Statewide Coordinated Statement of Need
and
Comprehensive Plan for HIV Care Services

State of Maine
2012

A collaborative effort of:

Maine's Ryan White Part B Program
Maine's Ryan White Part C Programs
Maine's Medicaid Program, MaineCare
Maine's AIDS Education and Training Center
Key Stakeholders
People living with diagnosed HIV/AIDS in Maine

Submitted by the Ryan White Part B Program

Maine Center for Disease Control and Prevention
An Office of the Department of Health and Human Services

Paul R. LePage, Governor Mary C. Mayhew, Commissioner

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Executive Summary

Current surveillance records indicate that there were 1,616 people living with diagnosed HIV in Maine at the end of 2011.

Maine is a sparsely populated state with a low prevalence of HIV. Although there is a huge geographic divide within the state and many generally stated needs, the HIV prevention and care communities have a history of working together to address Maine's needs. There is a broad array of both medical and support services available to people living with HIV in Maine; in 2011, there was more than $16.5 million spent on HIV-specific services in the state.

Most of the services assessed and described in this document are publicly-funded and supplied through Medicaid (MaineCare), Ryan White, and Housing Opportunities for People with AIDS (HOPWA) grants. MaineCare, HOPWA, and AIDS Drug Assistance Program (ADAP) services are available throughout the state; Ryan White Part C services are available through three strategically located providers; and Ryan White Part B-funded medical case management is offered by six community-based providers across the state. Other key medical providers also make up the continuum of care.

Over the last year, there were a number of opportunities to continue to assess the needs of a representative sample of people living with diagnosed HIV in Maine:

- HIV Care Needs Assessment (2011)
- HIV Medical Case Management Satisfaction Survey (2011)
- ADAP Satisfaction Survey (2011)
- MaineCare Satisfaction Survey (2011)
- Ryan White Part C Satisfaction Survey for the Regional Medical Center at Lubec (2011)
- Three focus groups for people living with HIV/AIDS (2012)

A synthesis of data collected through these studies highlights opportunities for creating a more needs-based funding model. As this funding allocation method is developed, there are opportunities for greater collaboration to provide outreach and education that support access to and retention in quality treatment and care.

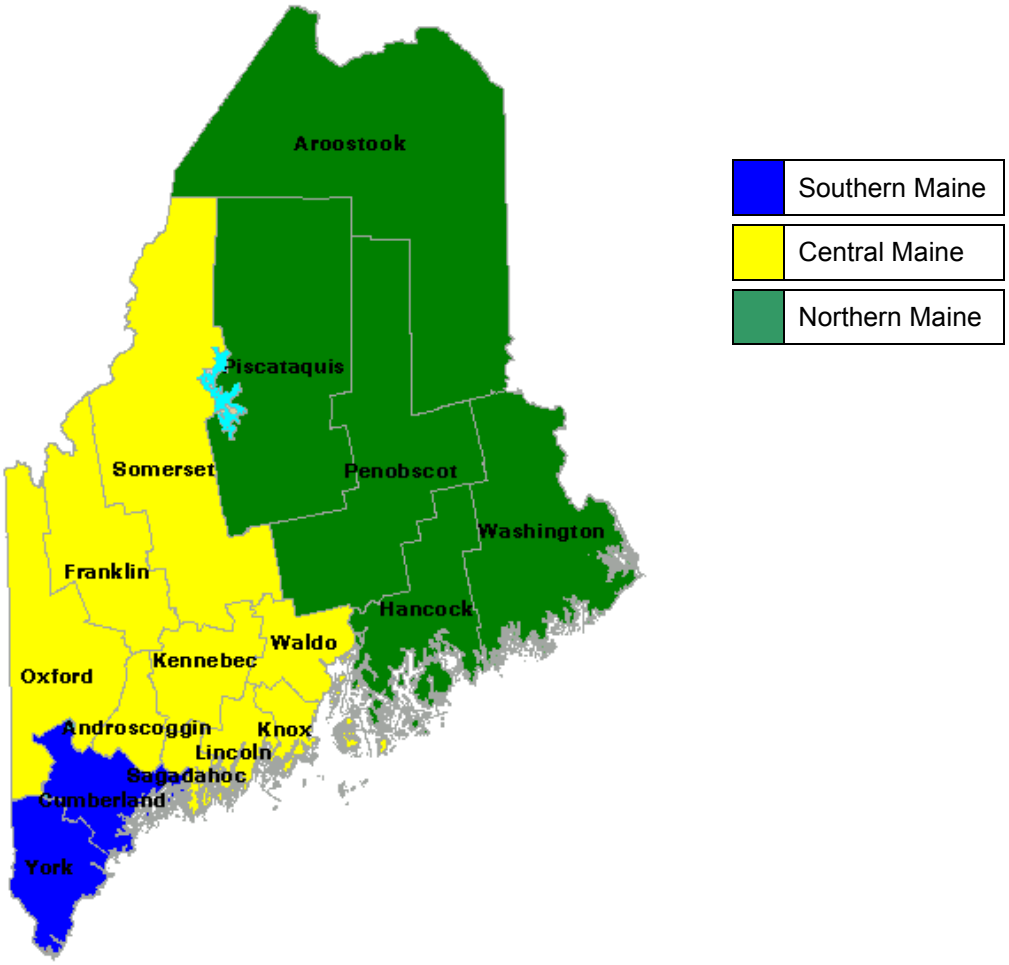
I. Where are we now?

A. HIV/AIDS Epidemic in Maine

1. Maine in Context

According to the 2010 U.S. Census, there are 1.3 million people living in Maine. The state is large and sparsely populated – there are 43 people per square mile in Maine, versus 87 people per square mile in the U.S. as a whole. The most densely populated areas lie in one of the three Metropolitan Statistical Areas: Portland, Lewiston, and Bangor.

Figure 1: State of Maine by County and Region



Although the state is divided into eight public health districts, these districts are often collapsed into three distinct regions – Central, Northern, and Southern Maine. Table 1 shows the counties that comprise each region and the region's population, according to the 2010 Census.

Table 1: Regions of residence, Maine population, 2010

Region	Counties	Population	% of Total Population
Central	Androscoggin, Franklin, Kennebec, Knox, Lincoln, Oxford, Sagadahoc, Somerset, Waldo	518,954	39%
Northern	Aroostook, Hancock, Penobscot, Piscataquis, Washington	330,602	25%
Southern	Cumberland, York	478,805	36%

Although the Northern Region represents only 25% of Maine's population, it accounts for almost 60% of the state's land area.

a. Age and Sex

Fifty-one percent (51%) of Maine's population is female.

Only 21% of Maine's population is under age 18; 44% are between ages 35 and 64; 16% are 65 and older.

b. Race and Ethnicity

The proportion of non-White and/or Hispanic residents in Maine is small—5.6% in total, compared to 36.3% for the nation as a whole. Table 2 shows the percent distribution of the population by race/ethnicity, according to the 2010 Census.

Table 2: Percentage Maine's population by race/ethnicity, 2010

Race	Total %
	n = 1,328,361
White	95%
Black	1%
American Indian or Alaskan Native	1%
Asian	1%
Native Hawaiian/other Pacific Islander	<1%
Some other race	<1%
≥ 2 races	2%
Ethnicity	
Hispanic or Latino	1%
Not Hispanic or Latino	99%

While there is geographic variability in the proportion of racial and ethnic minorities in Maine's cities and counties, there are few identifiable areas of high minority population concentration. Androscoggin, Cumberland, and Washington counties each have White not Hispanic populations that are slightly below the statewide average of 94.4%. In the Northern Region, Washington County has an American Indian/Alaska Native population of 4.9%, the highest in the state. Cumberland and Androscoggin counties, where the cities of Portland and Lewiston/Auburn are located, are the most racially diverse in the state.

Androscoggin, Aroostook, Cumberland, and Washington counties all have higher percentages of foreign-born residents than the statewide average of 3.3% (compared to 12.7% in the U.S.). Cumberland County has the highest percentage of foreign-borns with 5.5%. Cultural and language issues are critical for this population. More than 7% of Maine residents over five years of age report speaking a language other than English in the home.

c. Poverty

Maine's median household income ($46,933) is below the U.S. median ($51,914), with ranges from $34,016 in Piscataquis County to $55,658 in Cumberland County. Per capita income for Maine residents was also below the U.S. amount ($25,385 vs. $27,334) – ranging from $19,401 in Washington County to $31,041 in Cumberland County.

Between 2006 and 2010, about 12.6% of Maine residents were living below the federal poverty level (compared to 13.8% for the U.S. as a whole). Averages per county ranged from 8.5% in York County to 19.8% in Washington County.

Table 3 shows the percentage of individuals below the federal poverty level for Maine's 16 counties. Eight of 16 counties in Maine had a higher proportion of residents living below the federal poverty level than the U.S. rate of 13.8%. All eight counties are in the Northern and Central regions of the state.

Table 3: Percentage of population below poverty level, 2006-2010

Location	Percentage
Washington County	19.8%
Somerset County	18.4%
Piscataquis County	16.2%
Penobscot County	15.7%
Franklin County	15.5%
Aroostook County	15.4%
Waldo County	14.6%
Androscoggin County	14.3%
USA	13.8%
Oxford County	13.2%
State of Maine	12.6%
Kennebec County	12.5%
Knox County	12.5%
Hancock County	11.5%
Lincoln County	10.8%
Cumberland County	10.5%
Sagadahoc County	8.8%
York County	8.5%

i. Educational Attainment

As with poverty levels, educational attainment tends to be lower in the Northern and Central regions of the state. Aroostook is the only Maine County with a percentage of high school graduates lower than the U.S. rate (83.9% compared to 85%).

ii. Health Insurance Coverage

Health insurance coverage is an important indicator for access to preventive care and health services. The vast majority of Maine's population, including those living with HIV/AIDS, is covered by some form of insurance. The 2010 American Community Survey estimates that 15.5% of the total uninstitutionalized population in the U.S. is uninsured, while only 10.1% of Maine's uninstitutionalized population is uninsured.

2. HIV in Maine

Maine's informed consent law, 5 MRSA §19203-A, was amended in 2007 to allow for oral or written consent for an HIV test and again in 2011 to require health care providers to include an HIV test in the standard tests for all pregnant women, subject to the woman's consent.

As of April 1, 2008, Maine's Rules for the Control of Notifiable Diseases and Conditions (10-144 CMR Chapter 258) were amended to require mandatory reporting of all CD4

and Viral Load tests to the Maine Center for Disease Control and Prevention (Maine CDC). These lab tests, in addition to all new positive HIV antibody tests, are reported to Maine CDC's HIV/STD Surveillance Coordinator.

a. HIV Incidence

Since Maine CDC began recording new HIV diagnoses in 1987, more than 1,600 positive HIV tests have been reported among individuals resident in Maine. As has been seen nationally, the annual incidence of HIV-positive diagnoses in Maine has declined from more than 100 positive test reports in the late-1980s and early-1990s to roughly half that number in recent years.

Approximately 44% of individuals diagnosed with HIV in Maine during the past 5 years were ill enough to be classified with AIDS within one year of testing positive, probably indicating that they had been infected for a long while before diagnosis. Most of these individuals (93%) received a concurrent diagnosis of HIV and AIDS at the time of initial HIV testing.

Figure 2 illustrates annual totals of new HIV diagnoses in Maine, spanning the years 1987 to 2011. During 2011, 54 individuals in Maine received a new diagnosis of HIV infection.

Figure 2: Maine HIV Diagnoses, 1987-2011

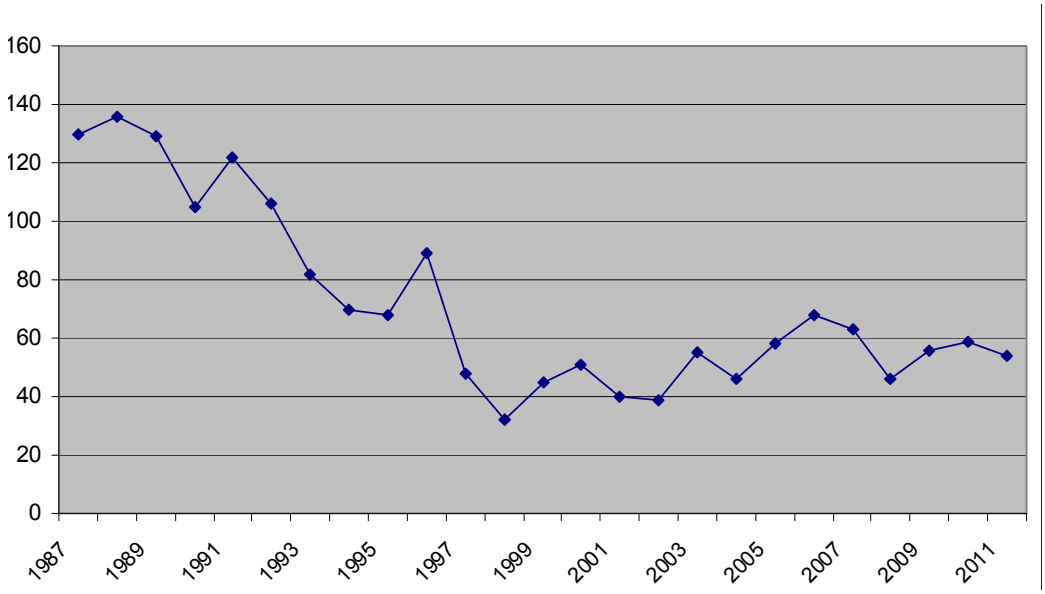
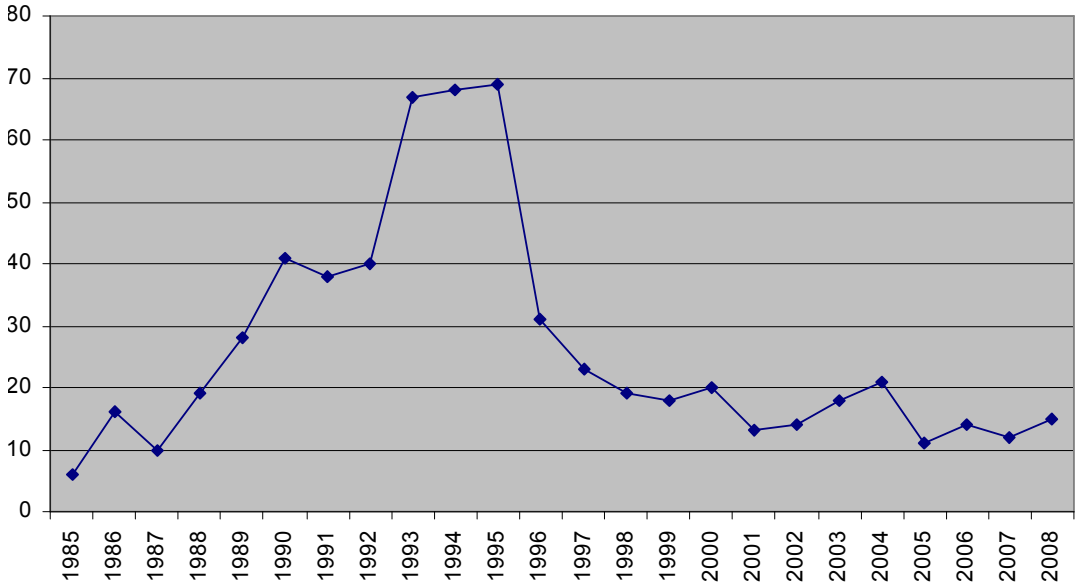


Figure 3 illustrates deaths among persons with AIDS by year from 1985 to 2008, the most recent year for which complete data are available. The figure shows a general decline in deaths, with the numbers of deaths in recent years at their lowest point since the 1980s. Overall declines in deaths among persons with AIDS are due in large part to widespread use of effective medical treatments for HIV disease.

Figure 3: Maine AIDS Deaths, 1985-2008



b. HIV/AIDS Prevalence Estimate

Approximately 1,616 people were estimated to be living in Maine with diagnosed HIV infection as of December 31, 2011. This includes individuals who were diagnosed with HIV infection and/or AIDS in Maine, along with people who were diagnosed elsewhere and subsequently moved to the state. US CDC estimates that 79% of people living with HIV know their status, therefore estimates of the total number of people living with HIV in Maine is 2,046 (approximately 430 people living with undiagnosed HIV). The table below presents demographic data for newly diagnosed and prevalent HIV cases in Maine.

