

**PS12-1201:**

**Comprehensive Human Immunodeficiency Virus (HIV)  
Prevention Programs for Health Departments**

# **Rhode Island Jurisdictional HIV Prevention Plan September 2012**

**Planning Period: 2012-2016**

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## I. Introduction

The Rhode Island Department of Health (HEALTH) is the lead state agency responding to the HIV/AIDS epidemic. The Rhode Island Community Planning Group for HIV Prevention (RICPG) in partnership with HEALTH in its continued commitment to improve the lives of those living with HIV/AIDS is fully engaged in making the necessary changes in order to be responsive to the new Centers for Disease Prevention and Control (CDC) guidance around the cooperative agreement, comprehensive program plan and jurisdictional plan.

The name of planning groups in the new *Guidance* has been changed by CDC to be called HIV Planning Groups (HPG). The RI (HPG) will continue to use the name RI Community Planning Group for HIV Prevention (RICPG). The rationale is as follows:

- Although the new direction has changed the “name, RICPG” is positively recognized and branded in RI as a result of much effort and resources that were put into identifying this group as the state planners in HIV. The group wants to build on the name recognition.
- Familiarity with the group will expedite the new focus of work especially in engaging participation from non-members.
- Although the membership will be enhanced and engagement outside the membership will be a priority, the term “community” is defined as any person, with an interest in contributing directly or indirectly to the HIV prevention goals in RI.
- It is more efficient to continue to use of printed and promotional material already purchased by the RICPG.

The RICPG in partnership with HEALTH, embraced the principles and the three steps process described in the guidance document. The RICPG membership (Appendix E) reflects the local epidemic by involving representatives of populations with increased prevalence of HIV infection and a wide range of HIV service providers. Community planning has evolved into HIV planning, which aims to contribute to HIV prevention through developing both targeted and broad-based collaboration among stakeholders. HIV planning will entail broadening the group of partners and stakeholders engaged in prevention planning, improving the scientific basis of program decisions, and targeting resources to those communities at highest risk for HIV transmission and acquisition. The RICPG membership reflects the diversity of the state in terms of geography, race/ethnicity, gender, and sexual orientation. The development of the RI Jurisdictional Plan for HIV is the result of the collaboration and cooperation of a multitude of stakeholders beyond the members of the RICPG including: Ryan White Grantees, AIDS Service Organizations (ASO), Rhode Island State Agencies, housing, substance abuse and other local stakeholders to achieve the goals of the National HIV AIDS Strategy.

In July 2010, the White House released the *National HIV/AIDS Strategy* (NHAS) that provided the vision and direction for HIV care and prevention activities. The NHAS identifies three primary goals:

1. Reducing HIV incidence
2. Increasing access to care and optimizing health outcomes
3. Reducing HIV-related health disparities

The Rhode Island 2012 Jurisdictional HIV Prevention Plan addresses the NHAS goals from a prevention perspective. The state also submitted a Comprehensive HIV Health Services (CHHS)

Plan to US Department of Health and Human Services Health Resources and Services Administration (HRSA) in July 2012. HEALTH's staff from the Office of HIV/AIDS and Viral Hepatitis, and RICPG members were involved in the development of CHHS plan and the RI Jurisdictional HIV Plan reflects both planning processes. It is HEALTH's goal to have an integrated plan in future years. As in the Comprehensive HIV Health Services Plan, the RI Jurisdictional Plan will address four (4) questions:

- Where Are We Now? – Overview of HIV Prevention Programming, Needs and Gaps
- Where Do We Need To Go? – Prevention activities and strategies to be implemented 2012-2016
- How Will We Get There? – Description of strategies addressing gaps and goals/NHAS, Responsible agency/group to carry out the activity
- How Will We Monitor Our Progress? Expected Outcomes and Relevant timelines

#### **A. Overview of the State of Rhode Island:**

In order to develop and implement priorities for Rhode Island's population at risk for or living with HIV/AIDS, it is first necessary to understand the health needs of the state's entire population and the general health care delivery environment. Equally important is an understanding of the geographical and cultural characteristics of the state, its localities (including their governmental structures), and the state's economic, housing, and educational characteristics since they also impact the health needs of the state's population.

The state of Rhode Island is a small, coastal area (1,214 square miles) with just over one million residents (1,051,302), which represents a .4% change in 2010 compared to 2000. According to the U.S. Census 2010, the racial/ethnic distribution of Rhode Island's population consisted of Whites (81.4%), Blacks (5.7%), Asians (2.9%), Native Americans (0.6%), Native Hawaiian or Pacific Islander (0.1%), some other one race (6%) and those who identified themselves as being two or more races (3.3%). Also, 12.4% of the population identified themselves of Hispanic or Latino origin. The State continues to grow in its diversity. The White and Native Hawaiian populations experienced decreases of .9% and 2.3% respectively since 2000. Other racial groups experienced increases in populations since 2000 as follows: Black (28.3%), Native Americans (18.3%), Asian (28.7%), some other race alone (21%), and two or more races (23.1%). Also the number of residents who identify as Hispanic or Latino origin has increased by 43.9% since 2000.

#### **B. State & Local Government Structure:**

Rhode Island has advantages for effective public health program implementation, given its small geographical size and unique governmental structure. With the exception of the state court system, there is no county level of government in Rhode Island. The state is made up of 39 cities and towns ranging from 1.3 to 64.8 square miles in size. In Rhode Island, local communities control primary and secondary education, subdivision of land and zoning, and housing code enforcement. A combination of cultural, socio-economic, and transportation-related factors makes "the neighborhood" the most important level of community in many

parts of Rhode Island, especially in low-income communities.

In 2010, Rhode Island elected its first independent Governor, Lincoln D. Chafee. The state legislature, the General Assembly, is a part-time legislature that is in session for about six months each year (January to June). The state House of Representatives includes 75 members, 87% of whom the Democrats. The state Senate has 38 members, 76% of whom are Democrats.

The Rhode Island Department of Health (HEALTH) is the sole public health authority making it legally responsible for the provision of core public health activities at both the state and local levels. HEALTH contracts for the provision of most non-regulatory services rather than deliver them directly. This strategy helps to create a seamless, uniform quality public health service system in Rhode Island. The absence of local health authorities means that health care providers in the state look to HEALTH for policy guidance and other forms of public health assistance.

### **C. Economy:**

Rhode Island's recession began months before the national recession began in December 2007. The economy in Rhode Island hit rock bottom in September 2009. In 33 months, the state lost 39,700 jobs, or 8% of its jobs. Although the US recession ended in the summer of 2009, Rhode Island's recession stretched into early 2010 with a slow and uneven recovery. In May 2012, Rhode Island's unemployment rate was 11%, the second highest in the nation after Nevada (11.6%). In contrast, the national unemployment rate was 8.2% in May 2012. It is predicted that after Michigan, Rhode Island will take the longest of the 50 states to regain all the jobs it lost during the recession. The unemployment rate, which hit double digits 3 years ago, is not expected to drop below 10% until next year. Racial and ethnic minorities are disproportionately impacted by the high unemployment rates in Rhode Island. According to the Economic Policy Institute, the Providence metropolitan area had, one of the largest increases in Hispanic unemployment in the nation from 2009 to 2010 – 4.6%. The unemployment rate for Hispanics is more than twice the unemployment rate for all of Rhode Island. Local communities have been hit hard by the economic situation. The efforts of multiple receivers to repair the city's finances, the City of Central Falls became the first municipality to file for bankruptcy in the state's history. East Providence has a state-appointed receiver. Five other cities and towns in Rhode Island face financial difficulties: Providence, Woonsocket, Pawtucket, North Providence, and West Warwick.

### **D. Health Indicators:**

According to the recently completed Healthy People 2010 (HP2010) closing data, RI has made significant improvements in some of the leading health indicators in the last decade:

- adolescent smoking rates have decreased from 35% in 1997 to 13% in 2010 and adult smoking rate decreased from 23% in 1998-2000 to 15% in 2010;
- the proportion of non-smokers exposed to environmental tobacco smoke have decreased from 39% in 2001 to 10% in 2010;
- the rates of death caused by motor vehicle crashes have decreased from 9/100,000 in 1996-1998 to 7/100,000 in 2010;

- childhood blood lead levels have decreased from 12% in 2000 to 2% in 2010;
- the proportion of persons living in homes tested for Radon increased from 5% in 1994-2000 to 10% in 2010.

Moderate improvements have been made in the following areas:

- the proportion of adolescents not using alcohol or any illicit drugs in the last 30 days increased from 45% in 1997 to 57% in 2010;
- the proportion of adolescents who have never had sexual intercourse, have abstained from sexual intercourse in the past three months or used condoms at last sexual intercourse increase from 86% in 1997 to 88% in 2010
- the proportion of unmarried sexually active adult females who use condoms increased from 30% in 2002 to 41% in 2010 and for adult males from 47% in 2002 to 58% in 2010;

*Areas in need of improvement:*

- the proportion of pregnant women who receive early and adequate prenatal care went from 91% in 1997-1999 to 87% in 2010;
- the rate of adult who are obese went from 17% in 1998-2000 to 22% in 2010;
- the proportion of adults using illicit drugs during the last 30 days went from 7% in 1999 to 13% in 2010);

RI continues to see, across all indicators, disparities by race and ethnicity, and socio-economic income. RI's statewide population-based data consistently show that adults with lower income and less formal education have higher prevalence of chronic conditions, worse health status, and lack of access to health care services; findings that are consistent with U.S. health data:

- In RI's core cities, where poverty and residential racial segregation are endemic, 9.1% of adults have diagnosed diabetes compared to 6.6% of RI adults not living in core cities.<sup>i</sup>
- Among Rhode Islanders aged 20 years and older, the prevalence of obesity, defined as a body mass index of 30.0 or higher, increased steadily from 17.7% in 2001 to 26.0% in 2010.<sup>ii</sup> RI adults with less than a high school education or a household income less than \$25,000 a year have the highest rates of obesity—close to 29%.
- The Hispanic/Latino population has the lowest percentage of adults participating in physical activity (35.8%) compared to all other minority groups and the overall state population (50.3%).
- Compared to the state and all other minority groups, Native Americans (66.9%) and African Americans (69.2%) have the highest percentage of adults who are overweight and obese, compared to a low of 36.4% in the Asian & Pacific Islander population.

In fact, 2007 to 2009 aggregated Behavioral Risk Factor Surveillance System (BRFSS) data for RI show that socioeconomic disparities, whether measured by education or household income, persist for all self-reported chronic disease risk factors (current smoking, physical inactivity, low consumption of fruits and vegetables, obesity, doctor-diagnosed high blood pressure and high cholesterol) and for two of the most prevalent, costly, and preventable chronic diseases—

cardiovascular disease and diabetes—as well as for current asthma and poor mental health.<sup>iii</sup> For instance, smoking rates among adults with lower income and less education remain high. Nearly one-third of RI adults (31.9%) with less than a high school education currently smoked in 2010, but only 8.3% of adults with a college education were smokers.<sup>iv</sup> One-fourth of Rhode Islanders with household incomes below \$25,000 currently smoked in 2010 compared with 11.0% of Rhode Islanders with household incomes of \$50,000 or more.<sup>v</sup>

## **II. Rhode Island HIV/AIDS Epidemiology**

### **A. Overview of Rhode Island HIV and AIDS Incidence and Prevalence:**

*See Appendix B for the complete 2010 Rhode Island HIV/AIDS Epidemiologic Profile with Surrogate Data.*

In 2011, there were more than 3,500 people living with HIV in Rhode Island, and approximately 72% were male and 28% were female. Race and ethnicity of these cases were similar to the AIDS cases. The majority of the cases were White (41%), followed by African Americans and Hispanics (All races, 29%, 27%). The predominant age group among these cases was the 40-49 year olds (37%). Majority of these HIV cases (36%) were MSM (men who have sex with men) as their risk, followed by No Identified Risk (25%) and Heterosexual Risk (21%). Without a doubt RI has focused upon reducing new infections with constant, persistent prevention program activities that focus upon target populations at risk for HIV, those who are unaware of their status, and by providing broader opportunities for the population at large to get HIV tested.

