

Ryan White HIV/AIDS Program, Part B
Department of Public Health and Social Services

Statewide Coordinated Statement of Need
and
Comprehensive Plan
2012-2015

Territory of Guam

INTRODUCTION

The Statewide Coordinated Statement of Need (SCSN) and Comprehensive Plan is a living document addressing HIV/AIDS care issues of people with HIV/AIDS (PLWHA) on Guam. The SCSN and Comprehensive Plan describe existing resources on Guam, barriers to care for HIV-positive individuals, and anticipated trends or issues that will affect HIV-positive people. It is also comprised of goals and strategies that will improve lives of PLWHAs and those who are at risk for HIV, with the long term objective of reducing the transmission of HIV/AIDS, and extending the lives of those who are positive.

The SCSN covers a period of three years and was last updated in 2009 by program staff at the Bureaus of Communicable Disease Control and Primary Support Services within Guam’s Department of Public Health and Social Services (DPHSS). The community based organization Guam HIV/AIDS Network Project (GUAHAN Project) also participated in the SCSN Working Group to address SCSN development.

Process

The 2012-2014 SCSN was developed with input from DPHSS Ryan White HIV/AIDS Program (RWHAP) staff, government, and community based participants in a series of five planning meetings. In compliance with the Health Resource and Services Administration (HRSA) regulations, SCSN input was gathered from: RHWAP Coordinator, RWHAP Medical Case Manager, three DPHSS physicians, STD/HIV Program (SHP) Supervisor, Ryan White clients, family members of Ryan White clients, Department of Mental Health and Substance Abuse/New Beginnings staff, Department of Education HIV Prevention Program, and community based organizations (Guam Alternative Lifestyle Association (GALA), WestCare Pacific Islands (WPI)).

Throughout the planning process, DPHSS reviewed and disseminated to group members documents and data to guide the SCSN update. These included the following documents:

<i>DOCUMENT OR SOURCE MATERIAL</i>	<i>DESCRIPTION</i>	<i>STAKEHOLDER PERSPECTIVE</i>
Ryan White HIV/AIDS Program SCSN and Comprehensive Plan 2009-2011	SCSN for 2009-2011	Planning group for 2009
Ryan White HIV/AIDS Program Part B 2011 Clinical Quality Management Plan Draft	Quality improvement plan draft that addresses RWHAP	RWHAP staff
Ryan White HIV/AIDS Program, Part B Evaluation 2011	<ul style="list-style-type: none"> • RWHAP outcomes evaluation for program capacity • Client needs assessment 	<ul style="list-style-type: none"> • RWHAP staff • Ryan White clients (44% participation) for 2011
Needs assessment/client satisfaction survey for 2011-2012	Client satisfaction survey of Ryan White clients for 2012	Ryan White clients (100% participation) for 2012
Data from DPHSS doctors treating HIV+ patients	Feedback received from interviews with DPHSS doctors;	DPHSS doctors

	data will also be used in RWHAP Clinical Quality Management Plan 2012	
HIV/AIDS epidemiological updates for 2011	Epidemiological data for HIV/AIDS cases in Guam for 2011	DPHSS HIV Surveillance Program
HIV/AIDS Framework of Unmet need for 2011	RWHAP data for HIV+ individuals not in care	DPHSS RWHAP
HIV Surveillance Report 2002-2011	HIV surveillance data	DPHSS HIV Surveillance Program
Preliminary STD testing data for 2011	Statistical data for STD testing from DPHSS-administered sites	DPHSS STD/HIV Program
Preliminary HIV counseling, testing, and referral data for 2011	Statistical data for HIV testing from DPHSS-administered sites	DPHSS STD/HIV Program
Preliminary Youth Risk Behavior Surveillance System data for 2011	Data gathered from Guam Department of Education students to track substance/alcohol use, sexual risk, dietary and physical activity habits	Public middle and high school students
2012 Summary: Guam HIV Prevention Strategies	Summary of prevention strategies and priorities for 2012	DPHSS STD/HIV Program

GUAM BACKGROUND

Guam is an unincorporated U.S. territory, designated as rural by the U.S. Census. It is 30 miles long and 4 to 12 miles wide, covering 212 square miles. The westernmost U.S. territory, it is 3,808 miles west of Honolulu, Hawai'i, 1,561 miles south of Tokyo, Japan, and 1,595 miles east of Manila, Philippines. While politically associated with the United States, Guam is also part of the Marianas Archipelago--which includes the Commonwealth of the Northern Mariana Islands (Saipan, Tinian, and Rota being the largest inhabited islands)—and shares common cultural links through the indigenous Chamorro populations who reside throughout the island chain.

The island's Chamorros and history have been impacted by colonization, which began with first contact in 1521 by the Spaniards. Reflecting colonial histories throughout the world, Spanish contact resulted in severe Chamorro depopulation due to disease and war. The Spaniards also wrought fundamental change, including the introduction of Catholicism and its accompanying institutions and beliefs, which to this day influence Guam politics and cultural mores.

In 1898 Guam was ceded to the U.S. as part of its victory in the Spanish American War. Since then the island experienced several decades of military administration, including one interlude of Japanese military occupation during World War II. While Guam's political institutions have

become civilian and democratically elected for at least three decades, it has limited self-governing authority in accordance with the Guam Organic Act of 1950.

Guam's unique territorial status and proximity to Asia and other Pacific Island jurisdictions have made it a popular point of entry and/or settlement for immigrants to the United States. Its two largest industries, tourism and military-related activities, also encompass significant facets of movement and change. As such, throughout its history Guam's culture has incorporated influences of those who have visited, occupied, and migrated.

One major change occurring since the 2009 SCSN is a proposed military build-up, which had original implementation dates of 2014-2018. The build-up, which projected the movement of up to 40,000 military and civilian persons to support a transfer of 8,000 Marines from Okinawa to Guam, could significantly impact risk factors or environments associated with HIV. These risk factors include economic destabilization and poverty (resulting from the build-up's projected "boom-bust" economic activities), healthcare infrastructure strain (as a result of more people using an already impacted healthcare system), and transient, transnational worker populations that will support increased construction for about two to three years.

As of 2012, military build-up planning has slowed due to a global recession, national budgetary considerations, and changes in diplomatic relations between the U.S. and Japan. The projected transfer of Marines is now between 4,700 and 5,000; however, there are no numbers yet as to how the supporting civilian workforce will change.

POPULATION AND ETHNIC DISTRIBUTION

According to the 2010 Census, in the past decade Guam's population has grown by 2.9% to a total of almost 160,000 residents. The population is comprised of the native Chamorro people (37%), followed by Filipinos (26%), other Pacific Islanders (11%), Caucasians (6%), other Asians (6%) and others (11%). Within the other Pacific Islander population, many residents are from the Federated States of Micronesia (Chuuk [4%] and Pohnpei [1%]), Republic of Palau (1.4%), and the Republic of the Marshall Islands. The population also skews young, with nearly 95% of the population between the ages of 0-64 years (35% up to age 14, and 60% 14-64 years).

As of September 2011, there were 6,275 active duty personnel currently stationed on Guam, and 7,247 dependents. On-base residing personnel and families are not counted in the overall Guam 2010 Census; however, some of these individuals and households were probably included due to personnel living off-base.¹

HEALTHCARE INFRASTRUCTURE

The only civilian inpatient medical facility on Guam is the Guam Memorial Hospital Authority (GHMA), which has an emergency room, inpatient wards, surgical suites, a pharmacy, laboratory and x-ray services, physical therapy services, and health administration and data management offices.

