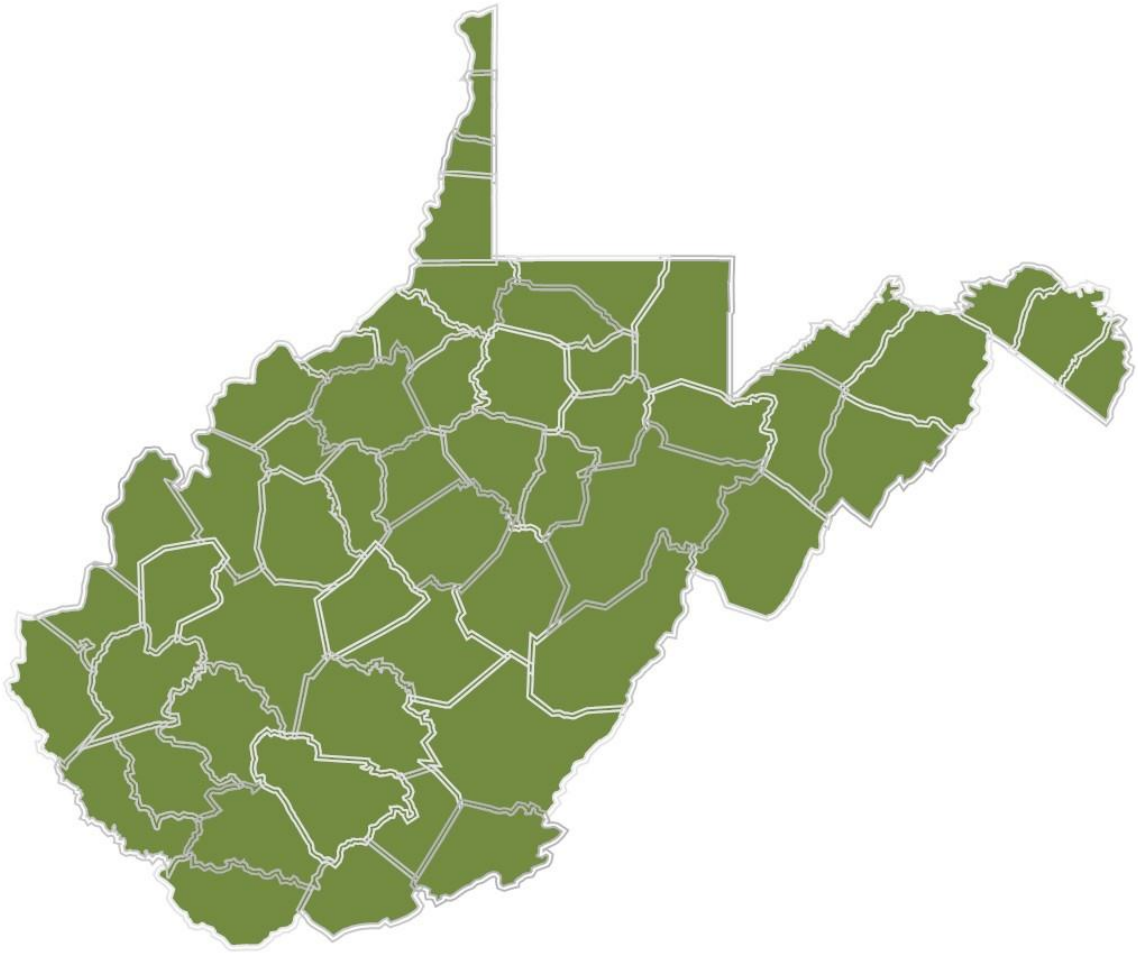
Jay Adams

Jay Adams, M.A.
HIV Care Coordinator
Chair, WV HIV Care & Treatment Planning Group

2012-2015

Ryan White Part B Program

Comprehensive Plan



West Virginia

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Acronyms

ACA	Affordable Care Act
ACTG	AIDS Clinical Trials Group
ADAP	AIDS/HIV Drug Assistance Program
ADR	ADAP Data Report
AETC	AIDS Education Training Center
AHP	Advancing HIV Prevention or also used as abbreviation for HIV/AIDS Program
AHPI	Advancing HIV Prevention Initiative
AIDS	Acquired Immune Deficiency Syndrome
AN	AIDS Network
AODA	Alcohol and other Drug Abuse
APC	AIDS Prevention Center
ARV	Antiretroviral
ASO	AIDS Service Organization
ATF	AIDS Task Force
AZT	Azidothymidine (chemical name for Zidovudine, brand name for Retrovir
BHC	Black Health Coalition
BMS	Bureau of Medical Services
BRFSS	Behavioral Risk Factor Surveillance Survey
CAMC	Charleston Area Medical Center
CAIR	Center for AIDS Intervention Research
CAPS	Center for AIDS Prevention Studies (University of California, San Francisco)
CARE Act	Ryan White Comprehensive Resources Emergency Act, now known as the Ryan White HIV/AIDS Treatment Extension Act of 2009
CAS	Client Assessment Sheet
CBA	Capacity Building Assistance
CBO	Community Based Organization
CD4	Cluster of differentiation 4 (T helper cell)
CDC	Centers for Disease Control and Prevention
CEO	Chief Executive Office
CHC	Community Health Centers
CLD	Client Level Data
CLI	Community Level Intervention
CMS	Centers for Medicare and Medicaid Services (Federal)
COBRA	Consolidate Omnibus Reconciliation Act
CPG	Community Planning Group
CQI	Continuous Quality Improvement
CTR	Counseling, Testing & Referral
DD	Developmental Disabilities
DEBIs	Diffusion of Effective Behavioral Interventions
DHHR	Depart of Health and Human Resources (West Virginia)
DHHS	Department of Health and Human Services
DNA	Deoxyribonucleic acid
DOC	Department of Corrections
DSHH	Division of STD/HIV/Hepatitis

EBIs	Effective Behavioral Interventions
EFA	Emergency Financial Assistance
eHARS	Enhanced HIV/AIDS Reporting System
EIIHA	Early Identification of Individuals with HIV/AIDS
EIS	Early Intervention Services
EMA	Eligible Metropolitan Area
FDA	Food and Drug Administration
FIMR	Fetal and Infant Mortality Report
FOA	Funding Opportunity Announcement
FPL	Federal Poverty Level
FTE	Full Time Equivalent
FTM	Female to Male (Transgender)
GLBT	Gay, Lesbian, Bisexual, Transgender
GLBTQ	Gay, Lesbian, Bisexual, Transgender, Questioning
GLI	Group Level Intervention
GPR	General Purpose Revenue
HAART	Highly Active Antiretroviral Therapy
HAB	HIV/AIDS Bureau (office within the Health Resources and Services Administration)
HAV	Hepatitis A Virus
HBV	Hepatitis B Virus
HC/PI	Health Communication / Public Information
HCV	Hepatitis C Virus
HIRSP	Health Insurance Risk Sharing Plan
HIV	Human Immunodeficiency Virus
HIV-positive	HIV-infected, person has tested positive on standard HIV-antibody test
HOH	Hard of Hearing
HOWPA	Housing Opportunities for People with AIDS
HRH	High Risk Heterosexual
HRSA/HAB	Health Resources and Services Administration/Health Administration Bureau
HUD	Housing and Urban Development (Federal)
IDU	Injection Drug use / Injection Drug User
ILI	Individual Level Intervention
IPN	Internet Protocol Intervention
IQ	Intelligent Quotient
LGBT	Lesbian, Gay, Bisexual, Transgender
LHD	Local Health Department
LLEGO	National Latina/o Lesbian, Gay, Bisexual & Transgender Organization
MA	Medicaid
MCM	Medical Case Management
MCSM	Men of Color who have sex with Men
MMWR	Morbidity and Mortality Weekly Report
MSM	Men who have sex with Men
MSM/IDU	Men who have sex with Men and are also Injection Drug Users
MTF	Male to Female (Transgender)
MUIM	Marshall University Internal Medicine
nPEP	Non-Occupational Postexposure Prophylaxis
NASTAD	National Alliance of State and Territorial AIDS Directors

NCHSTP	National Center for HIV, STD, and TB Prevention
NEP	Needle Exchange Program
NGLTF	National Gay and Lesbian Task Force
NGO	Non-Governmental Organizations
NH	Non Hispanic
NHAS	National HIV/AIDS Strategy
NNRTI	Non-Nucleoside Reverse Transcriptase Inhibitor – "Non-Nukes"
NQC	National Quality Center
NRTI	Nucleoside Reverse Transcriptase Inhibitor – "Nukes"
OEPS	Office of Epidemiology & Prevention Services
OLS	Office of Laboratory Services
OMB	Office of Management and Budget (Federal)
OSHA	Occupational Safety and Health Administration
PAP	Patient Assistance Program
PCR	Polymerase Chain Reaction (test or assay)
PCRS	Partner Counseling & Referral Services
PCSI	Program Collaboration & Service Integration
PEMS	Prevention Evaluation Monitoring System
PfH	Partnership for Health
PHIP	Prevention for HIV Infected Persons
PHS	Public Health Service (Federal)
PI	Protease Inhibitor
PIC	Policy Initiative Committee
PIR	Parity, Inclusion & Representation (Older CDC Prevention Language)
PLWA	Persons Living with AIDS
PLWH	People Living with HIV
PLWHA	People Living with HIV/AIDS
POL	Popular Opinion Leader
PrEP	Pre-Exposure Prophylaxis
PTLT	Prevent, Test, Link and Treat
PS	Partner Services, formerly Partner Counseling & Referral Services or PCRS
QA	Quality Assurance
QI	Quality Improvement
QM	Quality Management
QMP	Quality Management Plan
RDR	Ryan White Program Data
RFP	Request for Proposals
RNA	Ribonucleic acid
SAMHSA	Substance Abuse and Mental Health Services Administration (Federal)
SCSN	Statewide Coordinated Statement of Needs
SEP	Syringe Exchange Programs
SI	Structural Interventions
SIECUS	Sexuality Information and Education Council of the United States
SPNS	Special Projects of National Significance
STD	Sexually Transmitted Diseases
STI	Sexually Transmitted Infections
SVMS	Shenandoah Valley Medical Systems
TA	Technical Assistance
TB	Tuberculosis

VA	Veterans Administration
VL	Viral Load
WICY	Women, Infants, Children and Youth
WSW	Women who have sex with Women
WVRWPBP	West Virginia Ryan White Part B Programs
WVU	West Virginia University
YMSM	Young Men who have sex with Men
YRBS	Youth Risk Behavior Survey
ZDV	Zidovudine (generic name for azidothymidine, brand name is Retrovir)

Acknowledgements

The West Virginia STD/HIV/Hepatitis Program would like to acknowledge the collaborative work of the 2012-15 Comprehensive Panning Group, including representatives of all Parts of the Ryan White funded sites in West Virginia, people living with HIV/AIDS, prevention stakeholders and the West Virginia Ryan White Part B Program (WVRWPBP) medical case managers for their support in preparing this combined 2012-15 Comprehensive HIV/AIDS Care and Treatment Plan and the 2011 Statewide Coordinated Statement of Need.

Special thanks are extended, for their specific contributions and support to the following:

Jay Adams, Chair	**WVRWPBP**
Loretta Haddy	**WVHIV/AIDS/STD Program – Director OEPS**
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Claire Dye	**WVSTD Epidemiologist**
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Linda Davis	**CAMC Part C Clinic**
Denise Heflin- Peyton	**CAMC Part C Clinic**
Kathy Chase	**Shenandoah Valley Medical Systems; Parts A and C**
Mary Clarke,	**Portsmouth City Health Dept.; Part C Clinic**
Jeannette Southerly	**PA/MAAETC**
Carolyn Kidd	**PA/MAAETC**

Introduction

WV Comprehensive Planning Process

The WV STD/HIV/Hepatitis Program incorporated four planning processes into one statewide comprehensive planning process for the WV HIV/AIDS Care and Treatment Comprehensive Plan for 2012-15. The four processes include:

- Statewide Coordinated Statement of Need (SCSN)
- HIV Care Services Implementation Plan
- Quality Management Plan (QMP)
- Three Year Strategic Plan

The 2012 – 2015 WV HIV/AIDS Care and Treatment Comprehensive Plan includes data from the 2010-11 client needs assessment, client satisfaction surveys, core service utilization data, SCSN reports, the current Quality Management Plan, the state's epidemiological data, the 2011 expenditure report, goals and objectives and a review of resources available to people living with HIV/AIDS (PLWHA) in West Virginia. The 2011 SCSN is integrated into the 2012-2015 Comprehensive Plan.

The 2012 – 2015 Comprehensive Plan provides the West Virginia's response to four core HIV/AIDS planning questions:

- Where are we now: What is our current system of care?
- Where do we need to go: What is our vision of an ideal HIV/AIDS care and treatment system?
- How will we get there: How does our current system need to change to assure availability to core services?
- How will we monitor our progress: How will we evaluate our progress in meeting our short-and-long term goals?

In developing the 2012 – 2015 Comprehensive Plan, the state has reflected on its mission for HIV care and treatment services:

- Ensure that all eligible PLWHA in West Virginia, who are in need of HIV care and treatment services, will receive high quality services that include access to existing and emerging HIV/AIDS treatments
- Ensure that HIV care and treatment services are client centered, and have sound financing for establishing and sustaining a quality system of care
- Ensure that women, infants, children, youth, underserved and rural populations and emerging populations receive appropriate services that are in proportion to their HIV/AIDS prevalence in the state
- Ensure that all newly diagnosed PLWHA have access to opportunities for early entry into the continuum of care
- Ensure that the state documents and evaluates the impact of core services on improving access to quality care and treatment services and in sustaining the lives of PLWHA in West Virginia

Executive Summary

The West Virginia Continuum of Care is built upon the belief that all West Virginians should know their HIV status and that all of those who have tested HIV positive should have equal access to high quality HIV care and treatment and support services that sustain their lives.

The 2012 – 2015 WV HIV Care and Treatment Comprehensive Plan is the result of the collaborative work of all Ryan White funded Parts who participated in a strategic planning process that produced a concise vision and mission. The 2012 – 2015 Plan is clear and measurable and ensures that the delivery of HIV care and treatment services is fair, equitable and transparent.

While WV is a low incidence state, 1,887 PLWHA are reported in the HIV/AIDS Reporting System (HARS) on 12/31/10. The state has a disproportionate share of blacks living with HIV/AIDS; the state has a 3% black population, but 30% of the PLWHA are black. The Men Who Have Sex with Men (MSM), risk factor continues to account for 51% of the state's PLWHA and males represent 76% of the PLWHA cases. While the age group 45-54 dominates the PLWHA cases at 36%, the 35-44 age group represents 27% of the PLWHA. The PLWHA population is comprised of 58.7% AIDS cases and 41.3% HIV cases.

The WV Ryan White Part B award for ADAP, State Direct Services and Insurance Continuation services link PLWHA with quality health care that is vital to their survival. The components of the Part B Program, guided by the important work of the Planning Group, the epi profile and the identified needs of PLWHA, must eliminate the disparities in access to core medical services for all PLWHA populations in West Virginia. The state must accomplish this while avoiding duplication of services in order to maximize the state's resources. This can only be achieved through collaboration with all of the Ryan White funded Parts in West Virginia. With collaborative program planning, sharing of common goals and a dedication to 100% access and zero disparities in quality HIV care and treatment for PLWHA living throughout West Virginia, the state will continue to strengthen the overall continuum of care.

Without a doubt, there are challenges that lie ahead for the HIV care and treatment delivery system in West Virginia. Faced with geographic isolation, stigma that at times is crippling for PLWHA, a lack of transportation infrastructure, a calculated unmet need of 32.8% and level funding for Ryan White providers, the coalition of Part A, B and C funded sites must ensure that PLWHA enter care early after their diagnosis and be retained in care. These challenges are being undertaken by a dedicated HIV care and treatment workforce who have pledged to strengthen their collaboration. The 2012-2015 WV HIV Care and Treatment Comprehensive Plan provides a roadmap to meet these challenges.

1. Where Are We Now: What is our Current System of Care?

HIV/AIDS In West Virginia-Epidemiologic Trends

In the 2010 census, the total population reported for West Virginia was 1,852,994 persons, making it the 37th most populous state in the United States. West Virginia is comprised of 55 counties ranging in size from the smallest, Wirt County (pop. 5,717), to the largest, Kanawha County (pop. 193,063), also the site of the state capital, Charleston. The major cities in descending order of population size are Charleston, Huntington, Parkersburg, Morgantown, and Wheeling, ranging in size from 51,400 to 28,486 people. According to the 2010 Census, approximately 50.7% of the West Virginia population is female. The most prevalent age group in West Virginia is ages 45 to 64 years, with 29.2% of residents falling within that group. The second largest age group is ages 25 to 44 years (24.7%), followed by ages 65 years and older (16.0%). Only about 30% of the population is younger than age 25. The racial and ethnic composition of the state is estimated to be 93.2% non-Hispanic White, 3.7% non-Hispanic Black, 1.2% Hispanic, 0.7% Asian, and 0.2% American Indian or Alaska Native. In total, 18.1% of the West Virginia population lives below the poverty level. Less than 20% have a bachelor's degree or higher, while only 41.6% have a high school diploma or its equivalent. Slightly less than 15% of the population is without health insurance, while almost 35% is on public insurance.

West Virginia is a low prevalence state for both Sexually Transmitted Diseases (STDs) and Human Immunodeficiency Virus (HIV) disease. Between January 1, 2006 and December 31, 2010, a total of 329 new HIV infections[1] and 275 new AIDS cases were diagnosed among West Virginia residents and reported to the West Virginia Department of Health and Human Resources. Between 2006 and 2010, the number of new HIV cases increased by 31% (from 55 cases in 2006 to 72 cases in 2010). During that same period, the number of new AIDS cases diagnosed decreased by 26% (from 58 cases in 2006 to 43 cases in 2010). The reasons for the decrease in AIDS diagnoses are multiple, but include more widespread use of effective antiretroviral therapy.

As of December 31, 2010, there were 1,887 people currently living with HIV/AIDS (PLWHA) in the state of West Virginia. Almost one-fourth of these individuals resided in Public Health Management District 3[2]. This was followed by District 8 with 17%, District 7 with approximately 16%, District 2 with 13%, District 1 with 11%, District 5 with 7%, and Districts 4 and 6 with 6% of PLWHA each.

[1] HIV infection case counts include all new HIV diagnoses regardless of AIDS status. Thus, individuals who were initially diagnosed with AIDS are counted twice within the same year, once as a new HIV case and once as a new AIDS case.

[2] West Virginia's 55 counties are grouped into eight Public Health Management Districts. District 1 contains McDowell, Mercer, Monroe, Raleigh, Summers, and Wyoming counties. District 2 contains Cabell, Lincoln, Logan, Mason, Mingo, and Wayne counties. District 3 contains Boone, Clay, Kanawha, and Putnam counties. District 4 contains Braxton, Fayette, Greenbrier, Nicholas, Pocahontas, and Webster counties. District 5 contains Calhoun, Jackson, Pleasants, Richie, Roane, Tyler, Wirt, and Wood counties. District 6 consists of Brooke, Hancock, Marshall, Ohio, and Wetzel counties. District 7 contains Barbour, Doddridge, Gilmer, Harrison, Lewis, Marion, Monongalia, Preston, Randolph, Taylor, Tucker, and Upshur counties. Finally, District 8 includes Berkeley, Grant, Hampshire, Hardy, Jefferson, Mineral, Morgan, and Pendleton counties.

I. Risk

In West Virginia from 2008-2010[3], men who have sex with men (MSM) was the most frequently identified transmission category, accounting for 55% of all new HIV cases and 56% of new AIDS cases diagnosed. The second most common transmission category for HIV was heterosexual contact (20%), followed by injection drug use (IDU) (10%), MSM/IDU (3%), and perinatal transmission (2%). For AIDS, the second most common transmission category was IDU (16%) followed by heterosexual contact (15%), and MSM/IDU (3%).

Between 2006 and 2010, the distribution of newly diagnosed HIV infections across transmission categories has fluctuated. Though the number of cases attributed to MSM rose by 18% overall (from 34 cases in 2006 to 40 cases in 2010), the yearly number of HIV cases attributed to MSM ranged from 33 in 2007 to 42 in 2008. For heterosexual activity, the yearly number of cases ranged from 11 in both 2006 and 2008 to 18 cases in 2007. Finally, IDU peaked in 2008 at eight cases. Despite these fluctuations, MSM was the most common, and heterosexual activity the second most common, transmission category in all years studied.

With respect to new AIDS diagnoses, the number of cases due to MSM and heterosexual activity has decreased slightly over time—the attribution of new AIDS cases to MSM decreased 21% (from 33 cases in 2006 to 26 cases in 2010) while the attribution of new cases to heterosexual activity decreased 45% (from 11 cases in 2006 to six cases in 2010, with a temporary increase in 2007 to 16 cases). Between 2006 and 2009, AIDS cases attributed to IDU increased by 50% (from eight cases in 2006 to 12 cases in 2009). It is not yet clear if the sudden downturn in 2010 (to only two cases) will continue. Regardless of the increases or decreases in specific transmission categories, however, MSM was the most common, and heterosexual activity the second most common, transmission category in all years studied.

Among PLWHA in West Virginia as of December 31, 2010, MSM is the most prevalent transmission category, accounting for 54% of cases. Heterosexual activity is the second most prevalent transmission category (17%), followed by IDU (13%).

II. Race

The majority of HIV and AIDS cases diagnosed between 2008 and 2010 in West Virginia have occurred among non-Hispanic (NH) Whites. Almost three-fourths (72%) of the HIV cases and 68% of the AIDS cases reported between 2008 and 2010 were among this racial/ethnic group. A further 22% of HIV cases and 25% of AIDS cases occurred among non-Hispanic Blacks. Hispanics accounted for 4% of newly diagnosed HIV cases and 2% of newly diagnosed AIDS cases. These numbers show that non-Hispanic Blacks and Hispanics are disproportionately affected by the HIV/AIDS epidemic in West Virginia, as population data from the 2010 Census shows that Non-Hispanic Blacks make up only 3.4% and Hispanics represent 1.2% of West Virginia's population.

Over time, the number of new HIV infections among Non-Hispanic White men has increased while the number of new AIDS infections among this population has decreased. In 2006, 42 new cases of both HIV and AIDS were diagnosed among Non-Hispanic White men. By

[3] Because West Virginia is a low prevalence state, the years 2008 through 2010 are combined to examine the demographic and behavioral traits of recent HIV/AIDS cases. The years 2006 through 2010 are used to look at trends over time in the distribution of HIV/AIDS.

comparison, in 2010 there were 53 new cases of HIV and only 29 new cases of AIDS in this population, representing a 26% increase in the number of HIV cases and a 31% decrease in the number of AIDS cases. Among Non-Hispanic Black men, the pattern over time has been less clear, but generally appears to be remaining steady. In 2006, 12 new cases of HIV and 14 new cases of AIDS were diagnosed among Non-Hispanic Black men. In 2010 there were 12 new cases of both HIV and AIDS among this population.

When transmission category is broken down by race/ethnicity, MSM remains the primary transmission category for a majority of newly diagnosed Non-Hispanic Whites and Blacks. Among Whites, 62% of new HIV cases and 65% of new AIDS cases were ascribed to MSM between 2008 and 2010. For Blacks, 40% of newly diagnosed HIV cases and 45% of newly diagnosed AIDS cases are attributed to MSM. Among Whites, the second most common transmission category varies—heterosexual activity is the second most common transmission category (17%) for newly diagnosed HIV cases while IDU is the second most common transmission category (12%) for AIDS. In contrast, heterosexual contact is the second most common transmission category for both HIV and AIDS (30% and 25%, respectively) among Blacks.

Almost three-fourths (74%) of PLWHA in West Virginia as of December 31, 2010 are non-Hispanic White. Non-Hispanic Blacks account for 23% of PLWHA, while Hispanics account for only 2% and Asian, Hawaiian, or Pacific Islanders account for 1%.

III. Gender

As has been the case throughout the HIV/AIDS epidemic, more men were diagnosed with HIV and AIDS from 2008 to 2010 in West Virginia than women. Approximately 81% of new HIV and 86% of new AIDS cases reported in West Virginia were among men. Females accounted for 19% of the newly diagnosed HIV cases and 14% of new AIDS cases.

Since 2006, the number of men newly diagnosed with HIV has increased 49%, increasing steadily from 41 men in 2006 to 61 men in 2010. Meanwhile, the number of men diagnosed with AIDS increased 16% between 2006 and 2008 (from 44 to 51 cases) and then decreased 25% (from 51 to 38 cases) from 2008 to 2010. Among women, the number of new HIV diagnoses remained fairly steady (between 14 and 16 cases per year) from 2006 through 2009. In 2010, the number of new HIV cases among women decreased 31% (from 16 to 11 cases). It is not clear if this trend will continue. During this same 5-year time period, the number of new AIDS cases diagnosed among women decreased by 64% (from 14 to 5 cases).

The distribution of transmission factors is dependent on gender. Among men, MSM was the predominant transmission category cited accounting for 69% and 65% of new HIV and AIDS cases, respectively. For HIV and AIDS, IDU was the second most common transmission category (9% and 18%, respectively), followed by heterosexual contact (7% and 6%, respectively). The primary risk behavior reported for both HIV and AIDS among females was heterosexual contact, accounting for 73% of new HIV cases and 68% of new AIDS cases in women. IDU was the second most common risk behavior, accounting for 12% of new HIV cases and 23% of new AIDS cases.

Among West Virginia men, MSM has been cited as the transmission category for new HIV cases increasingly often. In 2006, 34 cases of HIV were attributed to MSM versus 40 in 2010, an increase of 18%. In contrast, the frequency with which MSM is listed as the transmission category

for AIDS has decreased from 33 cases in 2006 to 26 cases in 2010 (a decrease of 21%). The other transmission categories account for a small number of cases yearly and no clear trends are discernible. For West Virginia women, the frequency with which heterosexual activity has been cited as the transmission category for newly diagnosed HIV and AIDS cases has decreased over time. In 2006, 11 HIV and 10 AIDS cases were attributed to heterosexual activity. In 2010, only 8 HIV and 2 AIDS cases were attributed to heterosexual activity, representing a decrease of 27% and 80%, respectively. The other transmission categories represent a very small number of cases.

Among PLWHA in West Virginia as of December 31, 2010, 80% are male and 20% are female. Among male PLWHA, MSM is the most common transmission factor, accounting for 66% of cases currently alive and residing in West Virginia. For female PLWHA, the most common transmission factor is heterosexual activity, accounting for 59% of cases.

IV. Age

Most HIV infections diagnosed in West Virginia between 2008 and 2010 occurred in the 30-39 and 40-49 age groups (26% and 31%, respectively); most new AIDS cases also occurred in the 30-39 and 40-49 age groups (30% and 37%, respectively). Additionally, though only 10% of new AIDS cases occurred between the ages of 20 and 29, this age group accounted for 26% of new HIV cases. In contrast, 11% of HIV cases were diagnosed in the 50-59 year age range compared to 16% of new AIDS cases. Thus, it appears that HIV is diagnosed at younger ages, on average, when compared to AIDS.

Between 2006 and 2010, the number of newly diagnosed HIV/AIDS cases in most age categories has fluctuated by year, but has not shown a clear pattern of change. However, the number of new HIV diagnoses among individuals aged 40 to 49 has grown steadily and dramatically, climbing from less than 10 cases in 2006 to almost 25 in 2010, an increase of 150%. For AIDS diagnoses, the largest change has been in the 30 to 39 age group, which has seen a decrease of 67% from a peak of 24 new cases in 2008 to only 8 new cases in 2010.

Among PLWHA in West Virginia as of December 31, 2010, 35% are currently between the ages of 40 and 49 years. A further 28% are between the ages of 50 and 59 years, while 18% are between the ages of 30 and 39 years. Only 3% of PLWHA are under the age of 25 years.

V. Mortality

Between 2006 and 2009, the number of deaths among individuals diagnosed with HIV and/or AIDS in West Virginia increased 125% from 12 deaths in 2006 to 27 deaths in 2009. In 2010, this number decreased to 24 deaths.

HIV

Number of HIV Cases by Select Characteristics, West Virginia 9/1989-12/2010							
Characteristic	Cumulative through 2005 No.	2006 No.	2007 No.	2008 No.	2009 No.	2010 No.	Cumulative through 2010 No.
Age at Diagnosis							
<13	9	<5	<5	<5	<5	<5	**13**
13-24	243	15	13	13	9	14	**307**
25-34	487	16	17	14	19	20	**573**
35-44	274	19	19	25	23	16	**476**
45-54	144	6	14	14	14	19	**211**
55-64	35	<5	<5	<5	5	<5	**51**
65+	9	<5	<5	<5	<5	<5	**9**
Gender							
Males	967	42	51	54	56	63	**1,233**
Females	334	17	15	14	18	9	**407**
Race/Ethnicity							
White	837	42	55	50	51	50	**1,085**
Black	424	16	11	14	22	17	**504**
Hispanic	25	<5	<5	<5	<5	<5	**32**
Asian	<5	<5	<5	<5	<5	<5	**<5**
Native Hawaiian or Pacific Islander	<5	<5	<5	<5	<5	<5	**<5**
American Indian or Alaskan Native	<5	<5	<5	<5	<5	<5	**<5**
Multiple Race	<5	<5	<5	<5	<5	<5	**<5**
Exposure Category							
Male-to-male sex (MSM)	607	34	35	42	35	39	**792**
Injection drug use (IDU)	259	<5	<5	8	6	7	**287**
MSM/IDU	51	<5	<5	<5	<5	<5	**59**
Heterosexual contact	215	10	15	9	16	8	**273**
Perinatal	10	<5	<5	<5	<5	<5	**14**
Other*/Unknown	159	12	11	7	11	15	**215**
Total	***1,301***	***59***	***66***	***68***	***74***	***72***	***1,640***

Notes. These are actual numbers of cases of HIV that were reported to the West Virginia Bureau for Public Health as of December 31, 2010. No adjustments were made for reporting delays. Numbers include persons diagnosed with HIV infection (not AIDS), HIV infection and later AIDS, and concurrent diagnoses of HIV infection and AIDS. *"Other" risk category includes hemophilia, blood transfusion, and risk not reported or not identified.

Table 1

AIDS

Number of AIDS Cases Diagnosed by Select Characteristics West Virginia 4/1984-12/2010							
Characteristic	**Cumulative through 2005 No.**	**2006 No.**	**2007 No.**	**2008 No.**	**2009 No.**	**2010 No.**	**Cumulative through 2010 No.**
Age at Diagnosis							
<13	11	<5	<5	<5	<5	<5	**11**
13-24	85	5	5	<5	<5	<5	**105**
25-34	461	9	11	11	10	8	**510**
35-44	548	23	24	24	22	8	**649**
45-54	216	21	16	13	13	13	**292**
55-64	69	<5	<5	6	5	6	**94**
65+	22	<5	<5	<5	<5	<5	**25**
Gender							
Males	1183	47	46	50	46	36	**1,408**
Females	229	15	15	7	9	3	**278**
Race/Ethnicity							
White	1,110	42	42	44	34	25	**1,297**
Black	275	18	17	7	20	12	**349**
Hispanic	19	<5	<5	<5	<5	<5	**24**
Asian	<5	<5	<5	<5	<5	<5	**<5**
Native Hawaiian or Pacific Islander	<5	<5	<5	<5	<5	<5	**<5**
American Indian or Alaskan Native	<5	<5	<5	<5	<5	<5	**<5**
Multiple Race	6	<5	<5	<5	<5	<5	**11**
Exposure Category							
Male-to-male sex (MSM)	765	33	30	31	31	25	**915**
Injection drug use (IDU)	216	10	10	10	12	2	**260**
MSM/IDU	78	<5	<5	<5	<5	<5	**85**
Heterosexual contact	161	12	15	7	9	4	**208**
Perinatal	10	<5	<5	<5	<5	<5	**12**
Other*/Unknown	182	6	5	7	<5	5	**206**
Total	***1,412***	***62***	***61***	***57***	***55***	***39***	***1,686***

Notes. These are actual numbers of cases of AIDS that were reported to the West Virginia Bureau for Public Health as of December 31, 2010. No adjustments were made for reporting delays. *"Other" risk category includes hemophilia, blood transfusion, and risk not reported or not identified.

Table 2

HIV/AIDS

Number of HIV/AIDS Cases by Select Characteristics, West Virginia 4/1984-12/2010							
Characteristic	Cumulative through 2005 No.	2006 No.	2007 No.	2008 No.	2009 No.	2010 No.	Cumulative through 2010 No.
Age at Diagnosis							
<13	19	<5	<5	<5	<5	<5	**23**
13-24	293	16	13	13	9	14	**358**
25-34	756	18	22	17	19	20	**852**
35-44	695	30	22	28	23	16	**814**
45-54	248	12	18	17	14	19	**328**
55-64	76	<5	5	<5	5	<5	**95**
65+	24	<5	<5	<5	<5	<5	**26**
Gender							
Males	1,674	59	63	65	56	63	**1,980**
Females	437	20	18	14	18	18	**516**
Race/Ethnicity§							
White	1,497	57	67	59	51	50	**1,781**
Black	559	20	13	15	22	17	**646**
Hispanic	37	<5	<5	<5	<5	<5	**45**
Asian	<5	<5	<5	<5	<5	<5	**<5**
Native Hawaiian or Pacific Islander	<5	<5	<5	<5	<5	<5	**<5**
American Indian or Alaskan Native	<5	<5	<5	<5	<5	<5	**<5**
Multiple Race	6	<5	<5	<5	<5	<5	**10**
Exposure Category							
Male-to-male sex (MSM)	1065	47	41	48	35	39	**1,275**
Injection drug use (IDU)	363	8	7	10	6	7	**401**
MSM/IDU	96	<5	<5	<5	<5	<5	**105**
Heterosexual contact	287	11	18	10	16	8	**350**
Perinatal	19	<5	<5	<5	<5	<5	**23**
Other*/Unknown	281	12	14	9	11	15	**342**
Total	***2,111***	***79***	***81***	***79***	***74***	***72***	***2,496***

Notes. These are actual numbers of cases of HIV/AIDS that were reported to the West Virginia Bureau for Public Health as of December 31, 2010. No adjustments were made for reporting delays. Numbers include persons diagnosed with HIV infection (not AIDS), HIV infection and later AIDS, and concurrent diagnoses of HIV infection and AIDS. §Excludes 4 persons of unknown race/ethnicity. *"Other" risk category includes hemophilia, blood transfusion, and risk not reported or not identified. Required HIV reporting began January, 1989.