With the newly released Centers For Disease Control and Prevention (CDC) core components, Rhode Island has re-focused its attention from the model of “replicable, effective prevention strategies,” to the delivery of the core CDC components which include: Condom Distribution, HIV Prevention for Positives, Policy Initiatives (that focus upon barriers to receiving prevention), and HIV Testing. Rhode Island has admittedly struggled with consistent needs assessment data that augments Rhode Island’s epidemiologic profile (EPI). To overcome that struggle, within 2011 and 2012, HEALTH began to isolate missing data based upon trends analysis. One of the responsibilities of HEALTH is to produce an EPI profile on HIV/AIDS in the state. Typically the EPI profile assists in understanding the trends and distribution of disease throughout the region. In addition, the EPI profile is used as the foundation for the Statewide Coordinated Statement of Need (SCSN) to better understand the HIV/AIDS population and how it appears to be changing within the state, and whether needs assessment efforts are reaching representative populations most at risk for HIV.

As of December 31, 2010, a total of 3,080 cases of AIDS have been diagnosed in Rhode Island residents. Since 1993 the incidence, which is the number of new cases of AIDS, and deaths among AIDS cases have decreased dramatically coinciding with the widespread use of more effective treatments strategy along with increased testing leading to early linkage to care. AIDS incidence has decreased by 89% (from 317 new cases in 1993 to 36 new cases in 2010). During the same time period, the AIDS prevalence, or the total number of AIDS cases living in Rhode

Island each year, has increased 9 fold (from 203 cases in 1993 to 1,881 cases in 2010). Of the individuals living with HIV/AIDS in Rhode Island, 1,818 or 60% of them with AIDS, the other 1,192 or 40% with HIV/non-AIDS. Because Rhode Island does not yet have a mature name-based reporting system for HIV/non-AIDS, this is probably an understatement of the number of individuals with HIV in the state. Gender breakdowns are relatively stable at about 72% male and 28% female, although incidence data in 2009 indicate a small increase in the proportion of men among the newly diagnosed. The racial/ethnic breakdown for living cases (prevalence) tends to be over one-fourth Hispanic, over one-fourth African American, and under half White, with a small percentage of Asians and other groups. Incidence data for 2009 indicate a higher proportion of Hispanics (40% for both HIV/non-AIDS and AIDS) and a lower proportion of white non-Hispanics (31%). Newly diagnosed individuals with HIV/non-AIDS in 2009 were younger than those diagnosed with AIDS – more likely to be 20-29 and less likely to be 40 and over. In Rhode Island, there has been a *reduction* in cases related to injection drug use (IDU). IDU identified as the primary risk factor for 22% of all people living with HIV/AIDS but accounts for only 6% of new HIV/non-AIDS cases and 10% of new AIDS cases in 2009. The proportion of cases attributed to male-to-male sex is much higher among new HIV cases (47%) than among living HIV/AIDS cases (34%). Cases related to heterosexual sex are also lower (13% of new HIV/AIDS cases, and 24% of living HIV/AIDS cases). Given relatively small incidence numbers in a given year, these fluctuations need to be monitored over multiple years.

#### **B. AIDS in Rhode Island: Trends in AIDS Incidence, 2001-2005 versus 2006-2010:**

To summarize trends in AIDS incidence; the proportion of men is increasing, as is the proportion of new AIDS cases among individuals over 50, an increase in MSM transmission, and a decrease in IDU and heterosexual transmission.

#### **AIDS Summary:**

Clearly downward epidemiologic trends have been evident in the number of reportable Rhode Island AIDS cases over the last five years. Since 2004 and until 2010 it has been observed that there has been an overall decline in reportable Rhode Island AIDS cases by 75%. While the aforementioned data is encouraging, significant increases among minority populations such as Hispanics and women who have their first HIV tests and are simultaneously deemed both positive for HIV, as well as having an AIDS diagnosis. A potential rationale is the perception that women may not think they are at risk for HIV or AIDS due to the fact they believe they are in monogamous relationships. One solution may be more assertive provider testing among women so as to decrease the simultaneous diagnosis of HIV and AIDS upon first test.

Death trends associated with those who have AIDS are decreasing steadily despite the small increases found in 2000, 2005, 2006 and 2009. Antiretroviral therapies are highly effective, and it's critical to ensure the Rhode Island AIDS Drug Assistance Program (ADAP) continues to make HIV drugs accessible and available to all who really need them. The following Figures reveal comparisons of survey assessments from RI's consumer population survey, RSR information and the HIV/AIDS data herein.

Demographic Group	AIDS Incidence 01/01/09 to 12/31/09		HIV Incidence 01/01/09 to 12/31/09		AIDS Prevalence As of 12/31/09		HIV Prevalence As of 12/31/09		HIV/AIDS Prevalence As of 12/31/09	
	#	%	#	%	#	%	#	%	#	%
<b>Race/Ethnicity</b>										
Hispanic	24	40%	50	40%	444	24%	324	27%	768	26%
White	19	31%	39	31%	837	46%	489	41%	1326	44%
African American	18	29%	33	26%	489	27%	348	29%	837	28%
American Indian/Alaska Native	<5	*	<5	*	11	1%	9	1%	20	1%
Asian and Pacific Islander	<5	*	<5	*	37	2%	22	2%	59	2%
<b>Total</b>	<b>62</b>	<b>100%</b>	<b>125</b>	<b>100%</b>	<b>1818</b>	<b>100%</b>	<b>1192</b>	<b>100%</b>	<b>3010</b>	<b>100%</b>
<b>Gender</b>										
Male	46	74%	95	76%	1295	71%	859	72%	2154	72%
Female	16	26%	30	24%	523	29%	333	28%	856	28%
<b>Total</b>	<b>62</b>	<b>100%</b>	<b>125</b>	<b>100%</b>	<b>1818</b>	<b>100%</b>	<b>1192</b>	<b>100%</b>	<b>3010</b>	<b>100%</b>
<b>Age Group</b>										
<13	<5	*	<5	*	10	<1%	5	<1%	15	0%
13-19	<5	*	<5	*	12	<1%	9	1%	21	1%
20-29	9	15%	30	24%	110	6%	191	16%	301	10%
30-39	15	24%	29	23%	292	16%	379	32%	671	22%
40-49	25	40%	36	29%	699	38%	439	37%	1138	38%
50+	13	21%	27	22%	695	38%	169	14%	864	29%
<b>Total</b>	<b>62</b>	<b>100%</b>	<b>125</b>	<b>100%</b>	<b>1818</b>	<b>100%</b>	<b>1192</b>	<b>100%</b>	<b>3010</b>	<b>100%</b>

Demographic Characteristics	2001	2002	2003	2004	2005	Subtotal, 2001-2005	2006	2007	2008	2009	2010	Subtotal, 2001-2010
<b>Gender</b>												
Male	64 (65%)	75 (75%)	70 (71%)	95 (68%)	67 (64%)	371 (69%)	59 (66%)	55 (80%)	38 (68%)	46 (74%)	25 (69%)	223 (71%)
Female	35 (35%)	24 (25%)	28 (29%)	44 (32%)	38 (36%)	169 (31%)	30 (34%)	14 (20%)	18 (32%)	16 (26%)	11 (31%)	89 (29%)
<b>Total</b>	<b>99 (100%)</b>	<b>99 (100%)</b>	<b>98 (100%)</b>	<b>139 (100%)</b>	<b>105 (100%)</b>	<b>540 (100%)</b>	<b>89 (100%)</b>	<b>69 (100%)</b>	<b>56 (100%)</b>	<b>62 (100%)</b>	<b>36 (100%)</b>	<b>312 (100%)</b>
<b>Age Group</b>												
<20 (includes <13 and 13-19 age groups)	2 (2%)	1 (1%)	4 (4%)	0	1 (1%)	8 (1%)	*	*	*	*	*	*
20-29	14 (14%)	8 (8%)	11 (11%)	16 (11%)	8 (8%)	57 (11%)	5 (6%)	7 (10%)	14 (25%)	9 (15%)	*	41 (13%)
30-39	37 (37%)	37 (37%)	34 (35%)	58 (42%)	29 (28%)	195 (36%)	29 (33%)	24 (35%)	15 (27%)	15 (24%)	12 (33%)	95 (30%)
40-49	31 (31%)	41 (41%)	37 (38%)	47 (34%)	51 (49%)	207 (38%)	35 (39%)	28 (41%)	17 (30%)	25 (40%)	8 (22%)	113 (36%)
50+	15 (15%)	12 (12%)	12 (12%)	18 (13%)	16 (17%)	73 (14%)	18 (20%)	10 (14%)	9 (16%)	13 (21%)	13 (36%)	63 (20%)
<b>Total</b>	<b>99 (100%)</b>	<b>99 (100%)</b>	<b>98 (100%)</b>	<b>139 (100%)</b>	<b>105 (100%)</b>	<b>540 (100%)</b>	<b>89 (100%)</b>	<b>69 (100%)</b>	<b>56 (100%)</b>	<b>62 (100%)</b>	<b>36 (100%)</b>	<b>312 (100%)</b>
<b>Race/Ethnicity</b>												
Hispanic-All Races	27 (27%)	18 (18%)	24 (24%)	42 (30%)	21 (20%)	132 (24%)	20 (22%)	13 (19%)	15 (27%)	24 (39%)	8 (22%)	80 (26%)
African American	30 (30%)	32 (33%)	37 (38%)	39 (28%)	32 (30%)	170 (31%)	27 (30%)	16 (23%)	19 (34%)	18 (29%)	8 (22%)	88 (28%)
White	40 (40%)	47 (48%)	36 (37%)	55 (40%)	49 (47%)	227 (42%)	38 (43%)	38 (55%)	21 (38%)	19 (31%)	18 (50%)	134 (43%)
Other (Asian, Pacific Islander, Native American)	2 (2%)	2 (2%)	1 (1%)	3 (2%)	3 (3%)	11 (2%)	4 (5%)	2 (3%)	1 (2%)	1 (2%)	2 (6%)	10 (3%)
<b>Total</b>	<b>99 (100%)</b>	<b>99 (100%)</b>	<b>98 (100%)</b>	<b>139 (100%)</b>	<b>105 (100%)</b>	<b>540 (100%)</b>	<b>89 (100%)</b>	<b>69 (100%)</b>	<b>56 (100%)</b>	<b>62 (100%)</b>	<b>36 (100%)</b>	<b>312 (100%)</b>

<b>Figure 2: Demographic Characteristics of Rhode Island AIDS Cases by Year of Diagnosis 2001-2005 versus 2006-2010</b>												
<b>Demographic Characteristics</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>Subtotal, 2001-2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>Subtotal, 2001-2010</b>
<b>Exposure Category</b>												<b>2005-2009 only</b>
MSM	17 (17%)	28 (28%)	27 (28%)	38 (27%)	30 (29%)	<b>140 (26%)</b>	29 (33%)	28 (40%)	14 (25%)	23 (37%)	***	<b>94 (34%)</b>
IDU	37 (37%)	32 (32%)	26 (27%)	31 (22%)	26 (25%)	<b>152 (28%)</b>	17 (19%)	13 (19%)	21 (38%)	6 (10%)	***	<b>57 (21%)</b>
Heterosexual Contact	40 (40%)	34 (37%)	41 (42%)	56 (40%)	35 (33%)	<b>206 (38%)</b>	33 (37%)	6 (9%)	9 (16%)	8 (13%)	***	<b>56 (20%)</b>
All other**	5 (5%)	5 (5%)	4 (4%)	14 (10%)	14 (13%)	<b>42 (8%)</b>	10 (11%)	3 (4%)	1 (2%)	2 (3%)	***	<b>16 (6%)</b>
No Risk Reported	****	****	****	****	****	****	****	19 (28%)	11 (20%)	23 (37%)	[12 (33%)]	<b>53 (19%)</b>
<b>Total</b>	<b>99</b> <b>(100%)</b>	<b>99</b> <b>(100%)</b>	<b>98</b> <b>(100%)</b>	<b>139</b> <b>(100%)</b>	<b>105</b> <b>(100%)</b>	<b>540</b> <b>(100%)</b>	<b>89</b> <b>(100%)</b>	<b>69</b> <b>(100%)</b>	<b>56</b> <b>(100%)</b>	<b>62</b> <b>(100%)</b>	***	<b>276</b> <b>(100%)</b>

\* For 2006-2010, includes <29: Combines <13, 14-19, and 20-29 age groups because numbers in these groups are sometimes <5 in a year

\*\* Includes categories that have <5 in a category in some years, so are combined here. Included are MSM/IDU, Hemophilia/coagulation Disorder, Transfusion/Transplant, Perinatal, and No Risk Reported.

