



Section 3

Community Services Assessment

RICPG Comprehensive HIV Prevention Plan, 2005 – 2009: 2006 Update

The RICPG has assigned a Task Force to address the needs of four priority populations¹:

- men engaging in unprotected sex with men and/or men engaging in unprotected sex with men and women.
- injecting drug users and other substance users and their partners
- women engaging in unprotected sex with men
- youth engaging in unprotected sex, alcohol and other drug use.

This Section of the Plan captures the work of the Task Forces. For more than three years, the Task Forces have gathered information about the priority populations to add to the needs assessment component of the Community Services Assessment (CSA). The CSA is comprised of three components:

- Needs Assessment
- Resource Inventory
- Gaps Analysis

A Task Force Workbook has been drafted and piloted, and a training workshop was given to the membership to demonstrate the function of the Workbook. The Workbook was designed to keep the Task Forces focused on how the CSA can help the Task Force gather information to make recommendations to the RICPG.

¹ In the past, a fifth Task Force addressed the needs of people who don't know their status/HIV positives not in treatment. In 2003, however, the RICPG dissolved this Task Force and required the four remaining Task Forces to incorporate the needs of "unknowns" and people living with HIV & AIDS into their work.

Needs Assessment

Priority 1: Men engaging in unprotected sex with men and men engaging in unprotected sex with men and women.

The MSM Task Force continued to meet this year with and accomplished several goals that had been identified by the group:

- Reviewing last year's plan and used it as a guide for their continued work
- Identifying additional and subsequent steps
- Adding 3 new members. The group recommended that a person with substance abuse background be recruited to the larger RICPG due to the recent reports linking crystal meth, HIV, and MSM. As a result, a private consultant who has a long history of working with the R.I. Division of Substance Abuse joined the RICPG as a member in July, 2005.
- The MSM Task Force reports back to the RICPG monthly as a regular part of every RICPG general meeting.
- Using meeting notes, results of assessments, and "Next Step" suggestions from the February 2005 conference breakout session as the basis for the RICPG Comprehensive Plan update.

Next Steps Identified by the MSM Task Force

The MSM Task Force continues to recommend the use of both qualitative and quantitative data in conducting the community services and needs assessments for MSM. MSM of color and MSM who are living with HIV are priority populations that should be included in all recommendations of the MSM Task Force.

1. The Task Force identified "no identified risk" (NIR) in the epidemiological profile as an issue in its possible relationship to MSM/gay men. The Task Force questioned the percentage of NIR in Rhode Island and how many of them are possibly MSM or gay men who do not identify as such because of stigma, fear, or homophobia.

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The Provision of Care Manager, who is a member of the Task Force, preliminarily reviewed the data for the AIDS Drug Assistance Program (ADAP) to determine if NIR corresponds to the epidemiological data. Initial draft findings showed that NIR for ADAP client database corresponded closely with the NIR in the epidemiological database. However, further and more detailed analysis is necessary for a better understanding of the NIR. The group did, however, follow up the discussion with an invitation to the new HEALTH-RI Epidemiologist to continue the dialogue.

2. The Task Force continues to work to identify additional vehicles, data, and ways to gather information about status and risk.
3. The Task Force is working with provision of care providers, counseling and testing sites, and prevention providers to better ascertain sexual behavior of clients. The Task Force communicates regularly with the Men's Health Collaborative, a group that is conducting STD and HIV testing at the Megaplex, a gay bathhouse in Providence, to enhance this understanding.
4. The MSM Task Force works to determine if the sites are welcoming to MSM and LGBT clients/patients. A major goal of the Task Force is to raise awareness to broaden MSM & LGBT-friendly providers in Rhode Island.
5. The Task Force continues to identify training, professional development, and other needs to increase awareness of and access to HIV testing, prevention, and care services for MSM and the LGBT community. The Task Force has worked with REACH to provide trainings to that end. The Task Force has connected with the HIV Testing campaign and posters, and informational material has been presented to the RICPG for feedback on content and placement of ads. The Task Force has made community connections to get feedback on how to access medical doctors for training purposes.