Table 3

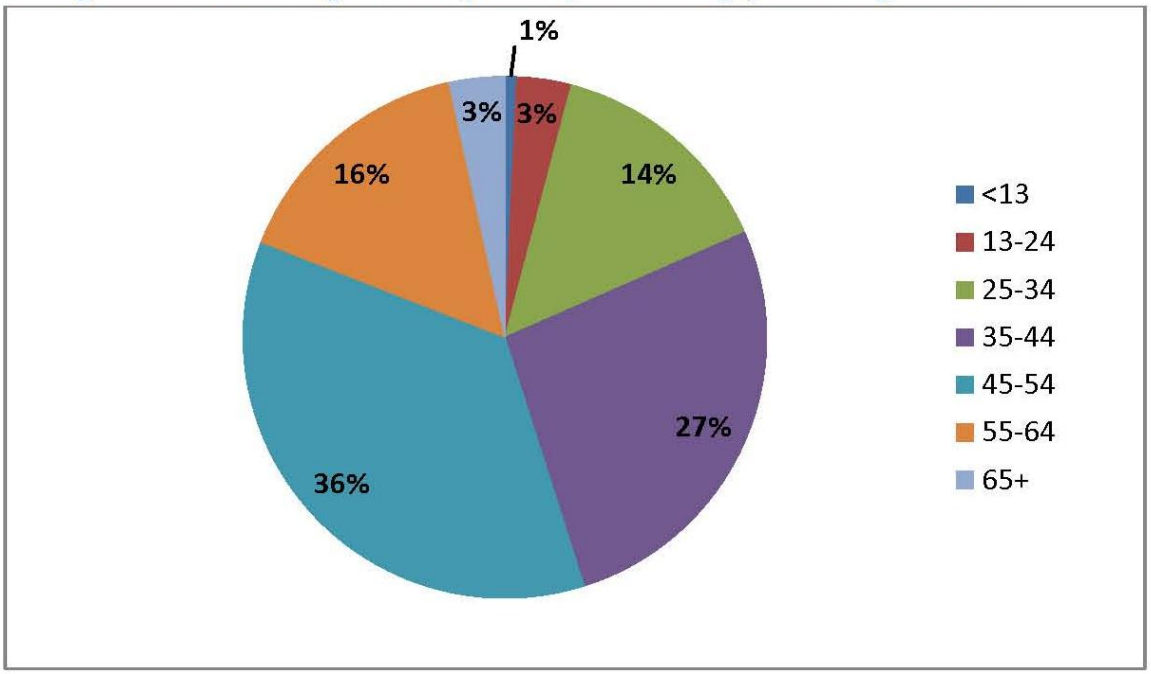
DEATHS

Deaths Among Persons with HIV/AIDS by Year of Death and Select Characteristics West Virginia 4/1984-12/2010							
Characteristic	**Cumulative deaths through 2005 No.**	**2006 No.**	**2007 No.**	**2008 No.**	**2009 No.**	**2010 No.**	**Cumulative deaths through 2010 No.**
Age at Death							
<13	6	<5	<5	<5	<5	<5	**6**
13-24	22	<5	<5	<5	<5	<5	**24**
25-34	235	<5	<5	<5	<5	<5	**245**
35-44	323	11	11	8	13	<5	**367**
45-54	146	11	16	11	8	<5	**195**
55-64	52	<5	7	11	9	<5	**85**
65+	24	<5	<5	<5	<5	<5	**31**
Gender							
Males	693	22	30	27	24	8	**804**
Females	115	6	8	9	10	<5	**149**
Race/Ethnicity							
White	645	17	28	20	19	5	**734**
Black	151	10	10	14	13	<5	**201**
Hispanic	9	<5	<5	<5	<5	<5	**10**
Asian	<5	<5	<5	<5	<5	<5	**<5**
Native Hawaiian or Pacific Islander	<5	<5	<5	<5	<5	<5	**<5**
American Indian or Alaskan Native	<5	<5	<5	<5	<5	<5	**<5**
Multiple Race	<5	<5	<5	<5	<5	<5	**6**
Exposure Category							
Male-to-male sex (MSM)	427	13	17	17	10	<5	**488**
Injection drug use (IDU)	130	10	6	6	9	<5	**161**
MSM/IDU	47	<5	<5	<5	<5	<5	**56**
Heterosexual contact	74	<5	6	6	13	<5	**101**
Perinatal	5	<5	<5	<5	<5	<5	**5**
Other*/Unknown	125	<5	5	7	<5	<5	**142**
Total	***808***	***28***	***38***	***36***	***34***	***9***	***953***

Notes. These are actual numbers of deaths and cases of HIV/AIDS that were reported to the West Virginia Bureau for Public Health as of December 31, 2010. No adjustments were made for reporting delays. Numbers include persons diagnosed with HIV infection (not AIDS), HIV infection and later AIDS, and concurrent diagnoses of HIV infection and AIDS. *"Other" risk category includes hemophilia, blood transfusion, and risk not reported or not identified.

Table 4

Percentage of Persons Living with HIV/AIDS by Current Age, West Virginia 2010



Percentage of Persons Living with HIV/AIDS by Gender, West Virginia 2010

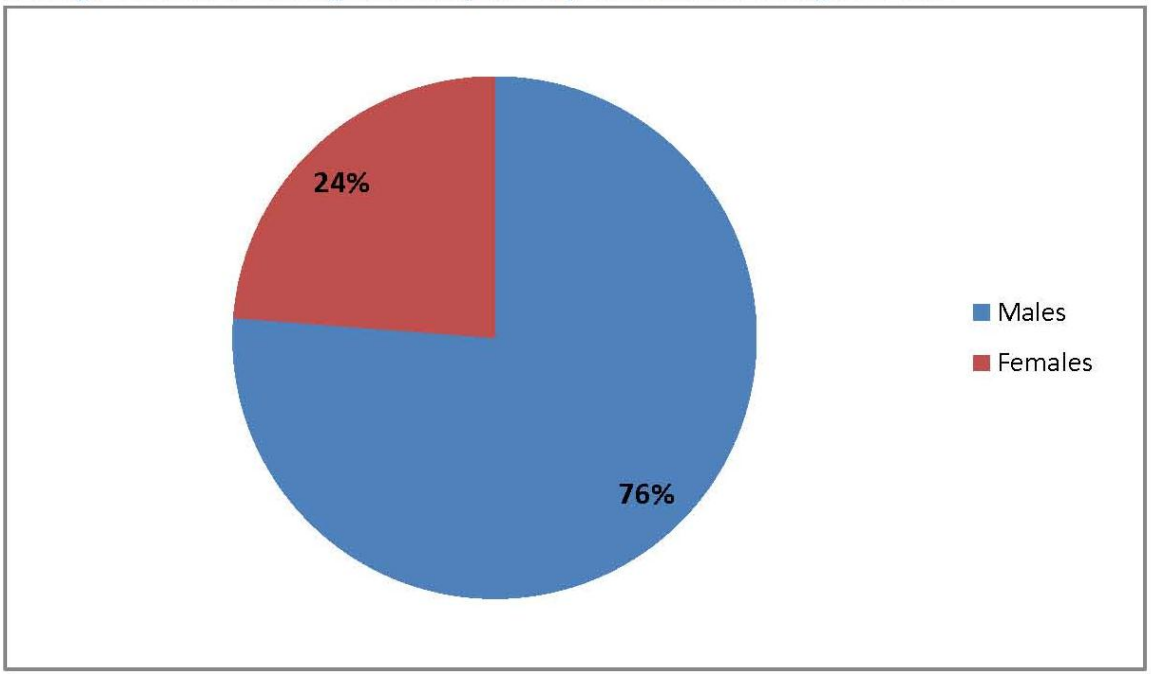
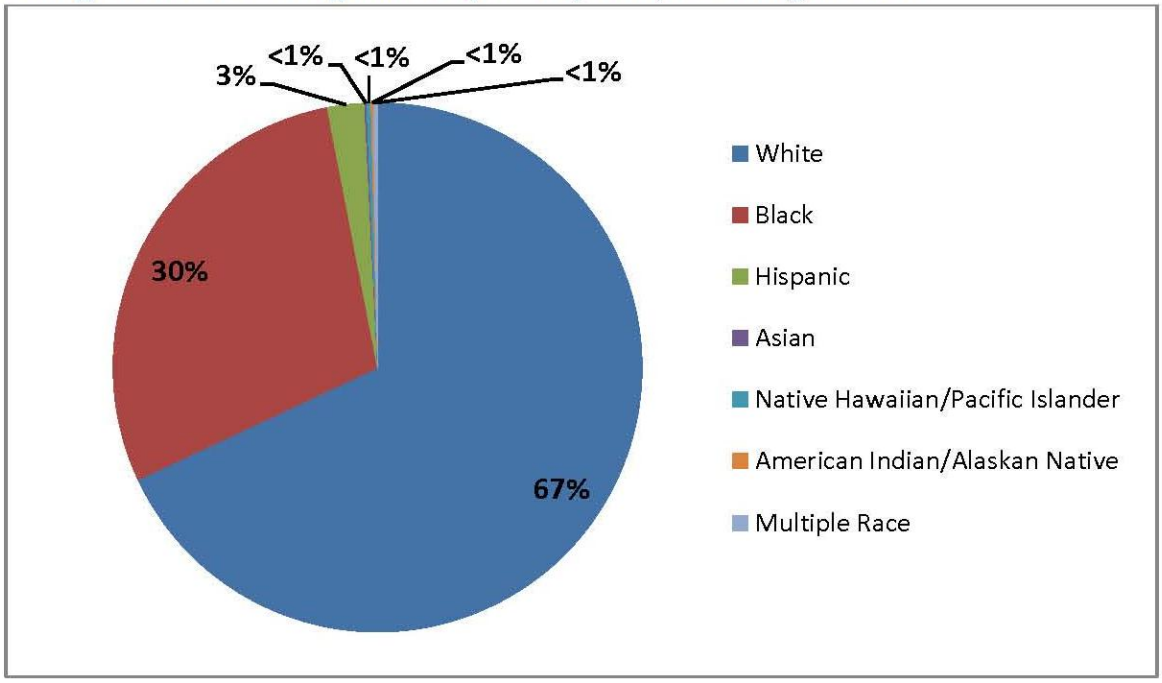


Illustration 1

Percentage of Persons Living with HIV/AIDS by Race, West Virginia 2010



Percentage of Persons Living with HIV/AIDS by Exposure Category, West Virginia 2010

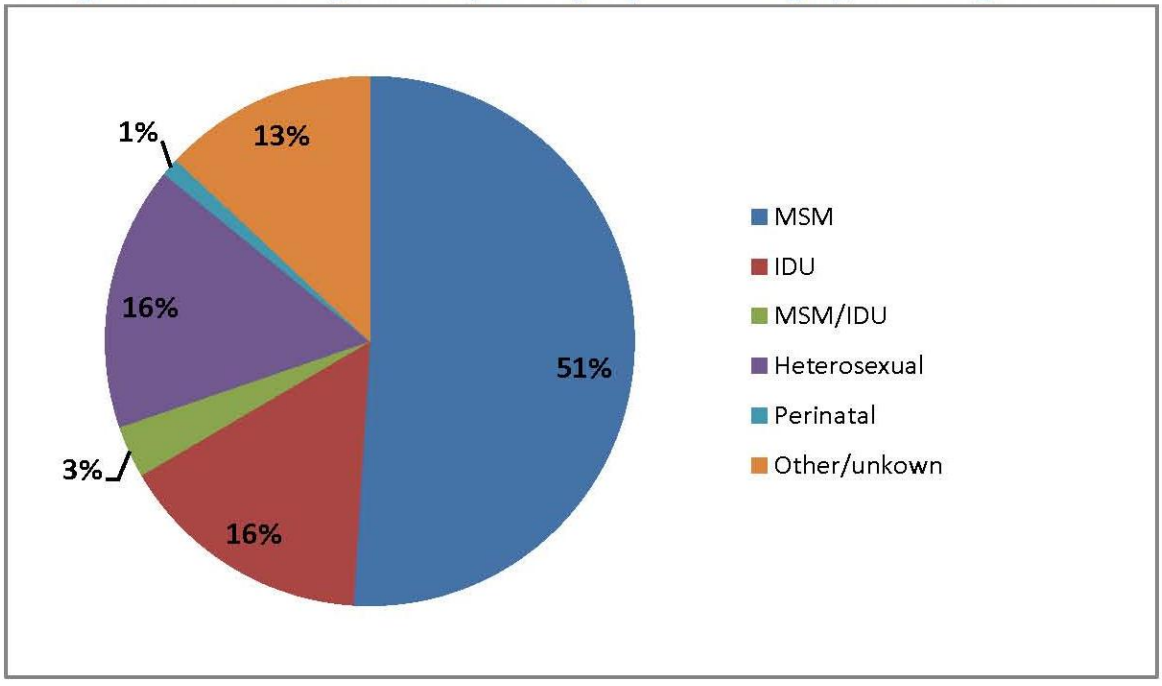


Illustration 2

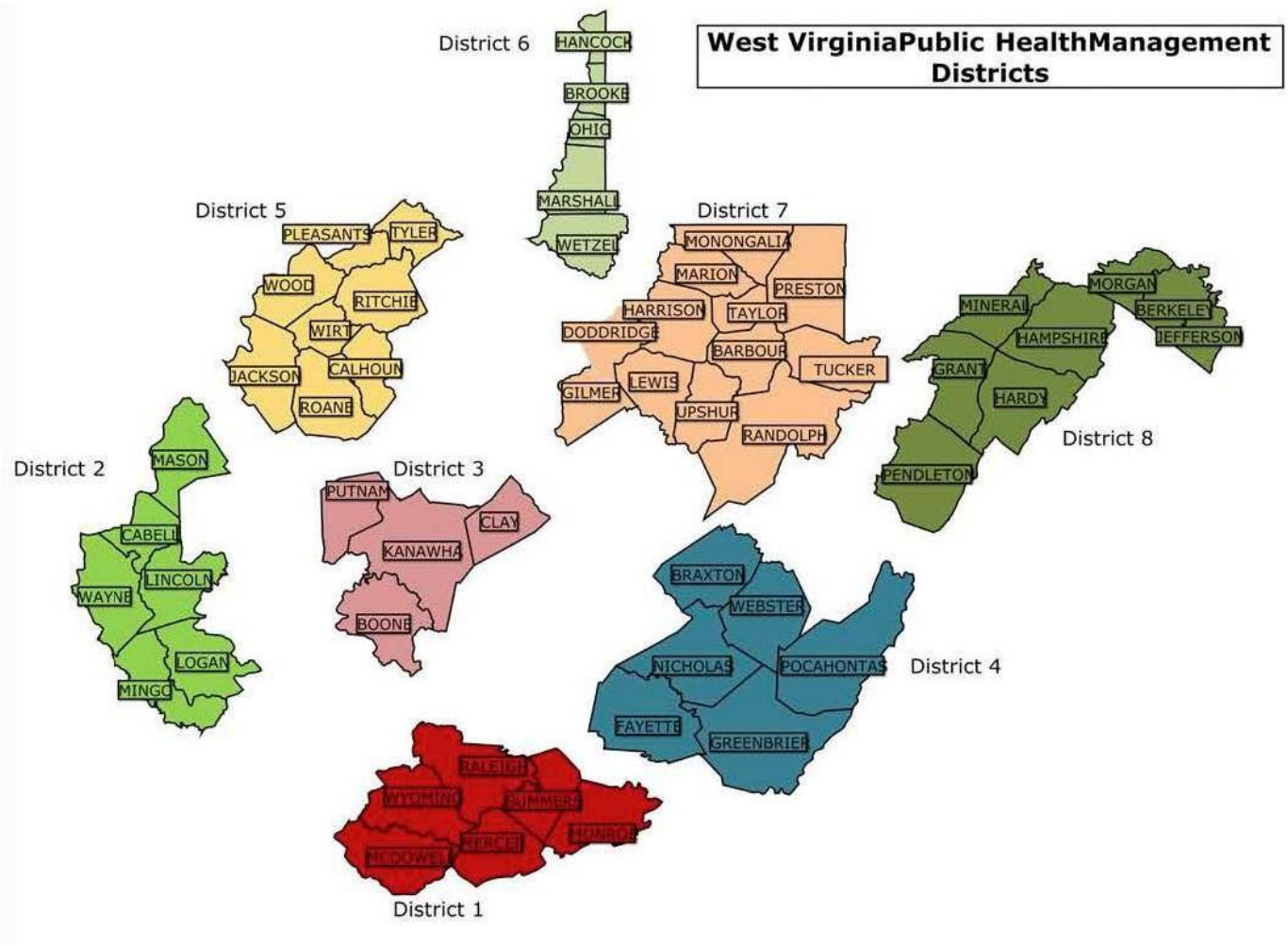


Illustration 3

Number of HIV/AIDS Cases by Public Health District, West Virginia 2010									
Characteristic	West Virginia Public Health District								
	1	2	3	4	5	6	7	8	Total
	No.	No.	No.	No.	No.	No.	No.	No.	No.
Age at Diagnosis									
<13	<5	<5	5	<5	<5	<5	<5	<5	**23**
13-24	58	54	95	16	24	11	48	52	**358**
25-34	140	150	170	48	58	63	136	87	**852**
35-44	111	104	191	51	48	63	105	141	**814**
45-54	50	32	72	20	14	27	53	60	**328**
55-64	7	15	22	6	5	6	16	18	**95**
65+	<5	<5	<5	<5	<5	<5	7	6	**26**
Gender									
Males	223	300	466	109	135	140	313	294	**1,980**
Females	148	57	91	38	18	35	56	73	**516**
Race/Ethnicity§									
White	178	302	411	103	139	155	271	222	**1,781**
Black	186	48	133	40	11	18	81	129	**646**
Hispanic	<5	<5	7	<5	<5	<5	11	14	**45**
Asian	<5	<5	<5	<5	<5	<5	<5	<5	**<5**
Native Hawaiian or Pacific Islander	<5	<5	<5	<5	<5	<5	<5	<5	**<5**
American Indian or Alaskan Native	<5	<5	<5	<5	<5	<5	<5	<5	**<5**
Multiple Race	<5	<5	<5	<5	<5	<5	<5	<5	**10**
Exposure Category									
Male-to-male sex (MSM)	119	217	340	65	98	103	171	162	**1,275**
Injection drug use (IDU)	111	37	59	30	7	16	59	82	**401**
MSM/IDU	15	21	17	6	7	7	18	14	**105**
Heterosexual contact	72	50	62	23	14	27	55	47	**350**
Perinatal	<5	<5	5	<5	<5	<5	<5	<5	**23**
Other*/Unknown	50	32	74	21	24	20	62	59	**342**
Total	***371***	***357***	***557***	***147***	***153***	***175***	***369***	***367***	***2,496***

Notes. These are actual numbers of cases of HIV/AIDS that were reported to the West Virginia Bureau for Public Health as of December 31, 2010. No adjustments were made for reporting delays. Numbers include persons diagnosed with HIV infection (not AIDS), HIV infection and later AIDS, and concurrent diagnoses of HIV infection and AIDS. §Excludes 4 persons of unknown race/ethnicity. *"Other" risk category includes hemophilia, blood transfusion, and risk not reported or not identified.

Table 5

People living with HIV/AIDS, West Virginia, December 31, 2010.

Characteristic	PLWHA*	
	Cases	Percent
Total	1887	100
Sex		
Male	1502	80
Female	385	20
Current Age Group		
< 13 years	9	0
13 – 19 years	14	1
20 – 24 years	44	2
25 – 29 years	103	5
30 – 39 years	345	18
40 – 49 years	664	35
50 – 59 years	534	28
60 and over	174	9
Race		
White	1391	74
Black	432	23
Hispanic	37	2
Asian, Hawaiian, or Pacific Islander	13	1
American Indian or Alaska Native	8	0
Other/Unknown	6	0
Transmission Category		
MSM	1021	54
IDU	250	13
MSM and IDU	83	4
Heterosexual	324	17
Perinatal	23	1
Blood Recipient	15	1
Unknown	171	9
Race x Sex		
White Male	1168	62
White Female	223	12
Black Male	291	15
Black Female	141	7
Public Health District		
District 1	208	11
District 2	243	13
District 3	445	23
District 4	113	6
District 5	124	7
District 6	123	6
District 7	312	16
District 8	319	17

Note: Percentages may not add to 100 due to rounding.

Characteristic	PLWHA*	
Race x Age group	Cases	Percent
White, < 13 years	<5	0
White, 13 – 19 years	<5	0
White, 20 – 24 years	20	1
White, 25 – 29 years	65	3
White, 30 – 39 years	252	13
White, 40 – 49 years	518	27
White, 50 – 59 years	399	21
White, 60 and over	133	7
Black, < 13 years	6	0
Black, 13 – 19 years	11	1
Black, 20 – 24 years	22	1
Black, 25 – 29 years	35	2
Black, 30 – 39 years	74	4
Black, 40 – 49 years	127	7
Black, 50 – 59 years	120	6
Black, 60 and over	37	2
Race x Transmission Category		
White, MSM	858	45
White, IDU	154	8
White, Heterosexual	181	10
White, Other/Unk.	198	10
Black, MSM	140	7
Black, IDU	86	5
Black, Heterosexual	126	7
Black, Other/Unk.	80	4
Race x Sex x Transmission Category		
White, M, MSM	858	45
White, M, IDU	99	5
White, M, Het.	41	2
White, M, Oth./Unk.	170	9
White, F, IDU	55	3
White, F, Het.	140	7
White, F, Oth./Unk.	28	1
Black, M, MSM	140	7
Black, M, IDU	57	3
Black, M, Het.	37	2
Black, M, Oth./Unk.	57	3
Black, F, IDU	29	2
Black, F, Het.	89	5
Black, F, Oth./Unk.	23	1

Table 6

Number of AIDS Cases by Public Health District, West Virginia 2010									
Characteristic	West Virginia Public Health District								
	1	2	3	4	5	6	7	8	Total
	No.	No.	No.	No.	No.	No.	No.	No.	No.
Age at Diagnosis									
<13	<5	<5	<5	<5	<5	<5	<5	<5	**11**
13-24	15	17	26	6	6	<5	18	13	**105**
25-34	68	94	107	29	41	41	78	52	**510**
35-44	74	89	163	36	39	57	89	102	**649**
45-54	38	34	70	20	11	23	44	52	**292**
55-64	6	13	22	6	5	8	11	23	**94**
65+	<5	<5	<5	<5	<5	<5	6	5	**25**
Gender									
Males	154	211	335	85	96	115	211	201	**1,408**
Females	51	39	56	18	7	24	36	47	**278**
Race/Ethnicity									
White	112	216	308	79	95	126	202	159	**1,297**
Black	88	29	75	23	6	13	38	77	**349**
Hispanic	<5	<5	<5	<5	<5	<5	<5	10	**24**
Asian	<5	<5	<5	<5	<5	<5	<5	<5	**<5**
Native Hawaiian or Pacific Islander	<5	<5	<5	<5	<5	<5	<5	<5	**<5**
American Indian or Alaskan Native	<5	<5	<5	<5	<5	<5	<5	<5	**<5**
Multiple Race	<5	<5	<5	<5	<5	<5	<5	<5	**11**
Exposure Category									
Male-to-male sex (MSM)	79	155	253	53	67	90	113	105	**915**
Injection drug use (IDU)	53	28	42	15	6	12	45	59	**260**
MSM/IDU	12	15	17	5	7	5	15	9	**85**
Heterosexual contact	30	32	44	16	5	19	29	33	**208**
Perinatal	<5	<5	<5	<5	<5	<5	<5	<5	**12**
Other*/Unknown	28	20	32	13	18	11	43	41	**206**
Total	***205***	***250***	***391***	***103***	***103***	***139***	***247***	***248***	***1,686***

Notes. These are actual numbers of cases of HIV/AIDS that were reported to the West Virginia Bureau for Public Health as of December 31, 2010. No adjustments were made for reporting delays. *"Other" risk category includes hemophilia, blood transfusion, and risk not reported or not identified.

Table 7

Excluding Federal Corrections Data

Number of HIV/AIDS by Public Health District Excluding Cases Diagnosed in Federal Prisons, West Virginia 2010									
Characteristic	West Virginia Public Health District								
	1	2	3	4	5	6	7	8	Total
	No.	No.	No.	No.	No.	No.	No.	No.	No.
Age at Diagnosis									
<13	<5	<5	5	<5	<5	<5	<5	<5	**23**
13-24	47	54	95	15	24	11	46	51	**343**
25-34	104	150	170	46	58	63	121	87	**799**
35-44	84	104	191	50	48	63	92	141	**773**
45-54	36	32	72	20	14	27	51	60	**312**
55-64	6	15	22	6	5	6	14	18	**92**
65+	<5	<5	<5	<5	<5	<5	6	6	**25**
Gender									
Males	209	300	466	109	135	140	278	293	**1,930**
Females	73	57	91	34	18	35	56	73	**437**
Race/Ethnicity									
White	175	302	411	102	139	155	268	222	**1,774**
Black	103	48	133	37	11	18	53	128	**531**
Hispanic	<5	<5	7	<5	<5	<5	7	14	**38**
Asian	<5	<5	<5	<5	<5	<5	<5	<5	**<5**
Native Hawaiian or Pacific Islander	<5	<5	<5	<5	<5	<5	<5	<5	**<5**
American Indian or Alaskan Native	<5	<5	<5	<5	<5	<5	<5	<5	**<5**
Multiple Race	<5	<5	<5	<5	<5	<5	<5	<5	**10**
Exposure Category									
Male-to-male sex (MSM)	116	217	340	65	98	103	163	161	**1,263**
Injection drug use (IDU)	64	37	59	30	7	16	46	82	**341**
MSM/IDU	15	21	17	6	7	7	16	14	**103**
Heterosexual contact	49	50	62	22	14	27	49	47	**320**
Perinatal	<5	<5	5	<5	<5	<5	<5	<5	**23**
Other*/Unknown	34	32	74	18	24	20	56	59	**317**
Total	***282***	***357***	***557***	***143***	***153***	***175***	***334***	***366***	***2,367***

Notes. These are actual numbers of cases of HIV/AIDS that were reported to the West Virginia Bureau for Public Health as of December 31, 2010. No adjustments were made for reporting delays. Numbers include persons diagnosed with HIV infection (not AIDS), HIV infection and later AIDS, and concurrent diagnoses of HIV infection and AIDS. *"Other" risk category includes hemophilia, blood transfusion, and risk not reported or not identified.

Table 8

Number of PLWHA by Public Health District Excluding Cases Diagnosed in Federal Prisons, West Virginia 2010									
Characteristic	West Virginia Public Health District								
	1	2	3	4	5	6	7	8	Total
	No.	No.	No.	No.	No.	No.	No.	No.	No.
Current Age									
<13	<5	<5	<5	<5	<5	<5	<5	<5	**11**
13-24	6	9	14	<5	<5	<5	7	10	**52**
25-34	23	31	49	15	18	8	36	29	**210**
35-44	44	64	97	23	22	22	56	51	**379**
45-54	66	63	129	28	33	35	78	76	**508**
55-64	19	24	46	12	12	25	33	56	**227**
65+	<5	10	11	<5	<5	<5	10	9	**51**
Gender									
Males	108	163	285	60	78	76	182	187	**1,139**
Females	56	38	64	23	13	20	41	45	**299**
Race/Ethnicity									
White	99	171	255	53	80	82	167	131	**1,038**
Black	64	25	85	27	8	12	42	90	**353**
Hispanic	<5	<5	5	<5	<5	<5	9	10	**31**
Asian	<5	<5	<5	<5	<5	<5	<5	<5	**<5**
Native Hawaiian or Pacific Islander	<5	<5	<5	<5	<5	<5	<5	<5	**<5**
American Indian or Alaskan Native	<5	<5	<5	<5	<5	<5	<5	<5	**<5**
Multiple Race	<5	<5	<5	<5	<5	<5	<5	<5	**<5**
Exposure Category									
Male-to-male sex (MSM)	71	117	212	39	61	55	117	107	**779**
Injection drug use (IDU)	40	21	28	17	5	8	22	52	**193**
MSM/IDU	<5	7	8	<5	<5	5	10	8	**47**
Heterosexual contact	30	37	47	13	10	18	40	28	**223**
Perinatal	<5	<5	<5	<5	<5	<5	<5	<5	**18**
Other*/Unknown	16	19	51	9	9	10	29	35	**178**
Total	***164***	***201***	***349***	***83***	***91***	***96***	***222***	***232***	***1,438***

Notes. Estimated number of Persons living with HIV or AIDS as of December 31, 2010. No adjustments were made for reporting delays. Numbers include persons diagnosed with HIV infection (not AIDS), HIV infection and later AIDS, and concurrent diagnoses of HIV infection and AIDS. *"Other" risk category includes hemophilia, blood transfusion, and risk not reported or not identified.

Table 9

Unmet Need

Each year, the state conducts a study to identify PLWHA who know their status and are not receiving HIV treatment and care services. The study's results are utilized to inform policy and resource allocation decisions related to HIV services in WV. As a requirement of the Ryan White Treatment Modernization Act, the unmet need estimate requires that the states determine the unmet need and service gaps through an established formula and established definitions of "in care". This study, in conjunction with the state's epidemiological profile, needs assessment data and other survey instruments, is utilized by the state to enhance access to HIV related services for PLWHA who are not in care.

The WV unmet need framework is based on the Louisiana model presented at the HRSA Unmet Need training during the summer of 2003. WV has mandatory laboratory reporting for CD4 counts and for viral loads. In addition, the surveillance program collaborates closely with WVRWPBP medical case managers who are able to report on their clients' antiretroviral activity.

The State Direct Services provider pays for Medicaid, Medicare and insurance co-pays for antiretrovirals and manages the ADAP data and thus has extensive access to records of antiretroviral activity. The WV framework relies on AIDS surveillance that was initiated in WV in 1984 and confidential name-based HIV reporting initiated in 1989. All AIDS and HIV cases are reported to the expanded HIV/AIDS Reporting System (eHARS). The framework chosen has been deemed the most reliable source for estimating unmet need in WV.

WV approached the RW HIV/AIDS Treatment Modernization Act Unmet Need requirements by developing two objectives for the state's unmet need framework:

1. To meet or exceed the legislative requirements for estimating unmet need for PLWHA in WV
2. To develop data that will enhance the state's HIV care planning and decision making process for increasing the number of PLWHA in WV who enter and remain in primary care

WV utilized the HRSA/HAB Unmet Need Framework. The only exclusions for data consideration were the federal correctional cases and those PLWHA who were documented as having moved out of state. Those who met the "in care" definition include:

- PLWHA who had at least one care-related laboratory test in calendar year 2010. These tests include CD 4 or a HIV viral load.
- PLWHA who had antiretroviral activity in calendar year 2010

For purposes of examining the unmet need in WV, distinct populations were examined to estimate the state's "in care" population. The HIV+ population (PLWH) and AIDS diagnosed population (PLWA) comprised the two base populations. Those living with HIV or AIDS were counted only if they were part of the state's expanded HIV/AIDS Reporting System (eHARS). For each population, verification of "being in care" was entered, if present, for each case. The calendar year 2010 care pattern activity was utilized as the twelve month period for estimating the state's unmet need. The 2010 Unmet Need Estimate is based on no evidence of any of the three components of HIV primary care (CD4, viral load or provision of antiretroviral therapy).

The WVRWPBP medical case managers play a crucial role in assisting the surveillance program in identifying the met need for the Unmet Need Framework. Their records for antiretroviral activity and care patterns for those who seek care outside the state and at VA hospitals assist the state in documenting met need.

Evidence of the 2010 care patterns was collected through the use of mandatory HIV viral load reporting and mandatory CD 4 count reporting. The state has implemented the requirement for mandatory reporting of all CD 4 counts. However, not all laboratories have become completely compliant with the regulation. Laboratory reporting in WV is an effective method for ensuring the inclusion of information that is sometimes difficult to obtain from other sources, especially when persons may be receiving care at privately funded providers. Lab reports are received confidentially by the surveillance staff at the Division of STD, HIV and Hepatitis. Client chart reviews supplement the lab reports. In addition, some laboratory reports were provided by the medical case management staff.

Antiretroviral activity for PLWHA in WV is confidentially reported to the surveillance staff through ADAP reports and medical case management records of the WVRWPBP which include Medicaid and private insurance data. Antiretroviral activity is monitored by the WVRWPBP medical case managers in CAREWare.

The WV Unmet Need Estimate has some limitations that inhibit the complete accuracy of the analysis. While the current state statute requires that CD 4 reporting is mandated for all counts, not all laboratories are in complete compliance. As a result, some CD 4 counts are not reported to the state. This problem is most prevalent with out of state providers. This limitation is lessened by a mandatory reporting of all viral loads, but again not all laboratories are compliant. In addition, federal facilities, such as the VA, are exempt from the statute. The state's Surveillance Program has made an effort to collaborate with the VA Medical System to collect the laboratory reports. The state is also aware that some of the earliest reported cases in the eHARS data base have either moved out of state or are possibly deceased, but the state is unaware of their status, while reporting them as unmet need. The eHARS data utilized for conducting the Unmet Need calculation has been adjusted to allow for the deletion of federal correctional facility cases and the deletion of cases known to have moved away from WV.

The state's eight public health districts have been ranked ranging from District 3 and 8 with 22 and 24% of the state's unmet need to District 4, a more rural region of the state, with 4% of the state's unmet need. The three highest ranked districts in the state for unmet need included two districts where Part C clinics are housed and the Part A region. In addition, the three regions account for 62% of the state's PLWHA unmet need.

The state is continuing to conduct additional analysis of the 2010 Estimate of Unmet Need. The planned analysis includes identifying the service needs, gaps and barriers to care for those with unmet need. Strategies developed to date, to find people who are aware of their status, but not in care, include outreach to emergency rooms, homeless shelters, food stamp offices, soup kitchens, food pantries, mental health centers, corrections, substance abuse treatment programs and public housing programs. Collaboration has also been established with the state's HIV prevention programs in order to strengthen the link between prevention and care. Brochures and posters were developed and are being widely distributed to promote entry and retention in HIV primary care. The Surveillance program has also integrated the care and treatment brochures into their standardized packet for providers who are points of entry into the HIV care system.

As the state conducts the additional analysis of the demographic information created thus far, the state will seek to determine how those not receiving care are similar or different than those currently in care. Through a thorough review of determining whether those out of care in the eight public health districts are a particular gender, race or transmission group in the respective public health districts, the state will be better able to target outreach and identify and remove the barriers to care by region and/or population. In addition, the state will look at dates of diagnosis in order to identify trends in entry and retention in care and treatment.

The state is also collaborating with the Part C clinics to identify and locate those who know their status, but are not in care. Particular attention will be devoted to specific counties of districts with a high unmet need in order to ascertain if the lack of transportation or infrastructure contributes to the unmet need. In collaboration with the Part C clinics, the Part B program is conducting a review of all existing client files for identifying those who were formerly in care. The WV Part C clinics conduct reviews of patients lost to care. Afterwards, the clinic staff review the names of the clients, not adherent to care, with the Part B medical case manager assigned to the respective region.

The Part B program has strengthened the collaboration with the state's DIS staff to discuss strategies for ensuring that newly identified positives successfully follow through with referrals to primary care. The DIS staff is an integral part of the outreach to those who have never entered care, as they are the only arm of the state's program that has had a face to face interview with the clients after they learned their HIV status. The DIS staff also plays a significant part of the state's implementation plan for rapid testing in WV.