\*\*\* Numbers in all categories except MSM and No Risk Reported were <5.

\*\*\*\* Cell was <5 so included in "All Other" category.

Source: Rhode Island Office of HIV/AIDS and Viral Hepatitis.

**Figure 3: Characteristics of PLWH Survey Respondents, Ryan White Clients, and the HIV/AIDS Population in Rhode Island, 2009-2011<sup>14</sup>**

Characteristic	2011 Needs Assessment Survey		2010 Combined Ryan White Client Utilization Data		2009 HIV/AIDS Prevalence Data	
	#	%	#	%	#	%
<b>Prevalence - All</b>						
People living with HIV/non-AIDS (PLWH)	108	72%	1,488	53%	1,192	40%
People living with AIDS (PLWA)	35	23%	910	33%	1,818	60%
HIV-negative people caring for PLWHA	5	3%	174	6%	-	-
Unknown/Not reported	2	1%	220	8%	-	-
Total number	150	-	2,793	-	3,010	-
<b>Prevalence – Gender</b>	<b>#</b>	<b>%</b>	<b>#</b>	<b>%</b>	<b>#</b>	<b>%</b>
Male	104	69%	1,860	67%	2,154	72%
Female	44	29%	924	33%	856	28%
Transgender	2	1%	3	<1%	-	-
Unknown/Not reported	-	-	6	<1%	-	-
Total number	150	-	2,793	-	3,010	-
<b>Prevalence – Race/Ethnicity</b>	<b>#</b>	<b>%</b>	<b>#</b>	<b>%</b>	<b>#</b>	<b>%</b>
Hispanic	19	13%	711	25%	768	26%
White (not Hispanic)	81	54%	1,159	41%	1,326	44%
Black or African American	42	28%	640	23%	837	28%
Asian	1	1%	29	1%	49	2%
Native Hawaiian/Pacific Islander	1	1%	3	<1%	5	<1%
American Indian/Alaska Native	2	1%	38	1%	20	1%
Other	3	2%	213	8%	5	<1%
Total number	150	-	2,793	-	3,010	-

<sup>14</sup> Sources: 2011 Needs Assessment Survey data from initial Mosaica analysis of 150 surveys received by July 22, 2011. Client utilization reports from data submitted to HRSA/HAB by the providers in the 2010 Ryan White Services Report and Data Report (RSR, RDR). 2009 prevalence data provided by the Rhode Island Office of HIV/AIDS and Viral Hepatitis surveillance staff; these are data as provided in the Part A application submitted in the fall of 2010.

**People living with AIDS (PLWA):**

Rhode Island implemented AIDS case surveillance in 1983 and HIV in 1989. Since then, information on demographics, risk factors and disease progression are collected through the surveillance system for better understanding of the epidemic in order to manage it in an appropriate way by directing resources and prevention programs for the people in need.

There were 1818 people living with AIDS at the end of 2009 in Rhode Island. Most of these AIDS cases were male (71%) followed by female (29%). The predominant race among the AIDS cases were White (46%) followed by African American and Hispanics respectively (27% and 24%). The majority reported AIDS cases were from 40-49 (38%) and 50+ (38%) age groups. Most of the AIDS cases had MSM as their exposure category (33%), followed by Heterosexual Contact (26%).

In 2010 the number of people living with AIDS in RI was 1881. Seventy two percent of these cases were male and 28% female. Race and ethnicity of the 2010 prevalent cases were similar to 2009 cases. Among the age groups for initial AIDS diagnosis, the majority of cases were in the 50+ age group (41%) followed by the 40-49 age group (36%). The predominant exposure category among 2010 prevalent AIDS cases were MSM (36%) followed by No Risk Reported (11%); both categories increased from 2009.

### New AIDS cases reported within last two years:

The number of new AIDS cases diagnosed and reported in Rhode Island during the last two years has steadily decreased compared to last five years. In 2009, there were 62 new AIDS cases reported to the Rhode Island Department of Health; and in 2010 there were 36 new AIDS cases reported. The incidence rate for new AIDS cases decreased from 5.8 in 2009 to 3.42 in 2010. Among these 2009 cases about 74% were male and 26% female; and most cases were from 40-49 age groups (40%). In 2010 69% of cases were male and 31% female; the leading age group was 50+ (36%) while there was an increase in the 30-39 age group compared to 2009. In 2009 most of the cases were Hispanics (40%, which was also seen among new HIV cases for that year) followed by Whites (31%) and African Americans (29%). In 2010 most cases were White (50%) followed by Blacks and Hispanics with 22%. In 2009, MSM and No Risk Reported were most common exposure category (37%) among the new cases. And in 2010 MSM was the predominant exposure category among the new cases (41%), which also increased from 2009; MSM was followed by No Risk Reported (33%) among 2010 new AIDS cases. Total number of people living with AIDS in Rhode Island in 2009 was 1818 in 2010 it was 1881.

Characteristic	2011 Needs Assessment Survey		2010 Combined Ryan White Client Utilization Data		2009 HIV/AIDS Prevalence Data	
	#	%	#	%	#	%
Prevalence – Age Group						
Under 13	15	-	56	2%	15	<1%
13 – 24	6	4%	112	4%	21 (13-19) <sup>16</sup>	1%
25 – 44	33	22%	1,008	36%	972 (20-39)	32%
45 – 64	103	68%	1,536	55%	1,138 (40-49)	38%
65 and older	8	5%	81	3%	864 (50+)	29%

The reporting of positive HIV test results has been mandatory in Rhode Island since 1989. From 1989 through 1999, reports purposely did not contain identifying information. Many people testing positive for HIV frequently received more than one test, and without name reporting it was difficult, if not impossible to determine duplicate counting of tests. Therefore, under these reporting conditions, the number of positive tests exceeded the numbers of persons with newly diagnosed HIV. For this reason, the number of positive HIV tests received annually during this period of observation was used only as a very rough indicator of the incidence of newly diagnosed HIV.

From 2000 onward, reports of positive HIV test results have contained unique personal identifiers with which duplicate test results may be culled from the aggregate with great certainty, allowing greater confidence in the interpretation of HIV data. In 2006 Rhode Island moved to name-based HIV reporting as a part of nationwide approach mandated by the CDC. Since July 2006 all HIV cases are being reported to the Rhode Island Department of Health with names. Both the CDC and the HEALTH are hopeful that in the long run this will overtime accurately capture the disease burden and risk. There were 1,451 new cases of HIV diagnosed

in the period from January 1, 2000 to December 31, 2010. Table 5 represents a breakdown of the HIV cases by demographic characteristics reported in last five years, and table 6 represents all HIV cases diagnosed and reported from 2000 to 2010 analyzed by demographic characteristics and risk factor.

**Demographic characteristics and risk factor of Rhode Island HIV Cases:**

	205	2006	2007	2008	2009	2010*
<b>Gender</b>						
Male	81 (65%)	90 (73%)	98 (81%)	79 (67%)	95 (76%)	84 (79%)
Female	43 (35%)	33 (27%)	23 (19%)	39 (33%)	30 (24%)	22 (21%)
Total	124 (100%)	123 (100%)	121 (100%)	118 (100%)	125 (100%)	106 (100%)
<b>Age Group</b>						
<13	<5*	<5 *	<5*	<5*	<5*	<5*
13-19	<5*	<5 *	<5*	<5*	<5*	8 (7%)
20-29	23 (19%)	23 (19%)	6 (5%)	21 (18%)	30 (24%)	20 (19%)
30-39	50 (40%)	42 (34%)	21 (17%)	36 (31%)	29 (23%)	27 (25%)
40-49	35 (28%)	38 (31%)	37 (31%)	42 (36%)	36 (29%)	27 (25%)
50+	15 (12%)	17 (14%)	34 (28%)	17 (14%)	27 (22%)	24 (23%)
Total	124 (100%)	123 (100%)	121 (100%)	118 (100%)	125 (100%)	106 (100%)
<b>Race/Ethnicity</b>						
White	57 (46%)	63 (51%)	62 (51%)	48 (41%)	39 (31%)	47 (44%)
African American	35 (28%)	34 (28%)	30 (25%)	33 (28%)	33 (26%)	26 (25%)
Hispanic	29 (23%)	22 (18%)	25 (21%)	35 (30%)	50 (40%)	27 (26%)
Asian	<5*	<5 *	<5 *	<5 *	<5 *	<5*
Native American	<5*	<5 *	<5 *	<5 *	<5 *	<5*
Total	124 (100%)	123 (100%)	121 (100%)	118 (100%)	125 (100%)	106 (100%)
<b>Risk Factor</b>						
MSM	45 (36%)	51 (41%)	47 (39%)	48 (41%)	59 (47%)	54 (51%)
IDU	12 (10%)	12 (10%)	18 (15%)	19 (16%)	8 (6%)	6 (6%)
MSM / IDU	<5*	<5*	6(5%)	<5 *	<5 *	<5*
Heterosexual Contact	20 (16%)	35 (28%)	11 (9%)	22 (19%)	16 (13%)	13 (12%)
Transfusion	6 (5%)	<5*	<5*	<5 *	<5 *	<5*
Mother with HIV/HIV Risk	<5 *	<5 *	<5 *	<5 *	<5 *	<5*
No Risk Specified	37 (30%)	21 (17%)	35 (29%)	26 (22%)	36 (29%)	32 (30%)
Total	124 (100%)	123 (100%)	121 (100%)	118 (100%)	125 (100%)	106 (100%)
<b>County of Residence</b>						
Homeless	<5*	<5 *	<5 *	<5 *	<5 *	<5*
Bristol	<5*	<5 *	<5 *	9 (8%)	<5 *	<5*
Kent	7 (6%)	6 (5%)	6 (5%)	<5 *	7 (5%)	9 (9%)
Newport	7 (6%)	5 (4%)	7 (6%)	<5 *	8 (6%)	8 (8%)
Providence	105 (85%)	105 (85%)	99 (82%)	102 (86%)	100 (80%)	81 (77%)
Washington	<5*	6 (5%)	6 (5%)	<5 *	6 (5%)	6 (6%)

Total	124 (100%)	123 (100%)	121 (100%)	118 (100%)	125 (100%)	106 (100%)
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**D. People living with HIV (non-AIDS):**

In Rhode Island HIV positive test reports were collected without names and to protect the patients’ privacy a unique identifier code has been used instead of name since the year 2000. In 2006, HIV Name reporting law was enacted requiring HIV to be reported by name along with other identifying information. Laboratories now are required to report CD4+ T Lymphocyte counts (less than 200, and/or 14%) and all detectable HIV viral loads for RI residents. They are required to report positive HIV test results as well. Tests are used are those approved by the U.S. Food and Drug Administration. All confirmatory HIV testing are done by the State Lab are reported to HEALTH directly.