¹ Naval Forces Marianas.

The current acute bed count, as of 2008, is .9 acute care beds per 1,000 population, or 158 beds. According to the Governor's Five-Year Health & Social Services Strategic Plan²:

GMH has a significant deficit in the number of acute care hospital beds in relation to the number of people that hospital services. As of 2008, the ratio of beds per 1,000 people on Guam was less than half the ratio of hospitals throughout Hawaii, the U.S., and some of the other islands in the Western Pacific. Furthermore, this ratio only accounts for Guam's resident population, and does not take into account persons who are sent to the hospital from off-island. (p. 5-6)

The U.S. Naval Hospital is the military's central facility for general acute care. The hospital also provides outpatient services in the various medical disciplines and maintains a dental clinic. The medical center is staffed to provide for the medical needs of active military personnel and their dependents, military retirees, veterans, and their eligible dependents.

The year 2014 may also see the addition of a new private hospital called Guam Medical Regional City (GMRC), which will be operated by The Medical City, a Philippines-based healthcare organization. Groundbreaking was slated for February 2012. GMRC projects 130 acute care beds and 20 intensive care beds, with the possibility of future growth allowing for a 350+ bed addition. The Governor's Five-Year Health & Social Services Strategic Plan suggests that the addition of a privately run hospital may exacerbate the healthcare professional shortage if those working within DPHSS and GMHA transfer to GMRC. Moreover, current GMHA fiscal woes, which include a disparity between service costs and reimbursements, could increase since the private hospital will not have to accept all patients as GMHA does.

EPIDEMIOLOGICAL PROFILE OF HIV/AIDS ON GUAM

According to the HIV Surveillance Report (February 2011), in the ten year period of 2002-2011 there were 50 new diagnosed or reported cases of HIV, for an average of 5 new cases a year. Of the 50 people infected, 37 were male and 13 were female. The high occurring age range for diagnosis was between the ages of 40-49, with 17 people receiving an HIV diagnosis, followed by the ages of 30-39 at 16 people. Of the 50 new cases, 38 were Pacific Islander (24 Chamorro, 10 Chuukese, and 4 other Pacific Islanders), 6 were Asian, 5 were Caucasian, and 1 was African American or Black. For modes of transmission, 23 individuals reported heterosexual contact, 18 reported male-to-male sexual (MSM) contact, 3 had no risk reported³, 1 reported MSM and injection drug use (IDU), 1 reported MSM and heterosexual contact, 1 reported injection drug use, and 1 reported injection drug use and heterosexual contact, and 2 were perinatal (mother-to-child transmission).

Out of the 50 reported HIV infections, 29 people with HIV/AIDS are still living, 13 died, and 8 left the jurisdiction. Of the 29 PLWHA, there are 18 males and 11 females. Of the 50 people, 22

² Office of the Governor of Guam. (Oct. 2011). *Five-Year Health & Social Service Strategic Plan Public Draft*.

³ A no risk category was applicable from 1998-2004.

were between the ages of 30 and 49 at diagnosis, 6 between the ages of 20-29, and 2 were 12 years of age or younger. Most of 50 new cases are of Pacific Islander descent (15 Chamorro, 7 Chuukese, and 1 other Pacific Islander).

According to doctors at the DPHSS Community Health Centers and the former Medical Case Manager, one potential trend that is likely to affect care is the age to which clients are living. For those clients whose compliance is very good to excellent, their advanced age brings with it chronic or age-related health issues such as high cholesterol and diabetes. Additionally, the severity of age-related diseases may be accelerated by HIV medications, if not caused by the HIV medications themselves. These co-existing conditions can include high cholesterol and osteoporosis.⁴

EARLY IDENTIFICATION OF INDIVIDUALS WITH HIV/AIDS (EIIHA)/UNAWARE ESTIMATE CY 2009

As of December 2010, there were 225 reported cases of HIV/AIDS on Guam, with an estimated 50 PLWHA. Of the 225 reported cases, males accounted for 85% (192) of all cases while Pacific Islanders were the most impacted ethnic group with 54% of all cases. Male-to-male sexual contact was the most frequently reported mode of transmission or exposure at 52%, followed by heterosexual contact at 20%. Ninety-three (93%) percent of all cases were between the ages of 20-49 at diagnosis.

In 2010, there were nine new HIV infections reported to the HIV Surveillance Program. Of the nine cases, seven (78%) were male, five (55%) reported MSM as their mode of transmission or exposure, six (67%) reported Pacific Islander as their ethnicity, and eight (89%) were between the ages of 30-49 at diagnosis.

Using the Estimated Back Calculation Methodology, there were 11 undiagnosed PLWHA who were unaware of their status.⁵

Special Populations

Chuukese

A slowly rising proportion of PLWHAs who are Chuukese is a cause for concern. Twenty percent of new HIV cases are Chuukese, compared to 48% of Chamorro and 8% other Pacific Islanders. Additionally, of the total 1,193 STD cases (Chlamydia, Gonorrhea, and Syphilis) reported island-wide in 2011, 224 cases or 19% were identified as Chuukese. Chuukese residents have tripled in population from 2000-2010, from 6,229 in 2000 and 17,974 in 2011.⁶

⁴ McNicoll, I. (July 2011). "Adverse effects of antiretroviral drugs." *HIV InSite*.

<http://hivinsite.ucsf.edu/inSite?page=ar-05-01>.

⁵ The 2009 number of undiagnosed PLWHA was taken from the 2012 RWHAP Grant Application.

⁶ Temkar, A. (12 Mar. 2012). "Migrants come for jobs: Guam draws islanders seeking 'a better life.'" *Pacific Daily News*.

Adolescents

According to preliminary results from the Youth Risk Behavior Survey (YRBS), nearly 50% of high school survey respondents reported that they ever had sexual intercourse. Of those respondents,

12% reported having four or more partners throughout their lives,

32% reported having sex within the past three months of the survey.

Of those students (the 32% reporting sex within the past three months), 32.5% reported using a condom.

Eighty-six percent (86%) of high school survey respondents said they had ever been taught about AIDS or HIV in school.

According to SHP, there was an increase of 37% in the total number of reported Chlamydia cases from 2009 to 2010. In 2010, the most impacted age group was 20-24 years (68%) followed by 15-19 years (19%). The 2010 prevalence of chlamydia was 498 per 100,000, an increase from 352 per 100,000 in 2009. Compared to the contiguous United States, current chlamydia rates are very high overall, ranking Guam ninth in the country for the number of cases relative to population.

In partnership with the Guam Department of Education (GDOE), SHP has two primary goals: 1) to develop a plan that addresses the need for sexual reproductive health programs that focus on STD/HIV Prevention and Unintended Pregnancy Programs at the secondary school level, and 2) to develop a school based program to reach youth that are at disproportionate risk for HIV transmission such as Lesbian, Gay, Bisexual, Transgender, Queer and Questioning Youth (LGBTQ).

GDOE in collaboration with SHP intends to expand clinical access for HIV/STD testing to schools by strengthening community and other governmental partners, and the current SHP Supervisor is included as a stakeholder.⁷ Additionally, DPHSS opened a teen clinic in March 2012 that offers STD and pregnancy testing/birth control counseling in Dededo two times a month.