Analysis of the unmet need data for PLWHA has revealed a disproportionate percentage of blacks with an unmet need. While 22% of the state's adjusted PLWHA population on 12/31/10 was black; 30% had an unmet need. This was most disproportionate in districts one, three, seven and eight. MSM, as a statewide group, had lower unmet need, IDU, heterosexual contact and non-identified risk each had a slightly greater unmet need than their percentage of the base population. All age groups had little significant difference in unmet need when compared to their percentage of the base population. Males and females with unmet need were in proportion to their percentages of the base population on 12/31/10.

The additional analysis of the unmet need data, scheduled for early summer 2012, will provide vital information for fine tuning the strategies for outreach to those who know their status, but are not in care. The further review of risk factors by race, gender, age and year of diagnosis will assist the state in revising previously identified strategies and in collaborating with Part C clinics to target those who were formerly in care or those who have never entered HIV primary care.

2010 Unmet Need Framework Report

2010 West Virginia Unmet Need Analysis Results

Population	Value	Data Source
A. Number of persons living with AIDS as of 12/31/10	961	WV HARS
B. Number of persons living with HIV (non-AIDS) as of 12/31/10	595	WV HARS
Care Patterns		
C. Number of PLWA who had CD4/ viral load or ART in 2010	675	WV Laboratory Care Charts/ADAP
D. Number of PLWH who had CD4/ viral load or ART in 2010	370	WV Laboratory Care Charts/ADAP
Calculated Results		
E. Number of PLWA who did not receive specified primary medical care services	286	(29.76%) A-C
F. Number of PLWH who did not receive specified primary medical care services	225	(37.81%) B-D
G. Total PLWHA not receiving specified primary medical care services	511	(32.84%) E+F
Total PLWHA Cases from HARS for WV as of 12/31/10	**1556**	A+B
Met Need	**1045**	**(67.16)**
Unmet Need for HIV/AIDS	**511**	**(32.84%)**

Illustration 4

West Virginia People Living with AIDS (PLWA) Cases Comparison by Public Health District, Age Group, Gender, Race, and Risk Behavior 04/01/1984 - 12/31/2010																		
Characteristic	Dist 1		Dist 2		Dist 3		Dist 4		Dist 5		Dist 6		Dist 7		Dist 8		PLWHA	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Age Group																		
Under 2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2-12	1	1	0	0	0	0	0	0	0	0	0	0	1	1	0	0	2	0
13-19	1	1	1	1	1	0	2	3	0	0	0	0	0	0	0	0	5	1
20-29	5	5	3	3	6	3	4	7	1	2	1	1	8	5	7	4	35	4
30-39	14	14	17	16	30	13	8	13	9	16	5	7	30	18	18	11	131	14
40-49	41	42	35	33	94	40	23	38	24	41	24	36	59	35	59	35	359	37
50+	35	36	50	47	104	44	23	38	24	41	37	55	70	42	86	51	429	45
Total	**97**	**100**	**106**	**100**	**235**	**100**	**60**	**100**	**58**	**100**	**67**	**100**	**168**	**100**	**170**	**100**	**961**	**100**
Gender																		
Male	73	75	91	86	197	84	47	78	53	91	56	84	145	86	140	82	802	83
Female	24	25	15	14	38	16	13	22	5	9	11	16	23	14	30	18	159	17
Total	**97**	**100**	**106**	**100**	**235**	**100**	**60**	**100**	**58**	**100**	**67**	**100**	**168**	**100**	**170**	**100**	**961**	**100**
Race																		
White	66	68	91	86	179	76	42	70	51	88	56	84	134	80	97	57	716	75
Black	28	29	12	11	46	20	16	27	4	7	9	13	26	15	66	39	207	22
Other/Unknown	3	3	3	3	10	4	2	3	3	5	2	3	8	5	7	4	38	4
Total	**97**	**100**	**106**	**100**	**235**	**100**	**60**	**100**	**58**	**100**	**67**	**100**	**168**	**100**	**170**	**100**	**961**	**100**
Risk Behavior																		
MSM	50	52	65	61	154	66	33	55	38	66	43	64	103	61	72	42	558	58
IDU	22	23	15	14	19	8	10	17	7	12	8	12	18	11	41	24	140	15
MSM/IDU	4	4	8	8	10	4	5	8	3	5	1	1	8	5	6	4	45	5
Hetero. Contact	13	13	14	13	35	15	6	10	5	9	13	19	21	13	29	17	136	14
Transfusion	2	2	1	1	2	1	1	2	3	5	0	0	1	1	0	0	10	1
NIR*/Other	3	3	3	3	14	6	3	5	2	3	2	3	15	9	21	12	63	7
Pediatric	3	3	0	0	1	0	2	3	0	0	0	0	2	1	1	1	9	1
TOTAL CASES	**97**	**100**	**106**	**100**	**235**	**100**	**60**	**100**	**58**	**100**	**67**	**100**	**168**	**100**	**170**	**100**	**961**	**100**
% PLWA	**10**		**11**		**24**		**6**		**6**		**7**		**17**		**18**		**100**	
% of Population	**12**		**14**		**15**		**8**		**9**		**8**		**21**		**14**		**100**	

***** No Identified risk

Illustration 5

West Virginia People Living with HIV(PLWH) Infection Cases Comparison by Public Health District, Age Group, Gender, Race, and Risk Behavior 01/01/1989 - 12/31/2010																		
Characteristic	**Dist 1**		**Dist 2**		**Dist 3**		**Dist 4**		**Dist 5**		**Dist 6**		**Dist 7**		**Dist 8**		**PLWH**	
	#	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**
Age Group																		
Under 2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2-12	1	2	0	0	2	1	0	0	1	2	0	0	1	1	0	0	5	1
13-19	0	0	1	1	1	1	0	0	0	0	0	0	2	2	4	4	8	1
20-29	11	22	13	14	31	22	2	6	5	10	2	6	9	9	9	9	82	14
30-39	8	16	26	29	36	25	15	48	14	29	3	10	25	25	23	23	150	25
40-49	17	34	29	32	44	31	8	26	18	37	13	42	34	34	21	21	184	31
50+	13	26	22	24	30	21	6	19	11	22	13	42	29	29	42	42	166	28
Total	**50**	**100**	**91**	**100**	**144**	**100**	**31**	**100**	**49**	**100**	**31**	**100**	**100**	**100**	**99**	**100**	**595**	**100**
Gender																		
Male	33	66	64	70	111	77	24	77	40	82	21	68	72	72	66	67	431	72
Female	17	34	27	30	33	23	7	23	9	18	10	32	28	28	33	33	164	28
Total	**50**	**100**	**91**	**100**	**144**	**100**	**31**	**100**	**49**	**100**	**31**	**100**	**100**	**100**	**99**	**100**	**595**	**100**
Race																		
White	37	74	79	87	98	68	25	81	44	90	25	81	81	81	55	56	444	75
Black	13	26	12	13	45	31	5	16	5	10	4	13	12	12	40	40	136	23
Other/Unknown	0	0	0	0	1	1	1	3	0	0	2	6	7	7	4	4	15	3
Total	**50**	**100**	**91**	**100**	**144**	**100**	**31**	**100**	**49**	**100**	**31**	**100**	**100**	**100**	**99**	**100**	**595**	**100**
Risk Behavior																		
MSM	23	46	43	47	86	60	15	48	32	65	10	32	50	50	43	43	302	51
IDU	4	8	7	8	11	8	6	19	2	4	5	16	12	12	16	16	63	11
MSM/IDU	0	0	4	4	1	1	2	6	1	2	1	3	8	8	0	0	17	3
Hetero. Contact	17	34	26	29	28	19	4	13	11	22	8	26	20	20	26	26	140	24
Transfusion	0	0	1	1	0	0	0	0	0	0	1	3	0	0	0	0	2	0
NIR*/Other	5	10	9	10	15	10	4	13	2	4	6	19	7	7	11	11	59	10
Pediatric	1	2	1	1	3	2	0	0	1	2	0	0	3	3	3	3	12	2
Total	**50**	**100**	**91**	**100**	**144**	**100**	**31**	**100**	**49**	**100**	**31**	**100**	**100**	**100**	**99**	**100**	**595**	**100**
% PLWH	**8**		**15**		**24**		**5**		**8**		**5**		**17**		**17**		**100**	
% Population	**12**		**14**		**15**		**8**		**9**		**8**		**21**		**14**		**100**	

***** No Identified risk

Illustration 6

West Virginia People Living with HIV/AIDS (PLWHA) Cases Comparison by Public Health District, Age Group, Gender, Race, and Risk Behavior AIDS 04/01/1984 - 12/31/2010, HIV 01/01/1989 - 12/31/2010																		
Characteristic	Dist 1		Dist 2		Dist 3		Dist 4		Dist 5		Dist 6		Dist 7		Dist 8		PLWHA	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Age Group																		
Under 2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2-12	2	1	0	0	2	1	0	0	1	1	0	0	2	1	0	0	7	0
13-19	1	1	2	1	2	1	2	2	0	0	0	0	2	1	4	1	13	1
20-29	16	11	16	8	37	10	6	7	6	6	3	3	17	6	16	6	117	8
30-39	22	15	43	22	66	17	23	25	23	21	8	8	55	21	41	15	281	18
40-49	58	39	64	32	138	36	31	34	42	39	37	38	93	35	80	30	543	35
50+	48	33	72	37	134	35	29	32	35	33	50	51	99	37	128	48	595	38
Total	**147**	**100**	**197**	**100**	**379**	**100**	**91**	**100**	**107**	**100**	**98**	**100**	**268**	**100**	**269**	**100**	**1556**	**100**
Gender																		
Male	106	72	155	79	308	81	71	78	93	87	77	79	217	81	206	77	1233	79
Female	41	28	42	21	71	19	20	22	14	13	21	21	51	19	63	23	323	21
Total	**147**	**100**	**197**	**100**	**379**	**100**	**91**	**100**	**107**	**100**	**98**	**100**	**268**	**100**	**269**	**100**	**1556**	**100**
Race																		
White	103	70	170	86	277	73	67	74	95	89	81	83	215	80	152	57	1160	75
Black	41	28	24	12	91	24	21	23	9	8	13	13	38	14	106	39	343	22
Other/Unknown	3	2	3	2	11	3	3	3	3	3	4	4	15	6	11	4	53	3
Total	**147**	**100**	**197**	**100**	**379**	**100**	**91**	**100**	**107**	**100**	**98**	**100**	**268**	**100**	**269**	**100**	**1556**	**100**
Risk Behavior																		
MSM	73	50	108	55	240	63	48	53	70	65	53	54	153	57	115	43	860	55
IDU	26	18	22	11	30	8	16	18	9	8	13	13	30	11	57	21	203	13
MSM/IDU	4	3	12	6	11	3	7	8	4	4	2	2	16	6	6	2	62	4
Hetero. Contact	30	20	40	20	63	17	10	11	16	15	21	21	41	15	55	20	276	18
Transfusion	2	1	2	1	2	1	1	1	3	3	1	1	1	0	0	0	12	1
NIR*/Other	8	5	12	6	29	8	7	8	4	4	8	8	22	8	32	12	122	8
Pediatric	4	3	1	1	4	1	2	2	1	1	0	0	5	2	4	1	21	1
Total	**147**	**100**	**197**	**100**	**379**	**100**	**91**	**100**	**107**	**100**	**98**	**100**	**268**	**100**	**269**	**100**	**1556**	**100**
TOTAL CASES	**147**		**197**		**379**		**91**		**107**		**98**		**268**		**269**		**1556**	
% PLWHA	**9**		**13**		**24**		**6**		**7**		**6**		**17**		**17**		**100**	
% of Population	**12**		**14**		**15**		**8**		**9**		**8**		**21**		**14**		**100**	

Illustration 7

West Virginia Unmet Needs for People Living with AIDS (PLWA) Cases Comparison by Public Health District, Age Group, Gender, Race, and Risk Behavior 04/01/1984 - 12/31/2010																		
Characteristic	Dist 1		Dist 2		Dist 3		Dist 4		Dist 5		Dist 6		Dist 7		Dist 8		PLWH	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Age Group																		
Under 5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
5-12	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
13-19	0	0	0	0	1	2	0	0	0	0	0	0	0	0	0	0	1	0
20-29	0	0	1	4	2	3	0	0	1	5	0	0	2	4	2	3	8	3
30-39	1	7	7	29	7	12	3	23	0	0	2	6	8	16	9	12	37	13
40-49	8	53	9	38	25	42	5	38	9	47	13	42	20	39	28	38	117	41
50+	6	40	7	29	25	42	5	38	9	47	16	52	21	41	34	47	123	43
Total	**15**	**100**	**24**	**100**	**60**	**100**	**13**	**100**	**19**	**100**	**31**	**100**	**51**	**100**	**73**	**100**	**286**	**100**
Gender																		
Male	11	73	19	79	49	82	9	69	18	95	29	94	41	80	60	82	236	83
Female	4	27	5	21	11	18	4	31	1	5	2	6	10	20	13	18	50	17
Total	**15**	**100**	**24**	**100**	**60**	**100**	**13**	**100**	**19**	**100**	**31**	**100**	**51**	**100**	**73**	**100**	**286**	**100**
Race																		
White	10	67	19	79	38	63	10	77	19	100	25	81	35	69	40	55	196	69
Black	4	27	4	17	20	33	3	23	0	0	4	13	10	20	32	44	77	27
Other/Unknown	1	7	1	4	2	3	0	0	0	0	2	6	6	12	1	1	13	5
Total	**15**	**100**	**24**	**100**	**60**	**100**	**13**	**100**	**19**	**100**	**31**	**100**	**51**	**100**	**73**	**100**	**286**	**100**
Risk Behavior																		
MSM	9	60	10	42	33	55	5	38	15	79	22	71	22	43	26	36	142	50
IDU	4	27	8	33	7	12	3	23	1	5	3	10	9	18	15	21	50	17
MSM/IDU	0	0	2	8	5	8	2	15	0	0	1	3	2	4	3	4	15	5
Hetero. Contact	1	7	3	13	10	17	3	23	1	5	4	13	11	22	17	23	50	17
Transfusion	1	7	1	4	0	0	0	0	1	5	0	0	0	0	0	0	3	1
NIR*/Other	0	0	0	0	5	8	0	0	1	5	1	3	7	14	12	16	26	9
Pediatric	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**15**	**100**	**24**	**100**	**60**	**100**	**13**	**100**	**19**	**100**	**31**	**100**	**51**	**100**	**73**	**100**	**286**	**100**
% UN	**5**		**8**		**21**		**5**		**7**		**11**		**18**		**26**		**100**	
% Population	**12**		**14**		**15**		**8**		**9**		**8**		**21**		**14**		**100**	

Illustration 8

West Virginia Unmet Needs for People Living with HIV(PLWH) Infection Cases Comparison by Public Health District, Age Group, Gender, Race, and Risk Behavior 01/01/1989 - 12/31/2010																		
Characteristic	Dist 1		Dist 2		Dist 3		Dist 4		Dist 5		Dist 6		Dist 7		Dist 8		PLWH	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Age Group																		
Under 2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2-12	1	7	0	0	1	2	0	0	1	5	0	0	0	0	0	0	3	1
13-19	0	0	1	3	0	0	0	0	0	0	0	0	0	0	3	6	4	2
20-29	3	20	6	19	14	28	0	0	3	14	1	6	2	6	6	12	35	16
30-39	1	7	11	35	13	26	4	50	6	27	2	11	7	22	10	20	54	24
40-49	7	47	6	19	10	20	2	25	6	27	7	39	13	41	10	20	61	27
50+	3	20	7	23	12	24	2	25	6	27	8	44	10	31	20	41	68	30
Total	**15**	**100**	**31**	**100**	**50**	**100**	**8**	**100**	**22**	**100**	**18**	**100**	**32**	**100**	**49**	**100**	**225**	**100**
Gender																		
Male	10	67	24	77	41	82	6	75	18	82	11	61	27	84	35	71	172	76
Female	5	33	7	23	9	18	2	25	4	18	7	39	5	16	14	29	53	24
Total	**15**	**100**	**31**	**100**	**50**	**100**	**8**	**100**	**22**	**100**	**18**	**100**	**32**	**100**	**49**	**100**	**225**	**100**
Race																		
White	9	60	24	77	28	56	6	75	17	77	12	67	25	78	22	45	143	64
Black	6	40	7	23	21	42	2	25	5	23	4	22	4	13	25	51	74	33
Other/Unknown	0	0	0	0	1	2	0	0	0	0	2	11	3	9	2	4	8	4
Total	**15**	**100**	**31**	**100**	**50**	**100**	**8**	**100**	**22**	**100**	**18**	**100**	**32**	**100**	**49**	**100**	**225**	**100**
Risk Behavior																		
MSM	3	20	15	48	25	50	3	38	12	55	3	17	20	63	20	41	101	45
IDU	2	13	4	13	5	10	2	25	2	9	4	22	3	9	8	16	30	13
MSM/IDU	0	0	0	0	0	0	1	13	1	5	1	6	1	3	0	0	4	2
Hetero. Contact	6	40	8	26	11	22	0	0	4	18	5	28	4	13	11	22	49	22
Transfusion	0	0	1	3	0	0	0	0	0	0	0	0	0	0	0	0	1	0
NIR*/Other	3	20	2	6	8	16	2	25	2	9	5	28	4	13	7	14	33	15
Pediatric	1	7	1	3	1	2	0	0	1	5	0	0	0	0	3	6	7	3
Total	**15**	**100**	**31**	**100**	**50**	**100**	**8**	**100**	**22**	**100**	**18**	**100**	**32**	**100**	**49**	**100**	**225**	**100**
% UN **	**7**		**14**		**22**		**4**		**10**		**8**		**14**		**22**		**100**	
% Population	**12**		**14**		**15**		**8**		**9**		**8**		**21**		**14**		**100**	

Illustration 9

West Virginia Unmet Needs for People Living with HIV/AIDS (PLWHA) Cases Comparison by Public Health District, Age Group, Gender, Race, and Risk Behavior AIDS 04/01/1984 - 12/31/2010, HIV 01/01/1989 - 12/31/2010																		
Characteristic	Dist 1		Dist 2		Dist 3		Dist 4		Dist 5		Dist 6		Dist 7		Dist 8		PLWHA	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Age Group																		
Under 5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
5-12	1	3	0	0	1	1	0	0	1	2	0	0	0	0	0	0	3	1
13-19	0	0	1	2	1	1	0	0	0	0	0	0	0	0	3	2	5	1
20-29	3	10	7	13	16	15	0	0	4	10	1	2	4	5	8	7	43	8
30-39	2	7	18	33	20	18	7	33	6	15	4	8	15	18	19	16	91	18
40-49	15	50	15	27	35	32	7	33	15	37	20	41	33	40	38	31	178	35
50+	9	30	14	25	37	34	7	33	15	37	24	49	31	37	54	44	191	37
Total	**30**	**100**	**55**	**100**	**110**	**100**	**21**	**100**	**41**	**100**	**49**	**100**	**83**	**100**	**122**	**100**	**511**	**100**
Gender																		
Male	21	70	43	78	90	82	15	71	36	88	40	82	68	82	95	78	408	80
Female	9	30	12	22	20	18	6	29	5	12	9	18	15	18	27	22	103	20
Total	**30**	**100**	**55**	**100**	**110**	**100**	**21**	**100**	**41**	**100**	**49**	**100**	**83**	**100**	**122**	**100**	**511**	**100**
Race																		
White	19	63	43	78	66	60	16	76	36	88	37	76	60	72	62	51	339	66
Black	10	33	11	20	41	37	5	24	5	12	8	16	14	17	57	47	151	30
Other/Unknown	1	3	1	2	3	3	0	0	0	0	4	8	9	11	3	2	21	4
Total	**30**	**100**	**55**	**100**	**110**	**100**	**21**	**100**	**41**	**100**	**49**	**100**	**83**	**100**	**122**	**100**	**511**	**100**
Risk Behavior																		
MSM	12	40	25	45	58	53	8	38	27	66	25	51	42	51	46	38	243	48
IDU	6	20	12	22	12	11	5	24	3	7	7	14	12	14	23	19	80	16
MSM/IDU	0	0	2	4	5	5	3	14	1	2	2	4	3	4	3	2	19	4
Hetero. Contact	7	23	11	20	21	19	3	14	5	12	9	18	15	18	28	23	99	19
Transfusion	1	3	2	4	0	0	0	0	1	2	0	0	0	0	0	0	4	1
NIR*/Other	3	10	2	4	13	12	2	10	3	7	6	12	11	13	19	16	59	12
Pediatric	1	3	1	2	1	1	0	0	1	2	0	0	0	0	3	2	7	1
Total	**30**	**100**	**55**	**100**	**110**	**100**	**21**	**100**	**41**	**100**	**49**	**100**	**83**	**100**	**122**	**100**	**511**	**100**
TOTAL CASES	**30**		**55**		**110**		**21**		**41**		**49**		**83**		**122**		**511**	
% UN	**6**		**11**		**22**		**4**		**8**		**10**		**16**		**24**		**100**	
% of Population	**12**		**14**		**15**		**8**		**9**		**8**		**21**		**14**		**100**	

Illustration 10

West Virginia People Living with HIV/AIDS(PLWHA) and Unmet Needs Cases Comparison by Public Health District, Age Group, Gender, Race, and Risk Behavior AIDS 04/01/1984 - 12/31/2010, HIV 01/01/1989 - 12/31/2010																		
Characteristic	Dist 1		Dist 2		Dist 3		Dist 4		Dist 5		Dist 6		Dist 7		Dist 8		Total	
	# ^	UN	#	UN	#	UN	#	UN	#	UN	#	UN	#	UN	#	UN	#	UN
Age Group																		
Under 2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2-12	2	1	0	0	2	1	0	0	1	1	0	0	2	0	0	0	7	3
13-19	1	0	2	1	2	1	2	0	0	0	0	0	2	0	4	3	13	5
20-29	16	3	16	7	37	16	6	0	6	4	3	1	17	4	16	8	117	43
30-39	22	2	43	18	66	20	23	7	23	6	8	4	55	15	41	19	281	91
40-49	58	15	64	15	138	35	31	7	42	15	37	20	93	33	80	38	543	178
50+	48	9	72	14	134	37	29	7	35	15	50	24	99	31	128	54	595	191
Total	**147**	**30**	**197**	**55**	**379**	**110**	**91**	**21**	**107**	**41**	**98**	**49**	**268**	**83**	**269**	**122**	**1556**	**511**
Gender																		
Male	106	21	155	43	308	90	71	15	93	36	77	40	217	68	206	95	1233	408
Female	41	9	42	12	71	20	20	6	14	5	21	9	51	15	63	27	323	103
Total	**147**	**30**	**197**	**55**	**379**	**110**	**91**	**21**	**107**	**41**	**98**	**49**	**268**	**83**	**269**	**122**	**1556**	**511**
Race																		
White	103	19	170	43	277	66	67	16	95	36	81	37	215	60	152	62	1160	339
Black	41	10	24	11	91	41	21	5	9	5	13	8	38	14	106	57	343	151
Other/Unknown	3	1	3	1	11	3	3	0	3	0	4	4	15	9	11	3	53	21
Total	**147**	**30**	**197**	**55**	**379**	**110**	**91**	**21**	**107**	**41**	**98**	**49**	**268**	**83**	**269**	**122**	**1556**	**511**
Risk Behavior																		
MSM	73	12	108	25	240	58	48	8	70	27	53	25	153	42	115	46	860	243
IDU	26	6	22	12	30	12	16	5	9	3	13	7	30	12	57	23	203	80
MSM/IDU	4	0	12	2	11	5	7	3	4	1	2	2	16	3	6	3	62	19
Hetero. Contact	30	7	40	11	63	21	10	3	16	5	21	9	41	15	55	28	276	99
Transfusion	2	1	2	2	2	0	1	0	3	1	1	0	1	0	0	0	12	4
NIR*/Other	8	3	12	2	29	13	7	2	4	3	8	6	22	11	32	19	122	59
Pediatric	4	1	1	1	4	1	2	0	1	1	0	0	5	0	4	3	21	7
Total	**147**	**30**	**197**	**55**	**379**	**110**	**91**	**21**	**107**	**41**	**98**	**49**	**268**	**83**	**269**	**122**	**1556**	**511**
# PLWHA	**147**		**197**		**379**		**91**		**107**		**98**		**268**		**269**		**1556**	
% PLWHA	**9**		**13**		**24**		**6**		**7**		**6**		**17**		**17**		**100**	
% UN **	**6**		**11**		**22**		**4**		**8**		**10**		**16**		**24**		**100**	

** Unmet Needs ^ PLWHA * No Identified Risk

Illustration 11

District 1 and West Virginia Unmet Needs for PLWHA by Race and Gender 2010																
Race	District 1												West Virginia			
	Males				Females				Total							
	AIDS		HIV		AIDS		HIV		AIDS		HIV		AIDS		HIV	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
White	8	73	7	70	2	50	2	40	10	67	9	60	200	70	142	63
Black	3	27	3	30	1	25	3	60	4	27	6	40	73	26	73	32
Other/Unknown	0	0	0	0	1	25	0	0	1	7	0	0	13	5	10	4
Total	**11**	**100**	**10**	**100**	**4**	**100**	**5**	**100**	**15**	**100**	**15**	**100**	**286**	**100**	**225**	**100**

District 2 and West Virginia Unmet Needs for PLWHA by Race and Gender 2010																
Race	District 2												West Virginia			
	Males				Females				Total							
	AIDS		HIV		AIDS		HIV		AIDS		HIV		AIDS		HIV	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
White	16	84	20	83	3	60	4	57	19	79	24	77	200	70	142	63
Black	2	11	4	17	2	40	3	43	4	17	7	23	73	26	73	32
Other/Unknown	1	5	0	0	0	0	0	0	1	4	0	0	13	5	10	4
Total	**19**	**100**	**24**	**100**	**5**	**100**	**7**	**100**	**24**	**100**	**31**	**100**	**286**	**100**	**225**	**100**

District 3 and West Virginia Unmet Needs for PLWHA by Race and Gender 2010																
Race	District 3												West Virginia			
	Males				Females				Total							
	AIDS		HIV		AIDS		HIV		AIDS		HIV		AIDS		HIV	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
White	34	69	27	66	4	36	1	11	38	63	28	56	200	70	142	63
Black	13	27	14	34	7	64	7	78	20	33	21	42	73	26	73	32
Other/Unknown	2	4	0	0	0	0	1	11	2	3	1	2	13	5	10	4
Total	**49**	**100**	**41**	**100**	**11**	**100**	**9**	**100**	**60**	**100**	**50**	**100**	**286**	**100**	**225**	**100**

District 4 and West Virginia Unmet Needs for PLWHA by Race and Gender 2010																
Race	District 4												West Virginia			
	Males				Females				Total							
	AIDS		HIV		AIDS		HIV		AIDS		HIV		AIDS		HIV	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
White	7	78	5	83	3	75	1	50	10	77	6	75	200	70	142	63
Black	2	22	1	17	1	25	1	50	3	23	2	25	73	26	73	32
Other/Unknown	0	0	0	0	0	0	0	0	0	0	0	0	13	5	10	4
Total	**9**	**100**	**6**	**100**	**4**	**100**	**2**	**100**	**13**	**100**	**8**	**100**	**286**	**100**	**225**	**100**

Illustration 12

District 5 and West Virginia Unmet Needs for PLWHA by Race and Gender 2010																
Race	District 5												West Virginia			
	Males				Females				Total							
	AIDS		HIV		AIDS		HIV		AIDS		HIV		AIDS		HIV	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
White	18	100	14	78	1	100	3	75	19	100	17	77	200	70	142	63
Black	0	0	4	22	0	0	1	25	0	0	5	23	73	26	73	32
Other/Unknown	0	0	0	0	0	0	0	0	0	0	0	0	13	5	10	4
Total	**18**	**100**	**18**	**100**	**1**	**100**	**4**	**100**	**19**	**100**	**22**	**100**	**286**	**100**	**225**	**100**

District 6 and West Virginia Unmet Needs for PLWHA by Race and Gender 2010																
Race	District 6												West Virginia			
	Males				Females				Total							
	AIDS		HIV		AIDS		HIV		AIDS		HIV		AIDS		HIV	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
White	24	83	8	73	1	50	4	57	25	81	12	67	200	70	142	63
Black	3	10	2	18	1	50	2	29	4	13	4	22	73	26	73	32
Other/Unknown	2	7	1	9	0	0	1	14	2	6	2	11	13	5	10	4
Total	**29**	**100**	**11**	**100**	**2**	**100**	**7**	**100**	**31**	**100**	**18**	**100**	**286**	**100**	**225**	**100**

District 7 and West Virginia Unmet Needs for PLWHA by Race and Gender 2010																
Race	District 7												West Virginia			
	Males				Females				Total							
	AIDS		HIV		AIDS		HIV		AIDS		HIV		AIDS		HIV	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
White	30	73	21	78	5	50	4	80	35	69	25	78	200	70	142	63
Black	6	15	3	11	4	40	1	20	10	20	4	13	73	26	73	32
Other/Unknown	5	12	3	11	1	10	0	0	6	12	3	9	13	5	10	4
Total	**41**	**100**	**27**	**100**	**10**	**100**	**5**	**100**	**51**	**100**	**32**	**100**	**286**	**100**	**225**	**100**

District 8 and West Virginia Unmet Needs for PLWHA by Race and Gender 2010																
Race	District 8												West Virginia			
	Males				Females				Total							
	AIDS		HIV		AIDS		HIV		AIDS		HIV		AIDS		HIV	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
White	36	60	20	57	4	31	1	7	40	55	21	43	200	70	142	63
Black	24	40	13	37	8	62	12	86	32	44	25	51	73	26	73	32
Other/Unknown	0	0	2	6	1	8	1	7	1	1	3	6	13	5	10	4
Total	**60**	**100**	**35**	**100**	**13**	**100**	**14**	**100**	**73**	**100**	**49**	**100**	**286**	**100**	**225**	**100**

Illustration 13

District 1 and West Virginia Unmet Needs for PLWHA Among MSM by Race 2010												
Race	District 1						West Virginia					
	AIDS		HIV		Total		AIDS		HIV		Total	
	#	%	#	%	#	%	#	%	#	%	#	%
White	6	67	3	100	9	75	120	85	80	79	200	82
Black	3	33	0	0	3	25	17	12	15	15	32	13
Other/Unknown	0	0	0	0	0	0	5	4	6	6	11	5
Total	**9**	**100**	**3**	**100**	**12**	**100**	**142**	**100**	**101**	**100**	**243**	**100**

District 2 and West Virginia Unmet Needs for PLWHA Among MSM by Race 2010												
Race	District 2						West Virginia					
	AIDS		HIV		Total		AIDS		HIV		Total	
	#	%	#	%	#	%	#	%	#	%	#	%
White	9	90	13	87	22	88	120	85	80	79	200	82
Black	1	10	2	13	3	12	17	12	15	15	32	13
Other/Unknown	0	0	0	0	0	0	5	4	6	6	11	5
Total	**10**	**100**	**15**	**100**	**25**	**100**	**142**	**100**	**101**	**100**	**243**	**100**

District 3 and West Virginia Unmet Needs for PLWHA Among MSM by Race 2010												
Race	District 3						West Virginia					
	AIDS		HIV		Total		AIDS		HIV		Total	
	#	%	#	%	#	%	#	%	#	%	#	%
White	26	79	17	68	43	74	120	85	80	79	200	82
Black	6	18	8	32	14	24	17	12	15	15	32	13
Other/Unknown	1	3	0	0	1	2	5	4	6	6	11	5
Total	**33**	**100**	**25**	**100**	**58**	**100**	**142**	**100**	**101**	**100**	**243**	**100**

District 4 and West Virginia Unmet Needs for PLWHA Among MSM by Race 2010												
Race	District 4						West Virginia					
	AIDS		HIV		Total		AIDS		HIV		Total	
	#	%	#	%	#	%	#	%	#	%	#	%
White	5	100	3	100	8	100	120	85	80	79	200	82
Black	0	0	0	0	0	0	17	12	15	15	32	13
Other/Unknown	0	0	0	0	0	0	5	4	6	6	11	5
Total	**5**	**100**	**3**	**100**	**8**	**100**	**142**	**100**	**101**	**100**	**243**	**100**

Illustration 14

District 5 and West Virginia Unmet Needs for PLWHA Among MSM by Race 2010												
Race	District 5						West Virginia					
	AIDS		HIV		Total		AIDS		HIV		Total	
	#	%	#	%	#	%	#	%	#	%	#	%
White	15	100	10	83	25	93	120	85	80	79	200	82
Black	0	0	2	17	2	7	17	12	15	15	32	13
Other/Unknown	0	0	0	0	0	0	5	4	6	6	11	5
Total	**15**	**100**	**12**	**100**	**27**	**100**	**142**	**100**	**101**	**100**	**243**	**100**

District 6 and West Virginia Unmet Needs for PLWHA Among MSM by Race 2010												
Race	District 6						West Virginia					
	AIDS		HIV		Total		AIDS		HIV		Total	
	#	%	#	%	#	%	#	%	#	%	#	%
White	20	91	2	67	22	88	120	85	80	79	200	82
Black	1	5	0	0	1	4	17	12	15	15	32	13
Other/Unknown	1	5	1	33	2	8	5	4	6	6	11	5
Total	**22**	**100**	**3**	**100**	**25**	**100**	**142**	**100**	**101**	**100**	**243**	**100**

District 7 and West Virginia Unmet Needs for PLWHA Among MSM by Race 2010												
Race	District 7						West Virginia					
	AIDS		HIV		Total		AIDS		HIV		Total	
	#	%	#	%	#	%	#	%	#	%	#	%
White	17	77	16	80	33	79	120	85	80	79	200	82
Black	2	9	1	5	3	7	17	12	15	15	32	13
Other/Unknown	3	14	3	15	6	14	5	4	6	6	11	5
Total	**22**	**100**	**20**	**100**	**42**	**100**	**142**	**100**	**101**	**100**	**243**	**100**

District 8 and West Virginia Unmet Needs for PLWHA Among MSM by Race 2010												
Race	District 8						West Virginia					
	AIDS		HIV		Total		AIDS		HIV		Total	
	#	%	#	%	#	%	#	%	#	%	#	%
White	22	85	16	80	38	83	120	85	80	79	200	82
Black	4	15	2	10	6	13	17	12	15	15	32	13
Other/Unknown	0	0	2	10	2	4	5	4	6	6	11	5
Total	**26**	**100**	**20**	**100**	**46**	**100**	**142**	**100**	**101**	**100**	**243**	**100**

Illustration 15

District 1 and West Virginia Unmet Needs for PLWHA Among IDU by Race 2010												
Race	District 1						West Virginia					
	AIDS		HIV		Total		AIDS		HIV		Total	
	#	%	#	%	#	%	#	%	#	%	#	%
White	2	50	1	50	3	50	26	52	18	60	44	55
Black	1	25	1	50	2	33	20	40	12	40	32	40
Other/Unknown	1	25	0	0	1	17	4	8	0	0	4	5
Total	**4**	**100**	**2**	**100**	**6**	**100**	**50**	**100**	**30**	**100**	**80**	**100**