Table 4: New HIV diagnoses and prevalent HIV cases in Maine as of Dec. 31, 2011

Mode of Transmission	New HIV Diagnoses, 1/1/11 to 12/31/11 n(%)	People living in Maine with diagnosed HIV n(%)
Men Who Have Sex with other Men (MSM)	28(52)	933(58)
Injection Drug Users (IDU)	1(2)	184(11)
MSM/IDU	1(2)	61(4)
Received Contaminated Blood Products	0	11(<1)
Heterosexual Contact with At-Risk Partners	4(7)	161(10)
Heterosexual, No At-Risk Partners Disclosed	12(22)	249(15)
Child Born to Mother with HIV	0	10(<1)
Undetermined (Pediatric and Adult cases)	8(15)	7(<1)
Total	**54(100)**	**1,616(100)**
Sex		
Male	43(80)	1,350(84)
Unknown/Unclassified	0	0
Female	11(20)	266(16)
Total	**54(100)**	**1,616(100)**
Race		
White	35(65)	1,388(86)
Black or African American	16(30)	183(11)
Asian	0	5(<1)
American Indian/Alaskan Native	0	12(<1)
Native Hawaiian/other Pacific Islander	0	1(<1)
Unknown	3(5)	27(2)
Total	**54(100)**	**1,616(100)**
Ethnicity		
Hispanic	1(2)	77(5)
Non Hispanic	50(93)	1,479(92)
Unknown	3(5)	60(3)
Total	**54(100)**	**1,616(100)**
Current Age		
Less than 13	0	4(<1)
13-19	0	6(<1)
20-29	8(15)	85(5)
30-39	14(26)	226(14)
40-49	17(31)	535(33)
Over 49	15(28)	758(47)
Unknown	**0**	2(<1)
Total	**54(100)**	**1,616(100)**

i. Regional Data

Table 5 shows region of residence for people living with diagnosed HIV/AIDS in Maine, along with the crude rate per 100,000 population. Regions are rank-ordered by rate, with the statewide rate included in the ranking. A total of 56 individuals living with HIV/AIDS in Maine had no information about their current county of residence.

Table 5: Region of Residence for People Living with Diagnosed HIV in Maine

Region of Residence	n	%	Rate per 100,000 population
Southern Maine	836	52%	175
State of Maine	1,616	100%	122
Central Maine	485	30%	93
Northern Maine	239	15%	72

3. Unmet Need

In 2007, Maine's Ryan White Part B Program launched a networked data system to consolidate program monitoring and evaluation in one secure database and to work toward the elimination of duplicate data collection and reporting. As of the fall of 2008, all of the Ryan White Part B and C grantees in the state use this networked CAREWare system. This single system allows for an unduplicated count of all people living with HIV in Maine who are utilizing Ryan White programs.

The following epidemiological data, presented in table 6, include all people living in Maine with diagnosed HIV through December 31, 2011, whose diagnoses were reported to Maine CDC, as well as those accessing a Ryan White care program – Part B, Part C, or ADAP – during calendar year 2011. Data were deduplicated by the State's HIV/STD Surveillance Coordinator.

Although Maine passed a law in 2008 requiring the reporting of all CD4 and Viral Load tests, Maine CDC estimates that HIV/AIDS reporting is 95% complete. In addition, some people living with HIV seek medical care out of state, choosing to go to New Hampshire or Boston, and those medical providers may not be aware of Maine's Rules for the Control of Notifiable Diseases and Conditions.

Table 6: Unmet need (2011)

All Living Cases of HIV/AIDS	Data Source	1-Year n (a)	1-Year %
# of living Maine residents diagnosed with HIV*	eHARS	1616	100%
Of those, # with CD4 in last 12 mos.	eHARS	609	38%
Of those, # with VL in last 12 mos.	eHARS	564	35%
Of those, # accessing ARVs (ADAP) in last 12 mos.	ADAP	522	32%
Of those, # accessing RW in last 12 mos.	CAREWare	845	52%
# of living Maine residents diagnosed with HIV accessing care**	Deduplication	1218	75%
# of living Maine residents diagnosed with HIV 'in care' ***	Deduplication	967	60%

* Number of living Maine residents diagnosed with HIV/AIDS as of 12/31/2011
** Defined as having one CD4 and/or one VL, and/or one ARV script filled, and/or one RW visit in the last 12 months
*** Defined as having one CD4 and/or one VL, and/or one ARV script filled in the last 12 months
(a) These data look only include those with at least one record of care in the past year

These data show that just over one-third of people living with diagnosed HIV have a record of one CD4 (38%) or Viral Load (35%) test in 2011. However, those in care (a record of one CD4 and/or one Viral Load and/or one ARV prescription filled by the

ADAP) is 60%. This discrepancy raises questions about the completeness of lab reporting beyond the above-acknowledged data limitations, as well as raising questions about physicians prescribing ARVs without appropriate lab work.

These data indicate that 30% of people who accessed Ryan White in 2011 were not in care, while case managers reported that only 11% of their clients were out of care. This discrepancy will be one area of focus in the goals detailed later in this report.

The data in table 7 include people living in Maine with diagnosed HIV who have at least one record of care in the past five years.

Table 7: Unmet need (2007-2011)

All Living Cases of HIV/AIDS	Data Source	5-Year n (b)	5-Year %
# of living Maine residents diagnosed with HIV*	eHARS	1616	100%
Of those, # with CD4 in last 5 yrs.	eHARS	1025	63%
Of those, # with VL in last 5 yrs.	eHARS	1035	64%
Of those, # accessing ARVs (ADAP) in last 5 yrs.	ADAP	747	46%
Of those, # accessing RW in last 5 yrs.	CAREWare	1076	67%
# of living Maine residents diagnosed with HIV accessing care**	Deduplication	1594	99%
# of living Maine residents diagnosed with HIV 'in care' ***	Deduplication	1354	84%

*Number of living Maine residents diagnosed with HIV/AIDS as of 12/31/2011
**Defined as having one CD4 and/or one VL, and/or one ARV script filled, and/or one RW visit in the last 5 years
**Defined as having one CD4 and/or one VL, and/or one ARV script filled in the last 5 years
(b) These data look only include those with at least one record of care in the past 5 years

The percentage of those accessing care over the last five years was 99%, up from 79% in 2008.

These data show that less than three-quarters of people living with diagnosed HIV have a record of even one CD4 (63%) or Viral Load (64%) test in the past five years. However, those in care (a record of one CD4 and/or one Viral Load and/or one ARV prescription filled by the ADAP) is 84%. This discrepancy raises questions about the completeness of lab reporting beyond the above-acknowledged data limitations, as well as raising questions about physicians prescribing ARVs without appropriate lab work.

While the percentage of people living with HIV who are in care is up to 84% (from 48% in 2008), this still indicates that 22% of people who accessed Ryan White in the last five years were not in care. Further, about one-third (29%) of those who were in care at some point in the last five years were not in care in 2011. This clearly demonstrates a need for better care retention strategies, which will be a focus in the goals presented later in this report.

Table 8 below examines only those who were newly diagnosed in 2010 and their care records for calendar years 2010 and 2011.

Table 8: Unmet need for 2010 new HIV diagnoses

2010 New HIV Diagnoses	Data Source	n	%
# of new HIV diagnoses	eHARS	59	100%
Of those, # with CD4*	eHARS	44	75%
Of those, # with VL*	eHARS	41	70%
Of those, # accessing ARVs (ADAP)*	ADAP	29	49%
Of those, # accessing RW *	CAREWare	41	69%
# of new diagnoses accessing care**	Deduplication	57	97%
# of new diagnoses 'in care'***	Deduplication	53	90%

*Data from 1/1/2010-12/31/2011
**Defined as having one CD4 and/or one VL, and/or one ARV script filled, and/or one RW visit from 1/1/2010-12/31/2011
***Defined as having one CD4 and/or one VL, and/or one ARV script filled from 1/1/2010-12/31/2011

As with the data presented in the two previous tables, the in-care percentage (those with one CD4 and/or Viral Load and/or record of an ADAP-funded prescription) of 90% compared to the percentage for CD4 (75%) and Viral Load (70%) indicates a data gap or poor prescribing practices.

In 2008, only 67% of new diagnoses were accessing care, compared to 97% in 2011. However, 10% of people diagnosed with HIV in 2010 and accessing Ryan White between 1/1/10 and 12/31/11 were not in care.

It is unclear whether these data indicate a data quality issue, a care issue, or both. These gaps will be discussed in greater detail in later sections of this report.

4. Estimated Number of People Living with HIV and Unaware of their Status

As mentioned above, there were 1,616 people living with diagnosed HIV in Maine at the end of 2011. Utilizing the national formula for estimating the number of people unaware of their status, there are approximately 430 undiagnosed individuals living in Maine with HIV as of December 31, 2011.

B. Maine's Continuum of Care

Maine's Department of Health and Human Services (DHHS) has functioned as the state's administrative lead in response to HIV/AIDS needs and care since the mid-1980s. Maine CDC's HIV, STD, and Viral Hepatitis Program is funded by state and federal dollars to provide HIV/STD/hepatitis C prevention and surveillance, disease intervention services, and HIV care services throughout the state.

The full continuum of care is comprised of services from three distinct categories: HIV-related services that are funded by Ryan White; HIV-related services that are not funded by Ryan White; and other services that are accessible to and utilized by people living with HIV/AIDS but are not specifically designated for that population. These categories of funding are described in greater detail below.

1. HIV-Related Services Funded by Ryan White

As the state's Ryan White Part B grantee, the HIV, STD, and Viral Hepatitis Program administers the AIDS Drug Assistance Program (ADAP) and subcontracts HIV medical case management services through six community-based organizations. These service dollars account for nearly half of all Ryan White funding that comes into the state, with 100% of service dollars currently funding core services. In calendar year 2011, 800 unduplicated people living with HIV/AIDS accessed medical case management while 814 unduplicated people living with HIV/AIDS were enrolled in the ADAP.

There are three Ryan White Part C grantees strategically located in each region of the state.

- **Central Maine:** Maine General Medical Center has received Ryan White Part C funding since 2003, which is administered through its Horizon Program. Horizon utilizes a clinic-based model to offer HIV primary and specialty care to its patients. Its Ryan White Part B medical case management, Ryan White Part C clinical services, and partner program HealthReach Harm Reduction are all housed in the same location. As part of the Maine General health system, Horizon has access to additional clinical resources. In calendar year 2011, Horizon served 182 unduplicated people living with HIV/AIDS.

- **Northern Maine:** The Regional Medical Center at Lubec (RMCL) has received Ryan White Part C funding since 2001. RMCL has implemented a coordinated referral network among providers who are sensitive to the needs and stigma of people living with HIV/AIDS. RMCL funds mental health and substance abuse counseling, oral health care, nutrition, pharmaceuticals, medical transportation and medical case management. RMCL served 160 unduplicated people living with HIV/AIDS in calendar year 2011.

- **Southern Maine:** The City of Portland's Public Health Division has received Ryan White Part C funding since 1999, which is administered through the Positive Health Care Program (PHC). PHC is the only health care practice in Maine where people living with HIV/AIDS can access primary medical care, HIV specialty care, psychiatric care, and HIV and STD testing at one clinic site. PHC served 200 unduplicated people living with HIV/AIDS in calendar year 2011.

The Maine AIDS Education and Training Center (MEAETC) receives Part F dollars from the New England AIDS Education and Training Center in Massachusetts. MEAETC provides HIV/AIDS education programs for health care providers, including doctors, nurses, advance practice nurses, physician's assistants, dentists, pharmacists, and medical case managers. MEAETC also provides funding for providers at PHC, Horizon, Virology Treatment Center, and Eastern Maine Medical Center to attend workshops and conferences.

All Ryan White-funded service dollars are broken out by Ryan White service category in table 9.

Table 9: HIV-Related Services Funded by Ryan White*

Service Category	Part B	Part C - PHC	Part C - MGMC	Part C- RMCL	Total
ADAP	$945,417				$945,417
Outpatient/ambulatory medical care		$241,774	$152,534		$394,308
Local AIDS pharmaceutical assistance				$5,830	$5,830
Oral health care		$14,456	$7,300	$35,436	$57,192
Early intervention services					$0
Health insurance premium and cost sharing assistance					$0
Home health care					$0
Home and community-based health services					$0
Hospice services					$0
Mental health services		$67,600	$5,760	$54,130	$127,490
Medical nutrition therapy			$1,000	$3,959	$4,959
Medical case management (including treatment adherence)	$520,346			$107,518	$627,864
Substance abuse services - outpatient					$0
Total Core Services	**$1,465,763**	**$323,830**	**$166,594**	**$206,873**	**$2,163,060**
Case management (non-medical)					$0
Child care services					$0
Pediatric development assessment/early intervention services					$0
Emergency financial assistance			$3,840		$3,840
Food bank/home-delivered meals					$0
Health education/risk reduction					$0
Housing services					$0
Legal services					$0
Linguistics services					$0
Medical transportation services			$1,880	$16,670	$18,550
Outreach services			$3,744		$3,744
Permanency planning					$0
Psychosocial support services				$41,020	$41,020
Referral for health care/supportive services					$0
Rehabilitation services					$0
Respite care					$0
Substance abuse services - residential					$0
Treatment adherence counseling					$0
Total Support Services	**$0**	**$0**	**$9,464**	**$57,690**	**$67,154**
HIV counseling and testing				$90,600	$90,600
Total HIV Counseling and Testing	**$0**	**$0**	**$0**	**$90,600**	**$90,600**
Grand Total	**$1,465,763**	**$323,830**	**$176,058**	**$355,163**	**$2,320,814**

*** In addition, the MEAETC is funded under Part F as follows: $8,000 for clinical care for minority populations; $7,000 for training programs for native communities; core budget of $54,149 for training and admin. Total budget is $69,149.**

2. HIV-Related Services Not Funded by Ryan White

The DHHS Office of MaineCare Services administers the state's Medicaid program. MaineCare covered 766 low-income people living with HIV/AIDS in Maine during calendar year 2011 (about 47% of all people living with diagnosed HIV in Maine). Full benefits are extended to those whose income falls at or below the federal poverty level. Maine has an 1115 waiver that allows MaineCare to extend limited benefits to people living with HIV/AIDS whose income falls between 101% and 250% of the federal poverty level. Medical costs, including general and specialty care and medications; limited mental health; medical transportation; and targeted case management are currently covered services under MaineCare.

Frannie Peabody Center, a community-based organization with offices in Portland and Ogunquit, is the recipient of four competitive Housing Opportunities for People with AIDS (HOPWA) grants from the U.S. Department of Housing & Urban Development. Combined, these four grants provide housing and supportive services to approximately 250 people living with HIV/AIDS statewide annually.

The U.S. Centers for Disease Control and Prevention (US CDC) provides formula-based funding for HIV prevention services to the State of Maine, which is administered by the HIV, STD, and Viral Hepatitis Program and subcontracted to a number of community-based providers. In addition, RMCL is directly funded through a cooperative agreement with the US CDC National Center for HIV, Viral Hepatitis, STDs, and TB Prevention to provide HIV prevention and rapid outreach HIV testing throughout the Northern Maine region.

Although the majority of Maine's ADAP funds come from Ryan White Part B, the program is sustained by State general funds and drug rebates. State general funds are also apportioned to housing for people living with HIV/AIDS and HIV prevention services. In addition, Maine's Office of Substance Abuse funds HIV prevention activities statewide, including comprehensive risk counseling services for people living with HIV/AIDS.

These HIV-related services are described in table 10 below.

Table 10: HIV-Related Services Not Funded by Ryan White

	MaineCare*	HOPWA (FPC)	US CDC	State of Maine	Maine Office of Substance Abuse	ADAP Rebate Funds	Total
Outpatient/ambulatory medical care	$2,648,463						$2,648,463
Medications	$6,212,079			$50,000		$512,504	$6,774,583
Oral health care	$23,842						$23,842
Home health care	$36,053						$36,053
Home and community-based health services	$195,763						$195,763
Hospice services	$45,333						$45,333
Nursing home	$13,708						$13,708
Mental health services	$240,171						$240,171
Case management	$809,223	$217,720					$1,026,943
Substance abuse services - outpatient	$52,005						$52,005
Housing services		$1,125,466		$37,869			$1,163,335
Medical transportation	$120,874						$120,874
Eye care	$4,846						$4,846
HIV prevention services			$1,521,149	$149,355	$125,000		$1,795,504
HIV surveillance			$106,383				$106,383
Total	**$10,402,360**	**$1,343,186**	**$1,627,532**	**$237,224**	**$125,000**	**$512,504**	**$14,247,806**

* Claims paid July 1, 2009-June 30, 2010 for people living with HIV/AIDS

In addition, the Maine Department of Education provides HIV/AIDS prevention programs through local school administrative units, and the Maine Department of Corrections provides necessary HIV/AIDS care services for inmates who are infected with HIV under the terms and conditions of the prison health care contract.

Many clients, particularly those residing in the Southern and Central regions, travel to Boston to access free or low-cost dental care at the Henry M. Goldman School of Dental Medicine at Boston University.

Finally, there are approximately eleven Shelter Plus Care (SPC) housing subsidy slots reserved for people living with HIV/AIDS who are literally homeless, representing less than 1% of all SPC slots in the state.

3. Other Services Not Funded by Ryan White

The continuum of care would not be complete without other resources that our clients utilize, even though they are not specifically targeted to people living with HIV/AIDS. These include community mental health and substance abuse services – both inpatient and outpatient – low-income housing programs, financial assistance programs, and other health services.

The State of Maine receives $334,760 in STD prevention and treatment funds and $116,102 in hepatitis prevention and surveillance funds.

Maine receives almost $16 million in SAMHSA grant awards. Some of these funds are included in the Office of Substance Abuse funds directed to HIV prevention activities statewide, including comprehensive risk counseling services for people living with HIV/AIDS (as noted in table 10).

There are a number of private physicians who provide care to people living with HIV/AIDS (most of whom are reimbursed by MaineCare or other insurances for their services). A limited number of clients access health care through the Veterans Administration, Community Health Clinics, or free clinics.