In 2009 there were total 1192 people living with HIV in Rhode Island, 72% of were male and 28% were female. Race and ethnicity of these cases were similar to the AIDS cases. Majority of the cases were White (41%) followed by African Americans and Hispanics (All races, 29%, 27%). The predominant age group among these cases was the 40-49 year olds (37%). Majority of these HIV cases (36%) had MSM (Men who has sex with men) as their exposure category, followed by No Risk Reported (25%) and Heterosexual Contact (21%).

In 2010 the Population living with HIV (Non-AIDS) was 1414; the demographic distribution was similar to 2009 for males and females. Race and ethnicity of the prevalent cases were mostly similar with a 1% increase among Whites and 1% among Blacks. Among the different age groups at diagnosis, in 2010 prevalent cases in 20-29 age group rose to 23% from 16% in 2009. There was also a decrease among 40-49 year olds compared to 2009. The predominant exposure categories among the 2010 cases were MSM (44%) followed by No Risk Reported (29%) and Heterosexual Contact (23%). The distribution of MSM increased from 36% (2009) to 44% in 2010.

A CDC assessment is highlighted in this plan as it represents a robust survey of approximately 215 MSM, with over sampling in the following areas: Hispanic MSM, African American MSM, and Adolescent MSM. It is referred to as the CDC/MSM Assessment and was completed in September 2011. This report along with the other assessments done in state, illustrate the supplementation of incomplete and/or missing data for this target group.

Two significant assessment goals were related to the CDC visit and the investigation:

1. Describe the knowledge, attitudes, and practices of healthcare providers practicing in and near Rhode Island concerning HIV and STD testing, reporting of these infections, and their prevention.
2. Describe the knowledge, attitudes, and practices concerning HIV and STD testing and prevention, the risk behaviors, and the social networking of MSM in Rhode Island.

***CDC Summary regarding MSM assessment demographics:***

- 75% were 35 years of age or younger
- Proportion of non-white race/ethnicity higher than census

- 28% full-time or part-time students
- Nearly 40% non-RI residents
- Over 30% of RI residents had anal sex with partners who were non-RI residents

***CDC summary of healthcare access issues for MSM:***

- Majority had health insurance (80%) and a primary care provider (74%)
  - Of those with PCP, majority had disclosed MSM history and had been offered HIV test by PCP
- 50% had HIV testing in past 6 months, 70% had HIV testing in the past 12 months
- 39% received their last HIV test at community health clinic, HIV testing and counseling centers, or STD clinic

***CDC summary regarding knowledge, attitudes, and practices concerning HIV testing and prevention, risk behaviors and social networking of MSM in Rhode Island:***

- 49% had more than 1 male sex partner in the past 3 months
- 23% of sexually active MSM had unprotected anal sex with a casual partner in the past 3 months
- 47% found sex partners at bars/clubs
- 36% found sex partners online/internet
- 26% were unsure of symptoms of acute HIV
- 60% were unaware of existence of test for acute HIV
- Less than 16% would ask for test for acute HIV if developed flu-like symptoms after possible sexual exposure
- Over 75% had not heard of nPEP before the survey, although >60% would ask their doctors for nPEP after possible sexual exposure
- Over 75% had not previously heard of nPEP, although >60% would ask their doctors for nPEP after possible sexual exposure
- Over 90% had not previously heard of PrEP, and 44% would ask their doctors about PrEP

***CDC Summary of Prevention and Care issues that surfaced in the assessment:***

- Over 60% did not receive STD testing in the past 12 months
- Over 50% have not been vaccinated against hepatitis A
- 50% have not been vaccinated against hepatitis B

***CDC recommendations regarding healthcare provider practices for MSM:***

- Incorporate critical disease reporting information in state-wide CME for physicians
- Encourage routine HIV testing in line with the 2006 revised guidelines on HIV testing among adults, adolescents, and pregnant women
- Encourage routine vaccination against hepatitis A and B among men
- Support development of national pre-exposure prophylaxis guidelines

***RI Community Planning Assessments:***

In addition to the MSM-CDC Assessment, the RICPG, and HEALTH revealed the following assessment areas/needs for their priority populations

❖ **MSM:**

- Implemented numerous assessments upon high risk MSM, including male sex workers, young MSM, racial and culturally diverse MSM.
- Social networking websites (e.g. Manhunt, Adam to Adam), Non-traditional outreach strategies
- Peer lead, peer outreach
- Materials need to be same sex sexually explicit
- Access peer social networks to educate and prevent HIV
- Need to involve the community as a whole
- Need to address MSM on the down low
- Identify key stakeholders and involve them
- Conduct outreach in anonymous sex settings (e.g., adult video stores, bars, clubs, etc.)

❖ **IDU:** Most recently in the years 2010 and 2011 the Office of HIV/AIDS & Viral Hepatitis staff as well as the RICPG and the Provision of Care Planning Body (PCPB) began to review data pertaining to IDUs. Although Rhode Island has seen a sharp decrease in IDU as a risk factor associated with HIV and AIDS, the review sought to better understand whether any data were missing and/or needed to revise existing data regarding both prevention and risk of getting HIV, as well as care issues associated with IDUs who are positive. In short the above groups recommended that we conduct a needs assessment of IDU due to the fact that an assessment on IDUs had not been done in a few years. According to the Epidemiological Profile for 2005-2009, IDU as a risk group individually represents 8% of new infections, but when combined with MSM/IDU, represent nearly 19% of newly diagnosed individuals. The RICPG has targeted a specific cohort of IDUS; Men and Women ages 20-39, who are Black/African American and Hispanic/Latinos, and who live in urban areas of Providence County (Woonsocket, Pawtucket and Central Falls). Following this recommendation to specifically target IDUs in this manner, the RICPG along with the support of the PCPB began to further assess both prevention and “care” needs for IDUS.

In short, resultant information from the assessment process for IDUS revealed the prevention program efforts around needle exchange proved to be effective in minimizing IDU-HIV transmission. In addition, another effective policy was the statutory changes that now allow for purchase of a syringe without a prescription. In addition, testing for the IDU population appeared to be stable and well attended to by community based agencies and by the IDUs themselves (e.g., the states needle exchange program has mobile services that test IDUs throughout the state and onsite in their stable site. For the care side, the notion of active IDUs who were positive receiving quality HIV care was discussed and analyzed. Throughout the Rhode Island HIV care system access surfaced with some specific confounders. Specifically, as one provider stated “Access to care for an active HIV, positive IDU requires a series of good fortune; including good access to substance use rehabilitation/recovery programs, maintenance of substance use services; mental health services ; in a majority of cases access to HCV services;

maintenance of HCV services, etc. At the end of the day keeping IDUS who are HIV positive in care is part luck and part availability of a plethora of services to assist both the patient and the provider.”

In late 2011, the RI Ryan White Part B Program developed and disseminated a survey to consumers of HIV services (including consumers in all areas of the state, consumers receiving HIV medical care through the Veterans Administration and recipients of Ryan White Part B, Part C and ADAP programs. In total 124 consumers responded to the survey. Please see **Appendix C** for a sample of the 2011 HIV Consumer Assessment Survey.

Of the respondents approximately 69% were male, 30% female and 1% transgender. The majority live in the Providence area with 69%, 20% in northern Rhode Island, 4 % southern Rhode Island and 7% listed other. Three quarters of the respondents list they live in an urban setting. The racial/ethnic breakdown of respondents is as follows: Black/African American, 16.4%; White (non-Hispanic), 54.1%; Hispanic/Latino, 20.5%; Cape Verdean, 5%; Asian, 1.6% and American Indian/Alaska Native, 2.5%. 82.9% were born in the United States or DC and the remainder of respondents listed Asia, Africa, the Caribbean and other.

Approximately 19.5% are working full time, 7.3% part-time, 11% are looking for work, and 2.4% working informally or under the table, and 58.5% are disabled or unable to work. Household income varied and 13% listed no income, 32% less than \$10,000, 27% between \$10,000-\$19,999, 9% between \$20,000-\$29,999, 8% between \$30,000-\$39,999 and 11.4% make \$40,000 or more. Approximately 40% listed they were on SSDI, 22% “only” SSI, and 2.5% SS retirement funds. Further 38.3% have Medicaid, 34.2% Medicare, 19.2% are privately incurred, and approximately 3.3% listed Qualified Medicare Beneficiary.

Housing status revealed approximately 75% rent or own a home, 11% stay with family or a friend, 3.3% homeless, 3.3% in a treatment or group home, 5% in an AIDS residential facility or assisted living facility, and 3.3% listed other.

Approximately 43.1% of the respondents had been diagnosed with HIV/AIDS for more than 15 years, 15% between 11-15 years, 16.4% 6-10 years, 7.8% 4-5 years, 11.2% 1-3 years and 6.9% less than one year. Of the respondents 82.2% said when they were first diagnosed they were HIV and not AIDS and 13.6% said they were diagnosed with AIDS at the time of testing, and 4.2% were not sure. Respondents were asked how long did it take for them to first see a doctor (after they were diagnosed), 28.8% said less than a day (they were sent to a doctor the day of testing), 44.9% between 1-30 days, 7.6% 1-3 months, 6.8% 4-12 months, 11.9% more than 12 months. No one responded that they had never seen a doctor for their HIV/AIDS. 43.2% of the respondents noted that they got HIV via male to male sex, about 165 by sleeping with an IDU or by sharing needles, 15.3% heterosexual sex, 3.4% through blood products or blood transfusion, and 14.4% were uncertain as to how they got HIV. Of the respondents the majority saw a doctor regularly with 30.3% noting they saw a doctor more than four times per year, 26.1% four times per year, 18.5% three times per year 20.2% two times per year, 2.5% listed one time per year, and 2.5% listed none.

### **III. Description of existing resources for HIV prevention services, care, and treatment in Rhode Island.**

#### **A. Description of HIV Prevention and Service Needs:**

As the only health department in the state, HEALTH has been solidly delivering integrated HIV prevention services since the mid-eighties. The HIV prevention program has received international acclaim (from the Committee on US China Relations, US Department of State grant, CDC) for its integrative approach of blending HIV, viral hepatitis and STI prevention into the funded components of all prevention venues. As a prime example, all funded HIV testing sites integrate hepatitis testing and preventive immunizations and directly promote voluntary STI and TB testing to existing venues in the state. As evidenced in RI law and regulations, HIV testing conforms to CDC testing guidelines and recommendations. Certified Counselors known as Qualified Professional Test Counselors (QPTCs) are required to attend “booster” courses in order to maintain their certification and Healthcare providers are required to receive continuing medical education pertaining to blood borne pathogens/HIV. 2010 incidence rates appeared to be on the decline from years past and Rhode Island revealed 106 incident cases of HIV compared to 125 in 2009. While certainly not indicative of a true epidemiologic trend, we speculate that either prevention programs were highly successful in reducing incident cases of HIV; or perhaps a need for more aggressive testing within high risk populations is in order.

HEALTH funded evidence-based programs as well as pre/post HIV test counseling through our funded agencies to various target populations. These target populations include, MSM, women, youth/young adults, Injecting Drug Users (IDU), and male and female commercial sex workers. Recent surveys and studies through CDC and local community partners have concluded that there are still gaps in the services we provide here in Rhode Island. The RI Community Plan Group (RICPG) for HIV Prevention (est. 1994) has performed numerous gaps and needs assessments pertaining to HIV prevention. All of these assessments reveal the need for specific adult MSM programs and the fact remains that RI has no dedicated community based agency to meet these prevention needs. Next, the gap associated with better understanding the high level of no identified risk has been a point of many discussions of the RICPG and the HEALTH-RI staff. Many have suggested that because of the fair amount of women unsuspecting of their HIV at the time of testing for HIV, and then the concurrence of AIDS within 12 months, may reveal that risk may not be revealed to these women when interviewed.