District 2 and West Virginia Unmet Needs for PLWHA Among IDU by Race 2010												
Race	District 2						West Virginia					
	AIDS		HIV		Total		AIDS		HIV		Total	
	#	%	#	%	#	%	#	%	#	%	#	%
White	5	63	2	50	7	58	26	52	18	60	44	55
Black	2	25	2	50	4	33	20	40	12	40	32	40
Other/Unknown	1	13	0	0	1	8	4	8	0	0	4	5
Total	**8**	**100**	**4**	**100**	**12**	**100**	**50**	**100**	**30**	**100**	**80**	**100**

District 3 and West Virginia Unmet Needs for PLWHA Among IDU by Race 2010												
Race	District 3						West Virginia					
	AIDS		HIV		Total		AIDS		HIV		Total	
	#	%	#	%	#	%	#	%	#	%	#	%
White	4	57	4	80	8	67	26	52	18	60	44	55
Black	3	43	1	20	4	33	20	40	12	40	32	40
Other/Unknown	0	0	0	0	0	0	4	8	0	0	4	5
Total	**7**	**100**	**5**	**100**	**12**	**100**	**50**	**100**	**30**	**100**	**80**	**100**

District 4 and West Virginia Unmet Needs for PLWHA Among IDU by Race 2010												
Race	District 4						West Virginia					
	AIDS		HIV		Total		AIDS		HIV		Total	
	#	%	#	%	#	%	#	%	#	%	#	%
White	1	33	1	50	2	40	26	52	18	60	44	55
Black	2	67	1	50	3	60	20	40	12	40	32	40
Other/Unknown	0	0	0	0	0	0	4	8	0	0	4	5
Total	**3**	**100**	**2**	**100**	**5**	**100**	**50**	**100**	**30**	**100**	**80**	**100**

Illustration 16

District 5 and West Virginia Unmet Needs for PLWHA Among IDU by Race 2010												
Race	District 5						West Virginia					
	AIDS		HIV		Total		AIDS		HIV		Total	
	#	%	#	%	#	%	#	%	#	%	#	%
White	1	100	2	100	3	100	26	52	18	60	44	55
Black	0	0	0	0	0	0	20	40	12	40	32	40
Other/Unknown	0	0	0	0	0	0	4	8	0	0	4	5
Total	**1**	**100**	**2**	**100**	**3**	**100**	**50**	**100**	**30**	**100**	**80**	**100**

District 6 and West Virginia Unmet Needs for PLWHA Among IDU by Race 2010												
Race	District 6						West Virginia					
	AIDS		HIV		Total		AIDS		HIV		Total	
	#	%	#	%	#	%	#	%	#	%	#	%
White	1	33	4	100	5	71	26	52	18	60	44	55
Black	2	67	0	0	2	29	20	40	12	40	32	40
Other/Unknown	0	0	0	0	0	0	4	8	0	0	4	5
Total	**3**	**100**	**4**	**100**	**7**	**100**	**50**	**100**	**30**	**100**	**80**	**100**

District 7 and West Virginia Unmet Needs for PLWHA Among IDU by Race 2010												
Race	District 7						West Virginia					
	AIDS		HIV		Total		AIDS		HIV		Total	
	#	%	#	%	#	%	#	%	#	%	#	%
White	5	56	3	100	8	67	26	52	18	60	44	55
Black	2	22	0	0	2	17	20	40	12	40	32	40
Other/Unknown	2	22	0	0	2	17	4	8	0	0	4	5
Total	**9**	**100**	**3**	**100**	**12**	**100**	**50**	**100**	**30**	**100**	**80**	**100**

District 8 and West Virginia Unmet Needs for PLWHA Among IDU by Race 2010												
Race	District 8						West Virginia					
	AIDS		HIV		Total		AIDS		HIV		Total	
	#	%	#	%	#	%	#	%	#	%	#	%
White	6	43	1	13	7	32	26	52	18	60	44	55
Black	8	57	7	88	15	68	20	40	12	40	32	40
Other/Unknown	0	0	0	0	0	0	4	8	0	0	4	5
Total	**14**	**100**	**8**	**100**	**22**	**100**	**50**	**100**	**30**	**100**	**80**	**100**

Illustration 17

District 1 and West Virginia Unmet Needs for PLWHA Among Heterosexual by Race 2010												
Race	District 1						West Virginia					
	AIDS		HIV		Total		AIDS		HIV		Total	
	#	%	#	%	#	%	#	%	#	%	#	%
White	1	100	1	17	2	29	19	39	16	33	35	36
Black	0	0	5	83	5	71	27	55	30	61	57	58
Other/Unknown	0	0	0	0	0	0	3	6	3	6	6	6
Total	**1**	**100**	**6**	**100**	**7**	**100**	**49**	**100**	**49**	**100**	**98**	**100**

District 2 and West Virginia Unmet Needs for PLWHA Among Heterosexual by Race 2010												
Race	District 2						West Virginia					
	AIDS		HIV		Total		AIDS		HIV		Total	
	#	%	#	%	#	%	#	%	#	%	#	%
White	2	67	5	63	7	64	19	39	16	33	35	36
Black	1	33	3	38	4	36	27	55	30	61	57	58
Other/Unknown	0	0	0	0	0	0	3	6	3	6	6	6
Total	**3**	**100**	**8**	**100**	**11**	**100**	**49**	**100**	**49**	**100**	**98**	**100**

District 3 and West Virginia Unmet Needs for PLWHA Among Heterosexual by Race 2010												
Race	District 3						West Virginia					
	AIDS		HIV		Total		AIDS		HIV		Total	
	#	%	#	%	#	%	#	%	#	%	#	%
White	1	10	1	9	2	10	19	39	16	33	35	36
Black	8	80	9	82	17	81	27	55	30	61	57	58
Other/Unknown	1	10	1	9	2	10	3	6	3	6	6	6
Total	**10**	**100**	**11**	**100**	**21**	**100**	**49**	**100**	**49**	**100**	**98**	**100**

District 4 and West Virginia Unmet Needs for PLWHA Among Heterosexual by Race 2010												
Race	District 4						West Virginia					
	AIDS		HIV		Total		AIDS		HIV		Total	
	#	%	#	%	#	%	#	%	#	%	#	%
White	3	100	0	0	3	100	19	39	16	33	35	36
Black	0	0	0	0	0	0	27	55	30	61	57	58
Other/Unknown	0	0	0	0	0	0	3	6	3	6	6	6
Total	**3**	**100**	**0**	**0**	**3**	**100**	**49**	**100**	**49**	**100**	**98**	**100**

Illustration 18

District 5 and West Virginia Unmet Needs for PLWHA Among Heterosexual by Race 2010												
Race	District 5						West Virginia					
	AIDS		HIV		Total		AIDS		HIV		Total	
	#	%	#	%	#	%	#	%	#	%	#	%
White	1	100	3	75	4	80	19	39	16	33	35	36
Black	0	0	1	25	1	20	27	55	30	61	57	58
Other/Unknown	0	0	0	0	0	0	3	6	3	6	6	6
Total	**1**	**100**	**4**	**100**	**5**	**100**	**49**	**100**	**49**	**100**	**98**	**100**

District 6 and West Virginia Unmet Needs for PLWHA Among Heterosexual by Race 2010												
Race	District 6						West Virginia					
	AIDS		HIV		Total		AIDS		HIV		Total	
	#	%	#	%	#	%	#	%	#	%	#	%
White	2	50	2	40	4	44	19	39	16	33	35	36
Black	1	25	2	40	3	33	27	55	30	61	57	58
Other/Unknown	1	25	1	20	2	22	3	6	3	6	6	6
Total	**4**	**100**	**5**	**100**	**9**	**100**	**49**	**100**	**49**	**100**	**98**	**100**

District 7 and West Virginia Unmet Needs for PLWHA Among Heterosexual by Race 2010												
Race	District 7						West Virginia					
	AIDS		HIV		Total		AIDS		HIV		Total	
	#	%	#	%	#	%	#	%	#	%	#	%
White	5	45	3	75	8	53	19	39	16	33	35	36
Black	5	45	1	25	6	40	27	55	30	61	57	58
Other/Unknown	1	9	0	0	1	7	3	6	3	6	6	6
Total	**11**	**100**	**4**	**100**	**15**	**100**	**49**	**100**	**49**	**100**	**98**	**100**

District 8 and West Virginia Unmet Needs for PLWHA Among Heterosexual by Race 2010												
Race	District 8						West Virginia					
	AIDS		HIV		Total		AIDS		HIV		Total	
	#	%	#	%	#	%	#	%	#	%	#	%
White	4	24	1	9	5	18	19	39	16	33	35	36
Black	13	76	9	82	22	79	27	55	30	61	57	58
Other/Unknown	0	0	1	9	1	4	3	6	3	6	6	6
Total	**17**	**100**	**11**	**100**	**28**	**100**	**49**	**100**	**49**	**100**	**98**	**100**

Illustration 19

Early Identification of Individuals with HIV/AIDS (EIIHA)

Prevention with positive focuses on individuals with HIV entering and remaining in care as a method to prevent new HIV infection in negative individuals. Strategies identified to promote entry into care include direct solicitation of current clients, increased media outreach, additional points of distribution of Ryan White Part B brochures and posters and the expansion of office hours. The WVRWPBP has also implemented offering support services that are state funded as an incentive to individuals with HIV to enter and remain in care. In addition, the DSHH has redesigned the HIV care section of the website to include additional information and links for promoting HIV primary care and support services. DIS provides PS and linkage to care often attending the client's first HIV care appointment with them.

The DSHH is also collaborating with the Part C clinics in identifying and locating those who know their status, but are not in care. Targeted attention will be devoted to specific counties of districts with a high unmet need in order to ascertain if the lack of transportation or infrastructure contributes to the unmet need. In collaboration with the Part C clinics, the Part B program continues to conduct a review of all existing client files for identifying those who were formerly in care. The Part C clinics in West Virginia have agreed to conduct a quarterly review of patients lost from care. After conducting the review, the clinic staff will review the names of clients, not adherent to care, with the Part B medical case manager assigned to the respective region.

For FY 2012, Part B dollars have been allocated for medication access and for transportation assistance to medical appointments. Though the refined analysis of the demographics has not yet been conducted, the limited identification of those who know their status, but are not in care, has shown that access to medications, once they have returned to care, and transportation to ensure that they are retained in care, are dominant needs. In addition, state dollars will support transportation assistance, which has been documented as the number one barrier to staying in care in West Virginia.

Additional FY 2012 outreach activities for PLWHA who know their status, but are not in care, include outreach to emergency rooms, nursing programs, homeless shelters, food stamp offices, soup kitchens, food pantries, mental health centers, correctional facilities, substance abuse treatment programs and public housing programs.

The southern region of West Virginia, an area with the state's highest rate of poverty and lowest health outcomes, has also been a consistent challenge in maintaining PLWHA in primary care. Currently discussions are occurring with Access Health Care in Beckley to provide HIV care services. If successful the newly established HIV clinic will provide an opportunity for PLWHA to access HIV primary care in their local area without having to travel more than an hour to the nearest Part C clinic.

Collaboration between the WVRWPBP and the state's Part C's clinics is especially evident whenever PLWHA drop out of care or miss medical appointments. Conversations regarding the whereabouts of a particular patient and documentation of the last contact with the patient are frequently conveyed to the clinics by the medical case management staff. The WVRWPBP also provides a medical case management home visit when clients provide misleading information regarding accessing HIV primary care. The targeted outreach often provides insight into why a

patient is non-adherent to their treatment plan or identifies additional issues such as depression or substance abuse.

The WVRWPBP case managers routinely refer and link clients to other medical and social services. Ryan White Part B funds are allocated to support those eligible for mental health services, substance abuse services, dental services, housing issues, and other needed services.

Ryan White Part B and C programs provide ongoing PS for HIV positive persons and their partners. Through the DSHH rapid HIV testing is available to this population. The DIS following up on Syphilis, Gonorrhea, and Chlamydia will offer partners an HIV test or recommend the test be conducted by the provider when they return for treatment. The STD Program and Surveillance Program operate under the PI and Director of the Ryan White Part B Grant. This structure allows for easy collaboration to coordinate PS activities. The DIS routinely visit CBO's, private medical treatment providers and student health clinics to provide education on STD treatment, reporting, and PS. DIS also participate in CBO and college student health outreach events by providing CTR services using rapid HIV testing.

The DSHH assures that HIV-positive pregnant women receive the necessary interventions and treatment for the prevention of perinatal transmission through a strong collaborative effort involving HRSA funded providers, HIV/AIDS Surveillance, HIV Prevention STD Program, and private providers. The HIV/AIDS Surveillance Coordinator is the key person in identifying and following the care of HIV-positive pregnant women. The Coordinator closely follows the case until delivery and then follows the baby's status for up to two years. The HIV Prevention Specialist charged with services for "women at risk" provides site visits to OB/GYN to provide literature on routine HIV testing of pregnant women, reporting HIV, and providing information on Ryan White HIV Care clinics. The DIS make referrals and links newly diagnosed HIV positive persons to care which would include pregnant women as well.

Since every perinatal HIV transmission is a sentinel health event, the HIV/AIDS Surveillance Coordinator conducts a case review. Upon completion of the case review the Coordinator will identify any missed perinatal HIV prevention opportunities. Then the Coordinator will consult with the PI and Director to develop strategies or improve on strategies to decrease the risk of perinatal HIV transmission in the future. In 2012, the Fetal and Infant Mortality Review (FIMR)- HIV Prevention Methodology will be utilized.

The HIV Prevention Program supports behavioral and clinical risk screening for HIV-positive persons which is accomplished at the Ryan White Part C clinics. The clinic also provides risk reduction interventions for HIV-positive persons/discordant couples at risk of transmitting HIV by implementing the PfH intervention, providing literature, and free condoms at the two Ryan White Part C clinics. Discordant couples are offered free rapid HIV testing and provided literature on how to stay negative. In 2012, PfH intervention, literature and free condoms will be offered to SVMS and MUIM to further promote access to HIV positive persons/discordant couples for risk reduction interventions.

The Ryan White Part B Program case managers work diligently to provide the resources necessary to implement behavioral and structural interventions for HIV infected persons. Case managers provide transportation vouchers, support services, mental health referral, substance abuse referral and other interventions needed to ensure continued care. Case managers and the HIV/AIDS Surveillance Coordinator receive copies of viral load and CD4 count laboratory results. The RWPBP case managers monitor their clients laboratory reports and follows up with the client

if no results are submitted. West Virginia does not have an AIDS Drug Assistant Program waiting list; therefore, accessibility to Highly Active Antiretroviral Therapy (HAART) is not a barrier at this time. RWPBP case managers provide counseling and support to person's positive with HIV to encourage treatment adherence.

The HIV Prevention Program supports and coordinates integrated hepatitis and STD screening by providing literature, condoms, and funding to the Office of Laboratory Services (OLS) for testing. The DIS offer rapid HIV testing to positive TB patients at the LHD TB clinic. PS is initiated on hepatitis B, syphilis, gonorrhea, Chlamydia (14 and under/pregnant females), and HIV according to DSHH criteria. DIS is directed to offer rapid HIV testing to all positive partners (hepatitis B, STD, HIV).

The AIDS Legislative Rule-Title 64 directs providers and laboratories to submit CD4 and viral load results to the health department. Failure by a provider to submit reports will result in a visit by a DIS to provide technical assistance on the Legislative Rule requirements on reporting. The HIV/AIDS Surveillance Coordinator uses the CD4 and viral load results to determine linkage and retention in care. The Coordinator will contact RWPBP case managers or HIV care providers any time laboratory results or lack of results indicate a treatment concern. The goal of all parties involved in care, treatment, and retention is to collaborate together to ensure quality health care is in place for HIV positive individuals in West Virginia.

HAART treatment is highly encouraged by all parties involved with a HIV positive person. West Virginia does not have an ADAP waiting list so medications are available as a payment of last resort to those that qualify. HRSA funds are used to pay medical insurance co-pays for the eligible client when necessary. Support services are provided to those eligible to ensure no barriers present a challenge to treatment adherence.

The linkage network/system the health department uses to ensure clients have easy access to medical care, treatment, prevention service and other medical and social services centers around the Ryan White Programs. Through the RWPBP case managers network with HIV care providers to ensure no barriers exist to obtain comprehensive HIV care and support for their clients. The case manager schedules appointments, secure transportation, medication, track service needs of their clients, and secures social services per individual need. The HRSA recommended CAREWARE system is used to capture each HIV care client services and outcomes. All Ryan White Programs and stakeholder develop a Statewide Coordinated Statement of Need (SCSN) every three years. This collaboration of stakeholders produces strategies that address all aspects of care. The RWPBP implements the strategies and tracks the outcomes to ensure the client's needs are met and barriers are reduced.

The DIS Supervisor reviews all PS activities on HIV cases to ensure partner notification, HIV testing of positive partners, referral and linkage to care occur. Beginning in 2012, the DIS will also ensure the client attends their first HIV care appointment.

As stated previously, the HIV/AIDS Surveillance Coordinator tracks all HIV pregnant women and monitors their CD4 and viral load results. The Coordinator will contact HIV care providers and RWPBP case managers to ensure necessary interventions and treatment for prevention of transmission is in place. In the event a pregnant female is non-compliant with HART, the treatment team i.e. the client, HIV care provider, RWPBP case manager, Surveillance Coordinator, discuss individualized strategies to promote treatment adherence. Since every perinatal HIV transmission is a sentinel health event, the HIV/AIDS Surveillance Coordinator

conducts a case review. Upon completion of the case review the Coordinator will identify any missed perinatal HIV prevention opportunities. Then the Coordinator will consult with the PI and Director to develop strategies or improve on strategies to decrease the risk of perinatal HIV transmission in the future. In 2012, the Fetal and Infant Mortality Review (FIMR) - HIV Prevention Methodology will be utilized.

DSHH plans to continue funding the DEBI intervention PfH to address comprehensive prevention with positives interventions. PfH will continue to be funded at WVU and CAMC. The DSHH will approach SVMS PfH in 2013. These sites are key areas for HIV care located in areas identified as having significant HIV/AIDS incidence. Adding SVMS to provide the PfH intervention will assist the DSHH in meeting the CDC's expectations to expand targeted efforts to prevent HIV infection using effective, evidence-based approaches to HIV prevention. PfH and RWPBP case managers will also provide interventions (counseling and support) that will encourage risk reduction behaviors and structural outcomes such as condom use.

The HIV/AIDS Surveillance Program by law receives all HIV indicated CD4 and viral load testing results. These results are entered into a CDC recommended database (eHARS) that allows data to be sorted to track individuals' care, treatment, and unmet needs.

The goals and objective of the Ryan White Part B 2012-2015 Comprehensive Plan support both the goals and objectives of the NHAS and Healthy People 2020. The WV plan strives to increase survival with HIV, reduce the number of new infections and increase the proportion of PLWHA in WV who are receiving HIV care and treatment in accordance with HHS Guidelines. Recognizing that untreated HIV and STDs can lead to serious health consequences, the WV plan aims to increase the proportion of HIV infections that are diagnosed in WV prior to progressing to an AIDS diagnosis. Through the Partnership for Health initiative, the state targets reducing new infections in the areas of the state with the highest burden of HIV morbidity. Through prevention education, free condom distribution to high risk individuals, linkage to care, partner services, HIV/AIDS surveillance, and targeted testing, the state addresses the goal of reducing HIV related disparities and health inequities. The WV Comprehensive Plan supports increasing access to care and improving health outcomes through the medical case management services, medical transportation, oral health services, and medical assistance, including ADAP.

Each year states are required to follow a precise formula in estimating the number of West Virginians living with HIV/AIDS who are Unaware of Their Status. The unaware estimate for CY 2009 is based on applying the formula to the known 1507 PLWHA. The resulting Unaware of their Status number is 400 West Virginians.

Strategy:

In compliance with the NHAS, WV HIV prevention efforts focus on reducing new infections, increasing access to care, improving health outcomes for PLWHA, and promoting health equity. Through program collaboration and service integration (PCSI) WV will promote improved integrated HIV, STD, TB and viral hepatitis prevention efforts. The DSHH will engage in activities that promote sexual health in an effort to reduce stigma and sensitivity associated with these conditions. DSHH 2012-2015 HIV prevention strategies include the following:

- HIV prevention activities and HIV testing will be targeted in areas of the state where the majority of HIV morbidity cases are located.
- Expanding WV HIV rapid testing program in high risk areas of the state.

- HIV education and prevention efforts will target communities at risk for HIV.
- Performance standards are in place for all CDC funded partners in HIV prevention activities.

HIV Testing:

Goal 1	**Increase HIV testing in areas with higher morbidity.**		
	Objective 1	By December 31, 2012, prevention staff will conduct 4 CDC CTR courses to include the CDC recommendations on HIV testing.	
			Activities
		1.1	Prevention staff will advertise CTR courses for CDC funded HIV testing sites
		1.2	Prevention staff will conduct CTR courses in four different Public Health Districts.
		1.3	Prevention staff will track approved tester and notify when recertification is needed.
	Objective 2	By December 31, 2012, DIS/HIV Prevention staff will provide rapid HIV testing at 4 outreach testing venues in areas identified as high HIV incidence achieving at least a 1% rate of newly identified HIV positive tests.	
			Activities
		2.1	HIV Prevention and/or DIS will collaborate with STD clinics, APC, CBO's, colleges/universities, gay bars, housing projects to set up an outreach testing event.
		2.2	The Public Information Specialist will advertise the outreach testing event.
		2.3	Condoms and STD/HIV/hepatitis literature will be provided.
	Objective 3	By December 31, 2012, 90% of newly diagnosed individuals with HIV will be informed of their test result.	
			Activities
		3.1	The HIV/AIDS Surveillance Coordinator will contact the site which provided the HIV testing service concerning their confirmed positive test result to ensure the patient has been informed and linked to care.
		3.2	The HIV/AIDS Surveillance Coordinator will initiate assignment of the new HIV case by giving it to the DIS Supervisor who will ensure
		3.3	The DIS will offer support to the site in providing the patient the test results if needed.
		3.4	DIS will make every attempt to locate a person that does not return to the site for their positive test result.
	Objective 4	By December 31, 2012, at least 80% of persons who receive their HIV positive test results are linked to medical care and attend their first appointment.	
			Activities
		4.1	The HIV/AIDS Surveillance Coordinator will ensure all individuals newly diagnosed with HIV are linked to medical care and attend their first appointment.
		4.2	DIS will refer the person to Ryan White Part B Program for case management services.
		4.3	DIS will attend the persons first medical care appointment whenever possible.
	Objective 5	By December 31, 2012, 80% of individuals testing for HIV will return for their test result.	
			Activities
		5.1	The HIV testing site will schedule a time for the person to return for their result.
		5.2	The HIV testing site will contact individual if he/she fails to return for their test result to reschedule a time for them to receive their result.
		5.3	The HIV testing site will provide all individual receiving an HIV test result literature on HIV/STD/TB/Hepatitis as well as support services

Prevention for Positives:

Goal 1	**Decrease risk of acquiring HIV by providing HIV prevention activities.**		
	Objective 1	By December 31, 2012, prevention staff will secure 3 HIV care sites to implement Partnership for Health (PfH) intervention.	
			Activities
		1.1	Prevention staff will contact each of the four HIV care providers in the state and explain the PfH intervention.
		1.2	Prevention staff will complete a subrecipient agreement with the provider which includes an MOU.
		1.3	Prevention staff will secure capacity building training on PfH for the "new" providers.
	Objective 2	By December 31, 2012, DIS will meet with 15 providers to discuss PS in an effort to maintain partnerships with non-health department providers.	
			Activities
		2.1	The DIS Supervisor and DIS will meet to identify non-health department providers not fully engaged in PS activities.
		2.2	The DIS Supervisor will provide the DIS training on creating partnerships with providers.
		2.3	DIS will schedule a site visit to discuss PS opportunities.

Condom Distribution:

Goal 1	**Maintain condom distribution that targets HIV positive persons and persons at highest risk of acquiring HIV infection.**		
	Objective 1	By December 31, 2012, condoms will be distributed to program approved sites for distribution to persons at highest risk of acquiring or transmitting HIV.	
			Activities
		1.1	Prevention staff will review list of approved sites to ensure the site serves persons high risk for HIV or HIV positive persons.
		1.2	Prevention staff will ensure stock of condoms is available to be distributed.
		1.3	Prevention staff will approve condoms for distribution at events targeting risk population.

Policy Initiatives:

Goal 1	**Improve enabling environment for HIV prevention efforts.**		
	Objective 1	By December 31, 2012, a Policy Initiative Committee (PIC) will be formed to review 100% of HIV/STD/TB/hepatitis policies/regulations/state law to ensure no barriers exist in creating an enabling environment for HIV prevention efforts.	
			Activities
		1.1	The prevention Quality Assurance, Evaluation, and Monitoring staff will invite stakeholders to participate in the PIC; 10-15 members to be selected.
		1.2	The PIC will review structures, policies, and regulations in WV to identify any barriers to providing HIV prevention activities.
		1.3	Any barriers identified by the PIC will be presented to the Office Director/PI.

Achieving increased numbers of individuals who are aware of their HIV status, early after infection, will require increased collaboration of local health departments (LHD) providing CTRS, private providers and rapid testing staff. Both increased venues and opportunities will be required to reach an increased percentage of West Virginians who are unaware of their HIV status. The HIV Prevention Planning Group (HPPG) has identified barriers that include stigma, discrimination, the rural nature of the state and a general apathy toward knowing one's status as obstacles to identifying new positives.

Effective November 2010, the two West Virginia counties that are located in the Washington, DC Part A EMA became under contract by a new Administrative Agent. The Shenandoah Valley Medical System (SVMS), which has been a Part C subcontractor for several years, has initiated Part A clinical and support services. In addition, as part of the expansion of the WV HIV Rapid Testing Initiative, SVMS has begun offering HIV rapid testing. Having rapid partner testing services available onsite at the HIV clinic, will provide opportunities for partners of HIV infected West Virginians to learn their status. The increased collaboration between the Part A Administrative Agent, SVMS, the WVRWPBP, and the OEPS will ensure that newly informed HIV positive individuals will have immediate referrals to onsite primary care.

The targeting of HIV testing through the LHD, and the WV HIV Rapid Testing Initiative as well as the efforts to decrease the barriers to accessing testing will complement the WV Comprehensive HIV Prevention Plan. CDC funding will be utilized to target high risk populations for HIV testing opportunities. Targeting HIV testing and identifying positives will expand on current efforts and will target high risk individuals who are unaware of their status in compliance with the NHAS goals. HIV testing providers are strongly encouraged to get the patient back to receive their test results whether positive or negative.

Prevention Programs

Prevention with positives Initiatives:

Partnership for Health (PfH) uses message framing, repetition, and reinforcement during patient visits to increase HIV positive patients' knowledge, skills, and motivations to practice safer sex. The program is designed to improve patient-provider communication about safer sex, disclosure of HIV serostatus, and HIV prevention. Implementation of PfH includes development of clinic and staff "buy-in" and training. PfH is currently being conducted at WVU and CAMC Ryan White Part C Programs. Shenandoah Valley Medical Systems will be asked to implement the program in 2013.

STD Program Interventions:

DSHH will continue to improve partner services offered to infected individuals and their partners. Targeted gonorrhea screening activities will be based on the evaluation of gonorrhea morbidity data per the 2010 high risk behavior/high incidence of morbidity by county data map. By the end of CY 2012 at least two outreach testing activities will be conducted. The CY 2012 activities will focus on evaluating the success of these activities, and conducting additional testing at other locations areas. These outreach activities will focus on men and women of all age groups, since they are being performed in high morbidity areas in a low incidence state. The Infertility Pregnancy Project will also be expanded in these same areas as a means of reaching sexually active women under the age of 26.

The IPP partners will continue to work toward establishing and maintaining a minimum three percent Chlamydia positivity rate at all participating prevalence monitoring sites, particularly in Family Planning clinics. The Family Planning Program will continue to work with specific sites to perform testing under the Infertility Pregnancy Project in an effort to increase Chlamydia positivity among females under the age of 26. The Family Planning Program extended participation in this project during the second half of 2009, but not all sites were able to participate. Participation will continue into CY 2012.

Partner Notification Initiatives:

Internet Partner Notification: DSHH, in collaboration with the Office of Epidemiology and Prevention Services (OEPS) Public Information Specialist and the Grant Principal Investigator developed and implemented Internet Protocol Notification (IPN) during CY 2011. West Virginia's IPN was modeled after those currently in use in New York, Tennessee, and Virginia. West Virginia's IPN requires all DIS complete a training video that provides an overview of the IPN, the logging effort required to access this service, the disciplinary action for misuse/noncompliance, and permissible on-line conversation language including e-mail communication. The DIS is required to complete a simple competency-based questionnaire and must pass an examination to use IPS. Combined with training, the IPN ensures that the DIS understands compliance is essential for protection of personal identifiable information (PII).

MSM are reported more likely to use the internet to find partners for sexual activity. MSM can maintain anonymity and interact with more men via the internet. The goal of IPN is to reduce the spread of STD and HIV and to prevent reinfection. Public Health prevention and education messages are on Twitter and Facebook.

Collaborative Partners:

Since proper diagnosis, treatment, and reporting are necessary for the initiation of partner services, DIS staff will continue to conduct site visits to county health departments, private

providers and clinics, laboratories, and correctional facilities in their respective areas in an effort to educate health care providers and promote increased disease prevention activities, testing, and treatment. Special emphasis will be placed upon conducting site visits in high gonorrhea morbidity areas. STD Program staff will continue to collaborate with middle and high schools, colleges, and correctional facilities to provide information on disease prevention, testing, and treatment to these populations in an effort to influence behavior change.

The Family Planning Program, the STD Program, and the OLS will continue to meet at least quarterly to discuss the outcome of activities performed to increase positivity at Family Planning clinics and targeted gonorrhea screening outreach activities.

Partner Services

HIV

Objective #1 – By December 31, 2012, the DIS staff will conduct an intensive disease intervention interview, including partner counseling and referral services, on at least 90 percent of all HIV/AIDS cases within seven days of assignment from the Division.

Objective #2 – By December 31, 2012, 95 percent of all HIV/AIDS cases assigned to the field will be closed in 45 days.

Syphilis

Objective #1 – By December 31, 2012, the DIS staff will conduct an intensive disease intervention interview on at least 90 percent of all early syphilis cases within seven days of assignment to the field.

Objective #2 – By December 31, 2012, the DIS staff will conduct an intensive disease intervention re-interview on at least 90 percent of all early syphilis cases within 10 days of the initial interview.

Objective #3 – By December 31, 2012, the DIS staff will initiate at least 1.5 sexual partners per case of early syphilis interviewed.

Objective #4– By December 31, 2012, 95 percent of all early syphilis cases assigned to the field will be closed in 45 days.

Gonorrhea

Objective #1 – By December 31, 2012, the DIS staff will conduct an intensive disease intervention interview on at least 80 percent of all gonorrhea cases within seven days of assignment to the field.

Objective #2 – By December 31, 2012, the DIS staff will initiate at least 1.0 sexual partner per case of gonorrhea interviewed.

Objective #3 – By December 31, 2012, the DIS staff will refer for examination at least 80 percent of all new, locatable, in jurisdiction sexual partners of gonorrhea cases within seven days of the initial interview.

Objective #4 – By December 31, 2012, 95 percent of all gonorrhea cases assigned to the field will be closed in 45 days.

Chlamydia[4]

Objective #1 – By December 31, 2012, the DIS staff will conduct an intensive disease intervention interview on at least 80 percent of all Chlamydia cases within seven days of assignment to the field.

Objective #2 – By December 31, 2012, 95 percent of all Chlamydia cases assigned to the field will be closed in 45 days.

[4] Criteria for assignment of Chlamydia to Field Staff (DIS): Pregnant Females and all patients 14 years of age and younger.

Continuum of Care

The responsibility of the general public's health, related to HIV/AIDS, lies with the WV STD/HIV and Hepatitis Division. HIV awareness education for the state is coordinated by the HIV Prevention Program and persons at risk are encouraged to access HIV testing services, available throughout the state supported clinics. West Virginians who test negative continue to receive HIV prevention services while those who test positive are directed to DIS workers and comprehensive HIV care and treatment services.

HIV Counseling and testing is available through a network of specialized county health departments, designated as state supported clinics, rapids testing performed by Ryan White Part C clinics, two AIDS Prevention Centers (APCs), DIS workers and DHHR AIDS prevention educators. Testing is also performed in primary care settings, emergency rooms and during in-patient hospital stays.

Ryan White funding in West Virginia is divided into four Parts. Part A of the Ryan White funds, awarded to Shenandoah Valley Medical Systems, are utilized for PLWHA who reside in Berkeley and Jefferson counties in the eastern panhandle, which have been designated as part of the Washington, D.C. eligible metropolitan area (EMA). The remainder of the Ryan White funding, Part B for the state, Part C at West Virginia University and Part C at Charleston Area Medical Center is available statewide. Individual Ryan White funded Part C clinics in West Virginia are located in Charleston and Morgantown with a traveling clinic in Wheeling once every three months. WVU, in Morgantown, also subcontracts with Shenandoah Valley Medical System (SVMS) in Martinsburg, WV. In addition, the Portsmouth City Health Department Part C Program provides funding for the Marshall University Internal Medicine Clinic in Huntington. Care is also provided to WV PLWHA by private providers, the VA Medical System and out of state Part C Clinics in Pittsburgh, PA and Charlottesville, VA.

After testing positive, PLWHA are required to meet with a DIS worker for partner counseling and referral services. The DIS worker provides an appropriate referral to a RWPBP medical case manager. The RWPBP medical case managers' services are available without regard to income or insurance coverage. The medical case management is the state's point of entry for PLWHA to access primary care and all of the core services of the RWPBP. In addition, the medical case managers serve as the gatekeepers for the WV ADAP, which provides a formulary of 72 drugs to eligible PLWHA. Referrals to HOPWA services and other community support services, as well as entitlement programs, are coordinated through the RWPBP medical case manager.

Planning for HIV care and treatment services is coordinated by the AIDS Task Force of the Upper Ohio Valley through an agreement with the WV Division of STD HIV and Hepatitis. All of the Ryan White funded Parts participate in the planning activities through the SCSN, which includes the HIV Care and Treatment Comprehensive Plan, the Implementation Plan and the ADAP Advisory Committee. PLWHA are included as vital members of the planning activities.

Quality Management for the Ryan White Part B Program is also coordinated through the ATF contract. All WV RWPBP staff as well as PLWLHA, the Division of STD, HIV and Hepatitis Director, and the Surveillance staff participate in the Quality Management Committee which reports its data to HRSA and the planning groups.