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6. The Task Force has discussed other social marketing campaigns that seem to show promise in reaching MSM, especially MSM of color. More research is needed in that regard.
7. The Task Force has updated the RICPG on MSM behavioral risk, issues for MSM prevention, epidemiology, co-morbidities, and surrogate markers for HIV risk as part of an orientation training at the June 2005 RICPG general meeting. The orientation training will continue to be updated as new RICPG members come on board.
8. Cultural sensitivity training on gay, lesbian, bisexual, and transgender issues into the REACH training offerings have been conducted and will continue. Such training is expected to be required for HIV Prevention Specialists certification in the future.
9. The Task Force works to identify additional MSM Task Force members to ensure broader community participation. The February RICPG Conference MSM breakout session was one strategy to assist with this. In addition, the group has provided a 6-month follow-up summary of activities with a cover letter inviting participation. The Empowerment Committee of RICPG has been approached to assist with MSM recruitment. An African American MSM is expected to be nominated for the RICPG as of September 2005. An African American gay youth co-chairs the RICPG Youth Task Force and may offer some assistance to the MSM Task Force.
10. The Task Force is working on gathering additional information on MSM, gay men, MSM of color, and people who are HIV positive. Possible vehicles for collecting information that have been discussed include focus groups with the following populations:
 - MSM of color
 - Young MSM
 - HIV positive MSM
 - MSM who frequent a local bathhouse
 - Population or location specific MSM (e.g. leather, “bears”, older gay, etc.)

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The Task Force has discussed the use of conducting focus groups instead of one town meeting to gather qualitative information from the MSM community. The feeling was that focus groups would allow more geographic diversity, as well as reach MSM who might not attend a town meeting or feel comfortable in that venue.

The breakout session in the 2005 RICPG conference was helpful in providing some insights. The continued communication with the Men's Health Collaborative, many members of whom are on the MSM Task Force, has also been a helpful vehicle for information gathering.

Other ideas that are being discussed by the MSM Task Force include:

- Holding a community forum that would provide information on MSM and HIV, using the forum to get community feedback and “testimony” regarding different perspectives, experiences, and knowledge. A community forum was held in March 2005 to discuss best practices and HEALTH-RI's funding decisions. This opportunity offered some insights. This was not however, an MSM-specific forum.
- Contacting other RICPGs to identify strategies and programs that have worked with MSM.

11. Identify and convene key stakeholders to develop a plan of action. The group has discussed ideas from focus groups to town meetings. A formal request of the group was made by a HEALTH-RI staff and MSM member to come up with a list of names to be part of a “stakeholder meeting to work potentially with the CBA to begin to develop a strategic plan of action regarding the prevention needs of MSM.” The request was made for no more than 15 people to participate in a facilitated discussion about MSM HIV prevention issues. It was agreed that the meeting include some individuals from Massachusetts and take a regional approach.

Priority 2: Injecting drug users and other substance abuse users and their partners

In 2003, the Substance Using Disorder Task Force identified the following issues to explore through focus groups with providers and clients:

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- What is the role of syringe exchange since the change in the relevant law? What is happening with the syringe exchange now that possession has been decriminalized?
- What is the current availability and access to IDU drug treatment issues?
- What are the substance treatment issues for inmates being released from prison? What are the contributions/barriers to access to services for inmates discharged from prison?

What has the Task Force accomplished to date?

In 2003, the Task Force met five times and decided to hold focus groups with clients and substance abuse treatment providers. The expectation is that the focus groups will help to set a focus for the RICPG around the three issues.

| Agency | Audience | Date Completed |
|--|------------------------------|----------------|
| A drug treatment provider focus group | 15 providers | March 11 |
| SSTAR men and women in detox focus group | 19 men and women in detox | May 22 |
| MAP Brothers for Life men in recovery focus group | 6 minority men in recovery | April 2 |
| CODAC men and women in methadone program | 6 women & 12 men in recovery | May 28 |
| Roger Williams HCV Support Group men with HCV recovering from substance use. | 6 men in recovery with HCV | June 11 |
| CODAC focus group with men and women in the methadone treatment program on their use of ENCORE | | October 2004 |

The focus group discussions yielded the following insights:

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- Access to services for the under -and uninsured appears to be an ongoing problem. Clients talk about having to be intoxicated to get service. Funding for more uninsured beds is unlikely.
- There are a number of substance abuse treatment provider training issues identified. IDU have a complex array of issues such as job training, social stigma, health problems, low-income housing, and family strife that hinder and/or jeopardize their recovery process. The impact on the treatment programs includes a need for more professional development to meet these challenges; provider burnout prevention; and collaboration across agencies to coordinate care.
- ENCORE is not routinely used by IDU, especially since syringes are available in the pharmacy. The program was rated highly by clients who were aware of (used) the ENCORE van and the exchange sites. Programs that work for IDUs include elements of holistic care such as family involvement and reconciliation; spirituality; client-centered timetables for treatment services; a broad array of life skill training for clients; and linguistically and culturally appropriate staff and programs.
- IDUs in prison have the added stigma/complication of a criminal record. Service coordination for IDU being discharged from the prison and jail appear to be non-existent.