Maine is home to 19 federally-qualified health centers, which operate over 100 delivery sites that can be found in areas and among populations in the state with the greatest needs, including 54 primary care sites. The Part C grantees in Northern and Southern Maine operate federally-funded Community Health Centers. There are 39 Rural Health Clinics throughout Maine, which receive about $900,000 in Rural Health Funds. There are also four free clinics in Southern Maine and one each in the Central and Northern regions.

MaineHealth CarePartners coordinates the provision of donated health care services for low-income, uninsured residents in Cumberland, Lincoln, Waldo, and Kennebec counties. The program, a partnership between MaineHealth, physicians, hospitals and other health care providers, helps community members who don't qualify for public or private health care coverage programs get comprehensive, medically necessary health care.

RMCL's Maine Telemedicine Services division maintains offices in Bangor and Augusta and serves projects throughout the state. Maine has one of the largest statewide telemedicine systems, comprised of more than 300 facilities among 100 health, mental health, and social service provider organizations in a collaborative network. Telemedicine services available include psychiatry, endocrinology/diabetes management, primary care, specialty pediatrics, genetic counseling, wound care, neurology, and pain management.

The Maine Breast & Cervical Health Program offers free breast and cervical cancer screenings to low-income, uninsured or underinsured women, and the Maine Colorectal Cancer Control Program offers free colorectal cancer screenings to low-income, uninsured or underinsured men and women. Both programs are administered by Maine CDC.

MaineHousing, an independent state agency that bridges public and private housing finance to benefit Maine's low- and moderate-income people, provides homeless assistance grants to emergency shelters serving people who are homeless. Emergency

shelters are located in 11 of Maine's 16 counties with a domestic violence shelter in a twelfth county.

Maine's Department of Health and Human Services administers the Bridging Rental Assistance Program (BRAP) and primarily administers Shelter Plus Care (SPC) through the Office of Adult Mental Health Services. BRAP has been established in recognition that recovery can only begin in a safe, healthy, and decent environment. People with psychiatric disabilities are often unable to afford to rent housing of their choice in the community. Although not targeted to people living with HIV/AIDS, those with an eligible mental health diagnosis can access BRAP assistance. Approximately 11 SPC slots are specifically for people living with HIV/AIDS who are literally homeless, although people living with HIV/AIDS can also access SPC through other eligibility criteria.

Other housing resources not specifically targeted to people living with HIV/AIDS but accessible to them are: Section 8 Housing Choice Vouchers, Public Housing, the Low Income Housing Tax Credit Program, and the Supported Housing Program.

People living with HIV/AIDS can access financial assistance through their local General Assistance programs, Temporary Assistance for Needy Families (TANF), and the Low Income Home Energy Assistance Program (LIHEAP). Many people living with HIV/AIDS also qualify for food stamps and assistance from the Women, Infants, and Children (WIC) program, which is administered by Maine CDC.

4. Continuity of Care

The very nature of available funding requires Ryan White and non-Ryan White resources to comingle to ensure continuity of care. No frontline providers receive their funding from a singular source. For example, the state's HOPWA grantee is a Ryan White Part B subgrantee for HIV medical case management services, is a MaineCare provider of targeted case management to people living with HIV/AIDS, and is a subgrantee of HIV prevention dollars from US CDC. The ADAP utilizes state general fund dollars and drug rebates to supplement its federal earmark.

Representatives from the different categories of funding sit on the state's HIV Advisory Committee as well as the Ryan White Advisory Committee. These committees meet once per month on the same day to reduce barriers to attendance. These meetings serve as a forum to exchange information and ensure that appropriate linkages between different sectors of care are happening.

Although the amount of funding for certain services may vary by region and may not be accessible in all communities within a region, all services identified in tables 9 and 10 are available in each of the three regions of the state.

The service system has already been affected by budget cuts, with the potential for additional cuts on the immediate horizon. Ryan White Part B awards to subgrantees for

medical case management services have been flat funded for years. Although the amounts of their Ryan White Part B awards have not changed, subgrantees have had to restructure their budgets in three ways, which has led to setting limits on or eliminating certain ancillary support services.

First, state matching funds for MaineCare services used to be encumbered in contracts with providers billing for the remainder at the time of service delivery. A change in the MaineCare billing system necessitated the removal of these funds from contracts, because providers now receive the full payment for each unit of service billed at the time of service. MaineCare payments have frequently been delayed due to processing issues; in the cases of subgrantees that are part of large hospital systems, payments have often been delayed for many months.

Second, a clarification from HRSA about the delivery of emergency financial assistance services led to a reallocation of all non-ADAP Part B service dollars into medical case management.

Thirdly, subgrantees used to be allowed to allocate rent and related costs for direct service personnel into the direct costs for their awards, in compliance with Office of Management & Budget standards. However, upon the release of the Monitoring Standards, HRSA clarified that all such expenses should be included in administrative costs.

These three budget restructuring issues have had the most significant impact on providers to date. Other state and local budget cuts have forced some providers to eliminate positions and reduce the amount of support services available.

A State of Maine supplemental budget for the period ending June 30, 2012, included a proposal to eliminate targeted case management services as an optional service in the MaineCare program. This proposal was ultimately rejected for the supplemental budget period, but may be revisited in future budget proposals. If this change were to occur, the Ryan White Part B Program would need to dramatically alter how it provides services and to whom those services are available. The elimination of this revenue stream would force most, if not all, of the current medical case management subgrantees to cease the provision of case management services, as MaineCare is the largest funder of such services and Ryan White Part B funds alone could not sustain the programs as they currently exist. The Ryan White Part B Program would likely need to reduce the number of subgrantees, tighten eligibility requirements for medical case management services, and reduce the number of units of medical case management services delivered each year.

Any significant change to the continuum of care would be presented to the HIV Advisory Committee and the Ryan White Advisory Committee for input into the restructuring of service delivery in the state.

In addition, US CDC changed its funding formula for HIV prevention services in its 2011 funding opportunity announcement. As a result, the State of Maine received a cut of about $420,000 (26% of previous funding) in its current year's funding and expects to see the reduction of an additional $200,000 (17% of current funding) by 2014. This has an impact not only on the provision of HIV prevention services in the state (including prevention with positives) but also on small community-based organizations that serve as subgrantees for both prevention and care and rely on both funding streams to maintain operations.

C. Statewide Coordinated Statement of Need

The Statewide Coordinated Statement of Need was developed through a collaborative process over the course of monthly Ryan White Advisory Committee meetings between July 2011 and May 2012 and a specially convened phone conference between Ryan White grantees in the state of Maine on April 20, 2012. Stakeholders who participated in the development of the SCSN include Ryan White grantees and subgrantees, which includes several Community Health Centers; the state's HOPWA grantee; representatives from Maine's Office of MaineCare Services and HIV/STD Prevention and Rural Health and Primary Care programs; the State's HIV/STD Surveillance Coordinator; and people living with HIV/AIDS.

1. Care Needs

In early December 2011, all people living with HIV/AIDS in Maine who accept mail and receive MaineCare and/or access the AIDS Drug Assistance Program (ADAP) and/or access HIV medical case management were mailed a packet of surveys. The packet included a MaineCare satisfaction survey, an ADAP satisfaction survey, a case management satisfaction survey, and a needs assessment. Incentive cards worth $10 were included in this mailing.

There were 1,616 people living with diagnosed HIV/AIDS in Maine in 2011.

- A total of 800 unduplicated clients received at least one HIV case management service in calendar year 2011.
- A total of 814 unduplicated clients were enrolled in ADAP in calendar year 2011.
- A total of 766 unduplicated PLWHA were enrolled in MaineCare in calendar year 2011.
- Approximately 930 surveys were mailed in early December 2011.

In addition to these surveys, RMCL conducted a satisfaction survey for its Ryan White Part C Program.

Three focus groups for people living with HIV/AIDS were held in early 2012 to augment the results of the 2011 written needs assessment survey.

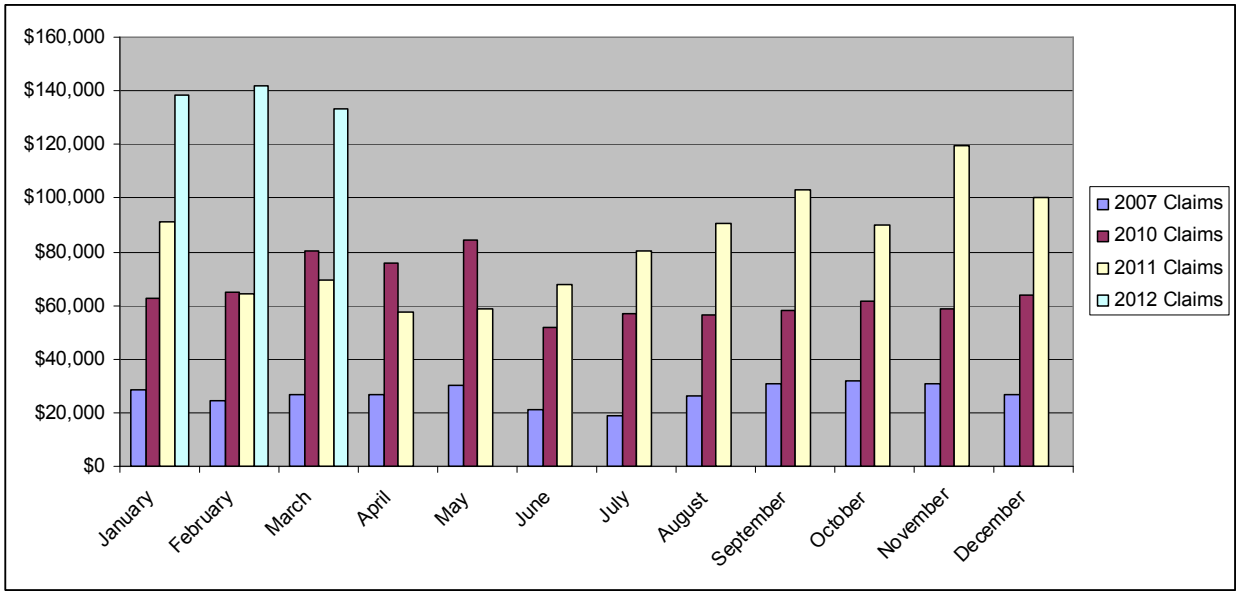
a. ADAP

Approximately half (53%) of all ADAP enrollees responded to the ADAP satisfaction survey. Satisfaction ratings were high with highly complimentary narrative responses. Most individuals who had suggestions for improvement requested expanding the program in some way. During focus group interviews, participants indicated that ADAP was a crucial service to continue and also expressed a desire to expand the formulary.

At this time, the ADAP is focused on sustainability rather than expansion. Although Maine has been one of few states to avoid cost containment measures in the last several years, sharply increasing costs in recent months have necessitated the convening of an ADAP Advisory Committee that will be evaluating different cost containment strategies to help sustain the program.

Figure 4 below shows the monthly totals for prescriptions paid at the pharmacy for the full years 2007, 2010, and 2011, as well as the first three months of 2012. Year 2007 data are included as a snapshot of ADAP spending at the time that most of its current policies were enacted. Although there was a trend in rising costs throughout 2010 and 2011, there was a substantial spike in the first three months of 2012. These data do not include co-pays that were reimbursed after the fact or the costs of labs and insurance premiums.

Figure 4: Maine ADAP Pharmacy Claims Totals by Month, Selected Years



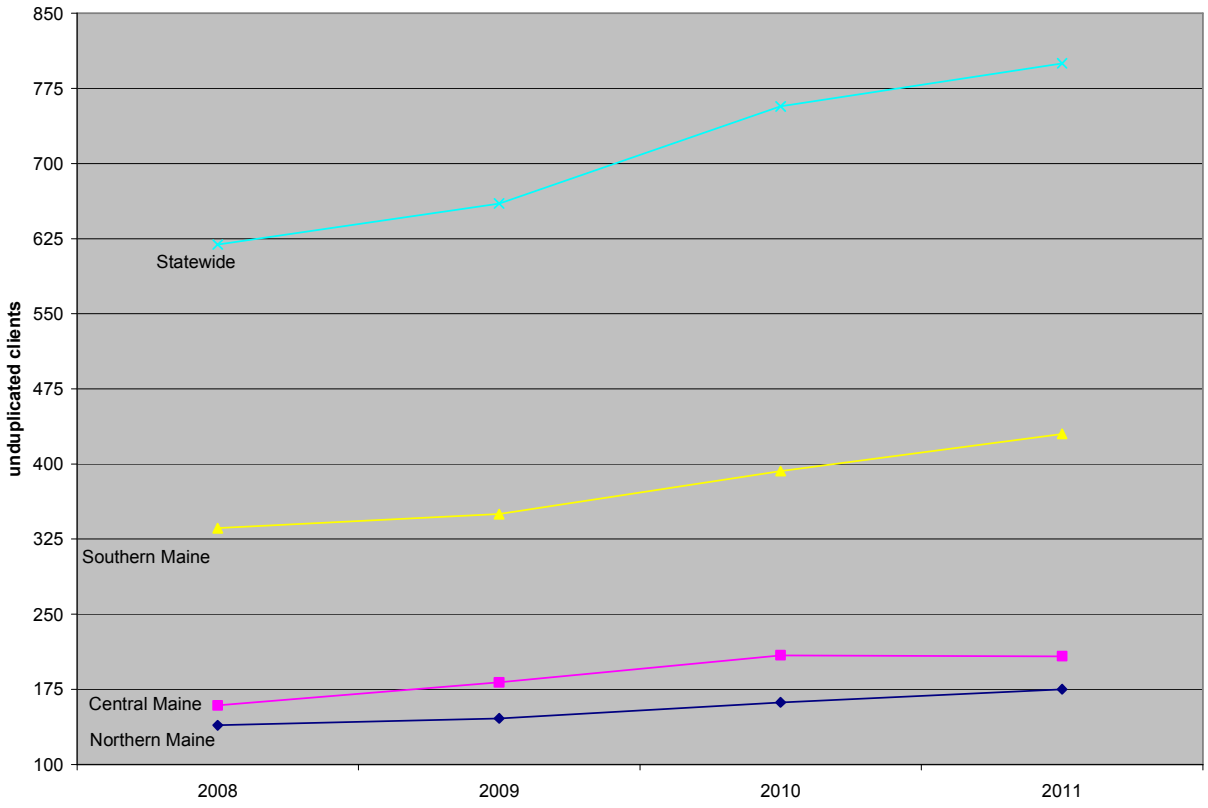
The new HIV treatment guidelines, which recommend that all people living with HIV be prescribed antiretrovirals, could have a profound impact on the ADAP's ability to provide services.

b. Medical Case Management

In FY2009, MaineCare reimbursed case management providers more than $450,000 for services delivered to 492 people living with HIV/AIDS; in FY2010, reimbursements increased to more than $800,000 for 584 clients.

The Ryan White Part B Program funds medical case management through subcontracted community-based providers throughout the state. The Ryan White Part C grantee in Northern Maine also provides medical case management through subcontracted community-based providers in the northern part of the state. The HOPWA program provides funding for case management and related support services at Frannie Peabody Center, based in Portland. In calendar year 2011, an unduplicated total of 800 people living with HIV/AIDS received at least one case management service. Figure 5 below shows the distribution of case management clients by region for 2008 through 2011.

Figure 5: Distribution of Case Management Clients by Region, 2008-2011



Approximately 50% of HIV case management clients served in 2011 responded to the medical case management satisfaction survey. Results from the past three years show an overall high rate of satisfaction with medical case management services.

Notably, new clients have consistently indicated some difficulty in finding services over the past three years. Of those who indicated there were services that they needed but didn't have on the needs assessment, 8% identified case management and 6% identified treatment adherence (a defining characteristic of medical case management). These data indicate that providers could improve their outreach efforts.

Satisfaction survey data show that the percentage of clients who agreed with “I am able to get appointments” dropped from 94% in 2009 to 90% in 2010 to 89% in 2011. The percentage of clients who agreed with “My case manager helped me find services” dropped from 90% in 2009 and 2010 to 89% in 2011. Although these are small fluctuations, it is worth noting and monitoring the downward trend.

The satisfaction survey solicited narrative responses for three questions; responses were grouped and categorized where possible, as follows:

“What is your case manager doing that is helpful?” had an 81% response rate. Of those who responded, nearly one-third (30%) described coordination of services, 21% described emotional support, and 19% indicated that contact and communication were helpful.

Please note that direct provision of emotional support is not an activity that is funded by MaineCare or Ryan White in Maine at this time.