Persons with HIV/AIDS who are from historically underserved communities have limited resources and broad needs related to healthcare, mental health/substance abuse treatment and social support services. Medical care is needed for HIV-related conditions, but also for other conditions such as hypertension and diabetes. Women with families need adequate health care for their children as well as themselves, including routine preventive care such as pap smears and breast exams. Clients need access to HIV-related medications and therapies as well as non HIV-related medications for the treatment of chronic health conditions (e.g., hypertension). They also need access to dental and vision services. Provision of healthcare

services is impacted in Rhode Island by the uneven distribution of providers, especially specialists such as infectious disease specialists, and the shortage of dentists, nurses, and other healthcare providers. For some individuals, substance abuse and/or mental health issues further complicate their HIV illness. Mental health and substance abuse treatment must be available in a non-threatening environment that affords confidentiality and support for persons with families, especially single parent households. Mental health and substance abuse treatment resources are limited in Rhode Island and eligibility requirements as well as limits on services provided could present barriers for at risk for HIV or PLWHA who need mental health and/or substance abuse treatment.

Identifying individuals, who are unaware of their HIV status is a key prevention need in the state. Individuals who are aware of their status, but not in care, continues to be a concern for RI HIV Prevention Programs. RI's Early Identification of Individuals with HIV/AIDS Plan (EIIHA) specifically denotes a strategic approach to isolating, designing and implementing strategies to reach individuals of highest risk, those of moderate to low risk, and historically underserved communities to educate and provide linkage to testing, referral to care and service, and ensure those referred have accessed care. Clearly RI's HIV testing data reveals "high scores" (specifically number of funded HIV testing sites 100% of recently diagnosed individuals are referred to care, and are frequently escorted to care appointments by HIV CTS staff and/or by Partner Services, the state's HIV partner notification specialist) for identifying individuals recently diagnosed in a rapid succession with immediate referral to care, access to medical treatment as soon as possible and an assertive approach from HIV (other) providers related to keeping PLWHA in care.

In addition, members of the RICPG group also conducted interviews and surveyed key stakeholders in order to complement the needs assessment information but from a prevention perspective. The RICPG gathered qualitative data from non-HEALTH funded community and state organizations who provide services to populations at risk for HIV and other STI. Over seventeen organizations were identified to be contacted for brief key informant (KI) interviews to gather information about HIV prevention services. The RICPG worked closely with HEALTH's HIV Prevention Evaluation consultant (JSI), to develop a KI guide and facilitate engagement of KI participants. The guide is attached in **Appendix E**. Eleven organizations completed interviews: Planned Parenthood of New England, McCauley House, RI College (RIC), RI Department of Education (RIDE), Open Doors, Center for Sexual Health and Pleasure, Sojourner House, Clinica Esperanza, ChiSpa, Boys and Girls Club (Foxpoint), and Comprehensive Community Action Program (CCAP). The findings are as follows: 50% currently distribute condoms and/or safe sex kits, 45% provide safe sex education messages as part of their service, 27% focused on positive, pleasure focused sex messages in addition to safe sex messaging, 55% refer participants to HIV testing resources, 27% share LGBTQ safe sex information but none have MSM specific messaging, 45% provide print materials only 18% offer materials in languages other than English, and 60% of the programs are supported by the broader organization to provide HIV prevention services or messaging.

Prior to January 2012, HEALTH funded a variety of community-based prevention programs based on CDC best practices. These programs include prevention for positives in a clinical setting, HIV prevention case management, health education/risk reduction, harm reduction, and HIV CTR. Funded prevention agencies included Sojourner House (health education/risk reduction and prevention case management targeting African American and Latina women), Youth In Action (health education /risk reduction and minority supplemental targeting youth), the Rhode Island Department of Corrections (HIV CTR, prevention case management, and health education/risk reduction targeting incarcerated individuals), AIDS Care Ocean State (harm reduction targeting injecting drug users), and Thundermist Health Center (prevention for positives). In addition, two Rhode Island agencies, the Urban League of Rhode Island and the MAP Drug and Alcohol Rehabilitative Services, were funded directly by the CDC to provide HIV prevention services for injecting drug users.

HEALTH released a Request for Proposals for CTR and Prevention for Positives spring of 2012. Currently, HEALTH funds approximately 5 HIV Counseling, Testing and Referral (CTR) “center” agencies and about 12 satellite agencies including: AIDS Project Rhode Island (the Men’s Health Complex at the Megaplex), Family Health Services (a federally qualified health center), AIDS Care Ocean State, Community Access, and Miriam Hospital. Two Prevention for Positive agencies, were funded, the first is a community health center with a long history working with PLWA and the second is community based organization whose focus is HIV prevention and care. Three of the Health Education/Risk Reduction providers continued to provide services to high risk population until December 30, 2012.

HEALTH funds three consultant agencies to provide facilitation of the RICPG, capacity building and technical assistance including training, program planning and monitoring and evaluation, and quality assurance.

**Table 1: Current HIV Prevention Funded Services**

<b>Service Category</b>	<b>Service Provider</b>
Testing	AIDS Care Ocean State
	MAP Behavioral Health Services
	Family Service of RI/APRI
Prevention for Positives	Thundermist Health Center
	AIDS Project of RI at Family Service of RI
Minority Initiatives	Youth in Action
Health Education/Risk Reduction	Youth Pride, Inc.
	Pawtucket CDC – Project Renew
	Youth in Action
Capacity Building	Drug & Alcohol Treatment Association of RI
HIV Planning	Uptyme Prevention Services
Program evaluation and TA	John Snow, Inc.

Counseling and testing has been and continues to be central to HIV prevention services in RI. Client level testing, demographic and risk behavior data is shared below.

**In 2011, January 1, 2011-December 31, 2012, 2192 clients were tested for HIV.**

<b>Demographics and Risk Factors for Counseling and Testing (CT) 2011</b>	
<b>Gender</b>	
Male: 63.1%	Transgender (M to F): .3%
Female: 36.4	Transgender (F to M): .1%
<b>Age</b>	
Under 20: 7.3%	30-39: 22.3%
20-29: 33.4%	40-49: 20.4%
50+: 16.6%	
<b><u>Race and Ethnicity:(Some clients may be counted more than once)</u></b>	
Native Hawaiian/Pacific Islander: 0.7%	American Indian/Alaska Native: 2.1%
Black/African American: 15.9%	White: 54.1%
Asian: 2.8%	Declined: 5.1%
Hispanic or Latino: 69.3%	Don't Know: 21.5%]
<b><u>In the past 12 months has client</u></b>	<b><u>Did client have vaginal or anal sex in past 12</u></b>
Vaginal or anal sex with male: 61.0%	without using a condom: 75.9%
Vaginal or anal sex with female 35.1%	with person who is an IDU: 5.7%
Oral sex with male: 55.1%	with person who is an MSM: 1.2 %
Oral sex with female: 31.5%	with person who is HIV positive: 7.4%
Sex with persons of unknown status: 63.7%	Sex with anonymous partner (s): 45.9%
Sex with multiple partners:59.4%	STD Diagnosis: 8.7%
Engaged in sex for drugs/money: 3.9%	Healthcare exposure: .7%
Sex with person with hemophilia or transfusion or transplant: .3%	Forced to have sex involuntarily: 4.9%
Sex while intoxicated: 41.9%	Shared injecting drugs: 49%

**In 2012, January 2012- August 2012, 806 clients were tested for HIV.**

<b>Demographics and Risk Factors for Counseling and Testing (CT) 2012- 8 months</b>	
<b>Gender</b>	
Male: 64.6%	Transgender (M to F): .5%
Female: 34.9%	Transgender (F to M): 0 %
<b>Age</b>	
Under 20: 3%	30-39: 25.1%
20-29: 32.9%	40-49: 20.7%
50+: 18.3%	
<b>Race and Ethnicity:(Some clients may be counted more than once)</b>	
Native Hawaiian/Pacific Islander: 0.2%	American Indian/Alaska Native: 3.3%
Black/African American: 16.3%	White: 57.2%
Asian: 3.4%	Declined: 3.3%
Hispanic or Latino: 23.9%	Don't Know: 19.9%
<b><u>In the past 12 months has client</u></b>	<b><u>Did client have vaginal or anal sex in past 12</u></b>
Vaginal or anal sex with male: 60.3%	without using a condom: 76.9%
Vaginal or anal sex with female 33.3%	with person who is an IDU: 6.4%
Oral sex with male: 56.8%	with person who is an MSM: 2.1 %
Oral sex with female: 30.3%	with person who is HIV positive: 10.3%
Sex with persons of unknown status: 60.2%	Sex with anonymous partner (s): 48.2%
Sex with multiple partners:58.8%	STD Diagnosis: 8.1%
Engaged in sex for drugs/money: 5.2%	Healthcare exposure: .6%
Sex with person with hemophilia or transfusion or transplant: .2%	Forced to have sex involuntarily: 4.6%
Sex while intoxicated: 41%	Shared injecting drugs:58.2%

As recommended by CDC, condom distribution is a key area of focus for HIV Prevention in RI. Historically, HEALTH has been the conduit for distributing condoms to funded agencies and other agencies proving need for many years. In the past 5 years, HEALTH-RI has made available to the funded and unfunded, HIV Prevention vendors, HIV testing sites, and HIV service organizations safer sex kits, condoms and other protection items through HEALTH condom purchases. HEALTH partnered with three primary agencies (AIDS Care Ocean State, AIDS Project RI, and MAP Behavioral Services) and a number of secondary agencies (including: Youth Pride Inc, Youth in Action, Thundermist Health Center). Through partnerships, HEALTH is able to offer over 20 distribution sites in the six core RI cities. In addition, agencies providing testing, outreach, and harm-reduction programs, are able to distribute condoms and safer sex supplies to MSM, IDU, High Risk Negatives, Partners of Positives, Positives as well as youth across the state. HEALTH has developed a plan to expand distribution sites to a number of Non-healthcare/agency venues. HEALTH will work with the RICPG, HEALTH STD/HIV education task force, contracted agencies, and other partners to develop a comprehensive statewide condom distribution process.

Partner services (PS) in RI is housed and administered at HEALTH. A trained and experienced PS specialists contact partners of HIV positive clients confidentially, to notify persons of exposure to HIV, link to testing and care if needed. In 2012 PS reached 35 index clients, 5 were referred to and accessed care, 28 partners reached, 25 partners received HIV testing and 2 partners who tested positive were referred to care. HEALTH will continue to be fund and provide highly effective Partner services.

As mentioned above, all of HEALTH's HIV prevention programs link to HIV Care services and support services including Ryan White programs, Minority AIDS Initiative, Adult Viral Hepatitis and/or HIV Surveillance Program. In fact, many of the vendors funded with HIV prevention monies also receive CARE funding allowing ease of integration of services internally and externally.

There are six (6) sites funded in 2012 to provide services such as care, treatment, and support services under the *Ryan White CARE Act. Part B* of the CARE Act provides grants for HIV care and services including outpatient medical care, medications, dental care, mental health, substance abuse, case management, transportation, and other core and supportive services. Under Part B of the Care Act, The AIDS Drug Assistance Program had 747 clients enrolled to receive anti-retroviral therapy in 2012, an increase of 208 cases (38% increase) since 2009 Using CAREWare Data, among clients receiving services for Part B statewide, In 2010, the majority of HIV cases in 2010 were White (44%), male (79%), 30 years of age or older (73%), with Men having Sex with Men (MSM) being the leading exposure category (51%), followed by No Risk Reported (30%) and heterosexual sex (22%). HIV disproportionately impacted females (21%); persons aged 30-49 (50%), Latinos (26%) and Black/African Americans (25%).