During 2004 and 2005, the Task Force continued to work on the issues in the following ways:

- Clarify and refine the issues and create issue statements.
- Set priorities on the issues
- Determine a plan of action to address the issue in a manner appropriate to the RICPG mission.

Clarify and refine the issues

- IDU behavior category needs to be expanded to include crack users. The Safety Count (Best Practice program) includes crack and IDU together because of cultural link.
- A number of “cross over” issues were raised, such as communities of color, HIV positives, and women and partners.

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- Communities of color and PLWHA are now a part of all Task Force work. This was decided at a de-briefing meeting with the co-chairs and staff. It makes more sense to include the issues with each priority population/behavior.

Set priorities on the issues

The group reviewed the findings and set the following priorities with a vote:

1. Access to services
2. Programs that work for IDUs
3. Discharge planning at the Department of Corrections for substance users
4. ENCORE awareness

Determine a plan of action

The primary issues centered on access to treatment and its role in HIV prevention. The Task Force agreed that clients in treatment and recovery were less likely to share syringes and engage in high-risk behavior (unprotected sex, multiple partners, untreated STI). The primary problem was identified as insufficient number of treatment sites in Rhode Island.

Currently one site for detox of alcohol and opiate addiction is funded to provide care to uninsured clients. While residential care after detox may be the desired treatment option, there are issues: not all clients want to use it; there is a concern that it is the treatment of choice for the homeless; not enough beds; and mental illness issues.

Access to care issues involving provider include: intake and screening procedures and documentation-sharing between agencies are interfering with access to care.

There appear to be different “realities” about access to care based on the where one is coming from—a client or treatment staff/agency. What people say on the street about access to treatment does not necessarily reflect the policy and practices at drug treatment agencies. In addition, there are issues that are associated with the disease process. There is a waiting list for indigent/uninsured clients, which is counterproductive for this type of client. There is poor follow up by clients (3 to 5%) for entering treatment after being on the waiting list. Clients’ risk behaviors are inconsistent over time, personal issues and drug use changes.

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There was a discussion about treatment modalities and methadone. Several articles about methadone were presented by a Task Force member. In addition, data from a local methadone treatment agency on the number of clients testing positive for opiates and cocaine in the methadone program were as follows:

- Clients testing positive for opiates: 11.7%
- Clients testing positive for cocaine: 10.7%

While methadone is not the treatment of choice for some clients, there is research and professional literature that supports the use of methadone in the treatment of opiate addiction.

The group decided to gather data to inform their process. The epidemiologist from the Office of HIV/AIDS & Viral Hepatitis and the data manager presented ENCORE and IDU/HIV data. It was pointed out there has been a drop in new HIV cases among IDUs since the syringe exchange and law repeal. Also noted was the data showing communities of color are more affected by HIV, with Latinos reporting that they are most affected by IDU infection transmission mode. The group requested race/ethnicity and gender data on people who learn they are HIV positive at the same time they learn they have AIDS. With the ENCORE program for syringe exchange, there has been a decrease in the number of people attending ENCORE, but not a major decrease in the number of syringes exchanged. Clients are exchanging for themselves and friend/partner. More clients are reporting difficulty getting into treatment.

A staff member from the Division of Behavioral Health presented data collected by that agency. The data is on individuals that are seen in licensed treatment facilities (does not include hospitals and non-licensed facilities such as the Salvation Army, St. Francis Chapel, Urban League, and the Jewish Community Center.). Of the 18,679 admissions in 2003, 4,942, or 26%, were IDUs. 98% of the IDU were heroin addicts. 25% of the IDUs had cocaine/crack as a secondary drug of choice. Of the 4,942 IDUs treated, 2,607 were white males and 1,480 were white females (4,087 total whites). 124 were black males and 67 were

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black females; 379 were Hispanic males and 123 were Hispanic females. The access to recovery for communities of color is much lower than for whites.

HIV status is considered confidential information and not collected in the treatment data. Other issues not included are sexual trauma (domestic violence) and sexual orientation.