The Pennsylvania Mid-Atlantic AIDS Education and Training Center, (AETC), which is funded by Ryan White Part F, provides training and educational forums to health care workers throughout the state.

2011 HIV Care and Treatment State and Federal Expenditures

The WV Division of STD, HIV and Hepatitis provides HIV care and treatment and support services through two statewide contracts. The calendar year 2011 expenditures of federal Part B funding and state funding represent services provided through the contract with the Bureau for Medical services (BMS) for ADAP and the AIDS Task Force of the Upper Ohio Valley, (ATF) for State Direct Services and the Insurance Continuation Program. Pharmaceutical company rebates also support the WV ADAP budget.

Through a single contract with the ATF, the WV HIV care and support services are provided seamlessly with both state and Ryan White Part B funding. Though tracked separately for reporting and auditing purposes, the funding is accessed with a single application filed by PLWHA with the WVRWPBP medical case manager.

The 2011 expenditures for ADAP included $4,404,754 paid by ADAP and additional $1,747,060 was billed to Medicare Part D Plans and private insurance for ADAP medications during calendar year 2011. Only the federal and state funding and rebates are reflected on the table.

Table of 2011 HIV Care and Treatment Expenditures

SERVICES	2011 EXPENDITURES	CORE SERVICE	SUPPORT SERVICE	ADMIN	PART B FUNDING	STATE FUNDING
ADAP	$4,404,754	X			X	X
Medical Case Management	$257,358	X			X	
Health Insurance Continuation	$61,941	X			X	X
Prescription and Drug Co-pays	$79,895	X				
Oral Health	$74,812	X			X	X
Outpatient Substance Abuse Treatment	$15,701	X			X	X
Ambulatory Outpatient Primary Care	$2,786	X				X
Mental Helath Treatment	$390	X			X	
Client Education	$291.20		X			X
Medical Transportation	$49,144		X		X	X
Vision	$4,853		X			X
Emergency Finacial Assistance(Nutritional Supplements,Food Vouchers)	$136,856		X			X
SCSN	$19,297			X	X	X

Illustration 20

The Ryan White federal awards to Parts A, B, C and F traditionally remain stagnant each year, despite a growing increase in the number of clients served and demands for additional services. Each of the different Parts relies on supplemental programs and resources to help in

meeting the growing need. Resources include rebates, Patient Assistance Programs at pharmaceutical companies, charity care at hospitals and community clinics. While WV has not suffered significantly from state budget cuts to HIV services, the entire care system is heavily reliant on the supplemental programs that experience periodic changes in guidelines and cuts in funding.

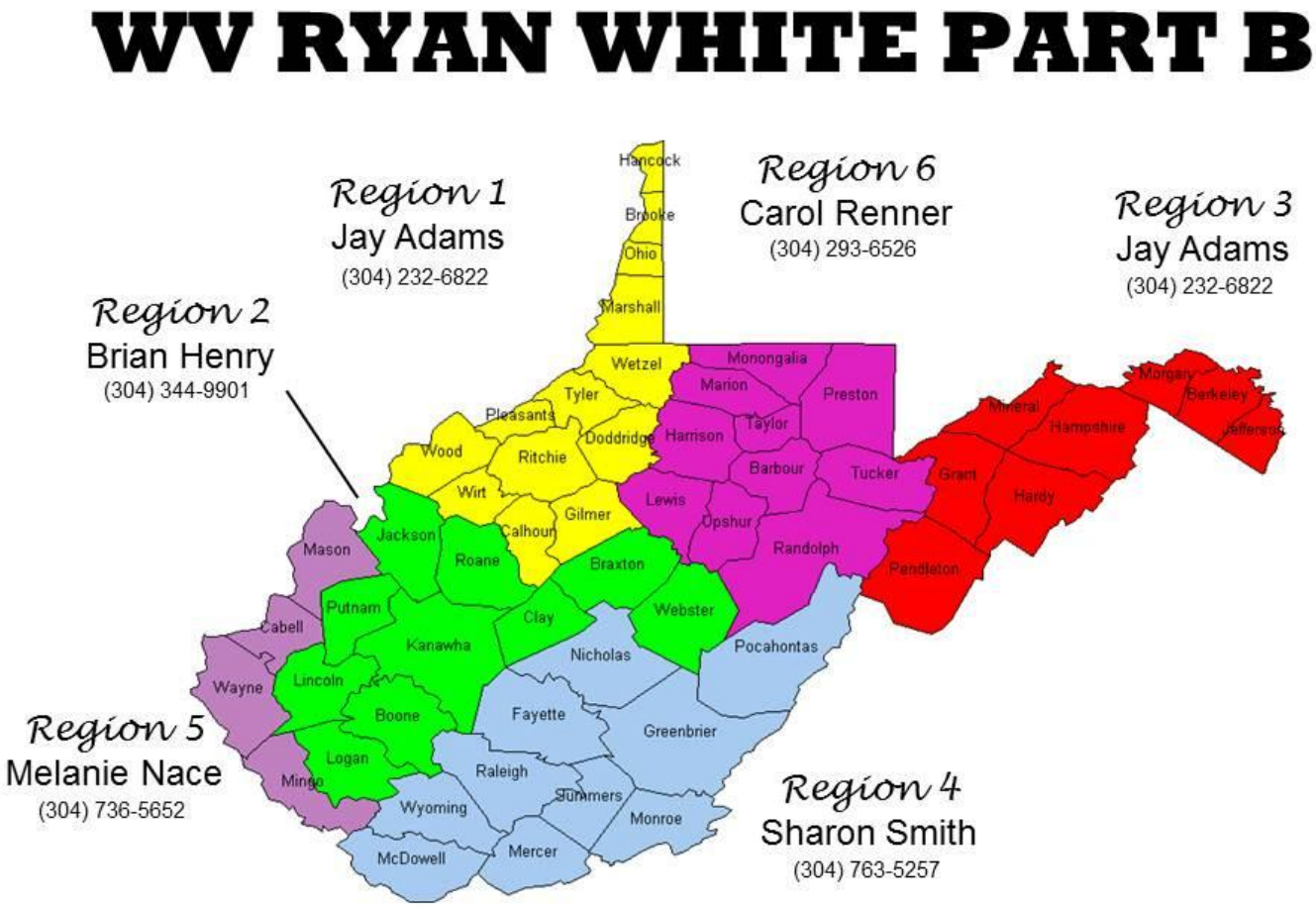


Illustration 21

Current System of Care

The WV Ryan White Part Program (WVRWPBP) utilizes Ryan White dollars to fund three components of the Part B allowable services. The state contracts with the Bureau for Medical Services (BMS) to administer the AIDS Drug Assistance Program (ADAP) and the AIDS Task Force of the Upper Ohio Valley (ATF) to administer the State Direct Services and the Insurance Continuation Program.

ADAP

The WV ADAP provides a formulary of 72 medications to eligible PLWHA in WV. Medications are distributed through the BMS network of pharmacies across the state. Participants may choose to utilize retail or mail order pharmacies. Participants must have an income at or below 325% Federal Poverty Level (FPL) and must not be eligible for Medicaid or any other full forms of medication coverage. Participants with insurance and Medicare Part D are eligible for ADAP, which is utilized as the payer of last resort. Eligibility for the WV ADAP requires residency in WV, but does not have an asset test or any specific requirements related to CD 4 counts or viral loads. WV ADAP formulary drugs are dispensed in a thirty day supply. All FDA approved antiretrovirals are currently available through the WV ADAP. Enrollment is coordinated by the WVRWPBP medical case manager. Applications are initiated at the local county DHHR (Medicaid) office. Completed applications are approved for activation in approximately seven days. WV ADAP regulations require that all other payers be accessed prior to utilizing ADAP benefits. The WV ADAP wraps around insurance and Medicare Part D by covering deductibles, co-pays and any coverage gaps for ADAP formulary medications.

State Direct Services

The State Direct Services component of the WVRWPBP provides medical case management services statewide through a contract with the ATF. All of the Part B core services are available through the medical case management system. Eligibility for the core services requires PLWHA to reside in WV and to have an income equal to or below 250% FPL. The WVRWPBP medical case managers conduct home visits and work in close collaboration with the Ryan White Part C clinics to ensure seamless services for PLWHA in WV. Electronic records are maintained for PLWHA in CAREWare for State Direct Services. The ATF coordinates the data collection and provides supervision for the medical case managers. In addition to offering all of the HRSA HAB core services, WV also provides one Ryan White funded support service in the form of medical transportation. State funding supplements the Ryan White funding for the core services and for limited support services, such as: food vouchers, nutritional supplements, medical transportation, and vision services.

Insurance Continuation Program

The WV Insurance Continuation Program provides insurance premium coverage for WV PLWHA who have existing health insurance coverage and who would otherwise lose that coverage due to a loss of job, temporary disability or a loss of income due to illness. Coverage includes participants eligible for COBRA and those who have private policies. The coverage of the insurance must offer pharmacy coverage that is equal to or better than the formulary of the WV ADAP. In addition, quarterly cost analysis must reveal that the premiums and co-pays provide the program a savings over the cost of providing the same medications through the WV ADAP.

Premiums are paid monthly through a contract with the ATF. Access to the Insurance Continuation Program is coordinated by the WVRWPBP medical case managers. Eligibility requirements include WV residency and that the participant's income must be equal to or less than 300% FPL. There is no asset test for the Insurance Continuation Program. The WVRWPBP does not offer assistance with Medicare Part B or Part D premiums.

WV AIDS DRUG ASSISTANCE PROGRAM FORMULARY

The WV ADAP assists eligible WV residents, with HIV infection, obtain the drugs listed on the formulary below. Applicants must apply at their county office of the Department of Health and Human Resources. Formulary drugs available in generic must be dispensed in generic.

To be eligible for the ADAP, HIV infected WV residents with a family income less than 325% of the federal poverty level, who are not eligible for other forms of reimbursement such as Medicaid or full insurance coverage, (ADAP will cover co-pays for eligible residents with insurance) **must** complete the applications at the Department of Health and Human Resources.

WV AIDS DRUG ASSISTANCE PROGRAM FORMULARY 6/12	
Trade Name	Generic Name
Aptivus	Tipranavir
Atripla	Efavireniz/Emtrictabine/Tenofovir
AZT, Retrovir	Zidovudine
Bactrim, or equivalent	Cotrimoxazole
Biaxin	Clarithromycin
Celexa	Citalopram
Cleocin	Clindamycin
Combivir	Lamivudine/Zidovudine
Compazine	Prochlorperazine
Complera	Rilpivirine/Tenofivir/Emtricitabine
Crestor	Rosuvastatin
Crixivan	Indinavir
Cytovene	Ganciclovir
Dapsone	Dapsone
Daraprim	Pyrimethamine
DDC, Hivid	Zalcitabine
DDI, Videx	Didanosine
Deltasone	Prednisone
Diflucan	Fluconazole
Edurant	Rilpivirine
Effexor	Venlafaxine
Elavil	Amitriptyline
Emtriva	Emtricitabine
Engerix	Hepatitis B Vaccine

Epivir, 3TC	Lamivudine
Epzicom	Lamivudine/Abacavir
Foscavir	Foscarnet **(Prior Authorization)**
Fuzeon	Evfuvintide **(Prior Authorization)**
Glucophage	Metformin
Havrix	Hepatitis A Vaccine
Imodium	Loperamide
Intelence	Etravirine
Invirase	Saquinavir
Isentress	Raltegravir
Kaletra	Lopinavir
Klonopin	Clonazepam
Lexapro	Escitalopram
Lexiva	Fosamprenavir Calcium
Lipitor	Atorvastatin
Myambutol	Ethambutol
Mycelex	Clotrimazole
Mycobutin	Rifabutin
Mycostatin	Nystatin
Nebupent, Pentam	Pentamidine
Neurontin	Gabapentin
Niaspan	Niacin
Norvir	Ritonavir
Paxil	Paroxetine
Prezista	Darunavir
Prozac	Fluoxetine
Rescriptor	Delavirdine
Reyataz	Atazanavir
Selzentry	Maraviroc **(Prior Authorization)**
Seroquel	Quetiapine
Sporanox	Itraconazole
Sulfadiazine	Sulfadiazine
Sustiva	Efavirenz
Toprol,Lopressor	Metoprolol
Tricor	Fenofibrate
Trizivir	Lamivudine/Zidovudine/Abacavir
Truvada	Tenofovir/Emtricitabine
Twinrix	Hepatitis A&B Vaccines
Valium	Diazepam
Viracept	Nelfinavir
Viramune	Nevirapine

Viread	Tenofovir
Wellcovorin	Leucovorin
Zerit, D4T	Stavudine
Zestril	Lisinopril
Ziagen	Abacavir
Zithromax	Azithromycin
Zoloft	Sertraline
Zovirax	Acyclovir

Applications and information are available by calling the WV Ryan White Part B Program Office at 304-232-6822 or by writing Jay Adams, HIV Care Coordinator, P.O. Box 6360, Wheeling, WV 26003.

Core and Support Services Provided in WV

All of the core services are available statewide in WV through the State. However, the state place emphasis on medical case management, ADAP, ADAP Local, Health Insurance Premiums, Oral Health and Substance Abuse Outpatient Treatment The only Ryan White funded support service is Medical Transportation. All services are provided through an agreement with the ATF and through the agreement with the BMS for the WV ADAP. The core services include:

a. ***Outpatient/Ambulatory medical care (health service**s)* is the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting. Settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not outpatient settings. Services includes diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties). Primary medical care for the treatment of HIV infection includes the provision of care that is consistent with the Public Health Service's guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies. This service is funded solely by state dollars in WV.

b. ***AIDS Drug Assistance Program (ADAP)*** is the state-administered program authorized under Part B of the Ryan White Program that provides a limited formulary of FDA-approved medications, including antiretrovirals, to low-income individuals with HIV disease who have limited or no coverage from private insurance or Medicare.

c. ***AIDS Pharmaceutical Assistance (aka ADAP Local)*** includes services through local pharmacies or mail-order pharmacies implemented or contracted by the Part B Grantee to provide HIV/AIDS related medications to clients. This program provides assistance with medication co-pays and deductibles and medications for the uninsured.

d. ***Oral health care*** includes diagnostic, preventive, and therapeutic services provided by general dental practitioners, dental specialists, dental hygienists and auxiliaries, and other trained primary care providers.

e. ***Early intervention services (EIS)*** include counseling individuals with respect to HIV/AIDS; testing (including tests to confirm the presence of the disease, referrals; other clinical and diagnostic services regarding HIV/AIDS; periodic medical evaluations for individuals with HIV/AIDS; and providing therapeutic measures.

f. ***Health Insurance Premium & Cost Sharing Assistance*** is the provision of financial assistance for eligible individuals living with HIV to maintain a continuity of health insurance or to receive medical benefits under a health insurance program. This includes premium payments, co-payments, and deductibles.

g. ***Home Health Care*** includes the provision of services in the home by licensed health care workers such as nurses and the administration of intravenous and aerosolized treatment, parenteral feeding, diagnostic testing, and other medical therapies.

h. ***Home and Community-based Health Services*** include skilled health services furnished to the individual in the individual's home based on a written plan of care established by a case management team that includes appropriate health care professionals. Services include durable medical equipment; home health aide services; day treatment or other partial hospitalization services; home intravenous and aerosolized drug therapy (including prescription drugs administered as part of such therapy); routine diagnostics testing administered in the home; and appropriate mental health, developmental, and rehabilitation services. Inpatient hospitals services, nursing home and other long term care facilities are **not** included.

i. ***Hospice services*** include room, board, nursing care, counseling, physician services, and palliative therapeutics provided to clients in the terminal stages of illness in a residential setting, including a non-acute-care section of a hospital that has been designated and staffed to provide hospice services for terminal clients.

j. ***Mental health services*** are psychological and psychiatric treatment and counseling services offered to individuals with a diagnosed mental illness, conducted in a group or individual setting, and provided by a mental health professional licensed or authorized within the State to render such services including psychiatrists, psychologists, and licensed clinical social workers.

k. ***Medical nutrition therapy*** is provided by a licensed registered dietitian outside of a primary care visit and includes the provision of nutritional supplements.

l. ***Medical Case Management services (including treatment adherence)*** are a range of client centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure

readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic re-evaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact, and any other forms of communication.

m. ***Substance abuse services outpatient*** is the provision of medical or other treatment and/or counseling to address substance abuse problems (i.e., alcohol and/or legal and illegal drugs) in an outpatient setting, rendered by a physician or under the supervision of a physician, or by other qualified personnel.

The support services include:

A. ***Emergency financial assistance (EFA)*** is the provision of essential services, such as food, for a limited frequency through a voucher system or a food bank. Direct cash payments or vouchers that provide access to cash are not permitted. This service is funded solely by state dollars in WV.

B. ***Medical transportation*** includes services that enable an eligible individual to access HIV related health and support services, including services needed to maintain the client in HIV medical care. Services are provided through either direct transportation services or vouchers or tokens.

Resource Inventory

Core medical services are available statewide through both HIV specific and non-specific providers:

Ambulatory outpatient medical care -

Ryan White Funded:Charleston Area Medical Center Part C Clinic; WVU Positive Health Part C Clinic; Shenandoah Valley Medical System Part C Clinic; University of Pittsburgh PACT Part C Clinic; Allegheny General Hospital Part C Clinic; Portsmouth City Health Department Part C Clinic @ Marshall University Internal Medicine Clinic; Winchester, VA

Private Providers: located in Wheeling; Parkersburg; Charleston; Beckley; Logan; Bluefield; Saint Clairsville, OH; Washington, DC and Winchester, VA

VA Medical Systems: located in Clarksburg, Huntington and Martinsburg, Pittsburgh, PA, Washington,D.C. and Baltimore, MD

ADAP - contracted through the Bureau for Medical Services (BMS); available statewide through mail order or any retail pharmacy that contracts with BMS. 85 pharmacies were utilized in calendar year 2011.

ADAP Local - contracted through the State Direct Services agreement with the AIDS Task Force of the Upper Ohio Valley (ATF); available statewide through retail or mail order pharmacies; facilitated through enrollment in Part B medical case management; provides full coverage, wrap around and co-pay services for medications.

Oral Health – contracted through State Direct Services with the ATF; available statewide through fee for service at private dental providers; network of Affordable Dentures; dental centers at WVU and CAMC Part C Clinics; coordinated by Part B medical case managers. Services are limited to cleanings, exams, xrays, fillings and dentures.

Early Intervention Services - available at WVU Part C Clinic; CAMC Part C Clinic; and Marshall University Internal Medicine Clinic; limited HIV Rapid testing is also available from the WVRWPBP.

Emergency Financial Assistance – limited food vouchers for assorted grocery chains are available from Part B medical case managers.

Health Insurance Premiums - contracted through the Part B agreement with the ATF; available statewide and coordinated through the Part B medical case managers.

Home Health Care – provided statewide as a fee for service provided by non HIV specific providers through the Part B agreement with the ATF; coordinated through the Part B medical case managers.

Home and Community Based Health Services – provided statewide as a fee for service through private non HIV specific providers; funded through the Part B agreement with the ATF; coordinated through the Part B medical case managers.

Hospice Services – available statewide through the network of non-profit hospice providers; supplemented when necessary through Part B agreement with the ATF as a fee for service; coordinated through the Part B medical case managers.

Mental Health – non-HIV specific services available statewide through Behavioral Health facilities; HIV specific counseling available through WVU Part C Clinic and CAMC Part C Clinic; fee for service available through Part B agreement with the ATF; coordinated by Part B medical case managers.

Medical Nutrition Therapy – provided statewide as a fee for service by private non HIV specific providers through the Part B agreement with the ATF; coordinated through the Part B medical case managers.

Medical Case Managers – provided statewide through Part B State Direct Services agreement with the ATF; available at all in state Part C Clinics and includes home visits.

Substance Abuse Outpatient Services – non-HIV specific services available statewide; include Behavioral Health programs and private for profit methadone treatment centers; coordinated by Part B medical case managers.

Ryan White Funded Service Providers Serving West Virginia

West Virginia's HIV continuum of care includes funding from Part A, B and C. Due to the close proximity of Part C clinics in cities outside the border of West Virginia, many PLWHA access their HIV primary care at Ryan White funded sites outside the state.

For the 2010 calendar year, the following West Virginia programs reported their number of clients served:

Part B ADAP - provides formulary medications statewide to WV residents only; Total PLWHA served: 348

Part B State Direct Services - provides core medical services coordinated through medical case managers to WV resident PLWHA statewide; Total PLWHA served: 877

Charleston Area Medical Center - provides Part C services to any resident of WV; 19 county target area; Total PLWHA served: 299

WVU Positive Health Clinic - provides Part C services to any resident of WV; 33 county target area; sub-contracts with Shenandoah Medical System; Total PLWHA served: 256

Shenandoah Valley Medical Systems- provides Part A services to residents of Jefferson and Berkeley counties and an expanded area as part of the Part C subcontract with WVU; Total PLWHA served: 114

Providers outside West Virginia:

University of Pittsburgh Medical Center (PA) - provides Part C services to anyone who meets the eligibility guidelines;

Allegheny General Hospital (PA) - provides Part C services to anyone who meets the eligibility guidelines;

University of Virginia - provides Part C services to anyone who meets the eligibility guidelines;

Portsmouth City Health Department - provides Part C services to residents of specific Ohio, Kentucky and three West Virginia counties

It should be noted that the presentation of numbers served for 2010 is for informational purposes only. The Part B PLWHA reported reflect some duplication of Part C data, but some PLWHA are served by Part B and may be accessing HIV primary care at private providers and thus will not be reflected in Part C reports. The report does not reflect the patients who receive HIV primary care in private practice nor at the VA Medical System. The HRSA/HAB reporting system does not unduplicate the data to present a total WV PLWHA receiving Ryan White funded services.

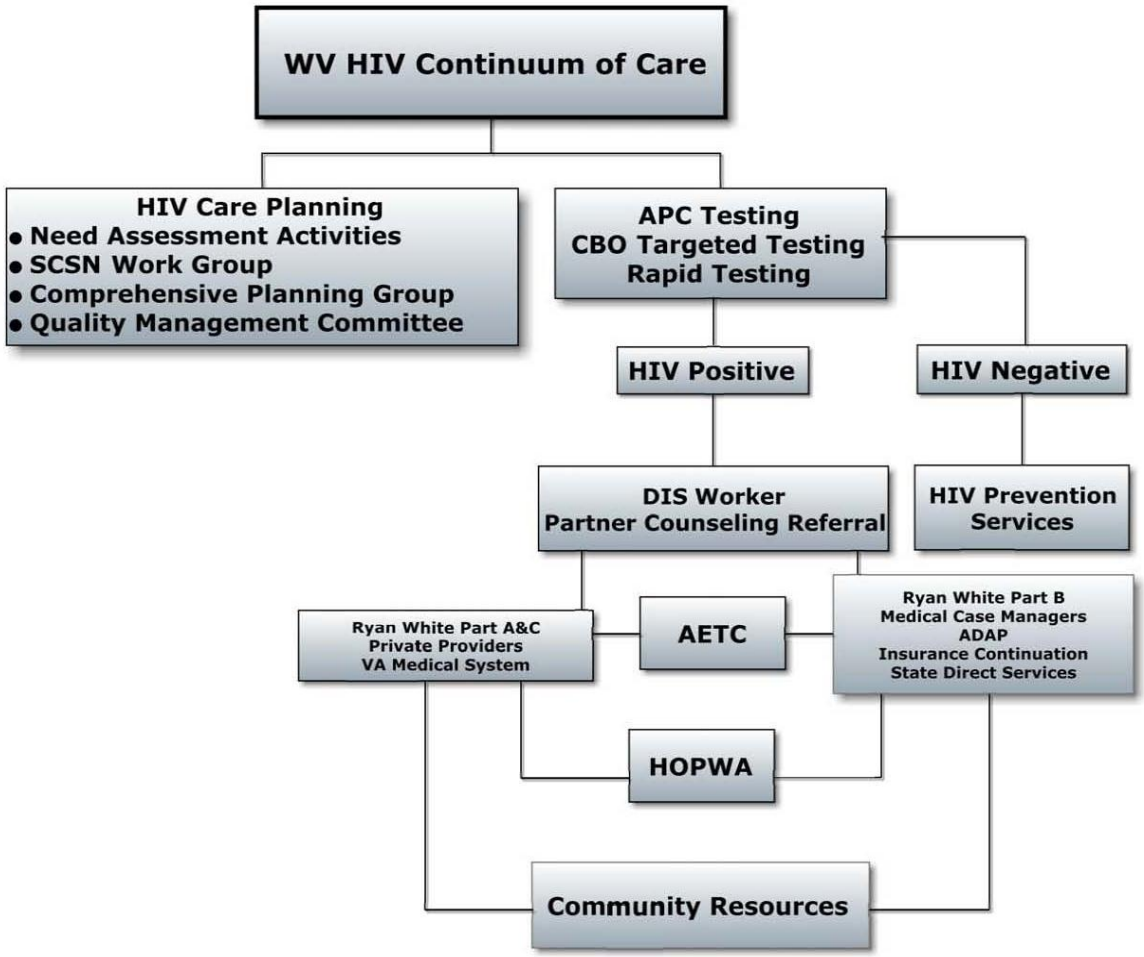


Illustration 22

Coordination of non Ryan White funded services for West Virginia's PLWHA is conducted by the WVRWPBP medical case managers, HOPWA case managers and through clinic staff at the Ryan White Part C and Part A clinics. Referrals are made to community agencies as needs are identified and/or requests are received.

HIV / AIDS Prevention Community Based Organizations

AIDS Task Force of the Upper Ohio Valley
Wheeling, WV

All-AID International, Inc.
Charleston, WV

Caritas House
Morgantown, WV

Community Networks, Inc.
Martinsburg, WV

Covenant House
Charleston, WV

Ebenezer Medical Outreach
Huntington, WV

HIV Testing Sites

AIDS Prevention Centers (APC)

Berkeley County Health Department
Martinsburg, WV

Cabell-Huntington Health Department
Huntington, WV

Fayette County Health Department
Fayetteville, WV

Greenbrier County Health Department
Fairlea, WV

Harrison-Clarksburg Health Dept.
Clarksburg, WV

Kanawha County Health Department
Charleston, WV

Marshall County Health Department
Moundsville, WV

McDowell County Health Department
Wilcoe, WV

Mercer County Health Department
Bluefield, WV

Monongalia County Health Department
Morgantown, WV

Morgantown Health Right
Morgantown, WV

Putnam County Health Department
Hurricane, WV

Raleigh County Health Department
Beckley, WV

Randolph County Health Department
Elkins, WV

Wheeling-Ohio Health Department
Wheeling, WV

Wood County Health Department
Parkersburg, WV

STD Clinics

Beckley - **Raleigh County Health Department**
Berkeley Springs - **Morgan County Health Department**
Bluefield - **Mercer County Health Department**
Buckhannon - **Upshur County Health Department**
Charleston - **Kanawha County Health Department**

Clarksburg -	**Harrison-Clarksburg Health Department**
Clay -	**Clay County Health Department**
Elizabeth -	**Wirt County Health Department**
Elkins -	**Randolph-Elkins Health Department**
Fairmont -	**Marion County Health Department**
Fayetteville -	**Fayette County Health Department**
Franklin -	**Pendleton County Health Department**
Glenville -	**Gilmer County Health Department**
Grafton -	**Taylor-Grafton Health Department**
Grantsville -	**Calhoun County Health Department**
Hamlin -	**Lincoln County Health Department**
Harrisville -	**Ritchie County Health Department**
Hinton -	**Summers County Health Department**
Huntington -	**Cabell-Huntington Health Department**
Hurricane -	**Putnam County Health Department**
Kearneysville -	**Jefferson County Health Department**
Keyser -	**Mineral County Health Department**
Logan -	**Logan County Health Department**
Marlington -	**Pocahontas County Health Department**
Martinsburg -	**Berkeley County Health Department**
Moorefield -	**Hardy County Health Department**
Morgantown -	**Monongalia County Health Department**
Moundsville -	**Marshall County Health Department**
New Cumberland -	**Hancock County Health Department**
New Martinsville -	**Wetzel County Health Department**
Parkersburg -	**Mid-Ohio Valley Health Department**
Petersburg -	**Grant County Health Department**
Philippi -	**Barbour County Health Department**
Pineville -	**Wyoming County Health Department**
Point Pleasant -	**Mason County Health Department**
Ripley -	**Jackson County Health Department**
Romney -	**Hampshire County Health Department**
Ronceverte -	**Greenbrier County Health Department**
Sistersville -	**Tyler County Health Department**
Spencer -	**Roane County Health Department**
St.Marys -	**Pleasants County Health Department**
Summersville -	**Nicholas County Health Department**
Sutton -	**Braxton County Health Department**
Union -	**Monroe County Health Department**
Webster Springs -	**Webster County Health Department**
Wellsburg -	**Brooke County Health Department**
West Union -	**Doddridge County Health Department**
Weston -	**Lewis County Health Department**
Wheeling -	**Wheeling-Ohio County Health Department**
Wilcoe -	**McDowell County Health Department**
Williamson -	**Mingo County Health Department**

Health Care Clinics

Ebenezer Medical Outreach
Huntington, WV

Family Care Services
Charleston, WV

Good Samaritan Clinic Inc.
Parkersburg, WV

Health Access, Inc
Clarksburg, WV

Mercer Health Right
Bluefield, WV

Milan Puskar Health Right
Morgantown, WV

Wheeling Health Right
Wheeling, WV

Women's Health Center
Charleston, WV

WV Health Right
Charleston, WV

Substance Abuse / Addiction Services / Outpatient

Beckley Treatment Center
Beaver, WV

Charleston Treatment Center
Charleston, WV

Clarksburg Treatment Center
Clarksburg, WV

Highland Hospital
Charleston, WV

Huntington Treatment Center
Huntington, WV

Martinsburg Treatment Center
Martinsburg, WV

Olympic Center
Kingwood, WV

Parkersburg Treatment Center
Parkersburg, WV

Southway at Thomas Hospital
South Charleston, WV

Williamson Treatment Center
Williamson, WV

Miracles Happen
Wheeling, WV

Substance Abuse/Treatment Residential Programs

ACT Unit/Valley Health Care
Fairmont, WV

Amity Center/Westbrook Health Services
Parkersburg, WV

FMRS
Beckley, WV

Futures Residential Treatment Center
Logan, WV

Mirador West
Vienna, WV

Legends
Princeton, WV

Mid-Ohio Valley Fellowship Home
Parkersburg, WV

New Beginnings
Fairmont, WV

Parcway Prestera Center
Huntington, WV

John D. Good Recovery Center
Terra Alta, WV

Mental Health / Counseling Services

Seneca Mental Health
Summersville, WV

United Summit Center
Clarksburg, WV

Valley Mental Health
Morgantown, WV

VET Center
Charleston, WV

WV Mental Health Consumer's Association
Charleston, WV

Comprehensive Mental Health Centers

Appalachian Community Health Center, Inc

Regional Offices:	**Randolph County**
	Barbour County
	Tucker County
	Upshur County

Eastern Panhandle Mental Health Center, Inc

Regional Offices:	**Berkeley County**
	Jefferson County
	Morgan County

FMRS Health Systems, Inc

Regional Offices:	**Fayette County**
	Monroe County
	Raleigh County
	Summers County

Healthways, Inc

Regional Offices:	**Brooke County**

Logan-Mingo Area Mental Health, Inc

Regional Offices:	**Logan County**
	Mingo County

Southern Highlands

Regional Offices:	**Mercer County**
	McDowell County
	Wyoming County

Northwood Health Systems, Inc

Regional Offices:	**Marshall County**
	Ohio County
	Wetzel County

Potomac Highlands Guild, Inc

Regional Offices:	**Grant County**
	Hampshire County
	Hardy County
	Mineral County
	Pendleton County

Prestera Center

Regional Offices:	**Cabell County**
	Lincoln County
	Mason County
	Wayne County

United Summit Center

Regional Offices:	**Braxton County**
	Doddridge County
	Gilmer County
	Harrison County
	Lewis County
	Marion County

Valley Health Care

Regional Offices:	**Monongalia County**
	Marion County
	Preston County
	Taylor County

Westbrook Health Services, Inc

Regional Offices:	**Calhoun County**
	Jackson County
	Ritchie County
	Roane County
	Tyler County

Arc of Three Rivers
Charleston, WV

Autism Service Center
Huntington, WV

Green Acres Regional Center, Inc
Lesage, WV

Potomac Comprehensive Diagnostic and Guidance Center, Inc
Romney, WV

Needs Assessment

The State Direct Service provider, the ATF, conducted a comprehensive needs assessment in 2010-11. In addition, key informant interviews were conducted and a special study was conducted with PLWHA who were out of care.

The Out of Care special study revealed variety of reasons that PLWHA were not engaged in HIV primary care. Of the 16 PLWHA interviewed, 25% were out of care due to being discharged by their previous physician. Clients self-reported either behavior problems or multiple cancellations of appointments as the reasons for being discharged. 50% of those interviewed commented that they 'felt fine', thus do not have the impetus to engage in care. Some reported that side effects of previous medications were unbearable. Transportation or distance to travel to the nearest Part C provider was also cited by over 50% as a contributing factor. Substance abuse was also reported by 25%. Many of those interviewed had multiple reasons for declining the opportunity to enter care, but each identified a predominant reason. WVRWPBP medical case managers continue to educate the study participants and encourage them to return to care. Two of the sixteen have been successfully linked to a new provider.

During the needs assessment period, 773 PLWHA had received Part B funded medical case management services. 379 or 49% responded to the client survey. Those surveyed included recipients of State Direct Services, ADAP prescriptions. Insurance Continuation Program participants were also included in the survey.

The survey collected data related to age, gender, race and ethnicity, county of residence and mode of transmission in order to ensure that the survey captured a representative cross section of the epidemic in the state. The survey was designed by the WV Ryan White Part B Program (WVRWPBP) staff and was reviewed by a panel of PLWHA. The survey was field tested to determine the efficiency of the instrument. A coded system allowed for surveys to be completed anonymously. The survey results were presented to the Statewide Coordinated Statement of Need (SCSN) Workgroup in October 2011.

2010-11 Needs Assessment Survey Results

The 2010-11 Part B Comprehensive Needs Assessment Client Survey has some limitations which should be considered in evaluating the results.

3. The survey instrument was distributed primarily to PLWHA who were in care. Efforts were made to distribute the survey to those who were not in care, but the numbers were minimal. However a special study was conducted for those out of care.
4. The survey respondents reflect the gender demographic of the state's PLWHA closely.
5. The survey respondents differ more significantly in the race/ethnicity demographics for the state's PLWHA. The state reports 67% White, 30% Black and 3% Other/Unknown. The survey respondents were 75% White, 23% Black and 2% Other/Unknown.
6. The age of the survey respondents differs significantly from the state's epi tables for PLWHA. The state reports 14% of PLWHA in the 25-34 age group

while 15% of the respondents were represented in the 20-29 age group. The state reports 27% of the PLWHA are in the 35-44 age group while 24% of the respondents reported being between 30-39. In the 45-54 age group, the state reports 36% PLWHA, but 38% of the survey respondents fell into the 40-49 age group. For the age group over 55, the state reports 19% PLWHA compared to 23% of the survey respondents being over 50.