Injection drug users

The Department of Mental Health and Substance Abuse (DMHSA)/New Beginnings was able to provide fourth quarter client data from 2011, which included 332 clients treated between DMHSA and three community based organizations (Lighthouse Recovery Center, Sanctuary, Incorporated, and OASIS Empowerment Center). Out of those clients, about 21, or 6%, of those clients were either confirmed or suspected injection drug users.⁸

⁷ Guam Department of Education, HIV Prevention Program. (1 Mar. 2011-28 Feb. 2012). *5 Year Strategic Plan, Year 04 Continuing Application*.

⁸ The substance use categories used in the data included "opiate," "polysubstance," "amphetamine/ice," and "prescription drugs."

Extrapolating from the 2011 fourth quarter total substance user data, the total number of substance abuse clients in treatment for 2011 was about 1,300 clients with an estimated 78 people who were IDUs.

Homeless

According to the Guam Homeless Point-in-Time Count (2009) and Guåhan Housing and Urban Renewal Authority (GHURA) Consolidated Plan 2010-2014, there was a total number of 1,088 homeless individuals, including 906 found to be completely unsheltered, in 2009.

A total of 136 families [total 567 persons] were reported. Unaccompanied individuals or groups with no children totaled 339 persons. Regionally, the largest single concentration of unsheltered homeless persons was found in northern Guam [537 persons]. Rural homeless consisted largely of families and fewer individuals or persons in groups with no children. There were unaccompanied minors during the count. Sixteen veterans were among the unsheltered persons counted, 2% of the total persons counted. Children represented 37% of the unsheltered homeless. Further, children under the age of five represented nearly two-thirds of this population [216 of 337 children, 64%]. Approximately eight percent of unsheltered homeless persons were identified as chronically homeless, 68 persons in total, most of whom were located in northern Guam. (p. 40)⁹

Since 2009, the homeless counts have been and continue to rise. In 2011, there were 1,541 people who were unsheltered or living in inadequate housing.¹⁰

Transgender

In general, more local data needs to be collected about this population. However, issues that face stateside transgender people could realistically apply to Guam's TG community—namely, anti-transgender bias and economic insecurity due to employment discrimination.¹¹

In regard to public participation and perception, there were two major pageants held last year, with each hosting about 30 male-to-female participants each. The Guam Alternative Lifestyle Association (GALA) conducts outreach at a weekly club show with performance group *The Untouchables*. Transgender representatives also participated in the University of Guam's 2012 sexual assault service provider fundraiser *The Vagina Monologues*.

According to SHP, TG individuals comprised .3% of all HIV testers in 2010. There are currently no TG Ryan White clients.

⁹ Guam Housing and Urban Renewal Authority. (2010). *Guam Consolidated Plan 2010-2014 Strategic Plan*.

¹⁰ Matthews, L. (2 May 2011.) "Homeless population grows 42%." *Pacific Daily News*.

¹¹ Grant, J., Mottet, L., & Tanis, J. (2011) *Injustice at every turn: A report on the national transgender discrimination survey, executive summary*. Washington: National Gay and Lesbian Task Force.

DPHSS in collaboration with the GUAHAN Project conducted a survey of MSM in 2007-2008¹². Respondent-driven sampling was used for enrollment. Respondents were eligible if they were 16 years or older, and either male or transgender person (TG) who had sex with a man in the past 5 years. Surveys were conducted in person. Participants were offered an HIV test following the survey. Of the 211 MSM surveyed, 200 (89%) were men and 11 (5.5%) were TG. Seventy-four percent of the survey respondents were born in Guam, 12% in the U.S., 10% in the Philippines, and 4% in some other place. Eighteen (9%) had ever been married and 10 (5%) were currently married. The mean age at sexual debut was 15 years and 192 (91%) reported sexual contact with a man or transgender person in the past 6 months. Of these, 189 (98%) reported oral sex and 52 (27%) reported anal sex with male partners. Ninety-one (43%) MSM reported ever having had vaginal or anal sex with a woman, of whom 17 (19%) had sex with a woman in the past 6 months. Overall, 80 (38%) reported two or more concurrent sex partners and 35 (17%) reported having had group sex in the past 12 months. There were 98 (48%) MSM who reported traveling from Guam in the past 12 months, of whom 57 (59%) reported having had sex with someone other than a sex partner from Guam. Outside of Guam, the median number of sex partners was two (range 1 – 20 sex partners); 53 (93%) MSM reported that the most recent sex partner outside Guam was male and 25 (44%) reported condoms were used with the most recent partner. Of the 208 who had ever heard of sexually transmitted diseases (STDs), 25 (12%) reported having ever been diagnosed with an STD, including 6 (3%) who had been diagnosed with HIV. Overall, 150 (71%) MSM reported having ever been tested for HIV and 82 (39%) reported having been tested for HIV in the past 12 months. Overall, 125 (59%) MSM were offered an HIV test, of whom 37 (30%) accepted to be tested; all test results were negative.

Although no new infections were identified as part of this survey, the prevalence of HIV and HIV-associated risk behaviors is high among MSM in Guam. Further, 27% of MSM reported having had sex off island, which may increase the risk for HIV infection and other STDs and increase the risk for their sex partners in Guam. It is recommended that prevention messages specifically for MSM in Guam and other nearby Asian and Pacific Island nations be developed.

CONTINUUM OF CARE

Ryan White-funded HIV Care and Service Inventory

DPHSS receives RWHAP (Part B) and AIDS Drugs Assistance Program (ADAP) funds, and administers these programs through the Bureau of Communicable Disease Control (BCDC).

Core Services

RWHAP funds three core services: Medical Case Management, ADAP, and Outpatient/Ambulatory Services.

Medical Case Management

According to the 2011 Medical Case Management Standards of Service, the RWHAP Medical Case Manager (MCM) has a responsibility to:

¹² 2007-2008 MSM Survey

- Provide access to care;
- Orientate the client and provide accurate information;
- Assist their client in understanding the implications of the issues facing them, and of the possible outcomes and consequences of decisions;
- Present options to the clients from which they may select a course of action or inaction;
- Offer direction when it is asked for, or when withholding it would place the client or someone else at risk for harm; and
- Be available to support and problem solve.

The MCM conducts the intake process, psychosocial screenings, medical assessments, care planning, and referral and follow-up activities. The goal of medical case management is to help individuals living with HIV access primary medical care and medications, identify and remove barriers to medical care, and ensure adherence to a prescribed treatment plan.

Primary activities include providing assistance and support in:

- Accessing health insurance or medical treatment payment programs such as the Guam Medically Indigent Program (MIP), Medicaid, or Medicare.
- Accessing primary medical care, including HIV medications.
- Screening, assessment, care planning, referral and appropriate interventions for treatment adherence/disease progression, HIV education and risk reduction counseling, oral health, nutrition health, mental health, and outpatient substance abuse treatment.

Secondary activities may include assistance with:

- Applying and accessing support services funded by both RWHAP and other publicly or federally funded programs such as: Medical Transportation, Food/Non-Food Assistance, Women Infants Children (WIC), Supplemental Nutrition Assistance Program (SNAP), Maternal Child Health Services (MCH), Family Planning (FP), and Guam Housing and Urban Renewal Authority (GHURA).

The MCM partners with DPHSS physicians, pharmacy and other professionals to assess the needs of the client and the client's family and support system, develops individualized client care plans, and coordinates, monitors, evaluates and advocates for a comprehensive package of services to meet the specific client's complex needs.