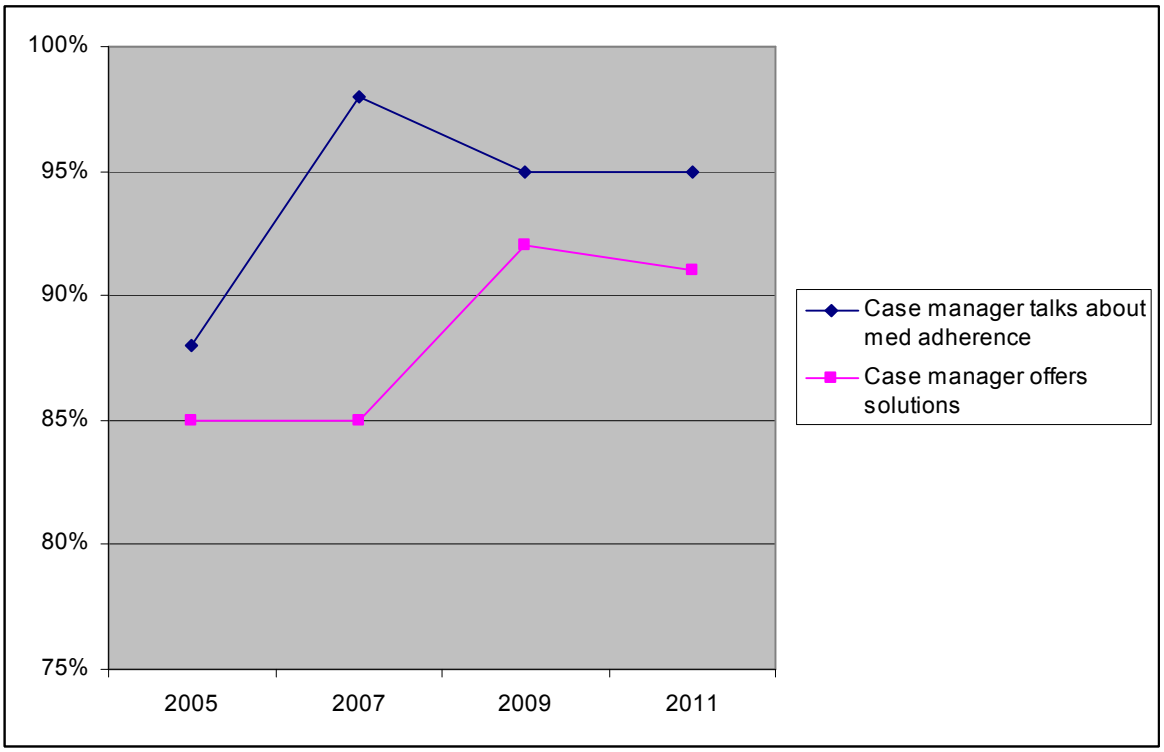
“How can your case manager help you more?” had a 57% response rate and the overwhelming majority of responses (65%) was “can’t” or “I don’t know.” Five percent of those who responded to the question (12 clients) indicated that case managers could be more available and/or provide better customer service; 5% (11 clients) indicated needs for transportation assistance and for improved case management (no specific suggestions for improvement were offered).

“Are there services that you need, but are not able to be provided by your case management agency?” had a 59% response rate, however, the vast majority (52%) of these responses were “no” or “don’t know.”

The last questions in the satisfaction survey ask how long clients have been accessing case management and their frequency of contact with their case managers. HIV medical case management is meant to be a short-term intervention. However, more than 100 clients indicated that they have been in case management for more than five years, and nearly half (47%) of those see their case managers monthly.

Because RMCL also funds medical case management in the Northern Region, its satisfaction survey includes questions about case managers providing help with medication adherence: “How well does your case manager discuss the importance of taking your medications as prescribed?” and “How well does your case manager help you find solutions for issues that interfere with taking your meds as prescribed?” The responses for 2005-2011 are presented in figure 6 below.

Figure 6: Help in Adherence Rated Excellent or Good, 2005-2011



In addition, this satisfaction survey asked clients to rate how helpful their medical case managers were in helping to obtain care and services. In 2011, satisfaction rates fell in the categories of dental care (from 100% in 2009 to 86% in 2011), mental health counseling (from 93% in 2009 to 83% in 2011), and nutritional counseling (from 100% in 2009 to 63% in 2011).

During focus group interviews, clients indicated that their case managers are skilled service providers who play an important role in the centralization of information and administration of services.

Although the majority of respondents (84%) to the needs assessment indicated that they have a medical case manager, only 15% indicated that their medical case manager helped them remember when to see their doctor or get labs or screenings; 11% indicated that their case manager helped understand how and when to take their meds; and 11% indicated that case managers could help more with staying on top of meds.

Overall, these data may indicate a need to more clearly define (with specific parameters and deliverables) the medical case management service, to ensure that provision of emotional support is not a primary focus, that medical case managers receive appropriate training to effectively provide treatment adherence services, and that clients are encouraged to move toward a state of independence. As noted above, additional outreach may be needed to initially engage people in medical case management and ensure their awareness of the service.

c. Insurance

Only 0.5% of HIV case management clients served in 2011 were identified as having no insurance at the end of 2011.

A total of 88% of respondents to the statewide needs assessment indicated that they always had insurance that paid for their medical visits during the past year. Sample sizes were too small to analyze the amount of time people spent without insurance.

Approximately half (54%) of MaineCare enrollees with HIV/AIDS responded to the MaineCare satisfaction survey.

About 84% of respondents to the MaineCare satisfaction survey indicated that it was easy to apply for benefits, while only 69% indicated that they understand their benefits. Only 61% of respondents indicated that they could afford their co-pays and premiums, but 91% indicated that they can easily get their prescriptions filled.

The 1115 waiver allows MaineCare to extend limited benefits to people living with HIV/AIDS whose income reaches a maximum of 250% of the federal poverty level. Coverage extended under the Affordable Care Act would increase full benefits coverage to people up to 133% of the federal poverty level, but at this time, it is still unclear if those with incomes from 134-250% would maintain their limited benefits.

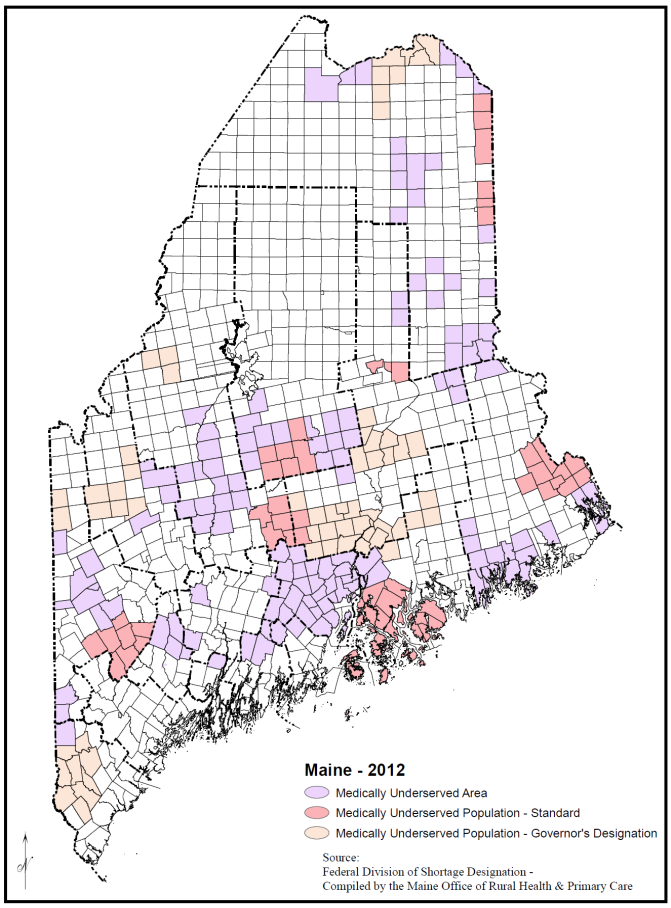
According to income information for clients who accessed case management in 2011, about 72% should maintain insurance coverage under the guidelines for the Affordable Care Act, if implemented as currently proposed. The Office of MaineCare Services estimates that about 38% of MaineCare members with HIV who might currently be eligible for MaineCare's limited benefits waiver for people living with HIV/AIDS (those with income between 134% and 250% of the federal poverty level) might lose coverage.

d. Medical Care

About 2% of HIV case management clients served in 2011 were identified as having no primary source of care at the end of 2011.

Cumberland County in the Southern Region of the state is the only county that does not contain a federally designated medically underserved area or medically underserved population, as illustrated in figure 7 below.

Figure 7: Federally Designated Medically Underserved Areas & Populations, Maine, 2012



Twelve of Maine's sixteen counties have at least one primary care provider or practice that has experience providing primary health care services to persons living with HIV/AIDS. Although there are health care providers in Cumberland, Kennebec, and Penobscot counties that see patients for both primary care and HIV/AIDS care, there are federally-designated primary care health professional shortages in the Northern and Central regions of the state. Please note that figure 8 does not take into account primary care providers with experience treating people living with HIV/AIDS.

Figure 8: Federally Designated Primary Care Health Professional Shortage Areas, Maine, 2012

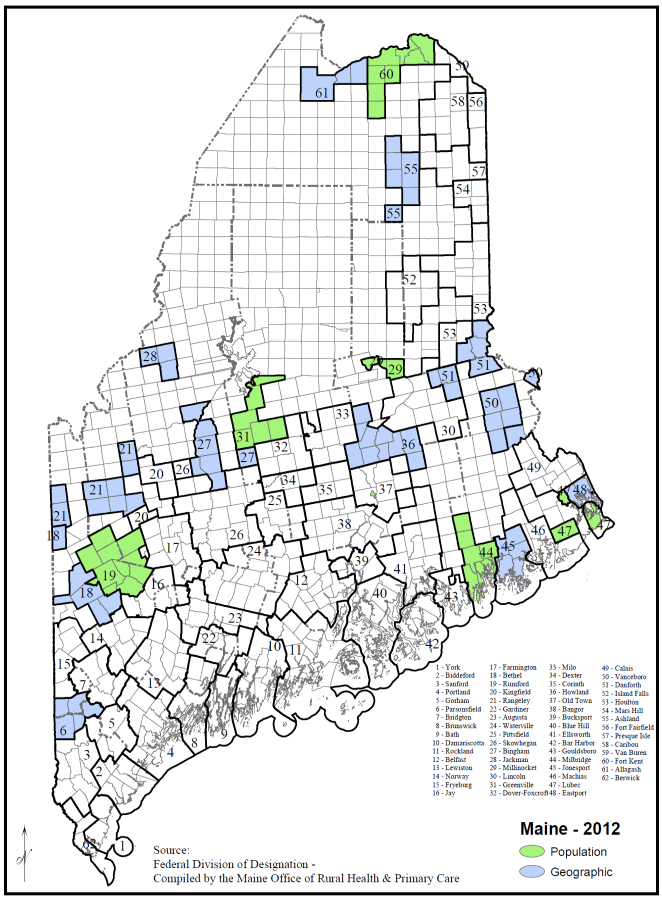


Table 11 shows the number of infectious disease doctors registered with the State Board of Licensure by public health region.

Table 11: Infectious disease doctors in Maine by public health region

Region	Counties	# ID Doctors
Central	Androscoggin, Franklin, Kennebec, Knox, Lincoln, Oxford, Sagadahoc, Somerset, Waldo	12
Northern	Aroostook, Hancock, Penobscot, Piscataquis, Washington	8
Southern	Cumberland, York	13

Maine is home to 19 federally-qualified health centers, which operate more than 100 delivery sites that can be found in areas and among populations in the state with the greatest needs, including 54 primary care sites. There are 39 rural health clinics throughout Maine; there are four free clinics in Southern Maine, and one each in the Central and Northern regions.

MaineHealth CarePartners coordinates the provision of donated health care services for low-income, uninsured residents in Cumberland, Lincoln, Waldo, and Kennebec

counties. The program, a partnership between MaineHealth, physicians, hospitals and other health care providers, helps community members who don't qualify for public or private health care coverage programs get comprehensive, medically necessary health care.

Two Ryan White Part C grantees, the City of Portland's Positive Health Care program in the Southern Region and Maine General Medical Center's Horizon Program in the Central Region, provide clinic-based care services for people living with HIV/AIDS. Both have interdisciplinary teams available to provide comprehensive HIV care services.

The Ryan White Part C grantee in Northern Maine, RMCL, is a federally-funded community health center. RMCL contracts with local HIV specialists to participate in comprehensive care team meetings, provider trainings, program coordination and oversight, and CQI initiatives. In addition, RMCL's Maine Telemedicine Services division maintains offices in Bangor and Augusta and serves projects throughout the state. Maine has one of the largest statewide telemedicine systems, comprised of more than 300 facilities among 100 health, mental health, and social service provider organizations in a collaborative network. Telemedicine services available include psychiatry, endocrinology/diabetes management, primary care, specialty pediatrics, genetic counseling, wound care, neurology, and pain management.

The Virology Treatment Center in Portland, funded in part by the MEAETC, provides statewide consultation and education services for physicians and other care providers treating people living with HIV/AIDS. While the center's practitioners do not serve as patients' primary providers, they are available to work closely with patients' primary care physicians or infectious disease specialists to ensure they are receiving quality care. This service is often particularly helpful for clients residing in rural areas where practitioners may have less experience treating HIV/AIDS. The service is available statewide.

MEAETC also provides funding for providers at PHC, the Horizon Program, and Eastern Maine Medical Center to attend workshops and conferences to increase their competency in treating people living with HIV/AIDS.

In FY2009, outpatient/ambulatory medical care services accounted for about 29% of MaineCare payments for services delivered to people with HIV/AIDS; in FY2010, these services accounted for about 25% of payments.

RMCL's client satisfaction survey indicates that the vast majority (97% of respondents) of Ryan White Part C clients in Northern Maine are satisfied with their medical care. Similarly, about 87% of respondents to the MaineCare satisfaction survey indicated that they are able to see the provider they want, an increase of 3% from the previous year.

Nearly all (94%) of statewide needs assessment respondents indicate that they see a doctor for their HIV at least once every six months.

The needs assessment survey asked who helps clients remember to see the doctor, get labs, or get screenings. There was a 93% response rate, with no variation among the three public health regions. Clients were asked to choose all that apply. Half (50%) of respondents indicated that no one helped them remember; 26% indicated that their doctors helped them remember; 21% indicated that their partners helped them remember; 15% indicated that a case manager helped them remember.

In follow up, the survey asked if anyone could help clients more with staying on top of their medical care. Almost a third (27%) indicated their doctors could help more; 24% indicated that their case managers could help more; and 19% indicated that their partners could help more.

The needs assessment survey asked about certain preventive care activities in the last year. Table 12 breaks down the percentages of affirmative responses for each activity.

Table 12: Percentages of respondents who have had preventive services in the last year

Had a flu shot?	88%
Had a cholesterol screening?	81%
Had a hepatitis screening?	51%
Been screened for STDs?	40%
Had a pap/anal pap screening?	40%
Had mental health therapy?	32%
Had drug or alcohol counseling?	9%

i. Hepatitis

PHC, the Ryan White Part C program in Southern Maine, estimates that about 22% of its patients are co-infected with HIV and hepatitis C. RMCL, Ryan White Part C grantee in Northern Maine, estimates that 20% of its clients are co-infected with HIV and hepatitis C. Maine General Medical Center's Horizon Program, the Ryan White Part C grantee in Central Maine, has recently begun treating patients co-infected with HIV and hepatitis C when in the past, these patients were referred out for hepatitis C treatment.

The statewide needs assessment polled respondents about hepatitis vaccinations; there was a 96% response rate for hepatitis A and a 98% response rate for hepatitis B, with some regional variation as represented by the tables below:

Table 13: Hepatitis A by Region

	Statewide	**Central Maine**	**Northern Maine**	**Southern Maine**
Yes	64%	62%	70%	64%
I don't know	22%	27%	16%	22%
No	14%	11%	14%	15%

Table 14: Hepatitis B by Region

	Statewide	Central Maine	Northern Maine	Southern Maine
Yes	65%	63%	73%	63%
I don't know	21%	25%	13%	21%
No	14%	12%	14%	17%

ii. Eye Care

Focus group participants indicated that there is an inadequate supply of eye care services, that coverage is only offered sporadically, and that clients do not have a clear understanding of what services are covered and where to access them.

Thirteen respondents to the case management satisfaction survey indicated that their case manager helped them with eye care, while 9 respondents indicated that this was a needed service that is not provided. In the ADAP satisfaction survey, one member requested expanding the ADAP to cover eye care.

Although the needs assessment survey did not include eye care as a needed service not provided, 5% of respondents wrote it in.

Less than $5,000 of MaineCare payments for people living with HIV/AIDS in FY2009 and FY2010 were for vision services as coverage is very limited.

iii. Nutritional Services

The state of Maine has few dieticians or nutritionists that those with HIV can access, either through MaineCare or Ryan White providers. Two are located at Portland's main HIV health care providers: Virology Treatment Center and PHC. Dietary counseling is available to all at St. Mary's Regional Medical Center in Lewiston, while Maine General Hospital's Diabetes Program provides nutritional counseling to people living with HIV/AIDS who have also been diagnosed with diabetes.

RMCL's satisfaction survey for its Ryan White Part C Program shows that only 73% of clients were satisfied with nutritional counseling services in 2011 (compared to 100% in 2005-2009). Only 63% of respondents indicated that their case manager was helpful or timely in obtaining nutritional counseling services. About 12% of respondents indicated a need for travel assistance related to nutritional counseling. RMCL has experienced difficulty in recruiting a qualified dietician who feels knowledgeable about the nutritional needs of people living with HIV. To help meet outstanding needs, RMCL is exploring telemedicine as a means to deliver professional nutrition services from providers in Southern Maine.