The vast differences in the age group comparisons between HARS data and the survey respondents may be attributed to various factors. The survey respondents include a population of 38% who were diagnosed outside of West Virginia, thus eliminating many of them from the eHARS data base. In addition, PLWHA who are farther advanced in their disease, and possibly thus older, are more likely to be in care and thus increasing their likelihood to be part of the survey respondents.

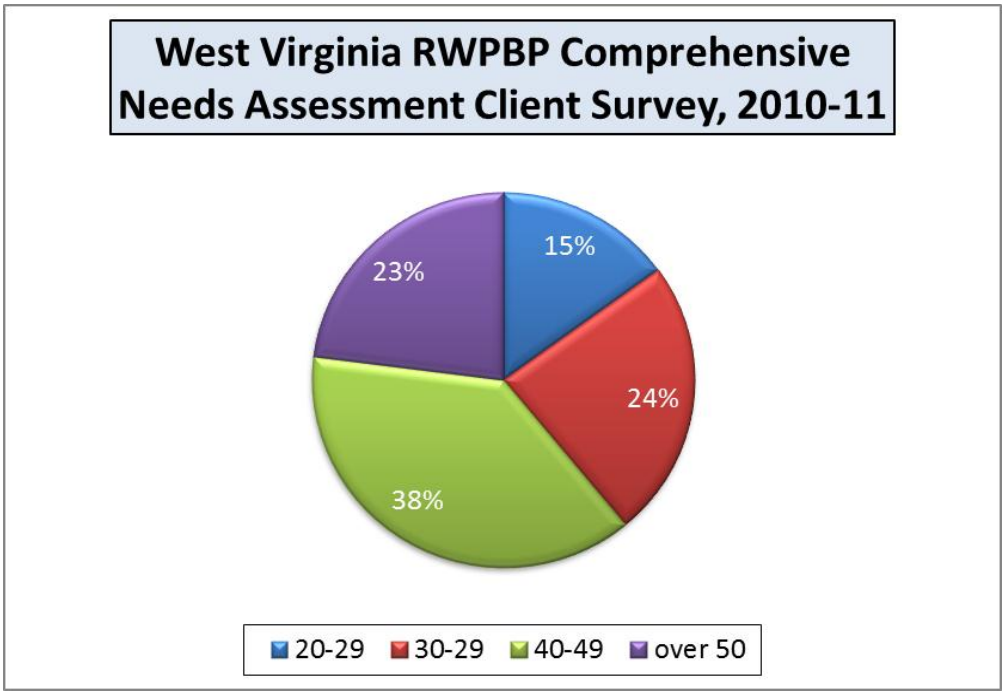


Figure 1

The survey respondents self-reported their HIV/AIDS risk factor. The state's HARS data reports PLWHA as:

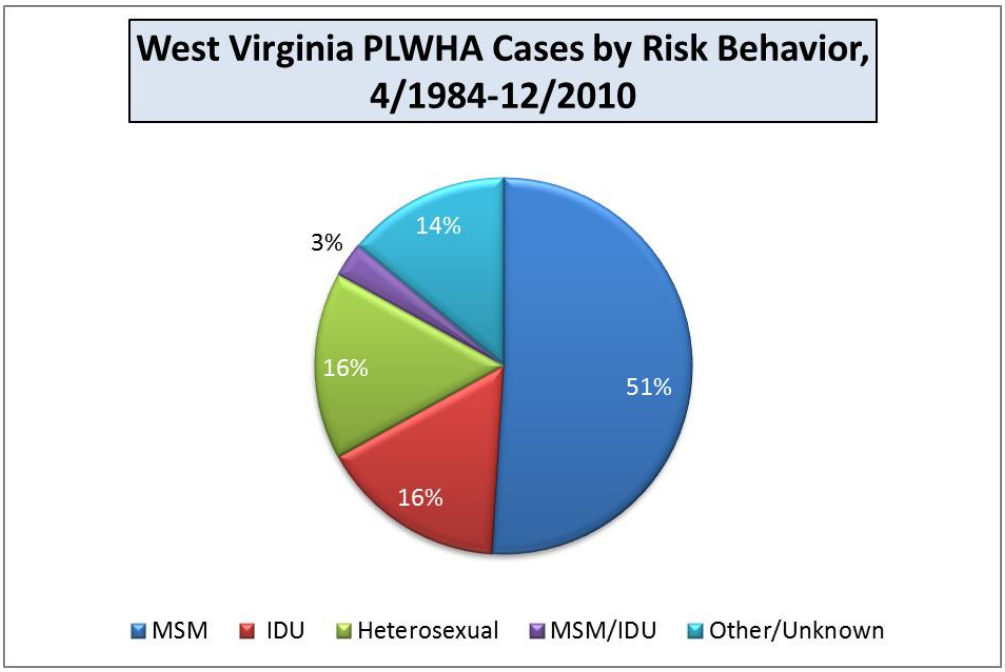


Figure 2

Survey Respondents reported:

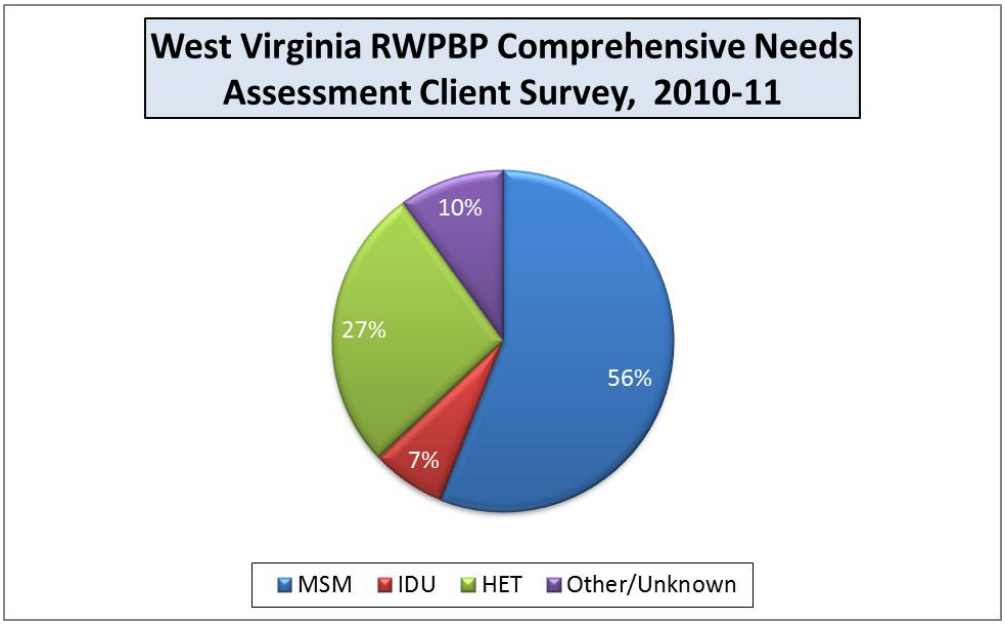


Figure 3

The Survey Respondents self-reported how long it took to first to see a HIV primary care physician after receiving a diagnosis. All of the respondents reported that they had seen a HIV primary care physician at least once:

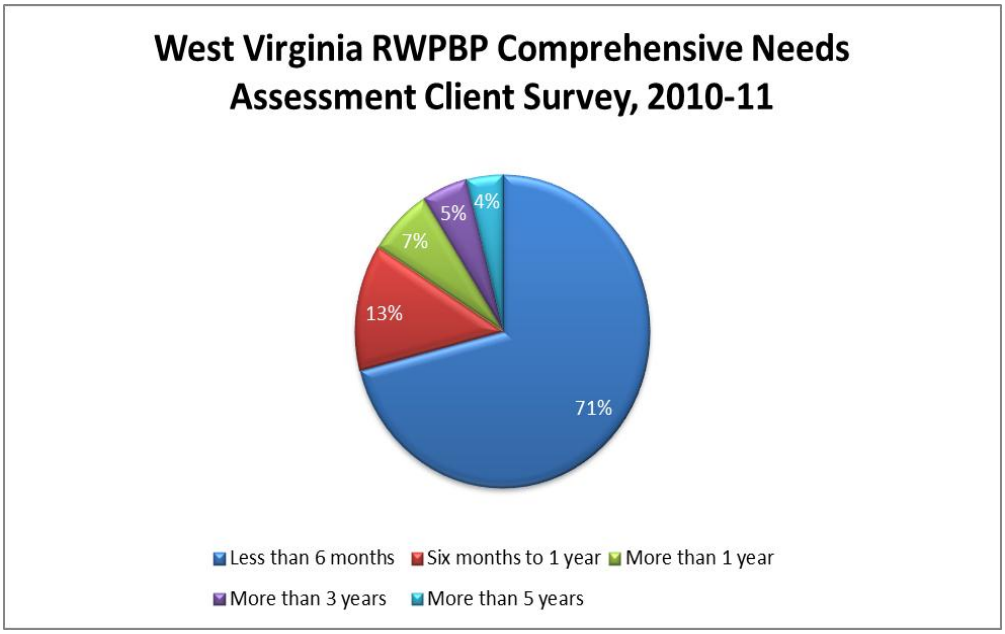


Figure 4

The respondents who delayed entering into care by more than 6 months indicated that fear and denial, stigma and lack of knowledge about resources were the predominant reasons for delaying entry into HIV primary care. Other reasons included substance abuse and feeling healthy.

The survey queried the respondents about their current HIV primary care. The survey asked about the frequency of health care appointments, the one way distance traveled to receive HIV primary care and the satisfaction with health care services being delivered.

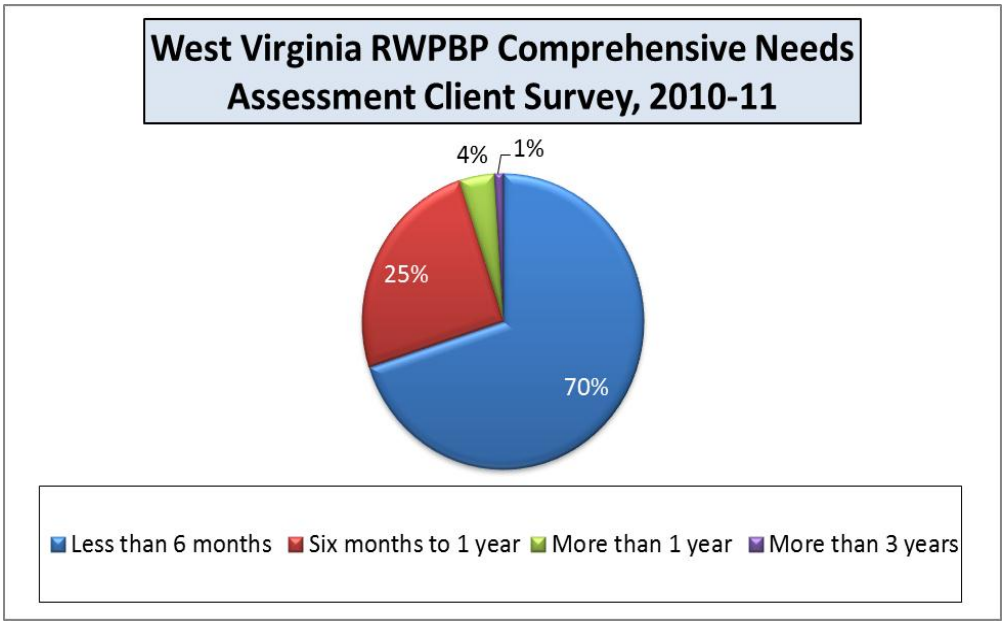


Figure 5

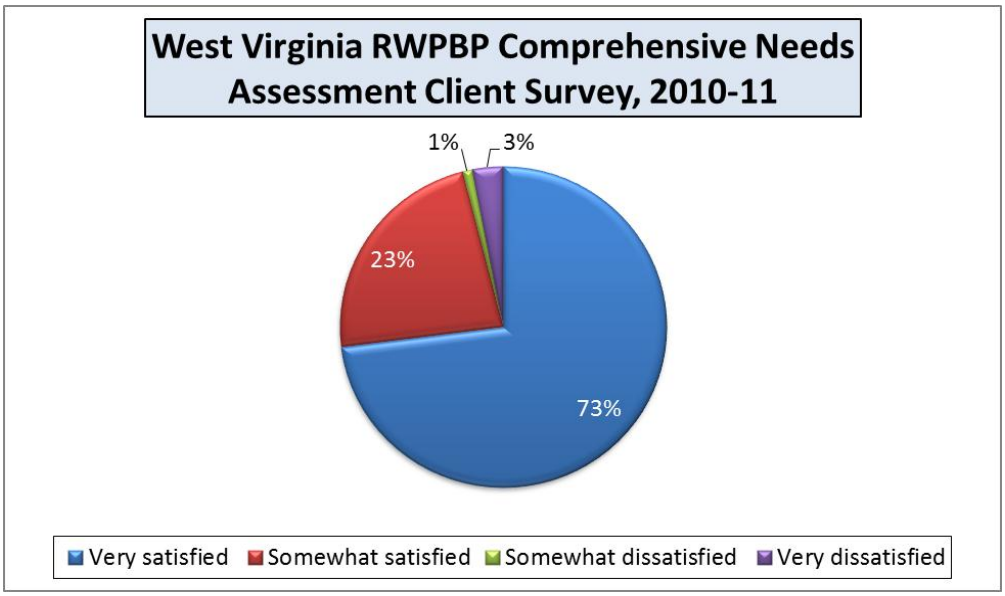


Figure 6

Distance Traveled One-Way for HIV Primary Care:

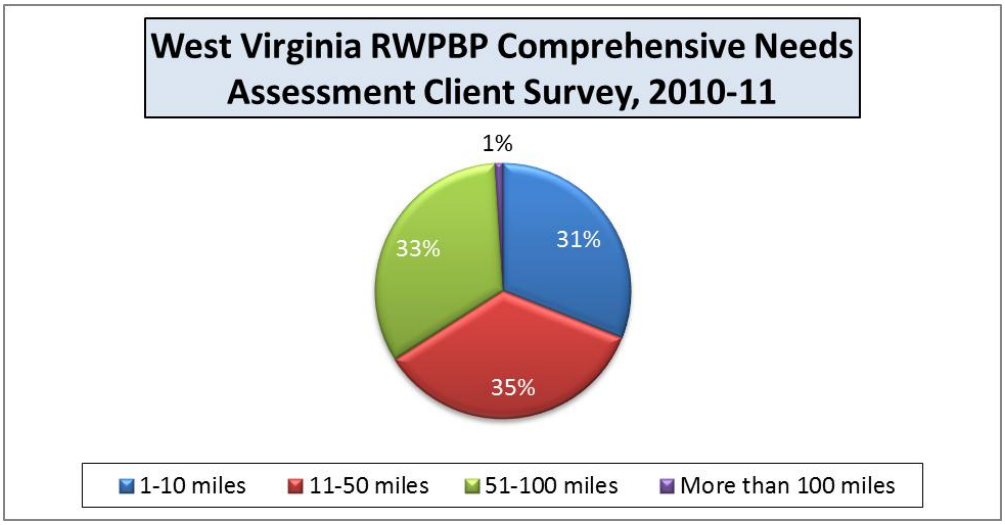


Figure 7

Respondents self-reported whether they have been prescribed and are taking antiretrovirals at the time of the survey:

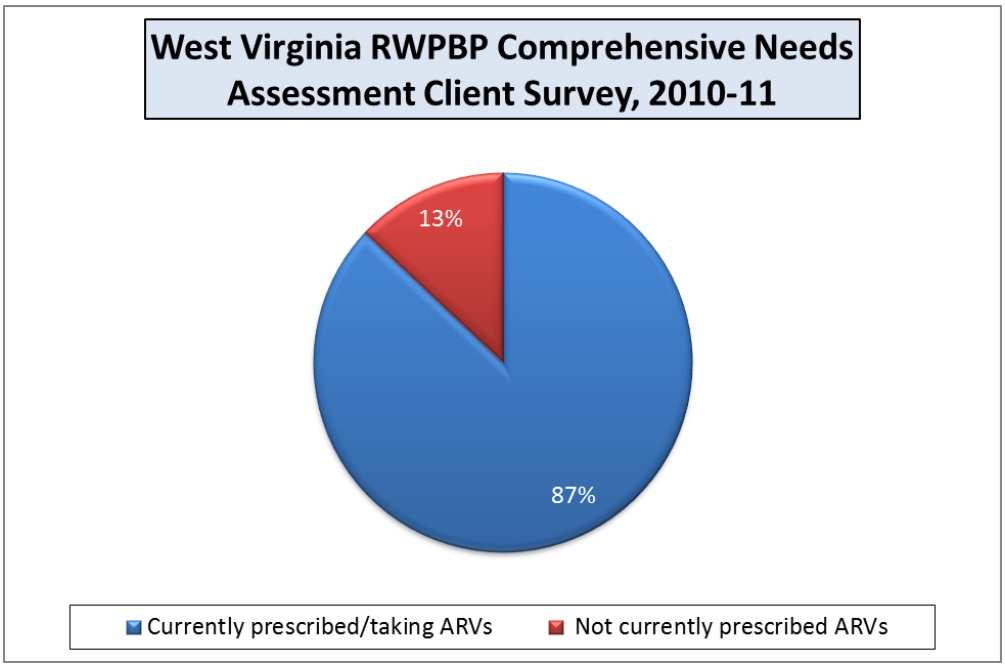


Figure 8

On the topic of oral health care, the respondents were queried regarding their dental needs:

West Virginia RWPBP Comprehensive Needs Assessment Client Survey, 2010-11	
Needs	**%**
Need Extractions	27
Need Fillings	16
Need Dentures/Partial	14
Last Dental Cleaning/Exam more than 6 mos ago	32

Table 1

The survey asked the respondents if they needed additional assistance in paying for any medications:

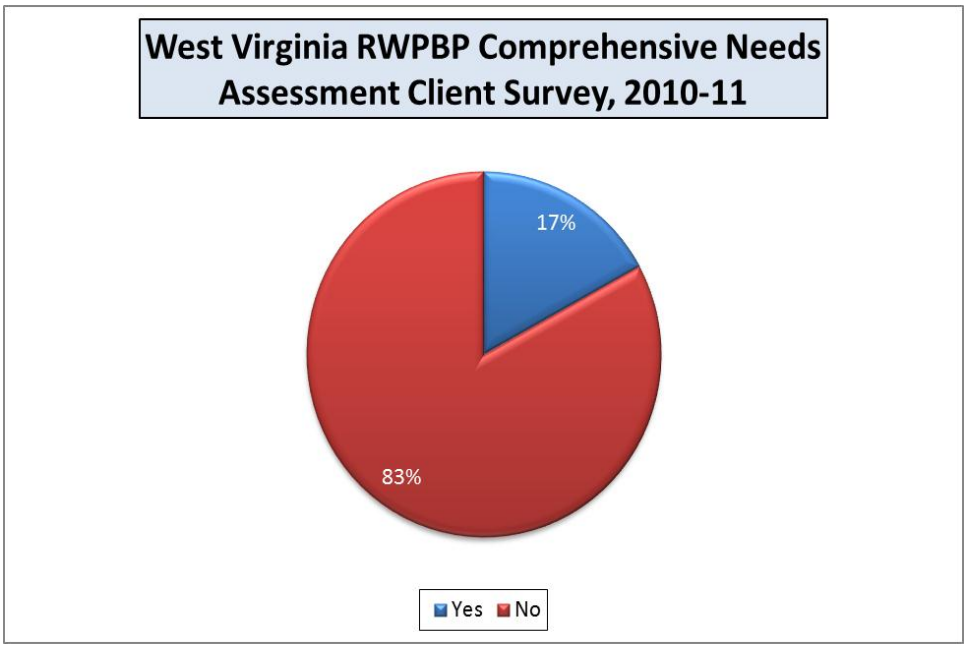


Figure 9

Survey respondents were asked to prioritize core services:

West Virginia RWPBP Comprehensive Needs Assessment Client, 2010-11	
Rank	**Services**
1	Primary Care
2	Medications
3	Medical Case Management
4	Oral Health
5	Mental Health

Table 2

In addition, respondents were asked to prioritize core services which needed to be increased:

West Virginia RWPBP Comprehensive Needs Assessment Client, 2010-11	
Rank	**Services**
1	Oral Health
2	Medications
3	Mental Health
4	Medical Case Management
5	Substance Abuse Treatment

Table 3

Medical case management recipients were requested to indicate their satisfaction with the timelines of medical case manager responses to client requests.

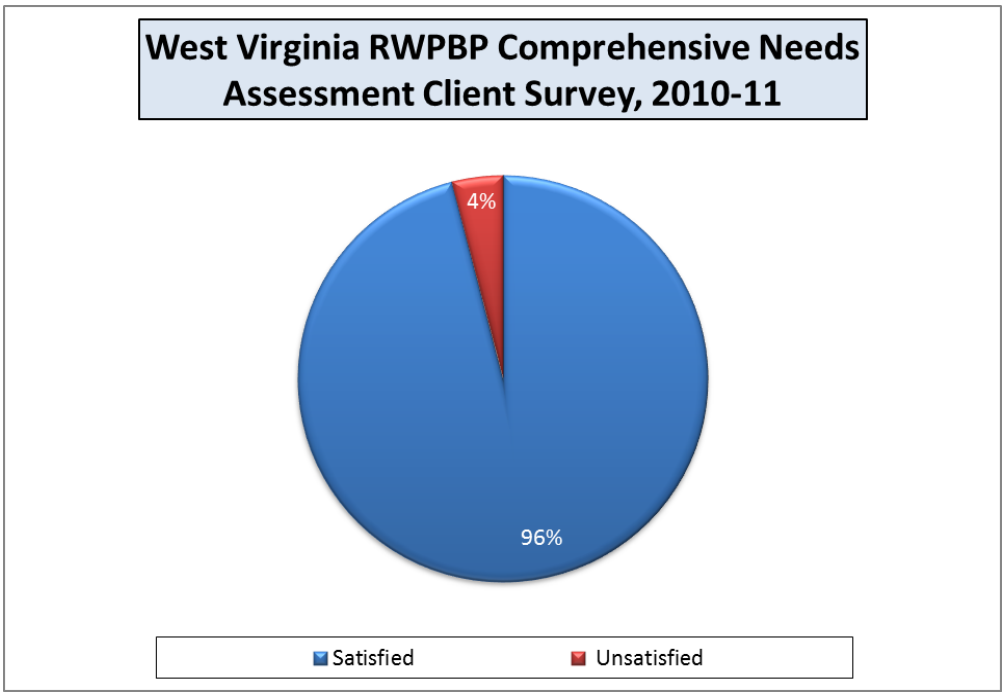


Figure 10

ADAP participants were queried with three questions related to the WV ADAP. The questions included their satisfaction with ADAP services, their need for additional medications on the ADAP formulary and the types of additional drugs needed.

West Virginia RWPBP Comprehensive Needs Assessment Client, 2010-11		
Questions	**Satisfied**	**Dissatisfied**
Satisfaction with ADAP services	99%	1%

Table 4

Additional drugs needed on the ADAP Formulary:

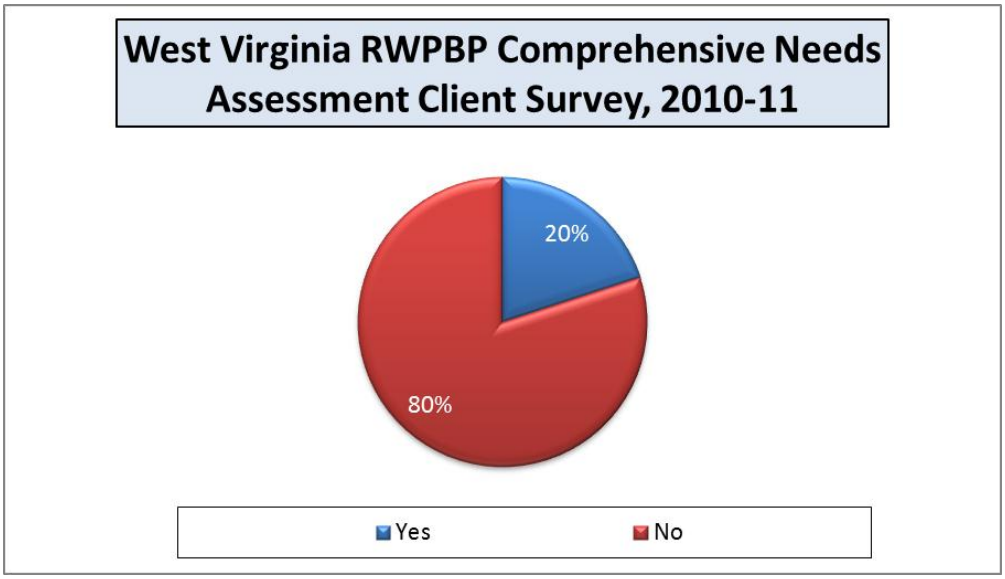


Figure 11

West Virginia RWPBP Comprehensive Needs Assessment Client, 2010-11	
Rank	**Drugs**
1	Pain
2	Testosterone
3	Sleeping aids
4	Appetite stimulants

Table 5

Although the Comprehensive Needs Assessment Survey concentrated on the Ryan White Part B core services, respondents also prioritized their needs in the area of support services. The top five areas needing increased are listed:

West Virginia RWPBP Comprehensive Needs Assessment Client, 2010-11	
Rank	**Services**
1	Transportation (bus tickets, gas cards)
2	Housing (rent, utility assistance)
3	Food (food vouchers, food bank)
4	Nutritional Supplements
5	Clothing

Table 6

Prevention Needs

Three focus groups were conducted with PLWHA to discuss prevention needs of PLWHA in West Virginia. The focus groups produced a list of HIV prevention needs for all PLWHA and a separate list for sub populations. The lists developed were not prioritized by the focus groups. It was the general consensus of the three groups that more CDC prevention dollars should be targeted toward statewide prevention efforts for PLWHA.

Greatest prevention needs among all PLWHA populations:

1. Reduce stigma associated with HIV/AIDS: Stigma reduction is needed in order to encourage more WV residents to be tested and to successfully encourage PLWHA who know their status to enter and remain in care.
2. Increase access to convenient rapids testing: Additional opportunities for rapids testing would provide increased numbers in PLWHA who know their status. Testing needs to be well publicized at convenient locations, during convenient hours and conducted by trusted members of the community.
3. Increase social marketing campaigns: Social marketing campaign and events directed towards PLWHA would increase adherence to medications, reduce unsafe behaviors and promote condom utilization. Campaigns such as "HIV Stops with Me" were discussed.
4. Conduct statewide meetings that provide education and advocacy training, including transportation assistance for accessing the meetings
5. Provide opportunities for retreats for PLWHA, with special emphasis on the newly diagnosed

Specific subpopulation prevention needs were also identified:

1. Heterosexual: general education to promote testing; domestic violence protection programs for women who test positive; condom negotiation skill workshops for women
2. MSM: reduce homophobia in rural areas of the state and in church communities; alcohol and drug use prevention activities; more presence of prevention activities including rapids testing at gay bars, adult bookstores and the state's two gay campgrounds; online activities for MSM websites
3. IDU: reduce stigma associated with chemical dependency; reduce stigma associated with HIV/AIDS at substance abuse treatment facilities; increase availability of rapids testing in low income housing developments and at food pantries; remove barriers to federal funding for housing for drug offenders
4. Newly diagnosed: target education for navigating the system of care and support, oral health, transportation, housing, support groups, less paperwork and applications and mental health
5. Out of care: reduce stigma associated with HIV, provide care and treatment and prevention services in more locations to help decrease travel barriers; more rural providers especially in the southern area of the state

Statewide Coordinated Statement of Need

In accordance with requirements of the Ryan White HIV/AIDS Treatment Modernization Act of 2006, Section 2617 (b) (6), the State of West Virginia's STD, HIV and Hepatitis Program convened a meeting of all Ryan White funded Parts in WV, PLWHA, providers and representatives of public agencies to develop a Statewide Coordinated Statement of Need (SCSN).

The Statewide Coordinated Statement of Need Meeting for 2011 was conducted as a single two day statewide meeting. The purpose of the meeting was to provide a statewide collaborative mechanism to identify and address significant HIV care issues related to the needs of people living with HIV/AIDS in West Virginia and to maximize coordination, integration and effective linkages across all Parts of the Ryan White HIV/AIDS Program in the state. The meeting, conducted on October 27 and 28 produced this document that reflects the input and the approval of all of the funded Parts in West Virginia as well representation of care and support services and PLWHA.

The 2011 meeting was conducted in Clarksburg, WV at the Hilton Garden Inn. The Part B Grantee assumed responsibility for all of the expenses related to the meetings. All of the funded Parts in West Virginia, A, B, C and F, fully participated in all of the meetings. A total of 85 persons were invited to the meetings; 61 persons accepted the invitations. Slightly more than 30 % of the participants were PLWHA. Participants represented Parts A, B, C and F, the Grantee, AIDS Prevention testing sites, local county health departments, private providers, community based organizations, all of the state's HOPWA sites, two Disease Investigator Specialists, eHARS Administrator, Medicaid representative, housing specialists, community clinic staff, Part B medical case managers, the Director of the Division of STD, HIV and Hepatitis and PLWHA. The following includes a partial list of participants. The names of some PLWHA have been omitted, at their request.

Jay Adams, Chair
Sharon Wood
Carol Renner
Stacie Mcie
Brian Henry
Larry Chancellor
Susan Hall
Tabatha Coombs
Thurston Stemple
Shawnna Walker
Angela Adkins
David Bennett
Jeanette Southerly
Bridgette Connard
Mary Clarke
Claire Dye
Darryl Cannady
Marilyn McClure
Paul Milam
Joey Poyner
Wes Thomas
Clyde Tyler
Larry Chancellor
Holley Hayes
David Lockhart
Scott Matthews
Christine Teague
Melanie Nace
Sharon Smith
Anndrea Rogers
Cheryl Moyer
Kathy Chase
Hugh Adkins
Reggie Cain
Carolyn Kidd
Brenda Cook
Linda Davis
Matt Eakle
Roger Prunty
Hank McMurray
Denise Heflin-Peyton
J.T.
Ashley Whaley
Mike Vincent
Mark Miller
Judson Talbott
John Sonneday
Nancy Parsons
John Restaino
David Grubb
Amy Richmond
M. Martin
B.H.
K.R.

The 2011 SCSN focused on HIV primary care and treatment. Each of the funded Parts in West Virginia presented data related to their 2010 Ryan White Services Report (RSR). Data was also provided to the participants for four clinics funded by Part C in Virginia, Ohio and Pennsylvania.

The meeting included extensive discussion of HIV related services provided in West Virginia. In addition, the Division Director of Surveillance and Disease Control provided an epidemiological report and description of specific populations of PLWHA in West Virginia. The combined work group developed a list of the needs of PLWHA in West Virginia. The group reviewed data related to those in care and discussed the needs of those who know their status but are not in care. Barriers to care and gaps in services were identified.

In 2011, the state organized the SCSN to include twelve headings for the needs section. All sections focus on primary care and treatment. Each of them is related to unmet needs and gaps in core medical services. Each of the twelve headings is followed by identified needs that assist in ensuring that PLWHA in West Virginia have access to life extending care and treatment.

The SCSN work group has also developed a list of fifteen over-arching issues that currently impact the lives of PLWHA in West Virginia throughout their disease progression. These issues particularly impact access to care and the quality of HIV primary care for PLWHA in West Virginia.

Over- Arching Issues

ADAP	As the safety net program for the uninsured, the continued stabilization of ADAP is essential.
Unmet Needs	Increased cross Part collaboration with the WV STD, HIV and Hepatitis Surveillance Program is required to reduce the unmet need of PLWHA who are aware of their status, but not in care period.
Parity	All PLWHA in West Virginia deserve parity in care and support services regardless of their geographic location in the state.
Funding	Increased federal, state and private dollars are needed to meet the overall current and emerging needs of the HIV community. Over-burdened care systems are not fiscally prepared to meet the unmet needs of those who know their status but are not in care.
Transportation	In order to improve access to all care and support services for PLWHA, the identification, development and enhancement of transportation, infra-structure must be fostered throughout the state, especially to meet the needs of rural and traditionally under-served populations.
Resource	In order to meet the current and ongoing needs of people infected or
Development	affected with HIV, existing resources and networks need to build effective programs and collaborate to meet the emerging needs.

Health Care	The current HIV primary care system needs to expand to ensure the state maximizes equal health access to compassionate, competent and comprehensive health care for all PLWHA in West Virginia.
Long-Term Survival	As the lives of PLWHA are extended through access to comprehensive HIV primary care, long-term survival needs and issues must be identified and addressed.
Mental Health	The current mental health treatment system needs to expand to ensure that the state maximizes equal access to compassionate, competent and comprehensive mental health treatment for all PLWHA in West Virginia.
Confidentiality	As stigma and fear of discrimination continue to be barriers to being in care, the maintenance of confidentiality, regarding all aspects of the clients' care and service must be enhanced and enforced.
Education	In order to reduce stigma, improve the quality of service to consumers and to improve the overall lives of PLWHA, education must be broadened to include knowledge of every aspect of HIV for the public, consumers and all providers.
Capacity Building	In order to meet the current and emerging needs of PLWHA, it is essential to broaden, promote, collaborate and build capacity for HIV/AIDS services agencies and other entities.
Affordable Care Act	Increase awareness and collaboration among Ryan White parts and service organizations to stay abreast with changes in the Affordable Care Act. Advocate for the continued Ryan White funding recognizing the unique needs of PLWHA and the overall public health consequences of the loss of Ryan White funding.
National HIV/AIDS Strategy	Strengthen a strong collaboration between care, prevention and non-profit organizations to develop, promote and utilize a statewide marketing campaign for promoting the goals of the NHAS in care and prevention services.
Substance Abuse	The current substance abuse treatment system needs to expand to ensure that the state maximizes equal access to compassionate, competent and comprehensive substance abuse treatment services for all PLWHA in WV.

The 2011 SCSN workgroup identified the following needs:

Care and Treatment

Maintain and increase funding and access for comprehensive HIV primary and specialty care, including preventive screenings.

Fund culturally competent models of care that expand HIV primary care services to rural Appalachian under-served parts of the state, including services for the undocumented.

Continue awareness and advocacy of charity care currently offered by hospital, laboratory and other indigent programs.

Ensure parity in services to undocumented persons.

Increase funding for qualified HIV providers.

Assure that all PLWHA have equal access to comprehensive primary and specialty care.

Increase the number of qualified HIV care providers with special attention to those who participate in the Medicaid program.

Increase / maintain funding for the delivery of quality care provided by competent HIV providers that is consistent with DHHS guidelines.

Recognize that a growing number of existing HIV primary care specialists and healthcare and service providers throughout the state are nearing retirement and encourage and support the training of new providers throughout the state.