AIDS Drugs Assistance Program (ADAP)

ADAP assists low-income individuals living with HIV/AIDS access and maintain prescription drug coverage for medications related to HIV disease. ADAP fills the gap for HIV-positive individuals who lack sufficient coverage by private insurance, Medicaid, Medicare, or MIP, the locally funded public health insurance plan. In compliance with Health Resources and Services Administration (HRSA), RWHAP enrolled in the 340B Drug Discount Program and established the ADAP Pharmacy in 2010.

Eligible ADAP clients must be enrolled in medical case management services and be registered patients at the Northern or Southern Region Community Health Centers (NRCHC/SRCHC).

In 2010, there were 4 PLWHAs enrolled in ADAP. There is no waiting list of eligible applicants. In 2011, there were 6 clients enrolled in ADAP.

Outpatient/Ambulatory Services

DPHSS Northern and Southern Region Community Health Centers, through the Bureau of Primary Healthcare Services (BPHS) provide primary healthcare services. Both Community Health Centers are federally qualified health centers that serve the underserved, indigent, and uninsured populations of Guam.

Those populations include children 0-11 years (including children with special needs), adolescents (including youths confined in the correctional facilities), women of childbearing years with health risk factors, pregnant women, the elderly (55 years and older), individuals staying in emergency and/or transitional shelters, individuals in substandard housing units, public health patients (i.e. patients with communicable, infectious, sexually transmitted, and/or chronic disease), citizens of the Federated States of Micronesia and the Marshall Islands, and immigrants.

Primary care preventive services include prenatal and postpartum care, women's health (OB/GYN care), well baby care, child health, immunizations, adolescent health, adult care, minor surgery and wound repair, TB screening, directly observed TB therapy, early periodic screening and diagnostic testing for children (EPSDT), family planning services, cancer screening, communicable disease screening and treatment (e.g., HIV, TB, STD), chronic disease care (e.g., hypertension, diabetes, heart diseases). Support services include diagnostic laboratory services, pharmacy services, vision screening, community outreach and health education.

Support Services

In response to direct client input, RWHAP funding supports medical transportation services (in the form of gas coupons or prepaid gas cards), food/non-food assistance (coupons for approved nutritional and personal hygiene items), outreach, and the beginnings of a support group (planning began January 2012). All of these services are provided by DPHSS.

Medical Transportation Services

Gas cards are provided to clients who require essential transportation resources to and from core medical services. The provision of gas cards is based on need; priority must be given to trips related to medical care so that clients may access health care services including HIV primary care medical appointments, medical case management, ADAP/pharmacy visits, dental care, mental health therapy, or substance abuse treatment. Gas cards may be used to access approved support services that directly relate to entry into and adherence to medical care as long as priority is given to medical and other core services first.

Food/Non-Food Assistance

Food coupons are provided to clients to purchase nutritious food items that promote a healthy diet and essential non-food household items such as personal hygiene products and household cleaning supplies. Food items are limited to products for human consumption and provide nutritional value to the client. Alcoholic beverages, tobacco products, candy, pet food, or any other product that does not provide nutritional value to the client is strictly prohibited.

Outreach

The RWHAP Outreach Program was developed in 2011 and is being piloted to determine its effectiveness. The program aims to increase the number of individuals who are aware of their HIV+ status and the number of HIV+ individuals who are in care. Target populations include MSM, Chuukese, transgenders, and injection drug users. Outreach team members are given incentives for referrals made to SHP for HIV screening.

Support Group

In response to client input, RWHAP staff held formal planning meetings with clients to discuss the development of a support group for RWHAP clients. As a result, guidelines were developed and a consensus was reached to hold the first official Support Group meeting in May 2012. The Support Group will start off small with clients who have expressed interest in participating, and be guided by clients that volunteered to take the lead roles.

Non Ryan White-funded HIV Care and Service Inventory

Private Healthcare

According to the Governor's Five-Year Health & Social Service Strategic Plan Public Draft—which relied on a 2008 Guam Statistical Yearbook for this information—there are 77 private clinics on island (excluding eye and dental).

Insurance (Private and Public)

There are four private insurance companies from which residents can either purchase individually or through employers, if offered. Otherwise, residents may depend on TRICARE (for active and retired military personnel and dependents), Medicare (for seniors), Medicaid, Children's Health Insurance Program (CHIP), and the Medically Indigent Program (MIP).

DPHSS Division of Public Welfare manages Medicaid; the program is 50% federally matched with 50% local funds. As with the other U.S. territories, there is a spending cap placed on the program. Significantly, Medicaid participation increases each year, in part because of migration from the Freely Associated States (FAS) where healthcare infrastructure may be insufficient:

The numbers of Guam Medicaid participants has steadily increased each year, with an overall increase of 30% between 2004 and 2010. The percentage of participants that are Compact Impact patients has also increased, from 17% of those served in 2004 to 20% in 2010 [DPHSS, 2011]. (Office of the Governor. [Oct. 2011]. *Five-Year Health & Social Service Strategic Plan Public Draft*. p. 7-11.)

CHIP is provided as an extension of Medicaid and targets children 19 and younger who are uninsured and ineligible for Medicaid.

Guam's MIP is a 100% local government-funded health assistance program that serves as a safety net for those who cannot afford health insurance/care. Established in 1983 per Public Law 17-83, MIP provides financial assistance with health care costs to low-income individuals. MIP covers most inpatient and outpatient services (i.e. hospitalization, intensive care, and diagnostic laboratory services), mental health services, prescription drugs, home health services, and dental services. MIP is supposed to be a payer of last resort after residents have exhausted Medicaid, Medicare, Children's Health Insurance Program, and other federal and local programs. DPHSS Division of Public Welfare administers MIP.

Effects of Budget on Service System

RWHAP is 100% federally funded on Guam, as are the program's core services. If program staff were to anticipate state/local cuts, they would first reassess the scope and continuation of RWHAP support services.

GAPS IN CARE

The greatest gap in care as identified by service providers is the medical personnel shortage which directly affects patient waiting times. For more detail, refer to the section Shortfall in Healthcare Workforce.

PREVENTION NEEDS

The STD/HIV Program outlined its 2012 HIV prevention goals and objectives following the 2010 White House-released United States National HIV/AIDS Strategy.

Outreach and Testing

Outreach and testing are the two primary public health strategies to reach populations at highest risk for HIV infection. SHP has been conducting outreach to target populations in collaboration with government and nongovernment agencies since 2001. SHP also coordinates the *Prutehi Hao or Protect Yourself* public information campaign that promotes HIV/STD screening and safe behaviors to targeted populations as well as the general public. To increase HIV testing levels to among the highest risk populations, HIV rapid testing was made available at the Central Public Health Laboratory in 2012. In progress, HIV rapid testing will be made available to designated CLIA waived counseling and testing sites by the end of FY2012.

These sites will include partners such as University of Guam Student Health Services, Healing Hearts (DMHSA), DPHSS Northern/Southern Community Health Centers and nongovernment organizations such as Guam Alternative Lifestyles Association and WestCare Pacific Islands.

GALA, WPI and Stepping Stones also conduct outreach to targeted populations. There are efforts to conduct outreach to populations at highest risk for STD/HIV, however, resources are limited. In progress, SHP in collaboration with its partners and stakeholders are working

towards securing additional resources to improve outreach as a vital public health strategy to reach targeted populations.