PHC, the Ryan White Part C program in the Southern Region, provides nutritional services by referral; however, the program requires a high level of commitment that

does not suit everyone. PHC piloted a wellness program in 2009 and purchased outcomes software to measure the effectiveness of the program, in response to consumer input. PHC enrolled 6 people in the 4-session program and demonstrated distinct improvement in areas such as weight management, nutritional literacy, and improved mood. However, the program has not been sustained due to reduced nursing hours.

e. Housing

Lack of affordable, stable housing for low-income people living with HIV/AIDS creates significant obstacles to treatment and services. Lack of permanent supportive housing exacerbates existing financial stressors (rising health care costs, loss of employment, and reduction in wages) that affect many people living with HIV/AIDS.

Each of the state's Consolidated Plans for housing shows a need for physical housing units and/or an increased need for housing assistance. The inferior condition of Maine's aging housing stock, including inadequate plumbing, ineffective heating systems, lead paint, electrical and other problems, adversely affects people living with HIV/AIDS as they seek permanent housing units.

Maine has a growing homeless population. City of Portland shelters are experiencing record numbers of utilization and are operating overflow plans.

Across the state, rent is rising faster than income. Between increasing housing demand and rental costs, the average wage earner has difficulty finding affordable housing. Currently, there are more than 100 clients waitlisted for HOPWA tenant-based rental subsidies in Maine with some having been waiting as long as three years. Clients who participated in the focus groups indicated that there was a lack of understanding about housing information and services.

A total of 23 respondents to the case management satisfaction survey (10% of respondents to the question) indicated that housing was an outstanding need.

A total of 93% of respondents to the statewide needs assessment reported living in their own house or apartment, someone else's house or apartment, or a combination of the two. However, 4% of respondents were homeless at some point in the past two years and 3% reported three or more housing types over the course of the last three years, indicating issues with housing stability.

Less than one-quarter of needs assessment respondents (18%) indicated a desire to move, with the majority of these currently residing in the Central Region. Financial issues were the number one reason people indicated that they would like to move, followed by proximity to services and proximity to support system.

f. Basic Needs

When asked if able to pay for basic needs, such as housing, food, and heat, only 58% of respondents to the MaineCare satisfaction survey indicated that they are able to pay for these needs, down 3% from the previous year.

Nearly half (40%) of statewide needs assessment respondents fall in the lowest income group (0-100% of the federal poverty level). An additional 24% fall between 101% and 133% of FPL, and 30% fall between 134% and 250%. Only 7% of respondents indicated an income above 250% FPL, and all indicated an income below 500% FPL, the current income threshold for both HIV medical case management services and the ADAP. There is slight regional variation in the distribution of clients among these income groups, as seen in table 15.

Table 15: Needs assessment respondents by income group and region

Income Group	Statewide	Central Region	Northern Region	Southern Region
Between 0-100% FPL	40%	39%	39%	40%
Between 101-133% FPL	24%	24%	30%	21%
Between 134-250% FPL	30%	32%	28%	29%
Between 251-500% FPL	7%	5%	3%	10%

Less than 15% of respondents indicated that they had looked at their budget with a case manager; 82% of these indicated that this occurred within the last year. Nearly all respondents (90%) said that they would not like someone to work with them on managing their budgets.

Of those who missed a payment or used emergency help in the last year, the most common need area (56%) identified was food; 40% identified rent/mortgage; 38% identified heat; 25% identified electric bill as an area of need.

Of those who indicated they got financial help from a case management agency and described the type of help received, 30% identified food assistance– it was the most common response in the Central Region and the second-most common response in the Northern Region; 16% identified rent and 14% identified utilities; rent was the third-most identified area in the Southern Region.

One-third (33%) of those who said they needed a service they didn't have identified housing/utilities assistance – it was the second-most identified service; 27% identified food assistance – it was the third-most identified area overall and ranked second in the Northern and Southern regions.

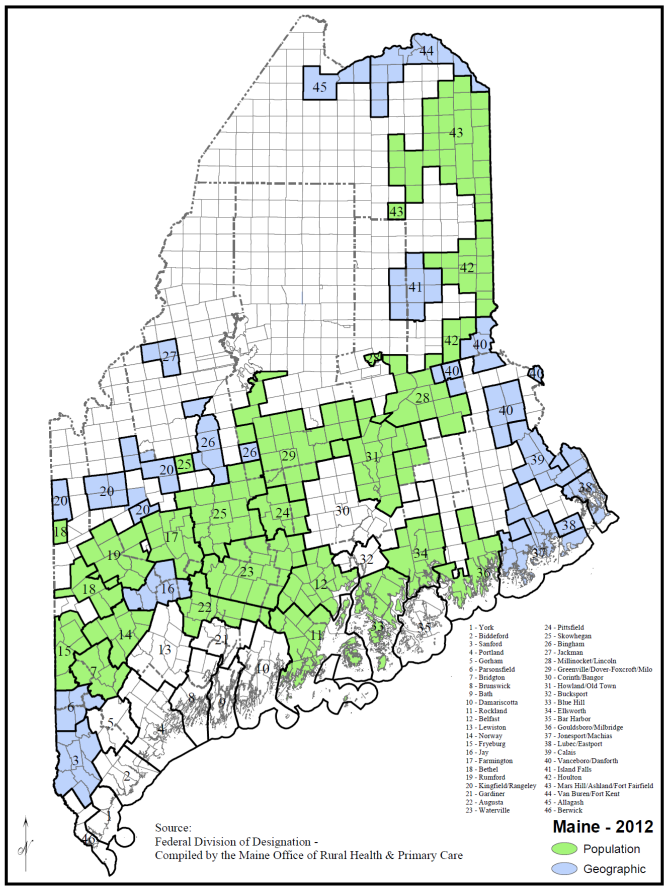
In addition, clients who participated in the focus group in the Central Region stated that additional food assistance for people who do not qualify for food stamps would help reduce barriers to care.

g. Oral Health

Focus group participants indicated that although dental care was a highly valued service, access is inconsistent.

Low-cost dental clinics are located in all Maine counties except for Piscataquis in Northern Maine and Lincoln in Central Maine. However, there are federally-designated dental health professional shortage areas throughout the state of Maine, based both on population and geography, as seen in figure 9.

Figure 9: Federally Designated Dental Health Professional Shortage Area, Maine, 2012



Less than half of needs assessment respondents (43%) indicated that they see a dentist at least once every six months. Those who do not see a dentist every six months were asked why not. The top three reasons in each region were cost, having dentures/few teeth, and insurance. Availability was the fourth most common response in the Central and Northern regions.

Table 16: Do you see a dentist at least once every six months? by region

	Central Maine	Northern Maine	Southern Maine
Yes	38%	48%	45%
No	62%	52%	55%

Elderly or disabled clients on Medicare are only covered for emergency procedures. MaineCare's dental coverage is also limited and those who are covered by the 1115 limited benefit waiver are not eligible for dental coverage at all. Less than 1% of MaineCare payments for people living with HIV/AIDS in FY2009 and FY2010 were for oral health services. Slightly more than half (53%) of respondents to the MaineCare satisfaction survey indicated that they are able to get dental services when needed, a 6% decrease from the previous year.

PHC, the Ryan White Part C program in the Southern Region, reports that it is not able to meet the need for oral health services for its patients. Many Ryan White practitioners across Parts B and C refer clients to the Henry M. Goldman School of Dental Medicine at Boston University to receive appropriate dental care. However, the travel to Boston is a significant barrier to care for clients who are ill and those who do not live in the southernmost part of the state.

A total of 27 respondents to the case management satisfaction survey (11% of respondents to the question) indicated that dental was an outstanding need. Of the needs assessment respondents who indicated they needed a service they didn't have, 54% identified dental care; it was the most frequent response in all regions.

Of the needs assessment respondents who indicated they got help from a case management agency and described the type of help received, 12% wrote in dental assistance.

RMCL, Ryan White Part C grantee for Northern Maine, reports that oral health funds are underutilized. Some of the reasons reported for clients not using the oral health funds are: they forgot to make appointments; they couldn't get to an appointment; or there were delays in accessing care as oral health care providers were scheduling out months in advance for routine appointments, let alone major dental care or oral surgery. RMCL's satisfaction survey showed that 86% of respondents were satisfied with dental care they received in 2011, compared to 92% in 2009. Only 86% of respondents indicated that their case manager was helpful in obtaining dental care, and only 79% indicated that their case manager was timely in arranging dental assistance. RMCL will be conducting additional outreach and education to both medical case managers and clients in the Northern Region to ensure awareness of available resources.

h. Transportation

Outside of Portland, Maine has very little public transportation available. Focus group participants indicated that public transportation and other community-service-based ride sources are becoming more difficult to obtain.

Through MaineCare, private companies and community action programs provide eligible people with HIV/AIDS with transportation to and from medical appointments and other selected services. In addition, MaineCare will reimburse friends or family for transporting a member to a MaineCare-covered service when no other transportation is available. About 1% of MaineCare payments for people living with HIV/AIDS in FY2009 and FY2010 were for medical transportation services. About 74% of respondents to the MaineCare satisfaction survey indicated that they always have transportation for their medical needs, which is a 2% decrease from the previous year.
Of statewide needs assessment respondents who missed a payment or used emergency help in the past year, 36% identified transportation as an area of need.

Of those who indicated they got help from a case management agency and described the type of help received, 32% identified transportation assistance – it was the top response in Northern Maine, third in Central Maine, and fourth in Southern Maine.

Of those who said they needed a service they didn't have, 21% identified transportation – it was the third most frequent response in Northern Maine and fourth most frequent response in Central Maine.

Of those who responded to barriers to service, 29% responded "I have no way to get there" and 15% responded "There are no providers near me."

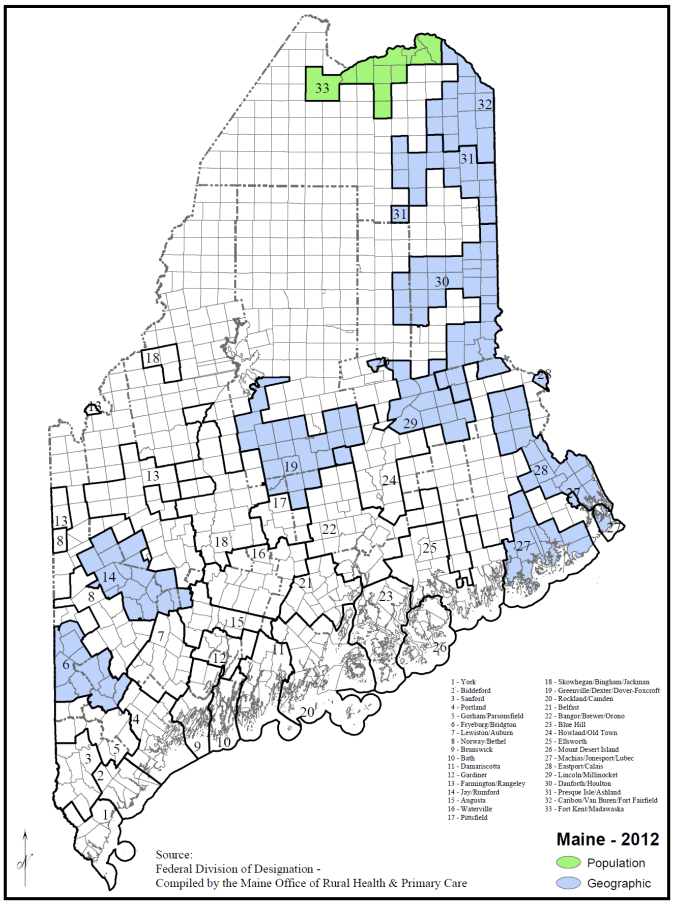
The last question of the needs assessment survey asked, "If you have trouble getting any services, please tell us more about what gets in your way." Only 24% of respondents answered this narrative question. Responses were categorized and aggregated. The most frequently mentioned barrier was transportation, with 35 responses.

i. Mental Health and Substance Abuse Services

Focus group participants observed that there is a lack of services available and a lack of information about services that do exist.

There are federally-designated mental health professional shortages throughout Northern Maine and in parts of the Central Region, as seen in figure 10.

Figure 10: Federally Designated Mental Health Professional Shortage Area, Maine, 2012



Many private mental health professionals do not accept either Medicare or MaineCare, which are the primary insurers of Ryan White clients in the state.

MaineCare has a cap on the number of visits it will reimburse. In FY2009 and FY2010, mental health services accounted for about 2% of MaineCare payments for services delivered to people with HIV/AIDS. About 78% of respondents to the MaineCare satisfaction survey indicated that they are able to get mental health services when needed, which is a 3% decrease from the previous year.

A total of 64% of needs assessment respondents indicated that they talk to someone about their HIV with most identifying family, friends, and partners as the people they talk to. About 20% also talk at support group, 6% indicated they utilize mental health therapy, and 14% identified case managers as the people they talk to.

There were some surprising regional variations. Northern Maine is usually considered to be more isolated, yet 75% of respondents in Northern Maine said they talk to someone about their HIV compared to 65% in Central Maine and only 59% in Southern Maine.

The Ryan White Part C grantees in Northern and Southern Maine have mental health professionals on staff while the Ryan White Part C grantee in Central Maine has some funds designated for mental health assistance.

PHC, the Ryan White Part C program in the Southern Region, reports that it is not able to meet the need for mental health and substance abuse services and further that these are the only services it offers that are waitlisted. RMCL is also seeking to expand its mental health program and increase the number of clients accessing substance abuse services.

MaineCare paid about $55,000 for outpatient substance abuse services delivered to people with HIV/AIDS in FY2009 and FY2010. About 76% of respondents to the MaineCare satisfaction survey indicated that they are able to get substance abuse services when needed, which is a 2% decrease from the previous year.

j. Special Populations

People living with HIV/AIDS in Maine represent a variety of special populations. For example, the following characteristics apply to people accessing Ryan White services in 2011:

- At least 23% report some history of domestic violence.
- At least 9% were veterans of the U.S. military.
- At least 24% have been incarcerated at some time.

i. Adolescents

Maine has the oldest median age of any state in the U.S. Children and adolescents make up about 1.6% of people living with diagnosed HIV/AIDS in the state. According to epidemiological data, there are 4 children younger than age 13 living with HIV/AIDS in Maine, all of whom are enrolled in case management services. However, there are 6 adolescents ages 13 through 19 living with diagnosed HIV/AIDS and only one of these is enrolled in case management. This may indicate a need for increased outreach to the parents/guardians of older children and adolescents with HIV/AIDS.

In addition, Frannie Peabody Center has provided interim case management for HIV-indeterminate infants born to HIV-positive mothers. Once an infant is determined to be HIV-negative, he or she is discharged from services. However, case managers have served as a valuable resource for parents who are positive themselves and managing a complex treatment plan (appointments, medications, etc.), among other barriers to accessing care, as well as for adoptive or foster families, who may be unfamiliar with HIV/AIDS and the importance of medication adherence.

Nearly all of the children living with HIV/AIDS in case management are foreign-born, which can cause certain challenges related to treatment adherence. Cultural needs related to foreign-born people living with HIV/AIDS in Maine are noted below.

ii. IDU

Injection drug users (IDU) represent about 11% of people living with diagnosed HIV/AIDS in Maine and MSM/IDU represent an additional 4%.

There are several factors, usually acting in combination, that influence the level of risk for HIV infection among IDU, such as:

- behavior;
- addiction;
- individual attitudes;
- beliefs and feelings;
- individual mental and emotional health status;
- HIV status;
- social and cultural norms, both from within the IDU population and from the society as a whole;
- and a variety of institutions and systems.

A statewide needs assessment of IDU is currently in the process of being developed and approved. A 2008 needs assessment of IDU in Maine had 54% of respondents reporting that they were not at risk for HIV; however 55% of these individuals reported sharing needles, 50% reported sharing works, and 55% reported using condoms rarely (15%) or never (40%). Nearly half (47%) responded that there were not enough places to get clean needles and 60% asserted that those locations where needles were available were not open when needed.

More than half of respondents to the 2008 survey were concerned about getting HIV, but only a little more than one-third were concerned about getting hepatitis C. About 88% of respondents had been tested for HIV and 80% had been tested for hepatitis C.

Almost one-third of IDU surveyed did not have a regular physician. Of those who reported having a physician, more than half had not told their doctor that they inject drugs. Although nearly 60% of respondents reported an injury from injecting, only 31% saw a doctor or went to the hospital as a result.

Recommendations from Maine's Community Planning Group for HIV Prevention related to IDU include:

- additional education for IDU on harm reduction techniques;
- easier access to treatment programs, including greater ease in obtaining MaineCare and transportation assistance;
- additional needle exchanges and clean needle opportunities despite the fact that neither state nor federal funds may be used to support syringe exchange programs;
- additional training for health care providers in addictions and related topics;
- and education intended to reduce stigma.

iii. Homeless

Maine has a growing homeless population. There are no emergency shelters of any kind in four Maine counties and many shelters have specific eligibility criteria (men only, families only, women fleeing domestic violence situations, etc.). City of Portland shelters have been experiencing record numbers of utilization and operating overflow plans.