The majority of HIV cases in Rhode Island live in Providence County (77%), followed by Kent County (9%), Newport County (8%), and Washington County (6%). Less than 1% of HIV cases live in Bristol County and less than 1% is homeless. All Ryan White-funded HIV/AIDS care services are located in Providence County. Providence is also the home of nearly all of the state's large HIV/AIDS medical care practices.

#### Supportive Services:

- Case Management (Non-medical services are implemented by AIDS care Ocean State, Family Resource of RI and AIDS Project RI);
- Medical Transportation Services (Implemented via case management services at AIDS Project RI; however all agencies offer this via other funding);
- Psychosocial Support Services (Offered through AIDS Project RI and Family Services) ;
- Emergency Financial Services (Offered through AIDS Project RI, ;
- Home and Community-Based Care (Offered via AIDS care Ocean State)

Minority AIDS Initiative (MAI) funds target specialize primary medical care and access-to-

care services to high-need populations. MAI funds 6 HIV/AIDS organizations to provide intensive case management services to persons located within minority communities and underserved persons who are lost to care using data generated from the program’s ADAP databases.

**Table 2: Ryan White Funded Services**

<b>Service Category</b>	<b>Service Provider</b>
ADAP	HP
Medical transportation Services	Project Bridge
Minority AIDS initiatives	Family Services of Rhode Island Miriam Immunology Clinic AIDS Cares Ocean State University Medical Group Family Resources Community Action Project Bridge
Outpatient and Ambulatory Medical Care	Miriam Immunology Clinic
Targeted Non Medical Case Management	Family Resources Community Action AIDS Cares Ocean State
Transitional Medical Case management for Incarcerated Persons	Project Bridge

CDC provides funding to Rhode Island for an Adult Viral Hepatitis Prevention Coordinator (AVHPC) position. The primary role of the AVHPC is to manage and coordinate activities directed toward the prevention of viral hepatitis infections. Program activities aim to increase awareness and knowledge about transmission of viral hepatitis, and decrease the incidence of viral hepatitis infections. The transmission of viral hepatitis is very similar to HIV; both can occur through transmission via contaminated blood, mother-to-child during birth, and sexual contact. Program collaboration at the state level also allows more opportunities to increase viral hepatitis education activities at the local level by encouraging HIV prevention contractors to include hepatitis education as part of their HIV prevention activities. Rhode Island’s local district health departments (DHD) provide Family Planning services, STD testing and treatment, HIV testing, and hepatitis B and hepatitis C testing. Six of the seven DHDs also provide adult immunizations including hepatitis A and hepatitis B.

The Rhode Island HIV Surveillance Program receives funding from the CDC for HIV epidemiologic services. The main surveillance project measures as guided by CDC include the following:

- Death ascertainment to improve accuracy of prevalent HIV/AIDS by matching registry data with vital statistics data

- Intra-state de-duplication of records to improve accuracy of data
- Interstate de-duplication of HIV cases to improve accuracy of diagnosis data among persons reported (every 6 months)
- Ascertainment of cases and case data ( $\geq 85\%$  of expected number of cases) in a complete and timely manner ( $\geq 66\%$  expected diagnoses within 6 months of diagnosis)
- Ascertainment of risk factors for  $>85\%$  of cases
- Security and confidentiality protocols must be in place and certified to meet CDC criteria

The primary goal of the HIV/AIDS surveillance program is to monitor the number of new HIV/AIDS cases in Rhode Island; monitor the changes in the disease transmission among people at high risk for HIV/AIDS infection; and identify HIV/AIDS cases of public health importance to better understand the disease impact. The program helps to assess the disease impact among certain target populations, especially among communities of color, who are disproportionately affected by HIV/AIDS. The HIV/AIDS Surveillance program works closely with several internal partners on projects that contribute to decreasing HIV/AIDS morbidity and mortality in Rhode Island. The HIV/AIDS Surveillance program works closely with HIV Provider Community of Rhode Island to capture important case related data from new and existing HIV/AIDS cases. Data collected as part of the case reports are de-identified, analyzed, and sent to the CDC on a regular basis. Data are also published in the Annual Epidemiological Profile that helps the prevention programs and the RICPG to identify target areas. The Profile also provides information directly to community resources so that caseworkers and providers can adequately identify and address HIV/AIDS health concerns among disproportionately affected communities in Rhode Island.

Rhode Island Housing received two grants to assist persons living with HIV/AIDS in Rhode Island. The grants, offered through the U.S. Department of Housing and Urban Development's (HUD) Housing Opportunities for Persons with AIDS Program (HOPWA), will provide service-enriched homes for dozens of families, allowing them to manage their illnesses while receiving critically-needed support services. The program is a collaborative partnership between Rhode Island Housing, AIDS Care Ocean State in Providence and Family Resources Community Action in Woonsocket. The funding will be used to continue the operation of 13 facility-based homes and 18 scattered site leased homes. Supportive services will help 73 families annually. Rhode Island Housing was also awarded a HOPWA permanent supportive housing renewal grant of \$741,355 for New Transitions. This program includes a five-home transitional substance abuse treatment facility and nine scattered site leased homes. It offers supportive services to 24 families each year. New Transitions is the result of a partnership between Rhode Island Housing and AIDS Care Ocean State. AIDS Care Ocean State will provide substance abuse treatment, intensive support services, and life skills training for about three months, after which clients move to their own apartments with the support of a service network to ensure they remain in their homes. AIDS Care Ocean State in Providence and Family Resources Community Action in Woonsocket are also funded by the Rhode Island Part B program to

provided support services.

Rhode Island receives:

- Two grants (Part C) to assist persons living with HIV/AIDS in Rhode Island.
- One grant Part D grants to assist persons living with HIV/AIDS in Rhode Island
- One grant Special Projects of National Significant (SPNS) grants to assist persons living with HIV/AIDS in Rhode Island.

The integrated Resource Inventory includes HIV care and prevention service providers; as well as other service providers including emergency housing, financial assistance, counseling and therapy, medical care, legal services, support groups, food banks, and other community services. It includes information on insurances accepted, location, languages spoken, services offered and eligibility and intake requirements for each organization. The organizations are grouped by geographical location. The Resource Inventory is available at <http://www.jsi.com/JSIInternet/Resources>.

**Overview of HIV related funding:**

According to the National Alliance of State & Territorial AIDS Directors (NASTAD), Rhode Island received a total of \$ 9,155,404 in HIV/AIDS federal funding in FY2010.

**Table 3: Total HIV/AIDS Federal Funding By Component: Rhode Island, FY2010**

<b>Component</b>	<b>Amount</b>
CDC HIV/AIDS Funding	\$2,651,953
Housing Opportunities for Persons Living With AIDS (HOPWA) Funding	\$804,273
Substance Abuse & Mental Health Service Administration (SAMHSA) HIV/AIDS Funding	\$753,333
OMH HIV/AIDS Funding	\$0
Ryan White Program Funding	\$5,942,864
<b>Total</b>	<b>\$9,155,404</b>

A breakdown of Rhode Island’s CDC HIV/AIDS funding by component in FY2010 is as follows.

**Table 4: CDC HIV/AIDS Funding by Component: Rhode Island, FY2010**

<b>Component</b>	<b>Amount</b>
HIV Prevention	\$2,032,934
HIV/AIDS Surveillance	\$224,293
CBO/CBA	\$0
DASH	\$319,726
Miscellaneous	\$75,000
Expanded HIV Testing in African American Communities	\$0
<b>Total</b>	<b>\$2,651,953</b>

A breakdown of Rhode Island's SAMHSA HIV/AIDS funding by component in FY2010 is as follows.

**Table 5: SAMHSA HIV/AIDS Funding by Component: Rhode Island, FY2010**

Component	Amount
Center for Mental Health Services	\$400,000
Center for Substance Abuse Prevention	\$335,333
Center for Substance abuse treatment	\$0
Total	\$735,333

A breakdown of Rhode Island's Ryan White HIV/AIDS funding by component in FY2010 is as follows.

**Table 6: Ryan White HIV/AIDS Funding by Component: Rhode Island, FY2010**

Component	Amount
Part A	\$0
Part B	\$3,794,189
Part C	\$1,169,743
Part D	\$578,941
AIDS Education Training Center (AETC)	\$0
SPNS	\$399,991
Part F Dental Reimbursement Program	\$0
Community-Based Dental Partnership Program	\$0
Total	\$5,942,864

A breakdown of Rhode Island's Part B funding by component in FY2010 is as follows:

**Table 7: Part B HIV/AIDS Funding by Component: Rhode Island, FY2010**

Component	Amount
Part B Base	\$1,233,921
Part B ADAP	\$2,286,237
Part B ADAP Supplemental	\$0
Part B Minority AIDS Initiative	\$21,101
Part B Emerging Communities	\$205,551
Total	\$3,746,810

A breakdown of Rhode Island's ADAP funding by component in FY2010 is as follows.

**Table 8: Part B HIV/AIDS Funding by Component: Rhode Island, FY2010**

Component	Amount
Part B ADAP Earmark	\$2,259,933
Drug Rebates	\$1,036,923
Total	\$3,296,856

RI is committed to coordinating prevention and care consistently throughout the state. Currently, RI has two planning bodies that work together and share cross representations. The RICPG is a coalition who work together to help prevent the spread of HIV in Rhode Island. The diverse group includes those living with HIV/AIDS, their partners and families, service providers, state department representatives, and other concerned citizens. Each year, the RICPG assesses HIV prevention needs, sets prevention priorities, and develops the Comprehensive HIV Prevention Plan and the Jurisdictional plan for the state of Rhode Island. The Rhode Island HEALTH uses this plan as the basis for its HIV/AIDS prevention funding decisions. Rhode Island Provision of Care Planning Body (PCPB) was created to comply with the statutory language associated with the Ryan White Modernization Act associated with HIV PCPBs. The PCPB was formed guidance of the Rhode Island Department of Health and act as advisors to the Director of Health and the Office of HIV/AIDS & Viral Hepatitis, and in cases allowable by state statute and/or regulations, and as outlined by HRSA, be decision makers regarding procedural and policy issues to the Rhode Island Department of Health. These two planning bodies incorporate the views, knowledge and experiences of many individuals and agencies, including persons infected by HIV, persons representing populations at risk of HIV, HIV care and prevention providers, health department representatives, educators and persons with expertise in behavioral science, substance abuse, corrections, health planning, epidemiology and evaluation.

As of July 2012, The Rhode Island Office of Health and Human Services/Medicaid, became the agency responsible for administering Part B of the Ryan White Part B HIV Care Program (including ADAP) in Rhode Island. A Memorandum of agreement was signed by HEALTH and OHHS/Medicaid to assure that service integration will continue.

While the state has made significant improvements in the delivery of the services by creating a system that meets many of the basic health and psychosocial needs of PLWHA, RI still has long way to go in guaranteeing full access to high quality, culturally and linguistically appropriate comprehensive services. A well coordinated system of prevention and care will improve the access to healthy and affordable housing, behavioral health and substance abuse services, improve retention in care for those aware of their status and bring into care those unaware of their status, those HIV-infected persons not in care and those at risk for HIV.