GALA was established in 2007 and enhances the quality of life of the LGBT community by advancing the causes and issues impacting Guam's LGBT community. Work revolves around three core areas: Advocacy, Support, and Education. Specific activities include: self sufficiency and job skills training, fighting anti-gay stigma, peer education, and helping to promote HPV and Hepatitis immunization services. Through a grant with Office of Minority Health Resources Center (OMHRC), GALA partnered with DPHSS to launch a Peer Education Program to address HIV/AIDS/STD prevention and testing in 2011. GALA also conducted outreaches at clubs targeting MSM and transgenders. They produced a social marketing campaign promoting DPHSS HIV prevention and testing, as well as their Live Proud Campaign, which addresses anti-gay and anti-stigma. The Live Proud Campaign includes booklets from LGBT and straight allies focusing on health and social service resources and topics like coming out, being gay, living as a transgendered person, and safe sex tips.

Established in 2003, the Guam HIV/AIDS Network (GUAHAN Project) historically provided critical HIV/AIDS support services like outreach, testing, and non-medical case management. In 2011, WPI absorbed GUAHAN Project. WPI houses the Pacific Resource & Training Center which provides a myriad of HIV-related material. This material includes a special section for the LGBT community, information on co-occurring conditions and co-factors to HIV, such as domestic violence, tuberculosis, breast and cervical cancer, hemophilia and more.

Additionally WPI's Project Isa-ta provides HIV/STI prevention education and supportive group counseling for girls ages 12-17 in three public high schools. Weekly group topics and activities are centered in risk behavior assessment, critical thinking, self-esteem, healthy body image, healthy lifestyles, substance abuse prevention, and violence prevention, to augment the HIV curriculum.

Stepping Stones is a program funded by DHPSS through a grant award from Pacific Response Fund coordinated by the Secretariat of the Pacific Community based in Pohnpei, Federated States of Micronesia (FSM). Stepping Stones program staff received training in Chuuk along with the Chuuk Health Department just prior to program roll-out in Chuuk. In Guam, the target populations are Chuukese male and female youth under the age of 27. Stepping Stones is an evidence based HIV risk reduction curriculum. Their activities include outreach, education and awareness, counseling and testing, and behavior change communication.

In addition to testing, SHP plans to increase targeted condom distribution to MSM, Chuukese, transgenders, STD clients (at SHP), and adolescents.

HIV Counseling and Testing

DPHSS provides HIV testing in all three Community Health Centers. It also coordinates with select community based nonprofit organizations to do so. For residents who can afford the cost, private clinics also offer testing.

SHP conducts STD/HIV surveillance activities, STD screening, HIV counseling, testing, and referral services (CTRS), and prevention and treatment services. SHP collaborates with community based organizations to plan and assess community service needs.

For 2012, SHP prioritized three populations: MSM, pregnant women, and STD clients accessing services as the public funded clinics. SHP made HIV rapid testing available at the Central Public Health laboratory for high-risk clients: 1) Pregnant women in the third trimester, whose HIV status is unknown 2) Sex partners of HIV positive patients; and 3) Injection needle sharing partners of HIV positive individuals. Pending approval of the Clinical Laboratory Improvement Amendments (CLIA) – waiver application, SHP is in the process of rolling out rapid testing and finalizing protocols and an algorithm for Western Blot confirmation at selected sites. These selected sites include the SHP, NRCHC, SRCHC, GALA, WPI, University of Guam Student Health Services, Healing Hearts, and the Department of Mental Health and Substance Abuse.

WPI also offers free confidential HIV/STI testing, referral and counseling services with three certified risk reduction counselors on staff, with one staff whose certification is in progress. The organization has partnered with DPHSS SHP to obtain a CLIA waiver to begin using the Clearview Rapid Test for HIV.

CARE NEEDS

In late 2011, the RWHAP Medical Case Manager was able to administer a needs assessment to 100% of clients (23 individuals). The results confirmed a smaller scale client satisfaction survey and evaluation completed in March 2011—that all enrolled clients are generally satisfied with their care. When asked about core Ryan White services, all clients were enthusiastic about medical case management quality, were able to access all HIV-related drugs, and were able to see physicians on a regular basis.

The Medical Case Manager was able to satisfactorily address most client-reported issues that came up, such as money for food purchase, transportation, and/or housing (see below in Barriers to Care for HIV-positive Individuals).

The most persistent complaint, according to clients, had to do with a lack of continuity in doctor relationships. Doctor turnover is a DPHSS-wide institutional challenge. There is a shortage of doctors (further explained in the section addressing Shortfalls in Healthcare Workforce) and a heavy reliance on private physicians contracting with DPHSS or working in one-year intervals.

Some clients also reported a general sense that confidentiality needed greater attention. However, upon further investigation, these concerns related to one or two incidents that were

outside RWHAP (for example, occurred in another DPHSS division), and had to do with not understanding medical equipment (like the Electronic Medical Records database).

It is notable that as SHP and other community organizations expand testing to target populations, care needs may change based on increased HIV prevalence rates in women, youth, Chuukese residents, and intravenous drug or other substance users.

There are no reported overlaps in care, either by clients or program administrators.

Capacity Development Needs

On an administrative level, the RWHAP Part B Evaluation (2011) found that program staffers have made considerable progress in understanding and implementing the software CAREWare which was developed for managing and monitoring HIV clinical and supportive care. The program has been using CAREWare since 2009 to collect, manage, and report client data to HRSA. The RWHAP Coordinator is continuing training efforts in CAREWare since it is a primary data source or aggregator for use in HIV surveillance activities and also used to measure progress on performance measurements in the 2012 Clinical Quality Management Plan.

Not contained in the evaluation but noteworthy is that the program transitioned almost all new staff within the past two years and finalized MCM standardized operating procedures, intake forms and other documents to support program work.

In the 2009 SCSN, RWHAP sought to increase confidence and knowledge of primary care physicians in treating HIV/AIDS, and successfully did so for that particular doctor cohort. Since then, the DPHSS doctor turnover has been 100%. Subsequent interviews with DPHSS doctors treating HIV-positive clients in 2012 affirm that they are confident in treating HIV-positive clients because of the internet or Medical Case Management assistance. Compared to other chronic disease medication regimens, like those for diabetes, drug treatment plans are perceived as “easy” to prescribe.¹³

However, not all DPHSS physicians are required to see HIV-positive clients. Those who currently do, report either seeing HIV-positive clients during their medical training or in prior practice, and were “given” HIV-positive clients with no DPHSS-administered orientation as to issues specific to Guam’s PLWHA.

Given that there has never been an HIV specialist on Guam and the stateside tendency of phasing out HIV specialty care, RWHAP can improve the capacity—either through orientation or clinical updates—of DPHSS doctors not seeing HIV-positive clients. To do so with both doctors who already see HIV-positive clients and those who do not will also bring the program into greater compliance with the 2012 Clinical Quality Management plan currently under review.

¹³ One reason given is that diabetes medication requires titration, whereas antiretrovirals were perceived as more straightforward in dosing.

Care Needs of HIV-Positive Individuals Not in Care

Starting in 2011, RWHAP began to track unmet need in compliance with grant requirements.

There were a total of 53 individuals who were living with HIV/AIDS as of December 31, 2010. Of those 53 individuals, 31 received HIV primary medical care in 2010.