Only about 13% of those receiving Ryan White services in 2011 were identified as having an unstable or impermanent housing arrangement at the end of 2011. A total of 74 people living with HIV/AIDS who accessed Ryan White services in Maine in 2011 meet the U.S. Department of Housing & Urban Development's definition of chronic homelessness by being continuously homeless for one year or more or by experiencing four or more episodes of homelessness in a three-year period; 62 of these (84%) were reported to be in stable housing situations at the end of 2011.

iv. Transgender

Transgender individuals identifying as male-to-female account for 0.5% of people accessing Ryan White services in 2011. State epidemiological data do not categorize individuals living with HIV/AIDS in Maine as transgender, nor do Census data categorize members of the general population as transgender. While we recognize that transgender individuals face health disparities and inequities, there are currently no Maine-specific data on this group. Thus, no needs specific to transgender individuals living with HIV/AIDS in Maine have been identified.

v. Racial and ethnic minorities

About 27% of people who accessed Ryan White services in 2011 were identified as a racial or ethnic minority.

There are four Native tribes of Maine in the Northern Region: the Passamaquoddy, Penobscot, Maliseet, and Micmac tribes, which are collectively known as Wabanaki,

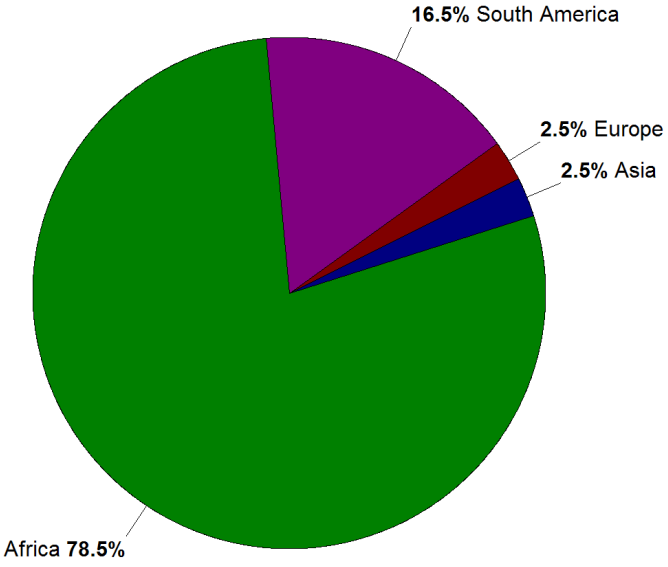
“People of the Dawn.” Each of these four federally-recognized tribes, consisting of five tribal communities, maintains its own government, cultural centers, schools, and manages its respective land and resources. Passamaquoddy, Penobscot, and Maliseets have their own Health Centers, and Micmacs have a service unit through Indian Health Services. Although most of the Native population of Maine belongs to one of these four tribes and resides on tribal lands, there are still many who live in towns and cities across the state. About 12% of people living with diagnosed HIV in Maine identify as Native American, compared to only about 1% of people accessing HIV case management in 2011.

About 5,000 migrant farm and forestry workers are transient residents in the Northern Region each year, a low-income subpopulation which is predominantly Hispanic, Caribbean, and Native American. This population poses particular challenges for HIV prevention and care services.

For several years, Maine has been a major immigrant/refugee resettlement area. The immigrant/refugee population is disproportionately poor, unemployed, and uninsured, and therefore more likely to access Ryan White services. In 2010, ten (17%) of the newly diagnosed cases of HIV in the state were foreign-born.

Almost 10% (79 individuals) of those who accessed HIV case management in 2011 were born in countries other than the U.S. and Canada. The vast majority of these foreign-born individuals (87.3%) now live in the Southern Region of the state; 8.9% live in the Central Region; 3.8% live in the Northern Region. As seen below in figure 11, most (78.5%) of these people were born in African countries.

Figure 11: Continent of Origin, 2011 Case Management Clients Born Outside the U.S. and Canada



Providing services to foreign-born individuals is often complicated by language and cultural barriers. In addition, many of these individuals are trauma survivors who have

come to the U.S. seeking asylum from their home countries. Due to a recent legislative change, many legal noncitizens who would otherwise be eligible for MaineCare coverage may not receive benefits until they have been in the U.S. for five years.

2. Prevention and Service Needs

During focus groups conducted with people living with HIV/AIDS in Maine in 2007, many people reported having a belief that their HIV-positive peers were engaging in unsafe behavior while survey results reported very few people engaging in behaviors that are defined as high risk.

In Maine, the concept of prevention for HIV-positive people is often misunderstood and confusing. Many have said, “I already have HIV. Why do I need to practice prevention?”

Some of the people living with HIV/AIDS who participated in the 2012 focus groups indicated that HIV prevention services in Maine are both inadequate and underfunded.

Currently, the HIV/STD Prevention Program funds comprehensive risk counseling services for people living with HIV/AIDS. Risk-reduction and health education are also incorporated as a contract deliverable in all Ryan White Part B-funded contracts for medical case management.

PHC, the Ryan White Part C Program in Southern Maine, has incorporated the Prevention for Positives curriculum developed by US CDC into its practice. All patients are assessed for risk behavior on an ongoing basis. All patients are offered complete STD screening at initial intake.

The Ryan White Part C grantee in Central Maine, Maine General Medical Center, receives funds for HIV prevention services. Although prevention and care funds are administered through separate programs – HealthReach Harm Reduction and The Horizon Program, respectively – both programs are located in the same space, which significantly reduces barriers in cross-connecting people to services.

The medical providers contracted with the Northern Maine Ryan White Part C Program incorporate prevention for people living with HIV in many ways, including screening for risk behavior with discussion on specifics of behavior and harm reduction, screening for clinical risk factors such as sexually transmitted diseases, screening for pregnancy, identifying and correcting misconceptions, and providing referrals for services such as comprehensive risk counseling services and substance abuse treatment.

The HIV, STD, and Viral Hepatitis Program hosts a conference every two years that offers skill-building and clinical updates. The evening prior to the conference is always reserved for programming specifically for people living with HIV/AIDS, such as panel discussions and question-and-answer sessions with clinicians.

Of those who responded to the statewide needs assessment about services they needed and didn't have, 1% identified HIV prevention services.

3. Gaps in and Barriers to Care

Only 39% of respondents to the needs assessment indicated that there were services they needed but didn't have, with some regional variation (38% in Central Maine, 32% in Northern Maine, 42% in Southern Maine). Those who needed additional services were asked to identify all needed services.

In the Central Region, the top responses were:

1. Dental care
2. Social opportunities
3. Housing/utilities assistance
4. Transportation

In the Northern Region, the top responses were:

1. Dental care
2. Food assistance
3. Transportation
4. Housing/utilities assistance

In the Southern Region, the top responses were:

1. Dental care
2. Food assistance
3. Housing/utilities assistance
4. Work or learning opportunities

Less than one-third of respondents indicated that there were things getting in the way of getting needed services, with some regional variation (28% in Central Maine, 27% in Northern Maine, 30% in Southern Maine). Top reasons included lack of transportation, fear of disclosure/stigma, resistance to asking for help, and lack of knowledge of providers.

Even when funds are available for dental, transportation, and housing, the availability and accessibility of the actual resources may be limited in certain parts of the state. Eye care has also been identified as a need, but the extent of the need is unknown.

Transportation is frequently cited as a barrier to care. Travel distances to access services are often substantial and made worse by poor roads and harsh, long winters. Maine lacks a statewide transportation infrastructure. Reliable transportation services are only available in major cities. In the Northern Region, the only public transportation outside of Bangor is a bus that makes one run among major towns per day and a limited van service for MaineCare patients run by two Community Action Program agencies,

which include long wait times and fear of disclosure by inadequately trained volunteer drivers.

Funds for transportation assistance cannot be used for car repairs.

MaineCare will reimburse friends or family for transporting a member to a MaineCare-covered service only when no other transportation is available, the friend or family member has made arrangements with the transportation agency prior to transport, and the member is actually in the vehicle.

The state of Maine has few dieticians or nutritionists that those with HIV can access, particularly in the Northern Region.
There are unmet needs related to mental health and substance abuse services. The Part C programs in Northern and Southern Maine have both recently sought to expand services in these areas.

Access to certain communities – including foreign-borns, Native Americans, and migrant workers – can be limited due to fear of disclosure, stigma, language barriers, and complex cultural norms.

D. Priorities for the Allocation of Funds

1. Size and Demographics of Populations

The Ryan White Part B Program issued a competitive Request for Proposals in the fall of 2009. A workgroup made up of members of the Ryan White Advisory Committee met and reviewed current epidemiological data as well as current case management data. The workgroup voted to blend these data to develop a funding formula broken down by the state's eight public health districts. Below is the funding formula table:

Table 17: Funds Available, HIV Medical Case Management Request for Proposals, State of Maine, 2010

Region of Residence	Epi Data		CM Data		Federal Funds Available
	N	%	N	%	
District 1 - York (York County)	209	15%	105	17%	$86,869
District 2 - Cumberland (Cumberland County)	495	37%	226	36%	$186,975
District 3- Western Maine (Oxford, Franklin, and Androscoggin counties)	155	11%	76	12%	$67,115
District 4 - Mid Coast (Lincoln, Knox, Waldo, and Sagadahoc counties)	95	7%	26	4%	$19,690
District 5 - Central Maine (Somerset and Kennebec counties)	151	11%	67	11%	$50,739
District 6 - Penquis (Piscataquis and Penobscot counties)	100	7%	61	10%	$51,791
District 7 - Downeast (Hancock and Washington counties)	74	5%	47	7%	$40,186
District 8 - Aroostook (Aroostook County)	36	2%	20	3%	$16,981
Unknown	38	2%	0	-	-
Total	1,353	100%	628	100%	**$520,346**

2. Needs of People Living with HIV/AIDS

In its most recent competitive proposal for Ryan White Part C funding, PHC requested expansion funds to increase the number of hours per week that the psychiatrist works, to contract a substance abuse counselor to work with patients, and to increase the number of hours for provision of direct patient care for one nurse and one nurse practitioner. These requests for additional funding were based on the needs of the clinic, including consideration of wait lists for mental health and substance abuse services.

In light of high satisfaction rates, the Ryan White Part B Program has consistently applied the majority of its base funding to the medical case management core service.

Given resource limitations and continued unmet needs, the Part B Program will be reviewing the allocation of its funding as it prepares for its next competitive Request for Proposals (RFP) process. The HIV Advisory Committee has engaged a consultant to complete an evidence-based HIV/AIDS services study and five-year comprehensive plan. This plan will help complete a data-driven model for needs-based funding.

E. Evaluation of 2009 Plan

Tables 18 and 19 below review the objectives and activities outlined in the 2009 plan for two primary goals – 1. Provide and Support Quality Treatment and Care and 2. Provide and Support Focused Outreach and Education. An assessment of successes and challenges associated with each activity is presented in each table.

Table 18: Evaluation of 2009 Plan Goal: Provide and Support Quality Treatment and Care

Objective	Activities	Successes	Challenges
Objective 1: Continue to provide funded HIV case management services delivered through contract agreements with Maine's community-based agencies	1.1 Provide individualized assessment and care planning, for client progress toward individualized goals	The percentages of clients with annual assessments and quarterly care plans increased steadily during each of the last three years. In FY2011, 99% of active clients were assessed.	Quarterly care plan completion has remained a challenge for about half of subgrantees, resulting in about 86% of active clients statewide having quarterly care plans during FY2011 (compared to a goal of 90%).
	1.2 Provide referrals to core medical and support services	A high percentage of sampled charts (97-100%) documented all referrals appropriately.	
	1.3 Provide advocacy to facilitate client access to core services	A high percentage of sampled charts (92-97%) documented advocacy.	
	1.4 Provide support and education for clients to increase skills for HIV prevention	Nearly all case management clients (92-98%) received at least one prevention service per year during each of the last three years.	

Objective	Activities	Successes	Challenges
Objective 2: Provide targeted financial assistance to meet unmet core service client needs	2.1 Provide financial assistance for oral health services, mental health services, substance abuse services, and medical care and related transportation and support service costs.	Services were appropriately entered in CAREWare for the first fiscal year. During FY10, the Part B Program discontinued use of Part B funds for financial assistance to comply with funded grant categories. Part C financial assistance services continue to be appropriately documented in CAREWare. Needs assessment data show that clients access financial assistance and continue to have needs that exceed the funds available.	Limited availability of financial assistance has led to unmet needs for some clients.
	2.2 Part B and Part C Programs will collaborate to maximize funding and client access to core services	Parts B and C share information at the monthly Ryan White Advisory Committee meetings and through other ad hoc meetings. Representatives of the HIV Advisory Committee are overseeing the completion of an Evidence-Based HIV/AIDS Services Study and Comprehensive Plan.	
Objective 3: Ensure ADAP is the payer of last resort	3.1 Screen ADAP enrollees for ADAP eligibility and for Medicaid eligibility two or more times a year	ADAP clients are recertified twice per year, including insurance eligibility and screening.	
Objective 4: Provide screening and referrals for all Ryan White Part B case managed clients to Substance Abuse services	4.1 Part B Case Management Providers will screen clients for the need for substance abuse services	Substance abuse screenings are part of the comprehensive assessment. All clients who are assessed annually are also assessed for substance abuse services.	

Objective	Activities	Successes	Challenges
	4.2 All clients identified with need for SA services shall be referred to SA services	A high percentage of sampled charts (97-100%) documented all referrals appropriately.	
Objective 5: Facilitate stakeholder involvement in design and implementation of QM program	5.1 Facilitate quality assurance committee process	The Quality Management Task Force met regularly in FY09 and was folded into the standing Ryan White Advisory Committee in FY10. There was one ad hoc meeting of this committee in FY11, otherwise QM is a standing item on the agenda for monthly Ryan White Advisory Committee meetings.	
	5.2 Facilitate stakeholder, consumer, and advisory committee collaborative process	Ryan White Advisory Committee meetings are held monthly. Part B subgrantees are contractually required to attend these meetings and facilitate the participation of at least one client.	
Objective 6: Establish standard case manager training requirements	6.1 Develop written profile of case manager training needs	The Part B Program maintains a spreadsheet of all trainings offered to providers and solicits information on training needs in quarterly reports. Agencies document trainings and competency assessments in personnel files (which are reviewed during site visits).	
	6.2 Research, develop, and implement standard training content and formats for case managers	The Part B Program delivered 44.25 hours of training in FY09, 27 hours of training in FY10, and 19.75 hours of training in FY11 for case managers and agency directors. A standardized curriculum has been developed and utilized for new personnel.	

Table 19: Evaluation of 2009 Plan Goal: Provide and Support Focused Outreach and Education

Objective	Activities	Successes	Challenges
Objective 1: Maintain outreach and education to agencies, providers, and potential clients of the ADAP	1.1 Provide educational sessions to agencies, providers, and potential clients of the ADAP	ADAP Coordinator and Medicaid staff provided on-site trainings to case managers and clients.	
Objective 2: Develop outreach efforts to reach PLWHA who are Out of Care	2.1 Maine CDC will provide partner agencies and stakeholders with data regarding Out of Care populations within agency catchment areas.	The "Ask for the Test" campaign reached 500+. AETC conducted outreach to 240+ regarding out of care populations.	We need to continue to work with clients to ensure that they maintain their access to care once established with a medical provider. Our unmet need data indicate that about 29% of those who were considered in care at some point in the last five years were not in care in 2011. There is also a 7% gap between those newly diagnosed who are accessing care (i.e. Ryan White services) and those who are in care. New medical case management clients have consistently indicated some difficulty in finding services over the past three years.
	2.2 ASOs will design and implement outreach activities specific to local community needs to bring PLWHA Out of Care populations into case management services	Subgrantees implemented local outreach activities including advertisements, developing relationships with CTR programs, and contacting former clients who were discharged due to inactivity. In addition, outreach to community providers who serve Out of Care populations, such as homeless shelters and primary and specialty health care providers was conducted.	
Objective 3: Provide education to medical providers serving people living with HIV/AIDS	3.1 Facilitate stakeholder process for offering educational sessions to medical providers serving people living with HIV	AETC trained more than 400 per fiscal year.	
Objective 4: Develop outreach and education plan to reach Refugee and Migrant communities	4.1 Create education plan about HIV care services in Maine	AETC provided outreach to about 100 people each fiscal year.	
	4.2 Outreach to agencies currently serving refugee and migrant communities to educate about available HIV care services	AETC provided outreach to about 100 people each fiscal year.	

Objective	Activities	Successes	Challenges
Objective 5: Support increase in HIV testing to help unknown HIV+ people access care	5.1 Case managers will refer all partners of case management clients to HIV testing services	Prevention-related counseling is conducted as part of the comprehensive assessment each year. Case managers encourage clients with HIV-negative partners to get tested regularly; safer sex practices are also discussed. Case management agencies are contractually required to have a policy about how to handle situations with clients who are having unprotected sex without disclosing their status.	
Objective 6: Develop outreach and education plan for Maine's correctional system	6.1 Provide education for medical staff in correctional settings	AETC trained 26 in FY09, 15 in FY10, and 10 in FY11.	
	6.2 Provide HIV/AIDS education for correctional facility staff	AETC trained 26 in FY09, 15 in FY10, and 10 in FY11.	

II. Where do we need to go?

A. 2012 Proposed Goals

1. Meeting Challenges from the 2009 Plan

Quarterly care plan completion has remained a challenge for about half of subgrantees, resulting in about 86% of active clients statewide having quarterly care plans during FY2011 (compared to a goal of 90%). Beginning in FY2012, the Ryan White Part B Program requires medical case managers to complete care plans semiannually, in line with HRSA standards.