In order to address unmet need, develop systems to support the identification, linkage and retention to HIV primary care.

Continue to improve medication adherence for PLWHA through comprehensive medical case management services.

Fund and implement Peer Advocacy at each Ryan White funded agency and other service providers.

Recognize and identify perceived patient and confidentiality concerns that may hinder efforts to linkage and retention to care.

In order to reduce stigma associated with HIV, provide reinforcement to all clients regarding the protection of confidentiality.

Increase access to care and provider training for Hepatitis C co-infection.

Maintain and increase collaboration between Hemophilia Clinics and HIV clinics.

Promote the decrease of the number of person that know their status but are not in care through increased outreach services and linkage to support services.

Identify and seek funding to increase transportation services / assistance to medical / supportive appointments.

Promote the importance of confidentiality in all realms of care and support services in accordance with HIPPA.

Hire and train culturally competent HIV / AIDS providers, staff and volunteers.

Increase access, support, funding and availability of Ryan White Part B funded services.

Ensure that extended provider and care facilities provide comprehensive care services, client safety and protection of PLWHA.

Strengthen a strong collaboration between care, prevention and non-profit organizations to develop, promote and utilize a statewide marketing campaign for promoting the care and prevention goals of the NHAS.

Create / maintain a safe environment for institutionalized or incarcerated individuals to access and receive education, testing and health care and transitional services.

Maintain / increase the capacity to provide prevention for positive services.

Continue collaboration between the Veterans Administration and the WV STD, HIV and Hepatitis Program.

Increase capacity to provide comprehensive services to all disenfranchised communities.

Increase the number of PLWHA who have Advanced Directives and increase awareness of end of life choices for care.

Increase access to in-home care services.

Build capacity to provide smoking cessation counseling and treatment.

Ensure that all Ryan White funded clinics explore the potential to become medical homes.

Ensure that during the transition to the Affordable Care Act, that all PLWHA continue to receive high quality care.

Advocate for continued Ryan White funding, recognizing the unique needs of PLWHA and the overall public health consequences of the loss of Ryan White funding.

Recognize the growing body of literature regarding PrEP and nPEP and ensure the capacity for ongoing education for providers, clients and prevention agencies.

Ensure that Community Health Centers (CHC) have training, resources and opportunities to collaborate with Ryan White service providers.

Build capacity to provide anal dysplasia screenings for HIV positive patients.

Increase capacity to provide cervical dysplasia screenings to female patients.

Medications

Increase funding for laboratory testing related to safe and appropriate use of antiretroviral medications in accordance with DHHS guidelines, such as, but not limited to: phenotype, genotype, tropism and HLA – B5701.

Maintain funding for the ADAP formulary and all FDA approved antiretrovirals and increase access for psychotropic, Hepatitis C therapies and medications for co-morbidities.

Maintain and increase ADAP funding to provide full access to the ADAP formulary for all who qualify.

Maintain and increase awareness of other potential avenues of medication support such as state programs and patient assistance programs.

Continue to explore all avenues of cost savings for acquiring and dispensing prescriptions for the WV ADAP.

HIV/HCV Testing

Maintain and increase funding and availability for HIV testing in medical and non-medical settings.

Ensure availability and funding for rapid testing.

Increase education, onsite rapid testing and screening for HIV in at risk populations (ex. WV drug treatment centers, correctional facilities, STD clinics and homeless shelters).

Maintain and increase education, testing and screening for HCV co-infection for at risk populations.

Increase outreach and education to disenfranchised communities.

Substance Abuse

Maintain / increase funding to provide substance abuse treatment.

Increase educational awareness and motivational strategies to encourage clients to engage in substance abuse treatment.

Support and increase the number of available substance abuse treatment centers and providers.

Oral Health

Increase the number of dentists and dental providers that offer competent oral healthcare to PLWHA.

Promote Ryan White Part F dental reimbursement funding opportunities in West Virginia.

Ensure that all PLWHA have a minimum of one oral healthcare screening per year.

Continue collaboration among all Ryan White providers to share costs of oral health services.

Mental Health

Maintain / increase funding to provide adequate and appropriate mental health services.

Increase number of mental health providers trained in HIV related issues.

Increase capacity to provide at least one mental health screening per year.

Increase funding and capacity to provide mental health services, including medications, provider fees and counseling.

Ensuring PLWHA Stay in Care

Promote access to and knowledge of all support services including case management, food banks, support groups and buddy plans.

Develop access to holistic support for PLWHA.

Increase counseling and address issues related to long term survival.

Provide timely and uniform communication to all PLWHA.

Implement and support the review / appeal process for allowing flexibility for determining client eligibility related to their income.

Increase and promote the availability of safe and affordable transitional and permanent housing, including HOPWA funding and Section 8 vouchers, for PLWHA and their families.

Develop and support available resources at drop-in centers for the homeless or those at risk of homelessness.

Increase and support access to nutritional programs and nutritional information.

Promote and increase awareness, knowledge and access to educational and vocational resources.

Continue and expand "Prevention for Positives" programs and activities.

Expand medical transportation assistance including gas cards and bus passes.

Ensure that all people living with HIV/AIDS are comfortable and feel safe by having access to culturally sensitive providers in a confidential environment.

HIV Related Legislation

Advocate for legislation for the WV Hate Crimes Act to include sexual orientation.

Advocate for the addition of sexual orientation to the Fair Housing Act.

Increase the Legislators' awareness of all HIV / AIDS issues for PLWHA, and advocate for specific legislation for HIV / AIDS.

Prevention

Seek legislation and funding for harm reduction program.

Continue to expand Rapid Testing in West Virginia.

Increase collaboration and linkage to care amongst all agencies.

Training / Capacity Building

Continue to provide and expand comprehensive and up to date HIV training and resources for providers and agencies serving PLWHA.

Increase capacity of agencies to access and implement all available client centered services and funding.

Increase awareness of HIV / AIDS resources for PLWHA and providers.

Increase utilization of services provided by DHHR through mutual collaboration by agencies.

Statewide Collaboration

Continue opportunities for statewide discussion for care and support issues, including an expanded annual statewide All Titles meeting.

Continue to increase cooperation with all housing agencies to facilitate services.

Increase cooperation / collaboration with all housing agencies to facilitate access and maintenance of safe affordable housing throughout the state.

Continue to increase coordination / collaboration in capacity building with all social service agencies.

Corrections

Continue to provide training and education to correctional facilities.

Continue to increase resources and training for all health care providers in corrections.

Continue to offer resources to assist in correctional referrals.

Disparities in Access to Care

Four historically under-served populations were identified in the analysis of the state's PLWHA population.

1. **Minorities** - West Virginia has a high disproportion of Blacks infected with HIV/AIDS. Common disparities in access to core services include a lack of medical insurance, lack of access to transportation for accessing services and delayed entry into care due to stigma and fear of discrimination, poverty and literacy levels related to health care.
2. **Rural Residents -** Overwhelmingly, West Virginia is a rural state. Rural residents are confronted with a lack of transportation infrastructure, an Appalachian fatalistic belief system, and stigma, increased distance to travel to providers, geographic isolation and poor telecommunication access (phones and internet).
3. **Mental Health and Substance Abuse -** PLWHA who have co-morbidities of chemical dependency or mental health issues experience compromised abilities to cope with an HIV diagnosis and frequently lack the ability or motivation to seek or connect to care.

4. **Homeless -** Faced with a lack of knowledge about HIV/AIDS resources and a lack of housing stability for staying connected to service providers, the homeless experience difficulty with stigma and maintaining a primary focus on HIV primary care.

Barriers to Care

The SCSN workgroup identified geography, transportation, stigma, lack of funding and a lack of competent and accessible mental health and substance abuse providers as barriers to care for PLWHA in West Virginia.

The geography of the state presents a barrier to care for PLWHA who reside in rural areas and in counties outside the immediate area of Part C Clinics. This barrier has been partially addressed by the establishment of a satellite clinic for the WVU Ryan White funded Part C clinic and one contract clinic. The WVU Positive Health Clinic has established a satellite clinic in Wheeling for the PLWHA who reside in the northern panhandle. The clinic serves patients once every three months and provides a full array of Part C services. WVU has also contracted with Shenandoah Valley Medical Systems (SVMS) to provide HIV primary care services in Martinsburg for eastern panhandle patients. The SVMS services are available daily and are integrated into the general daily schedule, with no special designated days for HIV services.

The southern region of the state has faced continued barriers related to geography and poverty. A private provider has established a weekly HIV primary care clinic in Beckley in early 2012. The addition of a private provider will help alleviate the barrier of distance to travel and the cost of tolls to access the nearest Part C provider in Charleston.

As a result of the many miles that are required for travel to primary care appointments, as evidenced in the Needs Assessment, the WVRWPBP medical case managers also refer WV PLWHA to Ryan White Part C clinics in the bordering states of Pennsylvania, Ohio and Virginia. Transportation assistance is provided for eligible PLWHA. Collaboration between the out of state Part C clinics and the WVRWPBP medical case managers ensures that WV Part B services are fully available to the WV patients at the bordering state Part C clinics.

Transportation remains an ever present barrier to care for PLWHA, as they are faced with aging vehicles, hazardous roads in winter months and a reliance on transports from neighbors, friends and family who are unaware of the patient's HIV status. The WVRWPBP introduced the distribution of gas cards to PLWHA in 2006 to support transportation to medical appointments.

This service, which is funded by both state and Ryan White dollars is coordinated through the WVRWPBP medical case managers and is available to PLWHA who have an income equal to or less than 250% FPL and who are not eligible for Medicaid transportation reimbursement. The expenditures for medical transportation have tripled since being implemented in 2006. Bus tickets for public transit systems are also available in Martinsburg, Charleston and Huntington.

Part C Clinics also distribute gas cards sporadically. Medicaid reimbursement for transportation is available to Medicaid recipients and specialized van service is available in select geographic regions by appointment. However, many Medicaid transportation vendors have ceased operations.

While geography and transportation present barriers for maintaining consistent adherence to primary care appointments, stigma is most associated with PLWHA who do not enter care after their HIV diagnosis. The stigma, associated with living in a rural state with an Appalachian belief system, hinders PLWHA from following up on referrals to WVRWPBP medical case managers and the ensuing referrals from the medical case managers. PLWHA, who know their status, but are not in care, cite fear of others knowing their diagnosis, fear of disclosing to primary care physicians and the emotional stress of dealing with an HIV/AIDS diagnosis as the primary reasons for late entry into HIV primary care. Both the Part B and Part C Programs have targeted outreach efforts for reducing stigma and encouraging PLWHA to enter care early after their initial diagnosis. The Part B Program has distributed posters and brochures to general population areas such as food pantries, DHHR county offices, HOPWA sites and homeless shelters.

All Ryan White funded Parts in WV experience the challenge of stretching flat funding to meet the needs of an increasing number of newly diagnosed PLWHA and the needs of those who migrate to the state of WV. Agreement has been reached among all of the Parts in WV to collaborate to serve the oral health needs of PLWHA. This collaboration will not only identify PLWHA who are not accessing oral health services, it will provide support in ensuring that oral health treatment plans will be followed with more services provided. While each of the Parts applies for supplemental funding when the opportunities arise, the commitment to collaborate and share data will also provide opportunities to cost share and more fully serve the PLWHA in WV.

As a low incidence state, WV does not have any full time HIV specific mental health counseling or substance abuse treatment programs. While the two Part C clinics in WV each offer mental health treatment as a part of their comprehensive services, the hours of availability are limited compared to the patient census at each clinic. Combined with the stigma associated with an HIV diagnosis and the lack of specific HIV mental health counseling, PLWHA are reluctant to access community resources, which are already limited throughout the state. PLWHA report in focus groups and key informant interviews that while HIV/AIDS is often at the root of their chemical dependency, they are reluctant to discuss those issues in 12 Step programs and group counseling environments. In addition, a lack of knowledge about HIV disease among the mental health and substance abuse practitioners presents barriers for achieving progress while in treatment.

Barriers to routine HIV testing in West Virginia include barriers for providers and patients. Providers are faced with very tight time constraints and lack the available time to concentrate on the requirements for testing. In addition, despite outreach to providers to inform them of new state testing laws, the providers frequently have a lack of knowledge of the CDC recommendations for routine HIV testing in their medical practices. Patients also lack knowledge about CDC recommendations and thus do not request tests at the provider setting. Finally, stigma, associated with the provider and patient present additional barriers. For providers, reluctance to discuss HIV and sexual or needle sharing behaviors, as well as, concerns about other reactions within the practice and fear of being identified as the “HIV doctor” cause providers to be reluctant to initiate conversations with patients regarding HIV. Fear and shame associated with HIV stigma also prevents patients from being proactive in pursuing HIV testing with their primary care providers.

Gaps in Care

The combined Comprehensive Plan and SCSN Planning Group identified nine gaps in the current system of care and treatment delivery.

Part F Dental Reimbursement Program: WV currently does not have any dental schools that participate in the Ryan White Part F Program. With an increasing need for oral health services, the state would benefit from having Part F dental funding to supplement the current fee for service oral health services from Parts A, B and C.

Clinical Trials: West Virginia does not have any HIV antiretroviral clinical trials available to PLWHA. In order to participate in clinical trials, PLWHA need to travel to neighboring states of Maryland, Ohio and Pennsylvania. The requirements to frequently report for clinical trials prohibit West Virginia PLWHA from traveling significant distances which may include distances that exceed 300 miles one way.

Dental Providers: Despite being in the third decade of HIV/AIDS, the state still experiences a reluctance of dentists to provide diagnostic, prophylactic and therapeutic oral health care to PLWHA. In addition, the state has very few dentists who participate in the Medicaid program. While WV provides only extractions to adult Medicaid participants, PLWHA sometimes travel in excess of 100 miles to access a dentist who accepts a WV Medical card.

Support Groups: While WV PLWHA, who have been diagnosed with HIV/AIDS for a year or more do not generally attend support groups, there is a need for support groups for the newly diagnosed. With very few groups operating on a regular schedule in the state, many newly diagnosed PLWHA do not have access to a peer support group that meets regularly in their geographic regions of the state.

Medicaid Application Process: Each county in WV develops their own policies for accepting walk in applications versus appointments. For some counties of the state, especially in the eastern panhandle, applicants wait 4-6 weeks to apply for Medicaid. This becomes a barrier when the applicant is attempting to enter the ADAP system and a Medicaid application is required. It is important to note that many counties allow same day applications and that this is not a statewide gap.

Public Transportation Infrastructure: Approximately 80% of the counties in West Virginia do not have access to a public bus system for accessing HIV primary care. This gap is exacerbated by the growing number of gaps in the Medicaid public transport system, when providers cease to provide services.

Funding: All of the state and federally funded care and treatment programs rely significantly on key resources from outside sources. While pharmaceutical companies, hospitals and community clinics have generously supported the Ryan White funded Parts, the continuum of care is fragile as it could not continue to provide comprehensive services to all that qualify if a major source of support was no longer available.

Rural Providers: With rising transportation costs and a failing system of Medicaid contracted transportation providers, an increasing number of PLWHA, who reside in rural areas, are faced with inequities in access to HIV primary care providers. Over a third of PLWHA surveyed in the 2010-11 Needs Assessment cited a one way distance traveled to their HIV doctor that exceeded 50 miles.

Mental Health Providers: As stigma and depression continue to be cited as major barriers to identifying PLWHA and ensuring that they enter and remain in care, access to culturally

competent mental health providers who accept Medicaid and Medicare and who provide treatment without long waiting periods is essential.

Addressing the care needs and gaps in care, particularly for underserved populations, such as women, youth, minorities and those PLWHA who are exiting the correctional system also requires continued investment and training to build capacity in existing service providers. AIDS service organizations have closed in Charleston, Martinsburg and Parkersburg. In addition, the state has an aging workforce that needs to attract new passionate providers who will carry on the work that has been accomplished during the last three decades.

Barriers identified by the Work Group for Ryan White funded programs were dominated by a lack of funding for providing the comprehensive services needed by PLWHA. Stagnant Ryan White funding during a period when caseloads are growing prohibits the various Parts in expanding their number of clinics and in hiring additional doctors and nurses. Caseloads for medical case managers have expanded while no additional staff has been added. Services such as oral health must be rationed in order to meet the increasing demand and the ADAP Formulary has limited new additions to newly approved antiretrovirals in order to ensure full access for those who qualify.

The Work Group identified provider barriers that were also related to funding. These barriers included a lack of funding for expanding to rural areas, delays in scheduling new patients and inequities in services between providers. Again, all of the barriers were related to a lack of funding for improving or expanding services.

The 2009-11 Comprehensive Plan contained 5 goals and 9 related objectives. Listed below are the results of the work towards the goals and objectives.

Goal 1	**Increase access and reduce barriers to quality HIV related health care services and engage WV PLWHA to enter HIV primary care soon after their diagnosis.**	
	Objective 1	By 3/31/2011, reduce by 10%, based on calendar year calculations, the unmet need in West Virginia.
		The Unmet Need in WV reduced significantly over the three year period. The 2009-11 Comprehensive Plan cited an overall Unmet Need of 50.2%. That has been reduced to 32.8%. The Unmet Need for AIDS dropped from 41.2% to 29.7% and the Unmet Need for HIV dropped from 61.2% to 37.8%.
	Objective 2	By 3/31/2012, in order to improve adherence to prescribed medications, increase by 20% over FY 2008 baseline, the number of PLWHA who receive financial assistance in accessing medications through ADAP Local.
		The number of PLWHA who were assisted with co-pays or other prescription costs during the base year FY08, was 309. This increased to 382 by 3/31/12. Overall, during the entire period covered by the Comprehensive Plan, the unduplicated number of PLWHA served by ADAP Local was 508 for the three year period. Total funds expended during the three year period for non ADAP medications: $ 224,292.
Goal 2	**Improve the quality of HIV care and treatment outcomes for PLWHA in WV.**	
	Objective 1	By 3/31/2012, increase by 50% over FY 2008 baseline, the number of PLWHA who receive an oral health exam at least once a year.
		The number of PLWHA who received an oral health exam during the FY 08 base year was 81. The total number of PLWHA served by Part B with oral health services, which included at least one oral health exam per year for the period ending 3/31/12 was 125. Overall, 230 unduplicated PLWHA received at least one oral health exam during the three year period covered by the Comprehensive Plan. Total funds expended during the year period for oral health services: $ 237,471.
	Objective 2	By 3/31/2010, expand the WV ADAP Formulary to include Hepatitis B and C treatments and psychotropic medications.
		As expenditures and enrollment began to rapidly increase in 2009, this objective was re-examined and placed on hold. Hepatitis treatments and psychotropic medications have been prioritized as the next group of drugs to be added to the ADAP Formulary. However, in order to maintain stability in the program and continue to maintain an open enrollment, only the addition of new antiretrovirals is being approved at this time.
	Objective 3	By 3/31/2012, increase by 15%, over FY 2008 baseline, the number of care plans documented twice per year in CAREWare by WVRWPBP medical case managers.
		The number of care plans documented twice per year increased from 513 during the base FY 08 year to 914 by 3/31/12.
Goal 3	**Eliminate disparities among underserved populations.**	
	Objective 1	By 3/31/2010, implement and maintain a comprehensive website to promote Ryan White funded services in West Virginia.
		A new website was implemented at the state level by the end of FY10 and the Part B contractor implemented a new website by the end of FY11. Both websites maintain up to date copies of the ADAP formulary; links to Part C funded sites are also included.
	Objective 2	By 3/31/2012, increase by 50% over FY 2008 baseline, the number of PLWHA who receive outpatient substance abuse treatment services through Part B State Direct Services.
		The number of PLWHA who received outpatient substance abuse treatment in FY08 was 2. This increased to 4 by 3/31/12. Overall, a total of 6 PLWHA have received outpatient substance abuse treatment during the three years covered by the Comprehensive Plan. Total funds expended for outpatient substance abuse treatment during the three year period: $55,534.
Goal 4	**Maintain an environment of quality management for all HIV related core services.**	
	Objective 1	By 3/31/2011, integrate a CQI process into all systems of delivery for Part B HIV care and treatment services.
		By 9/30/2010, the WV Ryan White Part B had implemented a CQI process into all systems of delivery for Ryan White Part B services.
Goal 5	**Improve statewide collaboration with all Ryan White funded Parts in WV.**	
	Objective 1	By 3/31/2010, create a coalition of Ryan White funded Parts in West Virginia, funded by Part B, to meet twice per year for discussion of HIV care related issues.
		This objective was adjusted due to lack of funding for meeting support. The Part B contractor has taken the lead in providing updates to other funded Parts regarding the Affordable Care Act, Ryan White reauthorization and nationwide ADAP waiting lists. Updates are provided through email alerts.

2. Where Do We Need to Go: What is Our Vision of An Ideal System?

The WV HIV Care Planning Group developed the 2012 – 2015 Comprehensive Plan based on 6 principles that made up a shared vision.

It is acknowledged that the ever changing epidemic presents strong challenges to the state's mission of ensuring that all WV PLWHA have access to quality HIV related health care services. However, the state strives to provide that access without disparities among all populations. The following values provided vision for the development of the WV 2012 – 2015 Comprehensive Plan.

1. **Sustainability -** Create and maintain a cost effective system of HIV/AIDS health care service delivery that assures continuous access to quality HIV primary care and medications through sound financing and comprehensive planning.
2. **Eliminate Disparities -** Provide PLWHA in WV with access to HIV primary care, medications and support services that would ensure sustaining their lives, with 0% disparities among the PLWHA populations.
3. **Health Outcomes –** Improve health outcomes for PLWHA in WV by increasing the number of undetectable viral loads among PLWHA, by reducing the AIDS mortality rate in WV, by decreasing the incidence of PLWHA progressing to AIDS, by decreasing the rate of opportunistic infections and by eliminating perinatal transmission.
4. **Quality –** Maintain a continuous quality improvement process for all HIV care and treatment programs by ensuring the CQI is integrated into all systems of delivery of care and treatment.
5. **NHAS –** Strengthen a strong collaboration between care, prevention and non-profit organizations to develop, promote and utilize a statewide marketing campaign for promoting the goals of the NHAS in care and prevention services.
6. **ACA -** Increase awareness and collaboration among all Ryan White Parts and service organizations to stay abreast with changes in the Affordable Care Act. Advocate for the continued Ryan White funding recognizing the unique needs of PLWHA and the overall public health consequences of the loss of Ryan White funding.

It is recognized that these values must guide the state's vision for the present and future. Through a concise vision and mission the state has conducted this strategic planning process and developed clear goals and objectives.

At no time in the history of HIV has the state faced such major challenges in responding to the restructuring of the HIV care and treatment delivery system as it does during the present planning period. As the nation prepares to adapt to the changing environment of health care reform, the state will need to restructure the AIDS Drug Assistance Program and greatly expand State Direct Services to integrate insurance purchasing and co-pay assistance.

In envisioning a restructured continuum of care of high quality core Ryan White services, the Planning Group was cognizant of the State's 5 principles of the mission for HIV care and treatment services.

- Ensure that all eligible PLWHA in West Virginia, who are in need of HIV care and treatment services, will receive high quality services that include access to existing and emerging HIV / AIDS treatments.
- Ensure that HIV care and treatment services are client centered, and have sound financing for establishing and sustaining a quality system of care.
- Ensure that women, infants, children, youth, under-served and rural populations and emerging populations receive appropriate services that are in proportion to their HIV / AIDS prevalence in the state.
- Ensure that all newly diagnosed PLWHA have access to opportunities for early entry into the continuum of care.
- Ensure that the state documents and evaluates the impact of core services on improving access to quality care and treatment services and in sustaining the livers of PLWHA in West Virginia.

In addition, the Planning Group adopted additional principles to ensure that the state meets legislative mandates and assurances. In order to ensure that the state supports a high quality full continuum of care and support services to all PLWHA in West Virginia with an emphasis on access and coordination during a changing environment in health care delivery, the following principles were added to the state's mission:

- Ensure that care and prevention services are supportive of the goals of the National HIV/AIDS Strategy and the objectives of Healthy People 2020.
- Ensure that through implementation of the Patient Protection and Affordable Care Act that the state reforms the HIV care delivery system with an emphasis on quality care, elimination of disparities in services and the expansion of health care services for PLWHA in West Virginia.

In order to provide a blueprint for where we need to go, the Planning Group reviewed the current issues for components of the continuum of care.

Medical Case Management

The medical case management system, operated through an agreement with the AIDS Task Force of the Upper Ohio Valley, (ATF), has grown significantly since its inception in 1991. The current system has 5 medical case managers and one person dedicated to data management. With continued growth in the caseload each year, and no additional medical case managers added in over eight years, the system is reaching its capacity. With nearly 1,000 clients served during the most recent year, additional staff is needed to meet the increasing complex needs of clients and the coordination responsibilities associated with the ACA.

- The state is divided into six case management regions with one staff member assigned to two regions due to one region being primarily covered by Part A.
- 4 out of 5 medical case managers are responsible for in excess of 200 clients each

- The ACA will require new responsibilities of insurance selection and coordination of benefits.
- Currently the HIV Coordinator, responsible for administrative duties, also doubles as a medical case manager.
- ACA will place new navigation responsibilities on the medical case management system.

In 2014, the services of medical case management must be expanded to meet the needs of the new healthcare paradigm. Medical case managers will be tasked with leveraging Ryan White funding in the new environment to support the continuity of care. The new system must have enough capacity to absorb the new PLWHA entering care. As navigators, the medical case managers will take on additional roles including extensive benefits counseling, client education regarding all of the coverage options and as monitors of recertification processes that ensure continuity of coverage. The need to maintain the present medical case management responsibilities and expand to meet the needs of integrating healthcare reform will require additional medical case managers in the Part B program.

Drug Reimbursement (Cost Sharing)

Both ADAP and ADAP Local will need to undergo major changes in service delivery as the ACA is implemented. The current agreement with the Bureau for Medical Services currently contains 100% of the ADAP Part B funding and all rebate funds expended for drugs. The ACA will require that ADAP dollars are primarily expended for insurance and the remaining dollars expended for drug deductibles and co-pays. With the exception of undocumented immigrants and legal immigrants who are not yet qualified for benefits, the ADAP will not be paying the full costs of drugs.

ADAP Local will also change significantly under the ACA. As a current system that pays co-pays for PLWHA who have insurance or Medicaid or the full cost of drugs for non-insured PLWHA, the ADAP Local will expand under ACA to pay co-pays for all of the newly enrolled Medicaid eligible recipients and also the deductibles and co-pays for the newly insured.

- The current system for ADAP Local expended funds for approximately 11,500 prescriptions during the most recent year. This will grow to 15,000 by 2015.
- The WV ADAP and the Part B's ADAP Local will require continued close scrutiny to ensure that all payers, such as insurance and Medicare Part D are promptly accessed by clients and that eligibility is continually maintained.
- Under the current system, all of the Ryan White Part C clinics coordinate medications being delivered through patient assistance programs (PAP). As PLWHA are insured, they will become ineligible for PAP and will become reliant on Ryan White Part B's ADAP Local for deductibles and co-pays.
- The increased responsibilities of coordinating medication co-pays will be absorbed by the medical case management staff.
- The implementation of the ACA begins on 1/1/2014. However, the Ryan White fiscal year runs from April 1 through March 31. ADAP dollars from Part B will have been spent in their entirety by the end of calendar year 2013. Thus rebate dollars will need to be utilized for the purchase of insurance on 1/1/2014.

- Pharmacy coverage offered through the health plans of the insurance exchanges will require that participants utilize national mail order pharmacies for accessing medications. The most generous plans allow two months of local pharmacy utilization, while others will require immediate participation in the mail order system. For PLWHA who have maintained relationships with local pharmacies for extended periods, change will be difficult. In addition to the client adjusting to the new mail order system, the Part B program will have to establish accounts and relationships with the new national pharmacies, educate clients regarding maintaining adherence in the new environment and work to meet other challenges of the new reimbursement and drug dispensing structure.

Outpatient / Ambulatory Care

The burden of providing HIV primary care is currently primarily a Part C responsibility. The Part C Clinics provide the care and rely significantly on charity care programs for paying for laboratory services. The ATF expends approximately three-thousand dollars in state funding towards Medicare Part B and insurance co-pays. Expenditures are made primarily for private provider services. It is anticipated that hospital charity care programs will continue to serve PLWHA with laboratory services in the form of writing off deductibles and co-pays. However, there is grave concern across the Planning Group regarding the continued future of Ryan White funding under the ACA and Ryan White reauthorization.

- The current system of delivering HIV comprehensive primary care is reaching its maximum capacity. Additional clinic hours are needed and additional staff to meet the growing demand for services are needed.
- Under the current system, insurance payments to Part C clinics qualify under program income, which is discretionary in allocations. With significantly more persons insured either through exchanges or Medicaid under the ACA, expansion of services is possible at Part C and Part A clinics. It is essential however, that Ryan White funding and structure be maintained under reauthorization. The Ryan White model of primary care prioritizes a dedicated staff for nursing, nutrition, mental health, pharmacy and physicians. Priority must be given under implementation of health care reform to retain this structure and Ryan White funding.
- Private HIV primary care providers must continue to be a component of the continuum of care. In areas where distance to the nearest Part C or Part A clinic exceeds an hour of driving, private providers will be not only more convenient, but also be more likely to retain PLWHA in care due to the lack of barriers in accessing care. Private providers must be encouraged to adhere to HHS Guidelines and to accept all payers, especially those who are part of the new insurance exchanges under ACA.
- The community health centers, especially in the rural underserved areas of the state, including southern West Virginia, will have an integral role in providing primary and comprehensive HIV care as part of health care reform. With sliding scale fees and in some cases, oral health opportunities, the burdens on Part C and Part B can be lessened and PLWHA will not have to travel significant distances. The AETC will continue to be a source of both education and recruitment for community health center providers.

Integrating healthcare reform changes into the existing Ryan White system of care will place a heavy burden on the system during the transition. Legal immigrants, not yet eligible for Medicaid and undocumented immigrants will continue to rely solely on the Part A and Part C system. Confused and overwhelmed PLWHA will be "churning" between programs unaware of certification processes and client level responsibilities of the new system. Ryan White dollars will need to be leveraged as a safety net and payer of last resort in order to ensure and support the continuity of care until all eligible PLWHA have enrolled in health plans. Patients will be required to move from trusted pharmacies to national mail order pharmacies thus requiring expert monitoring by primary care providers as multiple new pharmacies are utilized. In addition, many PLWHA face the possibility of enrolling in minimal coverage health plans offered through the exchange, thus having insufficient benefits that require significant Ryan White integration in order to maintain a continuity of care consistent with HHS Guidelines.

Health Insurance

While significant state and Part B dollars are expended on health insurance each year, the number of PLWHA served is a small fraction of the total clients served, less than two-tenths of a percent. The most recent year served eleven PLWHA in paying health insurance premiums. An analysis of the current client caseload reveals that an estimated 275 additional PLWHA will qualify for insurance coverage under the ACA. Coordination of these benefits will require navigation by the medical case managers, education of clients to introduce them to the new benefit and exchanges and a staff to maintain a current premium payment system. Provision of these services will require a restructuring of ADAP and additional staff for the ATF.

Similar to the implementation of Medicare Part D, resistance to change is expected from PLWHA who are comfortable with the current patchwork system. Fear of co-pays, collections and new government programs will contribute to this resistance. A structured client educational outreach will be required. Coordination with Part C and Part A will be needed to assist in educating patients that having health insurance will be a positive addition to their continuum of care.

- Transition to a system of purchasing insurance instead of drugs will require coordination with the Bureau for Medical Services and extensive meetings with the other Ryan White funded Parts. Extensive planning is required despite many unknowns, including a Supreme Court decision, Congressional and Presidential elections, potential budget cuts due to sequestration and a very contentious political and fiscal environment.
- Challenges facing the Part B program include redeveloping Ryan White services to fit into the new healthcare paradigm, building additional connections with Medicaid, anticipating cost shifting, preparing providers for changes in the reimbursement environment and ensuring that low reimbursement rates do not endanger the success of health care reform. Additional Part B staff will be needed to sustain integration of new services.

Oral Health

As the fastest growing expenditure in the area of core services, oral health has increased from $39.00 in expenditures in 1997 to nearly $75,000.00 in the most recent year. A significant portion of the growth can be attributed to dedicated outreach for oral health services that was

initiated in the 2009 – 2011 Comprehensive Plan. To date, the Part B Program has only tracked those patients who have received a Part B funded oral health service. To obtain an informed assessment of the percentage of PLWHA in West Virginia who are receiving an oral health service will require coordinating with Parts A and C to develop an unduplicated data system with documentation of who has received an oral health exam during the year. Developing such a system will require modifications to the current data system as it will be essential to document oral health exams that occurred during the year, regardless of the payer service; this would include those who self-pay. After establishing the data collection system, the state will have an excellent opportunity for a cross-Part quality improvement project.

- The majority of PLWHA who begin receiving oral health services have not seen a dentist in many years. Even with Part B restrictions that do not allow for cosmetic dentistry or root canals or crowns, the average treatment plan for new recipients of oral health services exceeds $3,500.00 per client.
- Despite the significant need for oral health services and a suspected high percentage of PLWHA not receiving at least one oral health exam per year, additional funding needs to be identified in order to increase capacity in the State Direct Services program. Part B served 135 PLWHA with oral health services with costs at nearly $100,000.00 in calendar year 2011. With these expenditures covering both oral health exams and extensive work, including dentures, it will be impossible to exceed the 2011 achievements without more funding.
- Additional oral health providers, particularly those who accept Medicaid, must be recruited to serve PLWHA in West Virginia. The additions will alleviate long distances that many PLWHA travel to secure services and will ensure that a payer of last resort is utilized for services. The AETC can play a vital role demonstrating need and providing training for providers.

After many years of oral health neglect, PLWHA in WV frequently present with compound oral health problems, with many related directly to their HIV disease. Dental decay, a lack of routine cleanings/exams, and gingivitis have frequently been chronic problems that are ignored due to stigma, fear of dentistry, ignorance regarding the importance of oral health and lack of finances. However, poor oral health of PLWHA in WV has been responsible for impeding nutrition and thus resulting in poor absorption of medications. In addition, chronic tooth decay and periodontal disease can be the impetus for bacterial infections that lead to systemic infections which endanger the lives of PLWHA with compromised immune systems. Over 60% of WV PLWHA who receive their initial oral health treatment plan require root planning and scaling. HIV medications may also contribute to the declining oral health as they contribute to dry mouth that creates opportunities for tooth decay, fungal infections and periodontal disease. As a safety net, WV adult Medicaid exacerbates these problems by covering only extractions and not the preventative maintenance that is essential for the health of PLWHA.

Mental Health

The current system of mental health services for PLWHA is fragmented. Part C clinics provide variations ranging from psychiatrists to mental health therapists. The state is served throughout its 55 counties by a network of behavioral healthcare providers. However, that network frequently has waiting lists and providers inexperienced with HIV related stigma and costs that exceed the resources of PLWHA who lack insurance coverage.