Most importantly, there were 22 PLWHA who did not receive any primary medical care. Of those 22, 7 (or 24%) had AIDS, and 15 (63%) were non-AIDS. These non-AIDS cases are critical to assess so as to prevent or prolong the progression of HIV disease.

RWHAP has identified two sets of HIV-positive individuals who are out of care: those who dropped out and those who never enrolled. In this plan's development, it became clear that more data is needed on these individuals to address program limitations that may have led to their drop-out or barriers to enrollment. This year's goals and objectives will address a systematic method for collecting data about why HIV-positive clients either drop out or do not enroll so as to choose or create interventions that reduce or eliminate this need.

Referrals and Linkage to Care Needs

One goal of SHP is Prevention for Positives, in which those who test positive are immediately referred to the RWHAP's Medical Case Manager. Specifically, SHP's 2012 Summary of Prevention Strategies will: 1) Provide 85% of newly infected clients with Partner Services within two weeks of receiving HIV-confirmed results, 2) Link 80% of newly infected clients to care, and 3) Be able to identify sex and needle sharing partners from the past year, with information from 80% of newly confirmed HIV-positive cases. Given the low HIV incidence rate and medical case management history on Guam, these objectives are attainable.

BARRIERS TO CARE OR NEED FOR CARE FOR HIV-POSITIVE INDIVIDUALS

Routine Testing

As identified in the 2009 SCSN, late testers are a concern on Guam. Late testers often show up symptomatic at Guam Memorial Hospital Authority Emergency Room. DPHSS assumes that the availability of rapid testing, which will reduce the potential wait time of two to four weeks to 20 minutes, will increase peoples' likelihood to test. The reduced cost of testing for providers, in terms of laboratory and processing fees, may also expand the number of tests available.

Program-Related Barriers

Stigma

Stigma associated with HIV remains a barrier to early testing and care. Communities still view the stigma associated with HIV/AIDS as one of shame, guilty, promiscuity, injection drug use, homosexuality, and unprotected sex. Stigma is fueled by ignorance, misinformation, and lack of education and awareness. The possibility of community rejection delays testing and/or treatment of PLWHA, which therefore leads to advanced stage diagnosis. Service provider and community perceptions of HIV/AIDS are at times based on stigma and fear. As such, services may also need improvement.

Cultural and language barriers

Guam's demographic profile indicates an ethnically and nationally diverse, young population.

Whereas the 2009 SCSN identified a reduction of language barriers as its third goal, some potential strategies identified then were later either deemed unnecessary due to service and/or funding duplication.

One strategy, a client needs assessment, was implemented. Lack of financial resources emerged as the predominant barrier to care, with clients reporting being able to "get around" linguistic barriers satisfactorily or without too much difficulty. Clients reported that they would bring a family member or friend to appointments if interpretation or translation was required. The use of informal, nonprofessional interpretation presents two issues, namely lack of confidentiality and the possibility of inaccurate interpretation. There is no official DPHSS cohort of medical interpreters. However, from the clients' perspective, they report that improving access to financial resources is their top needs priority.

Given that the SHP has already identified Chuukese as a target population for outreach and risk reduction services because of rising STD rates, and the steady increase of Chuukese enrollments in MIP (nearly half of overall MIP recipients¹⁴), Chuukese cultural and linguistic barriers may play a greater part in care access.

Transportation

The 2009 SCSN identified transportation as a significant barrier to accessing services. The SCSN specifically pointed out the high price of gas (the price of regular unleaded gas increased from \$3.24 per gallon in June 2009 to \$4.97 per gallon in March 2012), limited and/or non-functioning public transportation, and DPHSS department policy prohibiting client transport by personnel increased the likelihood that clients would miss or be extremely late for medical appointments. The 2009 SCSN further identified this barrier as a high priority item and made it the second goal to improve access to transportation resources for clients.

Since 2009, RWHAP has addressed transportation issues by issuing gas coupons. In a 2011 survey conducted with all Ryan White clients, 77% (17/22) received \$40 a month in gas coupons, which 100% of receiving clients said was satisfactory to cover core medical needs like seeing the doctor and picking up prescriptions.

Housing

The 2009 SCSN did not identify housing for PLWHA as a high needs area, but did anticipate that for a few clients, less than desirable conditions such as overcrowding or unsuitable sanitation could interfere with patient health. In a 2011 survey conducted with Ryan White clients, 14% (3/23) requested assistance with finding stable and affordable housing, which the Medical Case Manager was sufficiently able to address.

¹⁴ Matthews, L. (25 May 2011). "Migrants top MIP rolls. 55 percent of clients from FAS." *Pacific Daily News*.

Provider-Related Barriers

Other than shortfalls in the healthcare workforce (to be discussed below), there are no reported provider-related barriers.

Client-Related Barriers

Co-morbidity (substance abuse)

The 2009 SCSN generally identified co-morbidity as a barrier to care, primarily because it leads to poor treatment adherence and health outcomes. Moreover, “great efforts to follow up and offer care services to this population have been made resulting in negative outcomes” (p. 12) but there was no detail provided as to the exact nature of those negative outcomes. At this time, two clients are suspected of methamphetamine use but there is no confirmation.

The nature of co-morbidity and its accompanying client needs will change if testing is integrated more regularly into all of the island’s substance abuse centers. In planning meetings, SHP has discussed expanding the numbers of those in treatment for HIV testing.

Client-based behaviors

Current RWHAP staff have continued to or initiated several monitoring procedures to ensure that clients adhere as much as possible to their recommended regimens. The Medical Case Manager, for example, reviews receipts to ensure that grocery coupons pay only for nutritious foods. Gas coupon disbursements are based on the doctor, pharmacy, or lab appointments scheduled for the month. The MCM and doctors review medications to ensure clients understand their medications—and in 2011, all enrolled Ryan White clients reported that they did understand their medication.

Shortfalls in Healthcare Workforce

The U.S. Department of Health and Human Services has designated Guam as both a Medically Underserved Area (MUA) and Health Professional Shortage Area (HPSA). The Northern and Southern Region Community Health Centers are under the Bureau of Primary Care Services (BPCS) and are Federally Qualified Health Centers.

While the U.S. has a supply-side shortage of doctors—especially in primary care—the shortage is compounded on Guam by its geographical remoteness and the decline of healthcare professionals who accept MIP, the local government-funded assistance program that provides health care access for those persons who lack sufficient income. Guam historically and presently addresses the public health care system physician shortage by recruiting off-island doctors to the island, offering one-year contracts, and/or contracting private practice physicians to staff Community Health Centers.

As of this report’s writing, the Northern Region Community Health Center has three full-time doctors (two internists and one pediatrician) and three part-time contractual physicians to serve all patients. An interview with two of the doctors revealed that ideally, the clinic would staff five internists, five gynecologists, five pediatricians, and an additional 30 nurses.

The Southern Region Community Health Center has two physicians who exclusively see adults (two part-time contractual), one full-time physician who sees adults and children, and one pediatrician to serve all patients.

The health professional shortage most affects HIV care in two ways: 1) Ryan White clients must usually wait about one to two months to see a doctor after making an appointment, and 2) There is no HIV specialist.

In the last quarter of 2011 DPHSS implemented Electronic Medical Records at the Northern and Southern Region Community Health Centers, which has reduced the number of patients a physician can see in a day by 30% (30 appointments in one day before as opposed to 20 now). The number of clients seen is affected by the amount of data entry doctors are required to do while in clinic. However, physicians expect that once the transition and data entry from physical files to electronic is complete, the number of appointments in a day may increase.