**As a state, RI will strive to address the following National HIV goals within the next 5 years:**

**Goal 1: Lower the annual number of new infections by 25%**

**Goal 2: Increase the percentage of people living with HIV who know their status by 11%**

**Goal 3: Reduce the HIV transmission rate by 30%**

**Goal 4: Increase the percentage of newly diagnosed people linked to care within 3 months by 20%**

**Goal 5: Increase the proportion of HIV diagnosed gay and bisexual men, African Americans and Latinos with undetectable viral load by 20%**

**Goal 6: Reduce disparities in HIV and promote health equity (NHAS/CDC)**

In addition, working collaboratively with Ryan White Program and other key HIV related stakeholders, HEALTH will commit to adopting and working towards achieving the goals stated in the *Rhode Island Comprehensive Plan, Section II*, submitted to HRSA in July 2012 (see **Appendix D**)

**B. Where we need to go: Prevention activities and strategies to be implemented 2012-2016.**

The state has articulated the following HIV Prevention goals/strategies:

- Goal 1.** Increase the number of individuals aware of their HIV status by increased testing of groups at highest risk as well as universal/routine testing
- Goal 2.** Increase the number of newly diagnosed HIV positives linked to Care by determining necessary system level changes involving testing agencies and local disease investigation specialists and care providers
- Goal 3.** Provide training opportunities to increase the capacity and number of HIV prevention and care providers
- Goal 4.** Increasing the number of HIV positive individuals in care by working with the state surveillance program and other providers to improve the state unmet need calculation to target activities to PLWHA not in care
- Goal 5.** Increase access to care services and improve health outcomes for PLWHA with support of funded RW services particularly Targeted and Medical Case Management and adherence to HIV medications
- Goal 6.** Reduce new HIV infections by supporting/implementing Prevention with Positives activities in care settings as well as to engage in pro-active, aggressive in-care modalities related to primary prevention (e.g., PREP, PEP, etc.).

The Centers for Disease Control and Prevention (CDC) released a new five-year funding opportunity for state health departments to provide comprehensive HIV prevention programs. The Rhode Island HIV Prevention program receives funding from the CDC under this grant, which began January 1, 2012. The purpose of this grant is to implement HIV prevention programs that will reduce new infections, increase access to care, improve health outcomes for people living with HIV, and promote health equality.

To achieve CDC's and RI's HIV preventions goals, the state health departments received funding to provide the following:

- 1) HIV testing
- 2) Comprehensive prevention for HIV positives
- 3) Condom distribution
- 4) Policy initiatives

The Rhode Island HIV Prevention Program is also required to conduct the following: 1) jurisdictional HIV prevention planning, 2) capacity building and technical assistance including training, and 3) program planning, monitoring and evaluation, and quality assurance.

The CDC also included the opportunity for states with the resources and capacity to implement three recommended program components of which the Rhode Island HIV Prevention Program has chosen to fund activity under evidence-based interventions for HIV negative persons at highest risk for acquiring HIV and social marketing, media, and mobilization.

**C. How we will get there: Responsible Agency/group to carry out activities**

Bellow you will find some of the goals and objectives that HEALTH is proposing to implement as part of the HIV Comprehensive Program Plan. In addition the section “How to measure our progress” includes the goals and objectives for the statewide Jurisdictional Plan

**HIV Testing Goals:**

**Goal 1:** To provide and implement a comprehensive training plan that includes a certification for Qualified Professional Test Counselors (QPTC).

**Goal 2:** To increase the proportion of individuals in Rhode Island who know they are infected with HIV, HBV and HCV and reduce HIV and viral hepatitis transmission and continue to facilitate an action plan to screen individuals engaging in high-risk behavior with HIV and viral hepatitis testing and preventive HAV/HBV immunizations.

**Goal 3:** To increase the proportion and tracking of HIV infected persons who are linked to prevention and care services.

**Comprehensive Prevention with Positives:**

**Goal 1:** To increase identification of newly diagnosed HIV positives clients and engage into medical care, increase client engagement and retention in medical care and re-engage HIV positives back into care by HEALTH-RI funding two (2) agencies to accomplish.

**Condom Distribution:**

**Goals:**

1. Increase the number of condoms distributed from Year one from 26,500 condoms to 50,000
2. Maintain that distribution for the remainder of the 5 year grant.
3. HEALTH-RI will also be providing lubricant along with condoms at all distribution venues.
4. Collaborate with CBO’s and other community members to secure distribution venues during peak ‘cruising hours’ at adult venues, bars, clubs, and music venues.
5. Keep a detailed inventory and distribution records of distribution venues, what demographic/risk populations served, as well as how many condoms are distributed in each venue.
6. Develop a GSI Mapping plan to evaluate and visualize distribution locations to address any condom distribution gaps across the state.

**Policy:**

**Goal 1:** CD4 and viral load data collection updated by HIV regulation

**Goal 2:** 3<sup>rd</sup> trimester HIV testing among pregnant women

**Goal 3:** Initiating collection of all HIV test reports – in order to have *negative* and positive results as a denominator to better assess increases in HIV testing

**V. How will we measure our progress: Expected outcomes and relevant timelines:**

**Goals are from the National HIV Prevention Strategy. Objectives and Strategies are based on RICPG recommendations.**

**Goal 1: Lower the annual number of new infections by 25%**

Objectives	Strategies	Time Frame	Responsible Organizations	Measure
<p>Increase the number of RI state and community organizations who provide high impact HIV prevention initiatives.</p> <p>Increase the number of high risk populations referred to HIV testing</p>	<p>Provide cultural and linguistically appropriate safe sex practice information, educational material and condoms to state and community partners for distribution to high risk populations.</p> <p>Explore policy initiatives to require safe sex and HIV prevention education and condom distribution in all publicly funded high schools and college and universities including vocational education venues.</p> <p>Develop a social media campaign geared toward high risk populations highlighting the benefits of safe sex practices.</p> <p>Incorporate condom distribution into counseling and testing services.</p>	<p>01/2012-01/2016</p>	<p>HEALTH RIDE Funded CARE Providers Funder HIV Prevention Providers Healthcare providers RICPG Community partners</p>	<p>From 106 (2010) to 80</p>

**Goal 2: Increase the percentage of people living with HIV who know their status by 11%**

Objectives	Strategies	Time Frame	Responsible Organizations	Measure
<p>Identify a base line of person in RI who know their HIV status.</p> <p>Increase the number of RI residents who receive HIV testing.</p>	<p>Explore policy initiatives mandating reporting of all testing results regardless of the result status (i.e. positive or negative).</p> <p>Develop a social media campaign geared toward high risk populations highlighting the benefits of getting tested for HIV and knowing their status.</p> <p>Explore the opportunities to Increase access to testing including:</p> <ul style="list-style-type: none"> <li>• Increase hours for testing</li> <li>• Expand number testing sites</li> <li>• Include alternative or non-traditional test sites</li> <li>• Home based testing-rapid tests.</li> <li>• Provide incentives for HIV testing</li> </ul> <p>Explore including HIV testing as part of routine tests provided in healthcare setting e.g. considering an</p>	<p>01/2012-01/2016</p>	<p>HEALTH</p> <p>RIDE</p> <p>Funded CARE Providers</p> <p>Funder HIV Prevention Providers</p> <p>Healthcare providers</p> <p>RICPG</p> <p>Community partners</p>	<p>TBD after baseline is established.</p> <p>CT process data from EvaluationWeb</p>

	opt-out policy			
<b>Goal 3: Reduce the HIV transmission rate by 30%</b>				
Objectives	Strategies	Time Frame	Responsible Organizations	Measure
<p>Implement Prevention for HIV Positive initiatives in organizations who work with high risk populations.</p> <p>Increase the HIV testing with high risk populations.</p>	<p>Fund Prevention for Positive initiatives.</p> <p>Expand condom distribution through agencies offering HIV services and those who may not focus on HIV but have access to high risk populations. E.g. Boys and Girls clubs, Gay bowling, Transgender fundraisers</p> <p>Integrate condom distribution with testing</p> <p>Prevention for Positive Policy</p> <ul style="list-style-type: none"> <li>• Consider professional development to non-HIV focused agencies</li> <li>• Consider specific focus on domestic violence agencies</li> </ul>	01/2012-01/2016	<p>HEALTH</p> <p>RIDE</p> <p>Funded CARE Providers</p> <p>Funded HIV Prevention Providers</p> <p>Healthcare providers</p> <p>RICPG</p> <p>Community partners</p>	<p>Process and outcome data from prevention for positive programs.</p> <p>CT process data from EvaluationWeb</p> <p>Track number of condoms distributed to high risk populations</p>

**Goal 4: Increase the percentage of newly diagnosed people linked to care within 3 months by 20%**

Objectives	Strategies	Time Frame	Responsible Organizations	Measure
<p>Ensure newly diagnosed people are linked to care through referral, follow up and continued communication between prevention and care providers.</p>	<p>Build capacity through self esteem/self-care workshops (Education and messages should include peer led models)</p> <p>Explore providing referral and CARE resource to be provided with all “over the counter” testing kits sold in RI.</p> <p>Exploring tracking how many “over the counter” tests are being sold.</p> <p>Explore accessing referrals through a HIV crisis hotline</p>	<p>01/2012-01/2016</p>	<p>HEALTH</p> <p>RIDE</p> <p>Funded CARE Providers</p> <p>Funder HIV Prevention Providers</p> <p>Healthcare providers</p> <p>RICPG</p> <p>Community partners</p>	<p>HEALTH Funded process data from CT, Partner Services, Prevention for Positives</p>

**Goal 5: Increase the proportion of HIV diagnosed gay and bisexual men, African Americans and Latinos with undetectable viral load by 20%**

Objectives	Strategies	Time Frame	Responsible Organizations	Measure
<p>Gather the viral loads of RI African American and Latino MSM who are accessing CARE in RI.</p> <p>Increase engagement in continuous HIV care and medical compliance with HIV positive AA and Latino patients.</p>	<p>Implement peer mentor programs to provide peer support to promote participation in CARE services and medical compliance</p> <p>Increase the number of healthcare providers and agency staff providing HIV care and care support services who are culturally, linguistically competent.</p> <p>Assess and reduce barriers to CARE, e.g. transportation, access to insurance</p> <p>Explore policy initiatives to mandate reporting of all CD4 and viral load data to have an exact picture of the state HIV population</p>	<p>01/2012-01/2016</p>	<p>HEALTH</p> <p>RIDE</p> <p>Funded CARE Providers</p> <p>Funder HIV Prevention Providers</p> <p>Healthcare providers</p> <p>RICPG</p> <p>Community partners</p>	<p>Gather viral loads of HIV positive, AA and Latino MSM</p> <p>Develop consumer satisfaction data regarding CARE providers in RI.</p> <p>Implement a needs assessment to identify barriers to care</p>

**Goal 6: Reduce disparities in HIV and promote health equity**

Objectives	Strategies	Time Frame	Responsible Organizations	Measure
<p>Ensure HIV prevention and care provider agencies have a health equity work plan and measures for all HIV related services.</p> <p>Ensure HIV prevention initiatives are located where high risk populations can access services.</p>	<p>Require a health equity plan for all state funded HIV programs</p> <p>Provide services in high risk population communities e.g. Central Falls, Pawtucket, Providence</p> <p>Consider social marketing and diverse channels to access hard to reach populations</p> <p>Assess and eliminate barriers to HIV prevention and care services, e.g. transportation, connecting with care providers</p>	<p>01/2012-01/2016</p>	<p>HEALTH</p> <p>RIDE</p> <p>Funded CARE Providers</p> <p>Funder HIV Prevention Providers</p> <p>Healthcare providers</p> <p>RICPG</p> <p>Community partners</p>	<p>Equity work plan measures from funded HIV provider agencies</p> <p>GIS mapping of high risk population communities and HIV prevention and care services available in those communities.</p>

## VI. Engagement Process

RICPG Jurisdictional Plan Transition:

HEALTH in partnership with the RI Community Planning Group for HIV Prevention (RICPG) has transitioned its planning focus based on the new direction toward High Impact Prevention under the direction of the Center for Disease Control (CDC). The HIV Planning Group (HPG) will keep the name *RI Community Planning Group for HIV Prevention*, (RICPG). Engagement planning guide is provided below.