Limited availability of financial assistance has led to unmet needs for some clients. Given the variety of outstanding needs described in the Statewide Coordinated Statement of Need, the Ryan White Part B Program will be reviewing the allocation of its funding as it prepares for its next competitive Request for Proposals (RFP) process (see 2d below).

The only significant challenges from the 2009 plan relate to unmet need (see 3 below).

2. Care Goals

a. Medical case management services increase access to and retention in medical care

The Ryan White Part B Program will continue to subcontract medical case management services to community-based organizations. Dependent on the overall funding picture for services – particularly related to MaineCare – services may need to be more narrowly defined, eligibility criteria may need to be restricted, and time limits may be imposed.

The Statewide Coordinated Statement of Need illustrates a need to more clearly define the medical case management service with specific parameters and deliverables related to treatment adherence and retention in care.

This more focused service will need to be defined in provider contracts, which may be required to go out for competitive RFP.

b. Medical case management services will support greater independence

Contract deliverables will be established to monitor clients' acuity over time as a means of demonstrating that medical case managers are helping clients move toward a state of independence.

c. Primary care providers' competency will be increased

To ensure adequate treatment, improve retention in care, and provide for better overall health outcomes, the MEAETC will develop a webinar for primary care providers to help build competencies in treating people living with HIV/AIDS, testing people of unknown status, and linking clients to Ryan White services as appropriate.

d. Limited funds will be utilized efficiently to meet clients' needs

To ensure clients are aware of and have access to needed services, RMCL and its subgrantees will conduct outreach related to available oral health services in Northern Maine.

The Ryan White Part B Program will review its current funding allocation process to determine a more needs-based focus that will allow for more targeted distribution of funds.

3. Unmet Need Goals

Unmet need data for 2011 as well as the past five years indicate several gaps:

In care data are derived from CD4 and Viral Load test results reported to the state HIV/STD Surveillance Coordinator and records of clients receiving prescriptions through the ADAP.

The percentage of clients in care is much greater than the individual percentages of clients with CD4 or Viral Load records, indicating that lab data are incomplete or that physicians are prescribing medications for people with HIV without current lab work.

HIV medical case managers report a higher percentage of their clients being in care than surveillance data show. This could indicate that HIV medical case managers are not getting accurate information from their clients, or that surveillance data are incomplete.

a. Unmet need data will be complete and accurate

The Ryan White Part B Program and the HIV/STD Surveillance Coordinator will engage in more frequent data cross-matching to ensure adequate follow up on data completeness. The Ryan White Part B Program and the HIV/STD Surveillance Coordinator have developed a plan for data cross-matching to identify Part B clients whose records indicate a gap in care. Medical case managers will be utilized to confirm clients' care status to ensure continuity of care as well as complete and accurate data reporting.

The MEAETC will assure that health care providers are educated about current best practices for HIV care and treatment as well as Maine's Rules for the Control of Notifiable Diseases and Conditions.

b. Retention in care will be improved

In comparing unmet need data for the past five years with unmet need data for 2011 only, it is clear that retention in care is a concern. The state's Ryan White grantees, subgrantees, and other programs within the HIV, STD, and Viral Hepatitis Program will work together to improve the rate of people living with HIV/AIDS in Maine who are in care and ensure that that rate continues to increase.

4. Early Identification of Individuals with HIV/AIDS (EIIHA) Goals

a. High risk people are tested for HIV using rapid tests

Rapid testing allows for immediate feedback to let the client know if he or she should have a follow-up confirmatory test. Rapid tests are also easily conducted in outreach settings, reducing barriers to testing. This goal supports the National HIV/AIDS Strategy in that it focuses HIV prevention efforts in the communities where HIV is most heavily concentrated by targeting those individuals at highest risk for HIV infection.

b. Reactive rapid tests are confirmed using serum testing or OraSure testing

All publicly-funded HIV test sites have the capacity to offer follow-up confirmatory testing at the time of delivering the rapid test result. This makes it much more likely that the tested person will have a follow-up test. This seamless access to confirmatory testing reduces barriers for receiving confirmation of HIV infection. This goal supports the National HIV/AIDS Strategy by helping to reduce the number of new HIV infections since studies have shown that once a person learns his or her status, the individual is more likely to take steps to prevent the transmission to others.

c. Clients who receive a confirmatory test are given their results

Over the last 10 years, 100% of all individuals with an HIV positive test have received their test results. This goal supports the National HIV/AIDS Strategy by helping to reduce the number of new HIV infections since studies have shown that once a person learns his or her status, the individual is more likely to take steps to prevent the transmission to others.

d. Newly diagnosed positive people are referred to Partner Services and care services, including case management and medical care

Last year, 100% of newly diagnosed individuals were offered case management and partner notification services. These additional services help to ensure the newly positive person understands what his/her status means for both short- and long-term health and psychosocial considerations. This goal supports the National HIV/AIDS Strategy through the establishment and support of a seamless system to immediately link people to continuous and coordinated quality care when they learn they are infected with HIV.

B. Proposed Solutions for Closing Gaps and Overlaps in Care

1. Unmet Need

As described previously, it is unclear at this time if gaps in unmet need data reflect gaps in data collection, care, or both. Any identified gaps in care as a result of monitoring the Unmet Need Goals identified in II(A)(3)(a) will be addressed by conducting outreach and education with prescribing physicians to ensure their familiarity with the Rules for the Control of Notifiable Diseases and Conditions as well as best practices related to the frequency of labs for their clients. As needed, outreach will be conducted to laboratories to ensure their familiarity and compliance with the Rules for the Control of Notifiable Diseases and Conditions.

2. Outstanding Care Needs

The Statewide Coordinated Statement of Need identifies gaps mainly related to dental care, transportation, food, and housing/utilities assistance. Reallocating some of the Ryan White Part B base award into other core service categories and medical transportation may help to alleviate some of these unmet needs.

RMCL is addressing the lack of appropriately skilled nutritionists who are comfortable working with people living with HIV through telemedicine.

There are unmet needs related to mental health and substance abuse services. The Part C programs in Northern and Southern Maine have both recently sought to expand services in these areas in order to meet these needs.

In May 2012, the MEAETC and the Virology Treatment Center in Portland co-hosted a day-long seminar, “Minority Health: HIV/AIDS Care in the New Millennium; Taking Patients from Trauma to Treatment,” which focused on providing quality care to foreign-born people living with HIV/AIDS. This seminar featured speakers from Maine Medical Center’s international clinic, a medical interpreter, and a counselor for refugees/asylees who are torture victims. Additional learning opportunities such as these would allow providers to network and gain additional cultural competencies for serving this population.

Subgrantee Wabanaki Mental Health Services provides outreach and recruitment for HIV testing at Native American gatherings, health fairs, and migrant worker camps. Wabanaki Mental Health Services and the Maine Migrant Health Association provide outreach and testing to migrant workers. Continuing these activities despite cuts to federal HIV prevention dollars is imperative, as they lead to connecting people to care.

C. Proposed Coordinating Efforts

There are currently two standing statewide committees for HIV care services: The HIV Advisory Committee and the Ryan White Advisory Committee. In addition, the Ryan White Part B Program is now working with the HIV/STD Prevention Program to attempt to combine advisory committees for HIV prevention and care services and create a more distinct structure in order to make the committee more effective in terms of planning and accountability.

Continuing these coordinating efforts will help to ensure optimal access to care by giving members of different sectors of the continuum of care a monthly opportunity to discuss current activities and priorities, emerging needs, collaboration, and coordination of services.

III. How will we get there?

A. Strategies, Plans, and Activities

1. Closing Gaps in Care

The Statewide Coordinated Statement of Need has set a foundation of understanding about the unmet needs for people living with HIV/AIDS in Maine. Reallocating some of the Ryan White Part B base award into other core service categories and medical transportation may help alleviate some of these unmet needs. Further data are needed to guide a new funding formula to ensure that limited resources are allocated where they are most needed and can do the most good.

The Maine HIV Advisory Committee has engaged a consultant to complete an evidence-based HIV/AIDS services study and comprehensive plan. This plan will help complete a data-driven model for needs-based funding. The initial phase of this project is already complete and the second phase, which will include the delivery of a five-year plan for services, will be concluded on or before October 2012.

To meet unmet nutritional needs in Northern Maine, RMCL will utilize its established telemedicine system. RMCL has already reallocated some of its funding to increase mental health and substance abuse services.

PHC has sought increased funding to expand mental health and substance abuse services to meet needs.

2. Unmet Needs

As described previously, it is unclear at this time if gaps in unmet need data reflect gaps in data collection, care, or both.

The HIV/STD Surveillance Coordinator will review named unmet need data and identify clients who access Ryan White services but whose labs are not currently being reported to the state.

Any Ryan White Part C clients whose labs are not being reported will be noted so that the lab can be educated about Maine's Rules for the Control of Notifiable Conditions. Medical case managers will receive lists from the Ryan White Part B Program of their clients whose labs are not being reported to the HIV, STD, and Viral Hepatitis Program. Medical case managers will then follow up to determine if clients are either not receiving

labs as often as medically indicated or if labs are not reporting the result to the State in accordance with the Rules for the Control of Notifiable Conditions.

The MEAETC will complete any needed outreach and education with health care providers who are not following the Public Health Service Guidelines related to the frequency of labs.

Any laboratories that are not in compliance with the Rules for the Control of Notifiable Conditions will be contacted by the HIV, STD, and Viral Hepatitis Program to ensure their compliance going forward.

These activities will take place in FY2012 with unmet need data cross-matching occurring every six months.

3. EIIHA

The Maine HIV, STD, and Viral Hepatitis Program and RMCL will continue to improve their efforts to identify newly infected persons through integrated programming with contracted providers, a collaborative approach to Partner Services between the HIV Prevention Program, the STD Program, and the HIV Surveillance Program, and through targeted HIV testing.

Maine has a low incidence of HIV, averaging between 50 and 60 new diagnoses each year. HIV is a priority for Maine's Disease Intervention Specialists. Through the hard work of Maine's HIV prevention and medical providers, Maine has a high success rate in delivering positive.

HIV Prevention providers all possess the capacity to provide immediate confirmatory testing after a preliminary positive presents itself. HIV prevention providers work to engage those who decline confirmatory testing at the time in another prevention activity - primarily educational groups or a modified version of comprehensive risk counseling services - to keep patients in the prevention service continuum with the hopes of eventually having the patient agree to a confirmatory test.

Maine law requires all positive HIV test results be reported to Maine CDC. Upon report of a positive result, cases are immediately assigned to a disease intervention specialist (DIS) for follow up. If the provider administering the test is unable to locate the patient for the purposes of giving the patient his or her test results, the DIS are trained to locate and notify the patient per US CDC training and guidance.

The HIV Prevention Program promotes and encourages routine HIV testing and works with medical providers and the general public to understand the importance of routine HIV testing. Maine's HIV testing laws were changed in 2007 to reflect the recommendations from US CDC released in September 2006 related to universal testing. Due to the relative risk level of these individuals, HIV Prevention resources

cannot be directed to target education to this group as resources must target high-risk individuals.

Maine intends to continue to offer anonymous HIV testing through publicly-funded HIV testing sites. The HIV, STD, and Viral Hepatitis Program and RMCL – as the grantees for HIV prevention services in the state -- plan to continue to support the education and promotion of routine HIV testing as a standard part of medical care. Maine CDC, RMCL, the MEAETC, in conjunction with the Maine HIV Advisory Committee and the Maine Medical Association, continue to educate providers and patients on the importance of routine HIV testing.

Essential activities include maintaining online outreach to men who have unsafe sex with men (MSM) through sites commonly used to solicit sex, maintaining the www.deservetoknowme.org website as a tool to educate MSM who may or may not identify as such. Outreach directs them to HIV testing sites, maintaining and recruiting for MSM-specific educational groups throughout Maine, and maintaining the Code Red public service announcement tools all for the purposes of outreach and recruitment.

There is little the HIV Prevention Program or RMCL can do to support the financial health of Maine's syringe exchange programs as neither state nor federal funds can be used to support syringe exchange programs. The HIV Prevention Program will continue to foster relationships with partners who provide services to injection drug users (IDU) to maintain outreach and testing activities for this population. Essential activities include maintaining Maine's five needle exchange programs, maintaining relationships with the Department of Corrections and local correctional facilities, and maintaining relationships with substance abuse treatment facilities to provide testing to known IDU.

Essential activities for females at high risk of HIV infection include maintaining relationships with Maine's family planning programs, STD clinics, colleges and universities, and domestic violence/sexual assault programs all for the purposes of outreach and recruitment.

The services required by this strategy are provided by the HIV, STD, and Viral Hepatitis Program, RMCL, and their subgrantees.

These activities are already and will continue to be ongoing, routine activities.

4. Special Populations

a. Adolescents

Five of the six adolescents ages 13 through 19 living with diagnosed HIV/AIDS are not currently enrolled in case management. Medical case management providers will document the provision of outreach to community agencies and children's services

providers in an effort to assure that parents/guardians of older children and adolescents with HIV/AIDS are aware of available services.

Outreach efforts will be documented in quarterly reports. The HIV, STD, and Viral Hepatitis Program will continue to monitor service utilization data compared to epidemiological data for adequate coverage.

b. IDU

A statewide needs assessment of IDU is currently in the process of being developed and approved. The HIV, STD, and Viral Hepatitis Program will have final results and recommendations by FY2013.

Subgrantees will continue to provide outreach, testing, and medical case management services to IDU living with HIV/AIDS in Maine, including harm reduction education.

There is little the HIV Prevention Program or RMCL can do to support the financial health of Maine's syringe exchange programs as neither state nor federal funds can be used to support syringe exchange programs. The HIV Prevention Program will continue to foster relationships with partners who provide services to IDU to maintain outreach and testing activities for this population. Essential activities include maintaining Maine's five needle exchange programs, maintaining relationships with the Department of Corrections and local correctional facilities, and maintaining relationships with substance abuse treatment facilities to provide testing to known IDU.

To ensure adequate treatment, improve retention in care, and provide for better overall health outcomes, the MEAETC will develop a webinar for primary care providers to help build competencies in treating people living with HIV/AIDS, testing people of unknown status, and linking clients to Ryan White services as appropriate. In addition, the AETC will continue to provide training for health care providers that includes topics such as harm reduction and general education about IDU to reduce stigma.

c. Homeless

Only about 13% of those receiving Ryan White services in 2011 were identified as having an unstable or impermanent housing arrangement at the end of 2011. Housing stability screening will continue to be a part of the annual comprehensive assessment for medical case management, given the impact of housing stability on health outcomes. Ryan White Part B and C programs will continue to support the HOPWA program in the state and ensure cross-training for medical case managers related to housing assistance options for people living with HIV/AIDS. Training opportunities will be offered at least once per year.

d. Transgender

Transgender individuals identifying as male-to-female account for 0.5% of people accessing Ryan White services in 2011. State epidemiological data do not categorize individuals living with HIV/AIDS in Maine as transgender, nor do Census data categorize members of the general population as transgender. While we recognize that transgender individuals face health disparities and inequities, there are currently no Maine-specific data on this group. Thus, no needs specific to transgender individuals living with HIV/AIDS in Maine have been identified.

e. Racial and ethnic minorities

Cultural competency training is part of the standard curriculum provided by the Ryan White Part B Program for all medical case managers.

In May 2012, the MEAETC and the Virology Treatment Center in Portland co-hosted a day-long seminar, “Minority Health: HIV/AIDS Care in the New Millennium; Taking Patients from Trauma to Treatment,” which focused on providing quality care to foreign-born people living with HIV/AIDS. This seminar featured speakers from Maine Medical Center’s international clinic, a medical interpreter, and a counselor for refugees/asylees who are torture victims. Materials from this training will be incorporated into the standard training curriculum.

The MEAETC shall offer at least one similar training by FY2015.

Subgrantee Wabanaki Mental Health Services will continue to provide outreach and recruitment for HIV testing at Native American gatherings, health fairs, and migrant worker camps. Wabanaki Mental Health Services and the Maine Migrant Health Association will continue to provide outreach and testing to migrant workers.