According to the *Five-Year Health and Social Service Strategic Plan Public Draft*, Guam residents can anticipate the Guam Medical Regional Center (GMRC), a privately financed and operated hospital and doctors' offices. The plan suggests that this private hospital could drain physicians from GMHA. While the plan also notes that GMRC began a campaign in 2011 targeting Guam-originating physicians to return from the states or other areas to practice on island, it is doubtful whether they would be interested in or able to complement their private practices and/or hospital work with public health system contract work.

EVALUATION OF 2009 COMPREHENSIVE PLAN

In 2010, RWHAP commissioned an evaluation to assess progress towards the five goals from the 2009 Comprehensive Plan and to determine client satisfaction.

2009 Goal Successes

In terms of meeting the five goals, RWHAP made demonstrable progress towards or entirely fulfilled the stated objectives and activities from 2009. In summary:

RWHAP increased confidence and knowledge of four primary care physicians in treating PLWHA by organizing information sharing and training with the Hawaii AIDS Education and Training Center (AETC). RWHAP has also strengthened its partnership with the Pacific Island Jurisdiction AIDS Action Group (PIJAAG). In 2010, several program staff from RWHAP and SHP were able to share HIV prevention strategies, care and treatment options, challenges and best practices for PLWHA in the Pacific Island Jurisdictions.

RWHAP improved access to transportation resources by initiating Medical Transportation Services to supplement existing transportation resources. According to 100% of Ryan White clients, transportation has not been identified as a barrier to care, and none report needing any additional services to fulfill their medical care requirements.

The third goal for RWHAP was to reduce language barriers. The objectives and strategies towards this goal were deemed unnecessary. Furthermore, all current Ryan White clients presently confirm that it does not present, for them, a high priority barrier to care.

RWHAP is currently in progress towards its fourth goal, which is developing and implementing a quality management plan. Having already completed research into the HRSA Nine-Step Guide and sought technical assistance from the National Quality Center, RWHAP is on track to completing a plan using clinical measures to determine program efficacy.

RWHAP has made significant progress towards improving data collection as stated in the 2009 Plan. Staff implemented the RWHAP CAREWare system in 2009.

2009 Goal Challenges

The 2011 Part B evaluation, in light of the RWHAP success in meeting its goals, suggested focusing on longer term goals.

While there were no major challenges identified per se that inhibited the pursuit of these goals, the first goal of increasing confidence and knowledge of four primary care physicians was limited in its utility to patients insofar as doctors sign contracts with DPHSS for a year at a time. While four doctors did increase their confidence and knowledge of HIV/AIDS, three left island when their contracts expired.

WHERE DO WE NEED TO GO?

According to the evaluation and needs assessments that were conducted with Ryan White clients, clients are almost unanimously positive in terms of receiving care and support services. Their response indicates a higher likelihood that they will continue with the program, which in the long term projects longer, healthier lives. These clients are also able to directly give feedback about emerging or new barriers to accessing services and care. The immediacy of their feedback is essential in allowing RWHAP staff to anticipate or create solutions to such barriers.

However, as of the writing of this report there are 17 people on Guam who are HIV-positive and not in care. This number includes 11 with unknown status and 6 not in care or lost to care. Because all DPHSS HIV testing is confidential, there is at least some client contact information mechanism to allow for continued follow-up and linkage to care. Furthermore, the advent of rapid testing could potentially lead to 100% of HIV-positive individuals with unknown status who come into DPHSS for testing becoming aware of their serostatus.

In the interim, it is critical to address those HIV-positive individuals not in care, both to ensure that they can lead longer and healthier lives, and to reduce their likelihood of transmitting the virus to others in the community—both goals, which, coincidentally, are directly relevant to national priorities on HIV/AIDS strategy.

2012 Proposed Goals

The four proposed goals for the 2012-2015 SCSN and Comprehensive Plan are:

- ✓ Goal 1: Increase testing for individuals of unknown HIV status, with an emphasis on identifying and outreaching to target populations.
- ✓ Goal 2: Increase identification of HIV-positive individuals to provide links to care.
- ✓ Goal 3: Identify and address factors for known HIV-positive individuals that delay enrollment and/or cause program drop-out in RWHAP.
- ✓ Goal 4: Maximize the capacity of existing DPHSS and DPHSS-contracted doctors to continue delivering quality HIV/AIDS-care.

Goals Addressing Specific Comprehensive Plan Instructions

Goal 3 addresses unmet need.

Goal 1 addresses individuals unaware of their HIV status.

There are no proposed solutions for closing gaps in care, since none were identified by current clients. Goal 3 elicits responses from those not in care to identify these potential care gaps.

There were no identified care overlaps. As such, a goal addressing overlaps is not applicable.

Proposed Coordinating Efforts and Activities

There are currently no programs on island that receive Part A, C, D, or F Ryan White funding.

Private providers (non-Ryan White funded)

RWHAP, as part of its Goal 3 intended to develop a better picture of those lost to care or not in care, will attempt to assess how many PLWHAs might be utilizing services from private providers.

Prevention programs

RWHAP and SHP already work closely together. These programs have developed Goals 1 and 2 together in order to ensure that not only are target populations tested, but also linked to care.

Substance abuse treatment programs

At planning meetings, SHP has stated its desire to outreach to IDUs at treatment facilities. SHP and RWHAP will initiate a partnership with DMHSA/New Beginnings to provide HIV testing services. RWHAP will ensure that there is a referral mechanism between DMHSA/New Beginnings and DPHSS so that people undergoing substance abuse treatment can access HIV/AIDS care.

Medicare, Medicaid, CHIP

To date, the MCM has not reported any difficulties coordinating with or securing the appropriate insurance coverage for Ryan White clients. As of this report writing, the MCM reported that instead of staying on MIP, clients are transferring to Medicaid due to changes in eligibility requirements. This could result in better health outcomes for clients since Medicaid

provides more extensive health coverage than MIP. In the event that RWHAP enrolls new clients who need insurance, the MCM will continue to assist clients with applying for appropriate insurance services.

Community Health Centers

RWHAP proposes to address concerns with high doctor turnover and the resulting lack of continuity that clients feel through Goal 4, which ensures timely notification of new doctors and a physician orientation session that can minimize treatment disruption in client care.

ALL GOALS AND OBJECTIVES

Goal 1: Increase testing in the next three years for individuals of unknown HIV status, with an emphasis on identifying and outreaching to target populations.

Note: Objectives 1-4 were developed in consultation with SHP.

Objective 1:

SHP will increase counseling/testing/referral services (CTRS) to MSM by 10% each year.

Objective 2:

At least 70% of MSM STD clients who test at DPHSS SHP will know their status through post test counseling.

Objective 3:

80% of SHP clients screened for Syphilis, Gonorrhea, and Chlamydia will consent and receive an HIV test.

Activities

- SHP and community partners will continue and expand outreach services to targeted populations.
- SHP and community partners will develop and implement follow-up activities.

Objective 4:

100% of women with unknown HIV status, in the third trimester attending the public funded clinics, will receive an HIV rapid test.

Activities

- SHP will implement rapid testing at public funded sites such as the Community Health Centers, Maternal and Child Health (MCH) and Women's Health Program.