- The Ryan White Part B system has provided access to limited Ryan White funded therapy, but most frequently expends funds for medication checks by psychiatrists, mostly in the form of Medicare Part B co-pays or insurance co-pays.
- It is essential that as health care reform is implemented, that mental health providers become enrolled as providers in the insurance exchanges. Too often, private mental health providers pick and choose their payer programs and ignore those most frequently utilized by the under-served, such as Medicaid and Medicare.
- Treatment of mental health illness is integral to ensuring that PLWHA will both enter and be retained in care. Coordination with Part A and Part C is essential for simultaneous treatment and care.

Substance Abuse

Treatment of substance abuse issues is a major component in treatment adherence. Successful treatment is also dependent on the reduction of HIV related stigma in the lives of PLWHA in West Virginia. When treated inpatient or outpatient, recovery requires that one can honestly deal with all of related issues that contribute to dependency.

- Current outpatient substance treatment has been limited to methadone treatment centers for a very minute number of PLWHA. PLWHA have demonstrated a resistance to entering treatment and a lack of available resources to meet their immediate and long term needs. Residential programs offer limited inpatient stays and frequently have waiting lists. Payers frequently also limit the impatient stay.
- Expanded substance abuse inpatient and outpatient services are needed, with participating insurance providers under the ACA.
- The state must continue to address stigma related to HIV and stigma associated with the dual-diagnosis of HIV and mental illness or the multiple diagnoses which include substance abuse.

Transportation

Regardless of which core service is being delivered to PLWHA, the most dominant barrier to PLWHA to access is transportation. While the barrier permeates all 55 counties of the state, the most severe barriers exist for rural clients, especially those in the southern area of the state, where poverty is more intense and a toll road intensifies the barrier.

- Transportation to primary care and other core and support services is hampered by a lack of infrastructure. Public transportation, such as buses, is limited to a few large cities. The Medicaid transportation infrastructure is crumbling as vendors close their doors due to the lack of adequate reimbursement from the state and due to slow reimbursement.
- The rising cost of gasoline for personal autos has placed a tremendous strain on the medical transportation component of the State Direct Services, funded by both Ryan White Part B and state dollars, where $33,000.00 was expended in 2008, but increased to nearly $50,000.00 in 2011. In addition, the Part C clinics also provide gas cards from their program income. No reimbursement is available from Part B for tolls.

- Transportation expenditures show no signs or projections for decreasing during the next three years. Gas prices fluctuate, but never significantly decline. With the addition of over 100 new clients enrolled in Part B medical case management each year, a new infusion of funding will be required to keep pace.

Care and Treatment

The WV HIV Care Planning Group developed a list of what they envisioned as encompassing an ideal care and treatment service delivery system that were included in the 2011 SCSN. The Group shared this vision of where WV needs to go in order to develop an ideal system of care and treatment. All Ryan White funded Parts participated in developing the shared vision for an ideal system:

- Maintain and increase funding and equal access for comprehensive HIV primary and specialty care, including preventive screenings.
- Fund culturally competent models of care that expand HIV primary care services to rural Appalachian under-served parts of the state, including services for the undocumented.
- Continue awareness and advocacy of charity care currently offered by hospital, laboratory and other indigent programs.
- Ensure parity in services to undocumented persons.
- Increase funding for qualified HIV providers.
- Assure that all PLWHA have equal access to comprehensive primary and specialty care.
- Recognize that a growing number of existing HIV primary care specialists and healthcare and service providers throughout the state are nearing retirement and encourage and support training of the new providers throughout the state.
- Continue to improve medication adherence for PLWHA through comprehensive medical case management services.
- Fund and implement Peer Advocacy at each Ryan White funded agency and other service providers.
- Identify and seek funding to increase transportation services/assistance to medical/supportive appointments.
- Promote the importance of confidentiality in all realms of care and support services in accordance with HIPPA.
- Hire and train culturally competent HIV/AIDS providers, staff and volunteers.
- Increase access, support, funding and availability or Ryan White Part B funded services.
- Ensure that extended provider and care facilities provide comprehensive care services, client safety and protection of PLWHA.

- Strengthen a strong collaboration between care, prevention and non-profit organizations to develop, promote and utilize a statewide marketing campaign for promoting the care and prevention goals of the NHAS.
- Create/maintain a safe environment for institutionalized or incarcerated individuals to access and receive education, testing and health care and transitional services.
- Maintain/increase the capacity to provide prevention for positive services.
- Increase capacity to provide comprehensive services to all disenfranchised communities.
- Build capacity to provide smoking cessation counseling and treatment.
- Ensure that all Ryan White funded clinics explore the potential to become medical homes.
- Ensure that during the transition to the Affordable Care Act, that all PLWHA continue to receive high quality care.
- Advocate for continued Ryan White funding, recognizing the unique needs of PLWHA and the overall public health consequences of the loss of Ryan White funding.
- Recognize the growing body of literature regarding PrEP and nPEP and ensure the capacity for ongoing education for providers, clients and prevention agencies.
- Ensure that community health care centers have training, resources and opportunities to collaborate with Ryan White service providers.
- Build capacity to provide anal dysplasia screenings for HIV positive patients.
- Increase capacity to provide cervical dysplasia screenings to females.

Medications

- Increase funding for laboratory testing related to safe and appropriate use of antiretroviral medications in accordance with DHHS guidelines, such as, but not limited to: phenotype, genotype, tropism and HLA-B5701.
- Maintain funding for the ADAP formulary and all FDA approved antiretrovirals and increase access for psychotropics, Hepatitis C therapies and medications for co-morbidities.
- Maintain and increase ADAP funding to provide full access to the ADAP formulary for all who qualify.
- Maintain and increase awareness of other potential avenues of medications support such as state programs and patient assistance programs.
- Continue to explore all avenues of cost savings for acquiring and dispensing prescriptions for the WV ADAP.

HIV/HCV Testing and Education

- Maintain and increase funding and availability for HIV testing in medical and non-medical settings.

- Ensure availability and funding for rapid testing.
- Increase education, onsite rapid testing and screening for HIV in at risk populations (ex. WV drug treatment centers, correctional facilities, STD clinics and homeless shelters).
- Maintain and increase education, testing and screening for HCV co-infection for at risk populations.

Substance Abuse

- Increase educational awareness and motivational strategies to encourage clients to engage in substance abuse treatment.
- Support and increase the number of available substance abuser treatment centers and providers.

Oral Health

- Increase the number of dentists and dental providers that offer competent oral healthcare to PLWHA.
- Promote Ryan White Part F dental reimbursement funding opportunities in West Virginia.
- Ensure that all PLWHA have a minimum of one oral healthcare screening per year.
- Continue collaboration among all Ryan White providers to share costs of oral health services.

Mental Health

- Maintain/increase funding to provide adequate and appropriate mental health services.
- Increase number of mental health providers trained in HIV related issues.
- Increase capacity to provide at least one mental health screening per year.
- Increase funding and capacity to substantiated mental health services including medications, provider fees and counseling.

Ensuring PLWHA Stay in Care

- Promote access to and knowledge of all support services including case management, food banks, support groups and buddy plans.
- Develop access to holistic support for PLWHA.
- Increase counseling and address issues related to long term survival.
- Provide timely and uniform communication to all PLWHA.
- Implement and support the review / appeal process for allowing flexibility for determining client income eligibility.

Long Term Goals

Closing the gaps and eliminating barriers to care for all PLWHA in West Virginia will require a collaboration of all Ryan White funded Parts, HIV Prevention, private providers and coordination with all payers including Medicaid, Medicare, Ryan White, private insurance and new sources of payment established under the ACA.

1) Increase access to comprehensive HIV primary care and improve HIV related health outcomes for PLWHA in West Virginia by reducing health related disparities among under-served populations.
2) Respond to the changing healthcare environment by maximizing program resources through the utilization of all available payers, including the Affordable Care Act, by developing policies and systems that support a high level of quality and efficient services without lessening the scope of treatment and care service delivery.
3) Ensure that PLWHA in West Virginia have access to ongoing quality care and support services, in order to improve their health outcomes and their quality of life through quality management outcomes measurement and evaluation activities.
4) Develop, implement and evaluate a system wide initiative to improve health outcomes through annual oral health exams.
5) Decrease the percentage of uninsured Ryan White clients by ensuring that all WV PLWHA enroll in appropriate insurance programs provided through health care reform.
6) Collaborate with all of the Parts of Ryan White and private providers to ensure the delivery of high quality, cost effective care that meets the needs of PLWHA in West Virginia.

The early identification of individuals with HIB (EIIHA) is an integral part of the state's comprehensive plan for reducing new infections, as outlined in the National HIV/AIDS Strategy. The state has established four goals for EIIHA:

- Increase HIV testing in areas with higher morbidity.
- Decrease risk of acquiring HIV by providing HIV prevention activities.
- Maintain condom distribution targeting HIV positive persons and persons at highest risk of acquiring HIV infection.
- Improve enabling environment for HIV prevention efforts

3. How Will We Get There: How Does our System Need to Change to Assure Availability of and Accessibility to Core Services?

Central to the mission of the WV Ryan White Part B Program is the need to maintain a care system that is client centered. All Parts of the Ryan White care system in WV are challenged with PLWHA who enter primary care late in their disease progression, PLWHA who drop out of care and PLWHA who do not adhere to their care plans and antiretrovirals.

The 2012 – 2015 goals and objectives have been developed to support the state's mission that all eligible PLWHA in WV who need HIV care and treatment services will receive high quality services that support sustaining their lives.

Goal 1 **Increase access to comprehensive HIV primary care and improve HIV related health outcomes for PLWHA in West Virginia by reducing health related disparities among under-served populations.**

Objective 1 By 3/31/2015, reduce unmet need by 5%.

	Activities	Responsible Party	Target Date
1.1	Increase community knowledge of services	ATF	ongoing
1.2	Improve linkages between private providers	ATF	9/30/2013
1.3	Strengthen collaboration with DIS for linkage to care	DIS/ATF	6/30/2013
1.4	Conduct quarterly meetings with surveillance	ATF/DSHH	ongoing
1.5	Coordinate funding patterns to maximize resources	ATF/All Parts	3/31/2014
1.6	Enhance MCM outreach for adherence services	ATF	3/31/2013
1.7	Strengthen MCM activities to retain and re-engage PLWHA in care	ATF	9/30/2013

Objective 2 Increase by 15%, the number of PLWHA served by private non-Ryan White primary care providers

	Activities	Responsible Party	Target Date
2.1	Implement Ryan White Part B policies for staffing MCM at clinics operated by private providers	ATF	12/31/2012
2.2	Promote Ryan White Part B services at Community Health Clinics	ATF	6/30/2012
2.3	Link non-Ryan White providers to AETC for training	ATF/AETC	ongoing

Goal 2 **Respond to the changing healthcare environment by maximizing program resources through the utilization of all available payers, including the Affordable Care Act, by developing policies and systems that support a high level of quality and efficient services without lessening the scope of treatment and care service delivery.**

Objective 1 By 12/31/2013 develop a system for implementing healthcare insurance and cost sharing under the Affordable Care Act

	Activities	Responsible Party	Target Date
1.1	Develop contract for insurance premium assistance	DSHH	12/31/2013
1.2	Design and implement policies for cost sharing	ATF	12/31/2013
1.3	Review Ryan White reauthorization for changes in interacting with ACA	DSHH/ATF	9/30/2013
1.4	Develop plan for 2014 ADAP Formulary expansion	DSHH/ATF	12/31/2013
1.5	Conduct educational outreach to PLWHA affected by ACA	ATF	10/31/2013
1.6	Ensure that HIV providers enroll as participating providers for Medicaid and health insurance exchanges	ATF/All Parts	ongoing
1.7	Conduct monthly conference calls for Part B staff for ACA implementation during last quarter of 2013	ATF	12/31/2013
1.8	Prepare educational material related to West Virginia essential benefits	ATF	12/31/2013
1.9	Develop projections for insurance costs for 2014	DSHH/ATF	12/31/2013
1.10	Monitor CLD in ADAP for cost efficiency of service delivery	DSHH/ATF	ongoing
1.11	Ensure that MCM are positioned and trained to serve as ACA navigators	ATF	6/30/2013
1.12	Provide leadership for Cross Part training on ACA implementation	ATF	9/30/2013
1.13	Implement reimbursement system for out of state mail-order pharmacies	DSHH/ATF	12/31/2013
1.14	Strenghten collaboration with Bureau for Medical Systems (Medicaid) to ensure that PLWHA are served by expanded Medicaid	DSHH/ATF/BMS	9/30/2013

Goal 3 **Ensure that PLWHA in West Virginia have access to ongoing quality care and support services, in order to improve their health outcomes and their quality of life through quality management, outcomes measurement and evaluation activities.**

Objective 1 By 3/31/2015 incorporate three additional HAB performance measures into the WV Quality Management Plan.

	Activities	Responsible Party	Target Date
1.1	Review outcome measures and standards of care for medical case management	ATF	ongoing
1.2	Conduct consumer survey annually	DSHH/ATF	ongoing
1.3	Maintain and enhance data collection system	DSHH/ATF	ongoing
1.4	Implement CLD for ADAP	DSHH/ATF	9/30/2012
1.5	Conduct reviews and evaluations of QM data	DSHH/ATF	ongoing
1.6	Participate in NQC conference calls and webinars	DSHH/ATF	ongoing
1.7	Complete and review annual RDR	DSHH/ATF	ongoing
1.8	Assess success in meeting WICY requirements	ATF	quarterly

Goal 4 **Develop, implement and evaluate a system wide initiative to improve health outcomes through annual oral health exams.**

Objective 1 By 12/31/2013, implement a system for collecting oral health exam information, from all Parts, for each Ryan White client.

	Activities	Responsible Party	Target Date
1.1	Promote collaboration of all Parts to participate	DSHH/ATF	9/30/2013
1.2	Develop parameters for data collection	ATF	12/31/2013
1.3	Create data spreadsheet	ATF	12/31/2013
1.4	Initiate data collection for Part B (PDSA)	ATF	6/30/2013
1.5	Initiate data collection for all Parts	All Parts	1/1/2014
1.6	Document self pay visits in CAREWare	ATF	6/30/2013
1.7	Issue first annual report	ATF	3/31/2015
1.8	Plan improvement project	All Parts	4/30/2015

Goal 5 **Decrease the percentage of uninsured Ryan White clients by ensuring that all West Virginia PLWHA enroll in appropriate insurance programs provided through healthcare reform.**

Objective 1 By 6/30/2014, enroll 75% of uninsured Ryan White funded PLWHA in appropriate programs providing healthcare insurance. (ie: Medicaid expansion, Medicare or insurance exchanges)

	Activities	Responsible Party	Target Date
1.1	Ensure that Ryan White HIV primary care providers and private providers have enrolled as participating providers	ATF	12/31/2013
1.2	Ensure that all insures are covering 100% of ARV	ATF	12/31/2013
1.3	Coordinate with all Parts to identify uninsured PLWHA	ATF/All Parts	12/31/2013
1.4	Coordinate ADAP with new payer sources	ATF	3/31/2014
1.5	Assess the percent of Ryan White funded PLWHA who have some form of insurance, including Medicaid, Medicare, COBRA, self pay and private	ATF	6/30/2014

Goal 6 **Collaborate with al of the Parts of Ryan White and private providers to ensure the delivery of high quality, cost effective care that meets the needs of PLWHA in West Virginia.**

Objective 1 By 3/31/2015, increase by 20%, over 2011 baseline, the number of PLWHA receiving Part B State Direct Services.

	Activities	Responsible Party	Target Date
1.1	Recruit new non-Ryan White funded providers	ATF	ongoing
1.2	Link new providers to AETC for training	ATF/AETC	ongoing
1.3	Enroll PLWHA in medical case management within 72 hours of initial contact	ATF	ongoing
1.4	Approve or deny completed ADAP applications within 7 days of receipt	ATF	ongoing
1.5	Assess all Ryan White clients, across all Parts, for eligibility for Part B components	ATF	ongoing
1.6	Respond swiftly to changes in the epidemic	DSHH/ATF	ongoing
1.7	Provide seamless system for accessing all Part B funded services	ATF	ongoing

Objective 2 By 12/31/2013, provide training to all Ryan White funded Parts and non-Ryan White providers to promote the expanded capacity of Ryan White Part B services under the ACA.

	Activities	Responsible Party	Target Date
2.1	Conduct promotion of training	ATF	9/30/2013
2.2	Recruit presenters and establish CEUs	ATF	9/30/2013
2.3	Assess training preferences, ie. Webinar, face to face	ATF	10/31/2013
2.4	Schedule trainings	ATF	9/30/2013
2.5	Evaluate effectiveness	DSHH/ATF	1/31/2014
2.6	Assess additional training needs	DSHH/ATF	1/31/2014

The 2012 - 2015 goals, objectives and strategies address ten issues identified in the comprehensive planning process that support the NHAS and Healthy People 2020. The planning group identified ten topics that met consensus on improving access to quality care and treatment for PLWHA in WV, reducing the number of new infections and ensuring that clients are retained in care consistent with DHHS Guidelines. The topics were not prioritized:

1. Expand/ maintain ADAP formulary
2. Reduce unmet need
3. Improve linkages for the newly diagnosed
4. Increase number of PLWHA who have oral health exams/treatment
5. Adapt to changes in healthcare delivery through ACA
6. Expand the medical case management system
7. Expand ADAP Local – increase assistance and outreach
8. Monitor progress in achieving goals of NHAS
9. Continue quality management across all programs
10. Reduce HIV related stigma

The FY 12 Part B Implementation Plan reflects the state's first formal steps in reaching the 2012 - 2015 goals and objectives.

WV FY 2012 IMPLEMENTATION PLAN

STATE: WEST VIRGINIA
ADMINISTRATIVE AGENCY: WVDHHR STD/HIV/HEP Program
PREPARED BY: SUSAN HALL and JAY ADAMS

Ryan White Part B Implementation Plan

Grantee: West Virginia **Fiscal Year: 2012** **Page ___1____ of ___3__ Pages**

Service Priority Name: WV DHHR HIV/AIDS/STD PROGRAM				**Total Priority Allocation:** ADAP $1,821,846	
Service Priority Number: 1					
Service Goal: Ensure equal access to all enrolled participants and to all therapies on the WV ADAP formulary.					
1. Objectives: List quantifiable time-limited objectives related to the service priorities listed above	**2. Service Unit Definition:** Define the service unit to be provided	**3. Quantity** 3a) Number of people to be served	3b) Total Number of service units to be provided	**4. Time Frame:** Indicate the estimated duration of activity relating to the objective listed.	**5. Funds:** Provide the approximate amount of funds to be used to provide this service.
a. By 3/31/13, serve 400 participants in the WV ADAP, with a minimum of 92% of those prescribed anti-retrovirals, receiving HAART according to HHS Guidelines.	One prescription dispensed	400	7,700 prescriptions dispensed	12 months	$1,658,605.00
b. By 3/31/13, enroll and serve 70 new ADAP participants who have received at least one drug from the program.	One prescription dispensed	70	465 prescriptions dispensed	12 months	$163,241.00

6. Select a minimum of two objectives and list planned client level outcomes/indicators to be tracked, and include benchmarks for each.
a) 96 % of the active ADAP participants during the period of April 1, 2012- March 31, 2013 will have two screenings conducted for Medicaid eligibility with a minimum of three months between screenings.

b) During the period of April 1, 2012- March 31, 2013, 100% of the applying ADAP clients will receive an approval or denial of their application within 10 days of receiving a completed application.

Ryan White Part B Implementation Plan

Grantee: West Virginia **Fiscal Year 2012** **Page ___2____ of ___3__ Pages**

Service Priority Name: WV DHHR HIV/AIDS/STD PROGRAM			**Total Priority Allocation:** State Direct Services $490,000.00		
Service Priority Number: 1					
Service Goal: Ensure the provision of equal access for HIV primary care for all PLWHA in West Virginia.					
1. Objectives: List quantifiable time-limited objectives related to the service priorities listed above	**2. Service Unit Definition:** Define the service unit to be provided	**3. Quantity** 3a) Number of people to be served	3b) Total Number of service units to be provided	**4. Time Frame:** Indicate the estimated duration of activity relating to the objective listed.	**5. Funds:** Provide the approximate amount of funds to be used to provide this service.
a. By 3/31/13, increase by 8%, over FY 11 baseline, the number of PLWHA receiving oral health services.	Oral health service visits.	120	180 oral health visits	12 months	$68,250.00
b. By 3/31/13, in order to decrease 2012 unmet need, increase by 5% over FY 11 baseline, the number of PLWHA who are enrolled in comprehensive medical case management services.	One 30 minute medical case management visit.	915	10,400 medical case management visits	12 months	$253,584.00
c. By 3/31/13, serve 335 PLWHA with financial assistance for accessing medications through AIDS Pharmaceutical Local – wrap around services.	Prescriptions dispensed through AIDS Pharmaceutical Local	335	10,000 prescriptions dispensed through AIDS Pharmaceutical Local to PLWHA	12 months	$68,000.00
d. By 3/31/13, provide insurance continuation services to 12 PLWHA, with a minimum of 91% of the clients served maintaining HIV primary care appointments at least every six months.	1 month of insurance premium assistance	12	105 months of insurance premiums paid for PLWHA	12 months	$48,266.00
6. Select a minimum of two objectives and list planned client level outcomes/indicators to be tracked, and include benchmarks for each: a) 85% of PLWHA enrolled in medical case management will be offered an oral health screening during the fiscal year, April 1, 2012- March 31, 2013. b) 93% of PLWHA enrolled in medical case management services will be retained in medical case management at the end of the fiscal year, March 31, 2013. c) 95% of prescriptions provided through AIDS Pharmaceutical Local during the fiscal year April 1, 2012- March 31, 2013, will be approved for client pick up within 24 hours of the client requesting the prescription.					

Ryan White Part B Implementation Plan

Grantee: West Virginia **Fiscal Year 2012** **Page ___3__ of ___3__ Pages**

Service Priority Name: WV DHHR HIV/AIDS/STD PROGRAM				**Total Priority Allocation:** State Direct Services	
Service Priority Number: 1					
Service Goal: Ensure the provision of equal access for HIV primary care for all PLWHA in West Virginia.					
1. Objectives: List quantifiable time-limited objectives related to the service priorities listed above	**2. Service Unit Definition:** Define the service unit to be provided	**3. Quantity**		**4. Time Frame:** Indicate the estimated duration of activity relating to the objective listed.	**5. Funds:** Provide the approximate amount of funds to be used to provide this service.
		3a) Number of people to be served	**3b) Total Number of service units to be provided**		
e. By 3/31/13, provide medical transportation assistance to 500 PLWHA for accessing HIV primary care services.	Bus ticket/gas card	500	375 gas cards 150 bus tickets	12 months	$13,000.00

4. How Will We Monitor Our Progress: How Will We Evaluate Our Progress in Meeting Our Short-and-Long Term Goals?

The WV Ryan White Part B Program is fully committed to continuing to improve the quality of care and treatment services for PLWHA in WV. The WV Part B Quality Management Program (QMP) team members include the STD/HIV/HEP Division Director, Data Manager and AIDS Surveillance staff from the West Virginia STD/HIV/HEP Division, the HIV Care Coordinator, and the WVRWPBP medical case managers from the Administrative Agent level. A consumer representative is also on the committee. These individuals are responsible for coordination, monitoring and evaluation activities to measure desired quality management outcomes. The QMP addresses delivery of HIV/AIDS services to ensure that comprehensive services are provided for all eligible PLWHA in WV.

All QMP team members participate in quality management activities. The roles of the QMP Committee include the provision of epidemiological data and data analysis by the Data Manager, data from file reviews conducted by the AIDS Surveillance staff, coordination of activities by the STD/HIV /HEP Director, evaluation of QMP indicators and coordination of the QM Plan by the HIV Care Coordinator, consumer input from the HIV consumer and implementation of selected indicators and improvements by the WVRWPBP medical case managers. All members are responsible for developing the indicators. The process to evaluate the QM Plan includes data collection on a number of quality indicators that is compiled monthly. This information is formally reported to the STD/HIV/HEP Director and the HIV Care Coordinator a minimum of every three months. The quality management team communicates every three months on the progress of the quality management plan. Any issues or concerns identified through the quality management process are discussed to formulate ways to improve the program. The quality committee's effectiveness in improving the quality of HIV care and support services is evaluated annually.

The process that has been established to monitor and evaluate the clinical quality management program includes quarterly conference calls and / or physical meetings to discuss quality management indicator data for each reporting period. The committee discusses the reports and provides recommendations to improve quality services. The evaluation of the plan is conducted by the HIV Care Coordinator and reported to the QM Committee for discussion and for planning activities for the upcoming year.

The mission of the WVRWPBP QMP, for State Direct Services and ADAP, is to "Ensure equal access to quality comprehensive HIV care and support services for all eligible PLWHA in West Virginia." In support of the mission, WV has established five goals for the QMP:

1. Promote quality medical care and support services based on current guidelines and on professional standards
2. Maximize the retention in care of PLWHA in WV;
3. Promote accessible and appropriate HIV care and support services based on monitoring epidemiological trends in WV
4. Support the efficient and effective use of resources to meet the care and support needs of PLWHA in WV.

5. Maximize HIV care and treatment resources in West Virginia to meet the goals of the National HIV/AIDS Strategy

Ryan White Part B Program base funds of $12,000.00 (1.12%) for FY 2012 are allocated for the continued clinical QMP in WV. State funding also supplements the activities.

Data collected is entered in CAREWare by the WVRWPBP medical case managers and the data manager. In FY 12, ADAP data will be collected through CAREWare for completing the ADAP Data Report (ADR).

The SCSN and Comprehensive Plan workgroups utilized the FY 11 clinical quality management data in their decision making for FY 12 allocations and priority setting and in developing the goals and objectives for the 2012-2015 Comprehensive Plan. As part of the workgroups, all Ryan White HIV/AIDS funded Parts in WV reviewed the results of the clinical quality management data and offered comments on data collection activities for FY 10 and cross Part activities to improve reducing unmet need.

Planned Clinical Quality Management Activities

The addition of CAREWare and the quality management indicators to the state's RWPBP medical case management system were fully implemented by January 1, 2009. During FY 12, the state will add ADAP to CAREWare and will implement the ADAP Client Level Data system collection in preparation of submitting the ADAP Data Report (ADR). Medical case managers and all Parts will collaborate for collecting CD4 counts and HIV viral loads. BMS monthly utilization data for ADAP will be entered in CAREWare by the WVRWPBP Data Manager. Reporting will begin for the period of October 1, 2012 through March 31, 2013. The WVRWPBP participated in all of the HRSA/HAB and NASTAD vetting sessions and conference calls for implementation of ADAP CLD.

The indicators to be measured in the WV QMP in 2012 include:

State Direct Services

- Percent of Ryan White funded clients who have a CD4 count test conducted at least twice during the 12 months
- Percent of clients, who newly enter medical case management services, who have scheduled a HIV primary care appointment within 90 days of enrollment
- Percent of client, who are enrolled in case management, with at least two HIV primary care visits in the last 12 months
- Percent of clients receiving case management who have a current client service plan updated at least twice per year
- Percent of clients receiving case management services who receive treatment adherence counseling at least twice during the 12 months
- Percent of clients, who are enrolled in medical case management, with a CD4 count less than 200 cells/mm, who are prescribed PCP prophylaxis
- Percent of pregnant females, who are enrolled in case management, and prescribed HAART according to HHS Guidelines

- Percent of clients, who receive a support service, who have had a primary care appointment in the last four months
- Percent of Ryan White funded clients, enrolled in medical case management services, who were offered an oral health exam in the last 12 months

Description of ADAP Quality Management Program

The WV ADAP Quality Management Program (QMP), part of the overall Part B QMP, includes data specialists from the WV HIV/AIDS and STD Program, the HIV Care Coordinator, WVRWPBP medical case managers and the Division Director of the STD, HIV and Hepatitis Program as members. The HIV Care Coordinator and the Director co-chair the QMP activities. The Assistant Director assists with the coordination of quality services at the state level. The data specialists are responsible for providing epidemiological data and trends for WV. The HIV Care Coordinator provides monthly and quarterly ADAP utilization data. The WVRWPBP medical case managers and the HIV Care Coordinator are responsible for implementing program changes.

The WV ADAP is administered through an agreement with the BMS. An annual client survey is conducted to determine the satisfaction of ADAP consumers. A satisfaction rate of 99% was achieved in FY 10-11. The WVRWPBP staff provides monthly monitoring activities to assess the efficiency of dispensing formulary drugs to clients and the accuracy of interfacing with Medicare Part D prescription drug plans (PDP).

The ADAP QMP has chosen two indicators that strongly support quality services in accordance with HHS Guidelines for 2012. The state will be monitoring the percent of ADAP applications approved or denied within ten days of the receipt of the three part application. In addition, the state will monitor the percent of ADAP participants who refill their ARVs in accordance with HHS treatment guidelines and standards of care.

Data collected for the ADAP QMP is assembled by the pharmacy benefits manager (PBM), Molina, utilized by Medicaid. Individual client level utilization data is reported to the HIV Care Coordinator by the 15th of each month. The HIV Care Coordinator reviews the previous calendar month's client utilization to ensure that clients are refilling their ARVs in accordance with HHS Guidelines and that regimens are prescribed in accordance with HHS Guidelines. The PBM reports activity of the quarter, for all ARV utilization, that is later reported on the ADAP Data Report, (ADR). While the question on the AQR looks at all utilizing clients for the quarter, including those who have not been prescribed ARVs or those who have chosen not to take ARVs, the ADAP QMP looks separately at those clients who are prescribed ARVs and their pattern of refilling the full regimen in timely manner.

Three indicators will be measured in the WV ADAP during FY 12

ADAP

- Percent of applying ADAP clients who are approved/denied for ADAP within 10 days of receipt of a completed application
- Percent of active adolescent and adult clients with AIDS in ADAP who are prescribed HAART
- Percent of active ADAP participants who are screened for Medicaid eligibility two times during the 12 month period

Monitoring Progress of the Comprehensive Plan

The WV Ryan White Part B Quality Management Committee will be responsible for monitoring the progress of the 2012 - 2015 Comprehensive Plan. Once a year, the Committee will meet with all of the other funded Ryan White Parts in the state.

WV Ryan White Part B Quality Management Plan

I VISION / GOALS

The WV HIV Care and Support Services Quality Management Program (QMP) is established to assess and ensure the degree to which the performance of funded HIV care and support services in West Virginia achieve the standards established in the Ryan White HIV/AIDS Treatment Modernization Act for Part B Programs and the Public Health Service Guidelines.

Through adherence to the Act and Guidelines, the mission of the QMP is to ensure equal access to quality comprehensive HIV care and support services for all eligible PLWHA in West Virginia. In support of the mission, West Virginia has established four goals for the QMP.

1. Promote quality medical care and support services based on current HHS Guidelines and on professional standards;
2. Maximize the retention in care of PLWHA in West Virginia
3. Promote accessible and appropriate HIV care and support services based on the monitoring of epidemiological trends in West Virginia;
4. Support the efficient and effective use of federal and state resources to meet the care and support needs of PLWHA in West Virginia.
5. Maximize HIV care and treatment resources in WV to meet the goals of the National HIV/AIDS Strategy.

II QMP INFRASTRUTURE

The WV AIDS and STD Program has designated the HIV Care and Support Services QMP as the empowered mechanism for assessing the quality of state and federally funded HIV care and support services. The QMP co-chairs report directly to the WV AIDS and STD Director. The QMP Committee is co-chaired by the Assistant Director of the WV AIDS and STD Program and the HIV Care Coordinator.

The WV QMP Committee is comprised of the following state employees:

Director STD/HIV/HEP Division, Co-Chair
HIV Surveillance staff
eHARS Administrator

The following contractors are members of the WV QMP Committee:

ADAP/HIV Care Coordinator, Co-Chair
All Regional Part B funded case managers

The WV QMP Committee also includes a minimum of one Ryan White Part B consumer.

The QMP Committee meets face to face meetings a minimum of once annually and meets via conference calls during the remaining months of the year at a minimum of every three months. The co-chairs will be responsible for convening meetings, distributing evaluations and for

electronic communications. The QMP Committee may invite consultations from other partners and consumers as is needed for effectively conducting planning, assessment and evaluation activities.

The Division Director for STD/HIV/HEP is responsible for communicating the reports of the QMP to HRSA.

Stakeholder Responsibilities

Director of STD/HIV/HEP Division:

Co-chair of QMP committee
- Communication to and from HRSA
- Schedule committee meetings
- Communication to committee
- Provide guidance
- Participate in committee activities

Surveillance Staff:
- Link to Surveillance Program
- Provide surveillance and laboratory data
- Provide guidance
- Participate in committee activities

eHARS Administrator:
- Link to HARS data
- Provide data analysis
- Provide guidance
- Participate in committee activities

HIV Medical Case Managers:
- Link to client services
- Provide client service utilization data
- Provide clinical data
- Provide guidance
- Participate in committee activities

HIV Consumer:
- Link to client perspective
- Provide guidance
- Participate in committee activities

HIV Care Coordinator:
- Co-chair of QMP Committee
- Provide ADAP and Care Service Data
- Represent state for NQC activities
- Link to contracted services
- Conduct QI evaluation
- Provide guidance
- Participate in committee activities

Part C Clinics
- Provide laboratory reports for CD 4 counts and viral loads and confirmation of primary care appointments

III PREFORMANCE MEASUREMENT

The QMP Committee is charged with developing quality indicators that measure the success of the WVHIV Care and Support Services Quality Management Program. The Committee must specifically address those services funded with Part B and state dollars.

Services include:

Part B core service (State Direct Services)

Support services including emergency food vouchers and medical transportation

Insurance Continuation

ADAP

In developing quality indicators, the QMP Committee will give precedence to the following:

Unmet need as defined by HRSA

Annual Surveillance and Demographic Data

Changes in HHS Guidelines

Changes in the HIV health care delivery system

Changes in funding mechanism

Changes in state and local infrastructure

Current needs assessments and client surveys

Cross CARE Act collaboration

Service utilization data/reports

Changes in ADAP formulary/FDA approved antiretrovirals

Core indicators prioritized by HRSA

Statewide Coordinated statement of Need

WV HIV Care and Treatment Comprehensive Plan

National HIV AIDS Strategy

Implementation of the Affordable Care Act

IV EVALUATION ACTIVITIES

Progress for the measured indicators will be reported at a minimum of every three months. The progress will be reported at the committee meetings.

The committee's effectiveness in improving the quality of HIV care and support services will be evaluated annually.

The performance indicators for clinical and non-clinical services will be assessed annually for their effectiveness.

Evaluation will be conducted by the HIV Care Coordinator and reported to the QM Committee. Findings will be utilized by the QM Committee to plan activities for the upcoming year and will be reported to the Division Director for STD/HIV/HEP and HRSA.

The West Virginia Part B Quality Management Plan is updated with new or revised indicators each year during the committee meeting conducted during the first quarter of the calendar year.