Table 20: Summary of planned activities, responsible parties, and performance measures, FY2012-2015

Goal	Activities	Responsible Party	Indicators	Data Collected	Target
HIV medical case management services are delivered to clients who are eligible	Medical case management	Medical case managers	Active clients' eligibility is determined every six months, including verification of HIV status, verification of household income, and verification of insurance	Required standard forms are complete, according to record reviews	90% of client records audited during the contract year are complete
				Documentation of HIV status is present in records, according to record reviews	
				Income for legal household is verified and documented every six months, according to record reviews and CAREWare	100% of active clients have an income date less than 1 year old entered in CAREWare
				Insurance status is documented and entered in CAREWare	90% of active clients have a completed semi-annual certification every six months, which is documented in CAREWare, during the year
				Semi-annual review service logged in CAREWare every six months for each active client	
HIV medical case management services are client-centered	Medical case management	Medical case managers	Active clients are assessed annually to determine needs and goals for the year	Required standard forms are complete, according to record reviews	90% of client records audited during the contract year are complete
				Assessment service logged in CAREWare during the reporting year for each active client	90% of active clients have a completed assessment, which is documented in CAREWare, during the year
			Active clients are assessed every six months to determine short-term needs and goal achievement	Required standard forms are complete, according to record reviews	90% of client records audited during the contract year are complete
				Care Plan service logged in CAREWare every six months for active clients	90% of active clients have completed semi-annual care plans, which are documented in CAREWare, during the year

Goal	Activities	Responsible Party	Indicators	Data Collected	Target
Retention in care will be improved	The state's Ryan White grantees, subgrantees, and other programs within the HIV, STD, and Viral Hepatitis Program will work together to improve the rate of people living with HIV/AIDS in Maine who are in care and ensure that that rate continues to increase.	Medical case managers	Case managers screen clients' care status every six months	Care status screening is completed on required standard Semi-Annual Certification, according to record reviews	90% of client records audited during the contract year are complete
			Clients are linked with insurance and/or medical care	Insurance and medical care information collected at Intake is entered in CAREWare	100% of clients have insurance and medical care documented in CAREWare
				Percentage of clients reporting no insurance and/or medical care	95% of clients report having both insurance and medical care
				Percentage of clients who reported no insurance and/or medical care during the prior reporting year who are now linked with medical care and/or insurance	90% of active clients who reported no insurance and/or medical care during the prior reporting year report coverage during this reporting year
			Medical case management supports access to and retention in medical care and ensures readiness for, and adherence to, complex HIV/AIDS treatments.	Case notes describe how each contact supports treatment adherence	90% of client records audited during the contract year are complete
		Positive Health Care, Horizon Program	Patient retention rates increase from previous year	Patient enrollment status and dates, service data	Baseline data will be collected in FY2012; patient retention will increase by at least 2% in each subsequent year of the plan
HIV medical case management clients are connected to services they need	Medical case management	Medical case managers	Referrals are made for services that are not provided directly by case managers/the Provider	Referrals and follow up on them are documented in client files	90% of client records audited during the contract year are complete
				Case managers receive training in core competency areas to ensure knowledge of referral resources	20 hours per year of training in core competency areas is documented in personnel files for all case managers

Goal	Activities	Responsible Party	Indicators	Data Collected	Target
			Clients achieve at least 4 short-term goals per year	Achievement of short-term goals is documented on care plan forms	90% of client records audited during the contract year are complete
HIV medical case management clients are satisfied with services	Medical case management	Medical case managers	Clients indicate level of service satisfaction on annual surveys	Percentage of clients indicating "Strongly Agree" or "Agree" to "I would recommend this program to others"	Rate of satisfaction is at least 90% and not more than 2% less than previous rating
HIV medical case management clients receive information to help reduce the risk of spreading HIV to others	Medical case management	Medical case managers	Case managers provide information on HIV prevention and/or risk reduction at least once per year	Prevention services documented in client record at least once per year for active clients	90% of client records audited during the contract year are complete
Limited funds will be utilized efficiently to meet clients' needs	Development of new funding formula	Ryan White Part B and Ryan White Part C grantees	Funding for Ryan White services aligns with needs assessment data	Needs assessments, satisfaction surveys, focus groups	Needs-based funding formula developed for FY14 contracts
	RMCL and its subgrantees will conduct outreach related to available oral health services in Northern Maine.	Regional Medical Center at Lubec	Increased utilization and satisfaction rates	Service utilization, funds expended, client satisfaction	Funds for oral health care are fully expended; satisfaction rates in this area increase from prior year
	RMCL will utilize new strategies, such as telemedicine, to provide nutritional services	Regional Medical Center at Lubec	Increased utilization and satisfaction rates	Service utilization, funds expended, client satisfaction	Funds for nutritional services are fully expended; satisfaction rates in this area increase from prior year
HIV medical case management supports clients' independence	Medical case management	Medical case managers	Client acuity decreases over time	Acuity scores at annual assessment	75% of active clients experience a minimum of an 8-point decrease in acuity from FY11 to FY12
Primary care providers' competency is increased	AETC will develop a webinar for primary care providers to help build competencies in treating people living with HIV/AIDS, testing people of unknown status, and linking clients to Ryan White services as appropriate.	Maine AETC	KABS surveys conducted by AETC indicate that providers have increased competency	KABS surveys conducted after trainings	80% of participants will report increased competency

Goal	Activities	Responsible Party	Indicators	Data Collected	Target
Unmet need data will be complete and accurate	The HIV/STD Surveillance Coordinator will review named unmet need data and identify clients who access Ryan White services but whose labs are not currently being reported to the state.	HIV/STD Surveillance Coordinator	Data from two sources (case manager report and surveillance data) are more closely aligned	All CD4 and Viral Load tests are reported to HIV/STD Surveillance Coordinator	Care status data collected in CAREWare show in care percentages that are within 5% of in care percentages derived from surveillance data
	Any Ryan White Part C clients whose labs are not being reported will be noted so that the lab can be educated about reporting. Medical case managers will receive lists from the Ryan White Part B Program of their clients whose labs are not being reported; case managers will follow up to determine if clients are either not receiving labs as often as medically indicated or if labs are not reporting.	Ryan White Part B and Ryan White Part C grantees		Medical Case Managers screen clients' care status semiannually and log in CAREWare	
	The AIDS Education and Training Center will complete any needed outreach and education with health care providers who are not following the Public Health Service Guidelines related to the frequency of labs.	Maine AETC		AETC maintains records of all trainings provideded	
	Any laboratories that are not in compliance with the Rules for the Control of Notifiable Conditions will be contacted to ensure their compliance.	HIV/STD Surveillance Coordinator			
High risk people are tested for HIV using rapid tests	Continue to offer anonymous HIV testing through publicly-funded HIV testing sites.	HIV test sites	Data show high-risk individuals being tested in community and medical settings	Standard test data variables	

Goal	Activities	Responsible Party	Indicators	Data Collected	Target
	Continue to educate providers and patients on the importance of routine HIV testing.	Maine CDC, RMCL, the Maine AIDS Education and Training Center, in conjunction with the Maine HIV Advisory Committee and the Maine Medical Association	Training materials and announcements	Training and education records	A minimum of one training per year is presented that discusses the importance of routine HIV testing
Reactive rapid tests are confirmed using serum testing or OraSure testing	Continue to offer anonymous HIV testing through publicly-funded HIV testing sites.	HIV test sites	Data show that preliminary positive results are confirmed	Standard test data variables	100% of those with a preliminary positive result are given a confirmatory test
Clients who receive a confirmatory test are given their results	Continue to offer anonymous HIV testing through publicly-funded HIV testing sites.	HIV test sites	Data show that people testing positive are given their results	Result reporting data	100% of those testing positive are given their test results
Newly diagnosed positive people are referred to Partner Services and care services, including case management and medical care	Test sites offer referrals to new positives, including DIS, medical case management, and medical care	HIV test sites, DIS, medical case managers	During unmet need data analysis, surveillance data linked with care data show that newly diagnosed people are in care	Standard surveillance data, unmet need data (including lab results and care data)	In care rate for those newly diagnosed during semiannual unmet need data analysis will be at least 90% and not more than 2% less than previous rating
Adolescents with HIV receive appropriate care and services	Outreach to community agencies and children's services providers in an effort to assure that parents/guardians of older children and adolescents with HIV/AIDS are aware of available services	Medical case management providers	Other providers are aware of available services for adolescents with HIV	Outreach records	Quarterly, medical case management agencies document outreach to other social services provider to ensure awareness of services
IDU with HIV receive appropriate care and services	AETC will develop a webinar for providers to help build competencies in treating people living with HIV/AIDS, testing people of unknown status, and linking clients to Ryan White services as appropriate. Training will include topics such as harm reduction and general education about IDU to reduce stigma.	Maine AETC	KABS surveys conducted by AETC indicate that providers have increased competency	KABS surveys conducted after trainings	80% of participants will report increased competency

Goal	Activities	Responsible Party	Indicators	Data Collected	Target
Homeless people with HIV receive appropriate care and services	Clients are screened for housing stability and linked to services when possible	Medical case managers	Active clients are assessed annually to determine needs and goals for the year	Required standard forms are complete, according to record reviews	90% of client records audited during the contract year are complete
				Assessment service logged in CAREWare during the reporting year for each active client	90% of active clients have a completed assessment, which is documented in CAREWare, during the year
	Training opportunities related to housing services are offered	Maine HIV, STD, and Viral Hepatitis Program	Training materials and announcements	Training and education records	A minimum of one training per year is presented that discusses housing options for people living with HIV/AIDS in Maine
Racial and ethnic minorities with HIV, particularly those who are foreign-born, receive culturally competent services	Standard case manager training includes cultural competency information	Maine HIV, STD, and Viral Hepatitis Program	New medical case managers are trained	Training and education records	100% of new medical case managers are trained within 6 months of hire
	Maine AETC will present a training which focuses on providing quality care to foreign-born people living with HIV/AIDS	Maine AETC	KABS surveys conducted by AETC indicate that providers have increased competency	KABS surveys conducted after trainings	80% of participants will report increased competency

B. Ensuring Optimal Access to Care

There are currently two standing statewide committees for HIV care services: The HIV Advisory Committee and the Ryan White Advisory Committee.

Under 5 MRSA §19202, the HIV Advisory Committee is mandated to:

- Advise the Office of the Governor and state, federal and private sector agencies, officials and committees on HIV-related and AIDS-related policy, planning, budget or rules;
- Make an annual assessment of emerging HIV-related issues and trends;
- Initiate and respond to legislation, both state and federal; and
- Prepare and present, in person, an annual report on the status of HIV in the State to the Office of the Governor and the joint standing committee of the Legislature having jurisdiction over health and human services matters by January 31st of each year.

The HIV Advisory Committee consists of 19 members:

- Two members of the Legislature, one Senator nominated by the President of the Senate and one Representative nominated by the Speaker of the House of Representatives;
- The director of the HIV, STD and viral hepatitis program within the Department of Health and Human Services, Maine Center for Disease Control and Prevention;
- A representative of the Department of Education, nominated by the Commissioner of Education;
- A representative of the Department of Corrections, nominated by the Commissioner of Corrections;
- A representative of the Department of Health and Human Services, Office of Substance Abuse, nominated by the Commissioner of Health and Human Services; and
- A representative of the Department of Health and Human Services, Office of MaineCare Services, nominated by the Commissioner of Health and Human Services.

Currently, the Ryan White Advisory Committee is open to all Ryan White grantees in the state. Ryan White Part B subgrantees are contractually required to attend meetings and to provide for at least one client's attendance at meetings. Others regularly attend, including staff from the HIV/STD Prevention Program, staff from the Office of MaineCare Services, and local medical providers. Coincidentally, one of the Ryan White Part B subgrantees is also the state's only HOPWA grantee. The Ryan White Part B Program convenes these meetings.

The Ryan White Part B Program is now working with the HIV/STD Prevention Program to attempt to combine advisory committees for HIV prevention and care services and create a more distinct structure in order to make the committee more effective in terms of planning and accountability. These coordinating efforts help to ensure optimal access

to care by giving members of different sectors of the continuum of care a monthly opportunity to discuss current activities and priorities, emerging needs, collaboration, and coordination of services.

C. Addressing National Initiatives

1. Healthy People 2020

The 2011 amendment to 5 MRSA §19203-A, which requires health care providers to include an HIV test in the standard tests for all pregnant women, subject to the woman's consent, specifically addresses objective 8 – reduce the number of perinatally acquired HIV and AIDS cases.

That same state statute was amended in 2007 to allow for oral or written consent for an HIV test, to reduce barriers to routine testing in hopes of meeting objective 9 – increase the proportion of new HIV infections diagnosed before progression to AIDS. Not enough data are available to confirm a trend, but recent surveillance data show a decrease of people newly diagnosed with HIV in Maine receiving a concurrent AIDS diagnosis or progressing to AIDS within one year.

The MEAETC primarily works to increase awareness of best practices and treatment standards for people living with HIV/AIDS. Medical case managers and health care providers are working to support retention in care. Both of these tactics support of objective 10 – increase the proportion of HIV-infected adolescents and adults who receive HIV care and treatment consistent with current standards.

All of these activities support objective 12 – reduce deaths from HIV infection.

In addition, the full continuum of care in Maine supports all eighteen HIV-related Healthy People 2020 objectives.

2. Affordable Care Act

About 47% of people living with HIV/AIDS in Maine were enrolled in either full benefit MaineCare or the 1115 limited benefit waiver in 2011. Full benefits are currently available for those with incomes up to 100% of the federal poverty level, with limited benefits applied to those between 101% and 250% of the federal poverty level. Coverage extended under the Affordable Care Act (ACA) would increase full benefits coverage to people up to 133% of the federal poverty level. At this time, it is still unclear if those with incomes from 134-250% would maintain their limited benefits. However, the Office of MaineCare Services has indicated that it will be applying to renew its waiver beyond 2014. If this application is approved, the ACA will not have a significant impact on the model of services for people living with HIV/AIDS in Maine.

Very few people living with HIV/AIDS in Maine are uninsured, and the vast majority of these are undocumented immigrants or legal noncitizens who have lived in the U.S. for less than five years. These individuals are able to access medications and labs through

the ADAP. When possible and cost-effective, the ADAP pays insurance premiums for people with no insurance in order to get them more comprehensive coverage.

There are a number of essential services needed by people living with HIV/AIDS that are not fully covered by the Essential Health Benefits as outlined in the ACA, including dental services, case management, nutrition services, transportation, and mental health and substance use services. This further supports the Ryan White Part B Program's need to develop a needs-based funding allocation method and to further refine the medical case management service to ensure that medical case managers can serve as benefits navigators for their clients.

3. National HIV/AIDS Strategy

The Early Identification of Individuals with HIV/AIDS initiative supports all three of the National HIV/AIDS Strategy goals:

1. Reducing the number of people who become infected with HIV
2. Increasing access to care and optimizing health outcomes for people living with HIV
3. Reducing HIV-related health disparities

D. Response to State or Local Budget Cuts

1. ADAP

Maine has been fortunate to be able to sustain its ADAP without any cost containment measures for a number of years. However, the program is now incurring increased costs at an unprecedented rate in this state. The ADAP Advisory Committee is now reviewing program policies and convening meetings to review cost containment strategies. At this time, the State has not announced plans to cut its share of the ADAP's funding. If that were to happen, cost containment strategies would need to be put in place and reallocating a greater portion of Ryan White Part B base dollars to the ADAP would need to be considered.

2. Case Management

A State of Maine supplemental budget for the period ending June 30, 2012, included a proposal to eliminate targeted case management services as an optional service in the MaineCare program. This proposal was ultimately rejected for the supplemental budget period, but may be revisited in future budget proposals. If this change were to occur, the Ryan White Part B Program would need to dramatically alter how it provides services and to whom those services are available. The elimination of this revenue stream would force most, if not all, of the current medical case management subgrantees to cease the provision of case management services, as MaineCare is the largest funder of such services and Ryan White Part B funds alone could not sustain the programs. The Ryan White Part B Program would likely need to reduce the number of subgrantees, tighten eligibility requirements for medical case management services, and reduce the number of units of medical case management services delivered each year.

Any significant change to the continuum of care would be presented to the HIV Advisory Committee and the Ryan White Advisory Committee for input into the restructuring of service delivery in the state.

3. Prevention

The reduction of federal prevention dollars to the State over the next several years will result in substantial changes to service delivery, concentration of resources, and fewer funded providers. The HIV Prevention Program and the Ryan White Part B Program are both part of the state HIV, STD, and Viral Hepatitis Program, enabling close coordination to ensure that service dollars are maximized.

4. Other Cuts

Changes to MaineCare eligibility criteria, particularly related to legal noncitizens, have led to challenges for the medical providers serving uninsured people living with HIV/AIDS. While the ADAP covers the costs of medications and some labs, it does not reimburse for all labs or office visits. PHC, the Ryan White Part C grantee in Southern Maine, serves a number of foreign-born people living with HIV/AIDS who are currently not eligible for MaineCare. As a result, they have had to enroll these clients in Free Care at the local hospital in order to have labs covered for them.

IV. How will we monitor progress?

A. Monitoring & Evaluation

1. Improved Use of Client-Level Data

Maine has been utilizing client-level data since 2008, when all Ryan White Part B and C grantees began using a networked CAREWare system. In addition, the ADAP will soon be more fully utilizing CAREWare, which will allow for more seamless data analysis.

Ryan White Part B subgrantees have exceptionally high RSR data completeness rates, indicating that Maine is already making good use of its client-level data.

a. EIIHA and Unmet Need

The majority of the services required by the EIIHA strategy are provided by other parts of the HIV, STD, and Viral Hepatitis Program, and the Ryan White Part B Program supports these programs as necessary and appropriate, making every effort to effectively use limited resources by not duplicating services.

The Ryan White Part B Program and the HIV/STD Surveillance Coordinator have implemented a six-month schedule of data cross-matching for analysis of unmet need. Once individuals who are out of care have been identified by the HIV/STD Surveillance Coordinator, follow up will be conducted on any Ryan White Part B clients to determine if unmet need data are complete. If data are found to be complete and the client has truly lapsed from care, the Part B medical case manager will prioritize the client's return to care.

2. Monitoring Service Utilization

Medical case managers and Ryan White Part C staff enter services in CAREWare for encounters they have with clients. Service utilization is already closely monitored as part of contractually-required quarterly reporting of Ryan White Part B subgrantees.

3. Measurement of Clinical Outcomes

Ryan White Part C grantees are using CAREWare for their data entry. Using the CAREWare performance measures and other reports, grantees can measure clinical outcomes.