Short term outcome: Increased awareness by individuals of their HIV serostatus.

Long term outcomes: Greater life expectancy for HIV-positive individuals, reduced HIV incidence, and delayed progression of HIV to AIDS in HIV-positive individuals.

Goal 2: Increase identification of HIV-positive individuals in the next three years to provide links to care.

Note: Objectives 1-3 were developed specifically by SHP and have time frames of one year (until December 2012). Annual performance benchmarks will change depending on baselines set in 2012.

Objective 1:

85% of newly infected clients will be provided Partner Services within two weeks of receiving an HIV confirmed result.

Objective 2:

80% of newly infected clients will be linked to care.

Objective 3:

80% of newly confirmed cases will identify sex and needle sharing partners during the past 12 months.

Activities

- SHP will conduct partner services for clients confirmed with HIV infection.
- RWHAP Outreach will conclude its pilot program after one year and assess efficacy.

Short term outcome: Increased enrollment in care.

Long term outcomes: Greater life expectancy for HIV-positive individuals, reduced HIV incidence, and delayed progression of HIV to AIDS in HIV-positive individuals.

Goal 3: Identify and address factors for known HIV-positive individuals that delay access to care or cause program drop-out in RWHAP.

Objective 1:

RWHAP will be able to document for 90% of those clients not in care or lost to care reasons why they are not in care and/or not in contact with RWHAP.

Activities

- RWHAP and SHP will develop a protocol of continued contact with HIV-positive individuals after they test positive to encourage access to care by March 2013.
- RWHAP will develop a system by which clients lost to care are identified, contacted, and assessed for why they are lost to care or have dropped out (see CQM 2012) by April 2013.

Objective 2:

RWHAP and SHP will increase access to care.

Activities

- RWHAP will research proven strategies that reduce client-related barriers to care and program drop-out by April 2014.
- RWHAP will implement at least two strategies to reduce client non-enrollment and drop-out by April 2014.

Short term outcome: RWHAP will be able to decrease non-enrollment and program drop-out.

Long term outcomes: Greater life expectancy for HIV-positive individuals, reduced HIV incidence, and delayed progression of HIV to AIDS in HIV-positive individuals.

Goal 4: Maximize the capacity of existing DPHSS and DPHSS-contracted doctors to continue delivering quality HIV/AIDS care.

Objective 1:

Implement regularly scheduled doctors' needs assessment or elicit doctor feedback on process, structural, and client-based barriers to HIV medical service provision.

Activities

- Research and develop doctors' needs assessment by March 2014.

Objective 2:

Develop brief HIV/AIDS care orientation process for doctors.

Activities

- Organize and update existing treatment protocols, resources materials, and clinic checklists/patient flow sheets for doctors by March 2014.
- Research and develop brief HIV/AIDS care orientation process by March 2014.

Objective 3:

Orient at least 75% of DPHSS doctors to HIV/AIDS care and issues facing Guam's PLWHAs by 2014.

Activities

- RWHAP will establish regularly scheduled communication to find out when new doctors enter DPHSS system of care.
- Lead HIV doctor with the support of MCM will schedule and orient new doctors.

Short term outcome: RWHAP will have current feedback from doctors regarding improvements to care and treatment services.

Long term outcome: Clients will feel more confident about doctor-patient relationships.

How the Plan Addresses Healthy People 2020 and the National HIV/AIDS Strategy

Healthy People 2020 has two overarching goals: 1) To increase the quality and years of a healthy life, and 2) Eliminate our country’s health disparities. To address HIV/AIDS, Healthy People 2020 has adopted the National HIV/AIDS Strategy (NHAS), whose goals include: 1) To reduce the number of people who become infected with HIV, 2) To increase access to care and improve health outcomes for people living with HIV, and 3) To reduce HIV-related health disparities. There are an additional 18 national objectives that articulate how those goals will be accomplished.

The goals meet a select number of the 18 national objectives in the following ways:

<i>Guam 2012 SCSN and Comprehensive Plan Goals</i>	<i>Relevant Objectives per Healthy People 2020/NHAS</i>
Goal 1: Increase testing for individuals of unknown HIV status, with an emphasis on identifying and outreaching to target populations.	8, 9, 10, 11, 12, 13
Goal 2: Increase identification of HIV-positive individuals to provide links to care.	9, 10, 11, 12, 13
Goal 3: Identify and address factors for known HIV-positive individuals that delay access to care or cause program drop-out in RWHAP.	10, 11, 12
Goal 4: Maximize the capacity of existing DPHSS and DPHSS-contracted doctors to continue delivering quality HIV/AIDS-care.	10, 11, 12
<p>Key to Objectives HIV-8: Reduce the number of perinatally acquired HIV and AIDS cases. HIV-9: Increase the proportion of new HIV infections diagnosed before progression to AIDS. HIV-10: Increase the proportion of HIV-infected adolescents and adults who receive HIV care and treatment consistent with current standards. HIV-11: Increase the proportion of persons surviving more than 3 years after a diagnosis with AIDS. HIV-12: Reduce deaths from HIV infection. HIV-13: Increase the proportion of persons living with HIV who know their serostatus.</p>	

How the Plan Reflects the SCSN

The plan and its goals address a major shortcoming in the development of this document—specifically, how to describe and address needs for individuals who are aware of HIV-positive status but not in care. The RWHAP has committed to following up with these individuals in order to find out: 1) If they no longer have working contact information, 2) Have left the jurisdiction, 3) Have decided not to return to care, and 4) If not returning to care, some of the reasons why not (Goals 2 and 3).

The plan also directly addresses needs of individuals unaware of their HIV status and special populations through targeted testing events (Goal 1).

Goal 4 specifically addresses the shortfall in workforce. While hiring more doctors and preventing physicians from leaving island is beyond the scope of RWHAP, the program is committed to ensuring as much care continuity as possible by working with doctors to support them with needed information and protocols.

How the Plan Coordinates with and Adapts to Changes with Implementation of Affordable Care Act (ACA)

At this time, there is not enough information on how the Affordable Care Act may affect the U.S. territories. Medicaid eligibility has already expanded, so some Ryan White clients have transferred from MIP to Medicaid. Since Medicaid has better coverage than MIP, these clients may potentially experience better health outcomes. Otherwise, at the time of this writing ACA implementation will also be delayed until at least January 2013 due to challenges in the Supreme Court.

PROGRESS MONITORING

Throughout the development of the 2012 SCSN and Comprehensive Plan, several activities already form the foundation of future progress monitoring. Specifically:

- A RWHAP evaluation looking at administrative capacity and client satisfaction was commissioned
- RWHAP developed a client needs assessment
- RWHAP implemented the client needs assessment with 100% of enrollees
- RWHAP interviewed medical providers on existing service delivery and potential improvements
- RWHAP commissioned community planning sessions to receive feedback from stakeholders (including clients and service providers) on program delivery and improvement; these sessions also included reporting on the evaluation and needs assessment results
- Existing and new data was gathered, analyzed, and incorporated in the writing of the 2012 SCSN and Comprehensive Plan.

Several of these activities (client needs assessment, client satisfaction survey, planning sessions) will be repeated on a regular basis as per the 2012 Clinical Quality Management plan.

Progress on Goals 1 and 2 will be monitored by SHP on an annual basis.

Progress on Goals 3 and 4 will be monitored by RWHAP as per the 2012 Clinical Quality Management Plan process.