### **From: January 1, 2008-December 31, 2012: (HIV Planning Group History)**

The goals of the RICPG as identified in their charter was to *make a thorough HIV prevention needs assessment of the State of Rhode Island; set prevention priorities for the State; and write a HIV Prevention Plan for the state in cooperation with the Rhode Island Department of Health, for the purpose of reducing the incidence of HIV infection.*

The objectives for reaching these goals were as follow:

- To assure a logical, evidence-based process to determine the highest priority population.
- Implement an open recruitment process (outreach, nominations, and selection) for RICPG membership.
- Ensure that the RICPG's membership is representative of the diversity of populations most at risk for HIV infection and community characteristics in Rhode Island, and include key professional expertise and representatives from key government and non-governmental agencies.
- Foster a community planning process that encourages inclusion and parity among community planning members.
- Carry out population-specific prevention needs in Rhode Island.
- Ensure that prioritized target populations are based on an epidemiologic profile and a community service assessment.
- Ensure that prevention activities/interventions for identified priority target populations are based on behavioral and social science, outcome effectiveness, and/or have been adequately tested with intended target populations for cultural appropriateness, relevance and acceptability and demonstrate a direct relationship between the Comprehensive HIV Prevention Plan and the Health Department Application for federal HIV prevention.

The structure of the planning body included broad based representation to include those persons affected and affected with HIV/AIDS, representatives of the risk population, agency and governmental representatives sharing in the interest of reducing the incidence of HIV infection in the state.

A *Community Capacity Committee* was focused on policy initiatives, capacity building of the membership including orientation training and capacity building through training and technical assistance for RI service providers, and member and community engagement. Engagement included recruitment and retention of members to assure parity, inclusion and representation. (PIR) as well as engaging broader based community involvement through monthly reports by vendors, focus groups, survey participation, town meetings and an annual meeting awareness and update event. Charter monitoring and revisions were also addressed by this committee. ADHOC committees were used for additional time-limited projects.

RICPG used four task forces focusing on priority risk populations as identified by the epidemiological profile and other data sources. (MSM, Women, Youth, IDU) Positives and People who don't know their status were included in all four task force focus. As mentioned above, HEALTH uses three independent consultants to support the planning process in capacity building, facilitation, monitoring and evaluation.

#### **From: January 2012—September 2012 (The transition)**

The new direction: The planning goals are changed to be consistent with the *National HIV/AIDS Strategy (NHAS)* mentioned above.

HEALTH made a decision to continue to use current community planning group, (RICPG) to partner in carrying out the new planning process. The group already had good representation in membership, was fully engaged and was open and willing to support the new change. The name of planning groups in the new *Guidance* has been changed by CDC to be called HIV Planning Groups (HPG). The RI (HPG) will continue to use the name RI Community Planning Group for HIV Prevention (RICPG).

The rationale is as follows:

- Although the new direction has changed the “name, RICPG” is positively recognized and branded in RI as a result of much effort and resources that were put into identifying this group as the state planners in HIV. The group wants to build on the name recognition.
- Familiarity with the group will expedite the new focus of work especially in engaging participation from non-members.
- Although the membership will be enhanced and engagement outside the membership will be a priority, the term “community” is defined as any person, with an interest in contributing directly or indirectly to the HIV prevention goals in RI.
- It is more efficient to continue to use of printed and promotional material already purchased by the RICPG.

The Community Capacity Committee has been eliminated and those responsibilities will be handled on the agenda of the large planning group or in break-out sessions within a planning meeting.

### **The new Jurisdictional Planning Strategy:**

The planning strategy is now directed toward High Impact Prevention (HIP) core components as identified by CDC publication entitled *Guidance* are:

- Prevention for Positives
- Condom Distribution
- Policy Initiatives
- Testing

As mentioned in the above history, the RICPG is already positioned with a four- task force structure. The focus of the task forces will change from a priority risk population focus to a focus on the four components with emphasis on populations of highest risk for HIV transmission and acquisition and including geographic areas most affected by the epidemic. Task forces would be responsible for assuring adherence to scientifically proven, cost-effective, and scalable interventions in RI as directed in the CDC *Guidance*. The taskforces report to the larger planning body. See **Appendix E** for RICPG Charter.

### **A. Foster a planning process that encourages parity, inclusion, and representation**

#### **Planning Group Process:**

- HEALTH engaged the RICPG in their new funding opportunity announcement
- (FOA) process and provided presentations to the community planning group regarding the new CDC direction and reviewed final CDC Guidance document (See **Appendix E** for Planning Presentations).
- Upon receiving the new Guidance from CDC the first order of business involved the decision to continue the current partnership with RICPG or start with a new planning group.
- An agreement was made to continue with the current planning group
- The decision to keep the name RI Community Planning Group for HIV Prevention was made
- The planning group work began with the formation of sub groups focusing on the three planning steps identified in the CDC *Guidance*.

### **B. Identify and obtain key stakeholder input to ensure broad-based community participation in the planning process**

#### **STEP I: Stakeholder Identification**

- The sub group assessed for representation gaps based on the CDC Guidance recommendations. The current charter allows for 25 members with three member slots for state agency representatives
- Specific representation needs were identified to fill current member gaps
- Recommendations were made to the larger group
- Members took responsibility to recruit members to fill the identified gaps

### **C. Strategies for increasing coordination across HIV programs**

#### **STEP II: Results Orientated Engagement**

The sub group discussed and brainstormed Guidance Step II e.g. asking questions such as *How do we break the silos? How do we improve communication?* Solutions were generated Identify gaps-service & geography. CPG outreach to the 501c3's Develop referral networks Send informational material to agencies lacking material, e.g. publication "I Just Found Out". (The publication needs to be updated.) Identify "allies" Promote cross training cross referrals Memorandums of Understandings,(MOU's) See **Appendix E**

#### **STEP III: Jurisdictional Plan Development, Implementation & Monitoring**

The sub group discussed and brainstormed Guidance Step III e.g. Make contact list-multiple people from each agency. Meet with consultant from (JSI) to develop key informant survey. Survey should be simple questions to engage the community. The new guidance is looking for their expertise re: Gaps and strategies. See **Appendix E**. A Key informant (KI) tool was developed with input and approval from RICPG. See **Appendix E** for KI tool. Ten KI interviews were completed with state and community based organizations who do not currently receive HEALTH HIV prevention funding. The purpose of the KI interviews was to assess what non HEALTH funded HIV prevention services are occurring in the state. The process was expected to generate new membership interest in the RICPG.

Engagement planning guides:

Core Components	2012	2013	2014	2015	2016
Policy	<p>Transition from Priority Population to Core Components</p> <p>Collaborate with Health in preparing the Jurisdictional Plan for RI</p> <p>Brainstorm Potential Policy Concerns for the state</p>	<p>Continue to engage policy stakeholders</p> <p>Review Current Policies, e.g. required <i>Counseling &amp; Testing certification</i></p> <p>Assess feasibility of strengthening current policies.</p> <p>Insure policies are current &amp; inclusive of best practices</p> <p>Develop a Policy needs assessment for prioritizing and assessing feasibility of policy initiatives.</p> <p>Implement HIV Policy needs assessment</p> <p>Develop Policy needs assessment for prioritizing and</p>	<p>Continue engaging policy stakeholders</p> <p>Review results of needs assessment</p> <p>Prioritize policies based on needs assessment</p> <p>Select a minimum of two policy initiatives.</p> <p>Make Recommendations to Health based on selection process</p> <p>Begin policy implementation process</p>	<p>Continue engaging Policy implementation stakeholders</p> <p>Continue implementation of priority policies</p> <p>Review and update needs assessment</p> <p>Select a minimum of two additional policies</p>	<p>Continue engaging policy stakeholders</p> <p>Review results of needs assessment</p> <p>Prioritize policies based on needs assessment</p> <p>Select a minimum of two policy initiatives.</p> <p>Make Recommendations to Health based on selection process</p> <p>Begin policy implementation process</p>

		assessing feasibility of policy initiatives.			
Testing	<p>Transition from Priority Population to Core Components</p> <p>Collaborate with Health in preparing the Jurisdictional Plan for RI</p> <p>Release of RFP for Counseling &amp; Testing (CT) Providers. 5-HIV (CT) center agencies funded &amp; 12 satellite agencies</p> <p>Funded two Prevention for Positive Programs w/testing component</p> <p>Implement CT certification training for providers through (Project REACH)</p>	<p>Continue engage (CT) stakeholders</p> <p>Vendors will continue to provide HIV Testing Services, REACH will continue to provide (CT) training.</p> <p>Assess potential testing venues to reach High Risk Populations, e.g. MSM of color, commercial sex workers, transgender, minority youth</p>	<p>Continue engage (CT) stakeholders</p> <p>Vendors will continue to provide HIV Testing Services, REACH will continue to provide (CT) training.</p> <p>Assess potential testing venues to reach High Risk Populations, e.g. MSM of color, commercial sex workers, transgender, minority youth</p>	<p>Continue engage (CT) stakeholders</p> <p>Vendors will continue to provide HIV Testing Services, REACH will continue to provide (CT) training.</p> <p>Assess potential testing venues to reach High Risk Populations, e.g. MSM of color, commercial sex workers, transgender, minority youth</p>	<p>Continue engage (CT) stakeholders</p> <p>Vendors will continue to provide HIV Testing Services, REACH will continue to provide (CT) training.</p> <p>Assess potential testing venues to reach High Risk Populations, e.g. MSM of color, commercial sex workers, transgender, minority youth</p>

Condom Distribution	<p>Transition from Priority Population to Core Components</p> <p>Collaborate with Health in preparing the Jurisdictional Plan for RI</p> <p>Implement Key Informant Interviews with non funded Community based Organizations (CBO) who currently provide condom distribution</p>	<p>Based on KI findings, input from HEALTH, RICPG membership and task force members provide recommendations for condom distribution venues to high risk populations, e. g. MSM of color, commercial sex workers, transgender, minority youth</p> <p>Focus on Six Core Cities w/ a minimum of 20 distribution locations</p>	Assess success of Condom Distribution Plan and Identify new distribution sites	Assess success of Condom Distribution Plan and Identify new distribution sites	Assess success of Condom Distribution Plan and Identify new distribution sites
Prevention for Positives	<p>Transition from Priority Population to Core Components</p> <p>Collaborate with Health in preparing the Jurisdictional Plan for RI</p> <p>Release of RFP for</p>	Monitor and Assess Prevention for Positive Programs	Monitor and Assess Prevention for Positive Programs	Monitor and Assess Prevention for Positive Programs	Monitor and Assess Prevention for Positive Programs

Prevention for Positives (continued)	Prevention for Positives  Funded two Prevention for Positive Programs w/testing component				
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Our deep appreciation go to all of the members of the RI Community Planning Group, the community co-Chairs, facilitator and consultants for their dedication and engagement in the development of the RI Jurisdictional Plan and for the continued commitment to accomplish the goals set by this plan.

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<sup>i</sup> Jiang Y., 2011.

<sup>ii</sup> Jiang Y. Analysis of the 2005 - 2009 Rhode Island Behavioral Risk Factor Surveillance System Aggregated Data. Rhode Island Department of Health. Center for Health Data and Analysis. July 2011.

<sup>iii</sup> Jiang Y., 2011.

<sup>iv</sup> Centers for Disease Control and Prevention. Prevalence and Trends Data. Rhode Island – 2010. Tobacco Use.

<sup>v</sup> Ibid.