2005 RICPG Conference

In February 2005, the RICPG invited the community to a day-long meeting of workshops and information sharing. Structured workshops were conducted in each of the priority populations: MSM, IDU, Women, and Youth. A panel of “experts” from the community and the workshop participants were invited to have a dialogue and offer their responses to the following questions:

- What are the overarching problems or concerns with getting this population HIV prevention services (access and availability)?
- What HIV prevention services are needed to fill gaps in delivering HIV prevention to this population?
- What, in your opinion, works for this population? What doesn't work? (Here, there was an opportunity to discuss both the CDC best practices for this group as well as local, effective programs.)
- What specific short-term and long-term next steps would you like to see occur to enhance HIV prevention services among this population?

The comments were collected and reviewed by each of the Task Forces to be incorporated into the work of the Task Force, including this document.

Issues to be explored

- What does the data collection on HIV, domestic violence, sexual assault, and sexual orientation tell us?
- What is the capacity for state regulations mandating that HIV, STD, and hepatitis education be included during treatment (including curriculum and staff training)? What would substance abuse agencies need to build their capacity to do this?

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- What is the capacity for substance abuse agencies to provide HIV testing to clients?
- What is the best way to reach IDUs with clean syringes? How can ENCORE increase enrollment in general and among the minority community specifically?
- Are there agencies, consumer groups, and/or advocates that should be informed of the Task Force's work? Could these entities support the work, recommendations, and/or efforts of the Task Force?
- What are the barriers to insurance parity for mental health and substance abuse treatment? Currently some third party will pay for a physical exam and two to three mental health counseling sessions per month to substance abuse treatment agencies.
- How does the lack of sober housing and transitional housing impact the substance using community?
- How would the increase in the number of ENCORE sites affect enrollment in syringe exchange?
- Would rapid HIV testing in community-friendly sites increase the rate of HIV testing among the substance using community?
- Why is there no reimbursement for methadone treatment from third party insurance? Why does the state reimburse for Medicaid and RIte Care clients, but not require third party parity?
- What are the barriers to insurance coverage for long-term methadone treatment?
- What are the barriers to more state slots for substance abuse disorder treatment?
- Why are Soboxin, Subutex, Buprenorphine and Moloxin medical office visits covered by third party insurance, but not the medication? Why aren't medical office visits for methadone covered by insurances? Why is methadone not covered by insurances?
- How does stigma associated with HIV and substance use impact the minority community?
- How well do substance abuse treatment agencies meet the Office of Minority Health cultural and linguistic standards and mandates?

Guiding principles²

² The guiding principles were adapted from *Ending Discrimination Against People with Alcohol and Drug Problems*, 2003.

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Guiding Principle 1: Addiction to alcohol or other drugs may increase an individual's risk for HIV.

Based on Rhode Island HIV data, IDU is the risk factor in 16% of all new HIV cases. In addition, minority populations are disproportionately affected by HIV. For example, 29% of HIV infected Hispanic men and 20% of HIV infected Hispanic women acquired their infection through IDU in the period from 2000 to 2004. While IDU remains a major risk factor for HIV for both men and women, a greater proportion of women are infected with HIV through IDU. Among Rhode Island women, a greater proportion of minority women (African American and Hispanic) are infected through IDU when compared with their white counterparts.

Guiding Principle 2: Addiction to alcohol or other drugs is a treatable chronic disease that should be viewed and addressed as a public health issue.

Consider the decline in HIV among injecting drug users in Rhode Island. While Intravenous Drug Use remains a significant risk factor for HIV infection, there has been a steady decline in both HIV (not AIDS) and AIDS cases associated with IDU. HIV infection due to intravenous drug use dropped from 50% in 1989 to 16% in 2004. The decline in both AIDS and HIV cases associated with IDU follows a national trend.

We believe that a myriad of public health interventions contributed to this decline, including education among IDUs on safer needle use practices, availability of clean needles and needle cleaning kits through needle exchange programs, availability of non-prescription needle sales at pharmacies, and a general shift away from parenteral drugs among illicit drug users in the past years.

The Rhode Island Needle Exchange Program was launched in 1995. The Syringe Repeal Act was passed in Rhode Island in 2002, which allows individuals to purchase needles at pharmacies without the need of a prescription. In addition, clients are offered education and referrals for drug and hepatitis treatment.

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Guiding Principle 3: Barriers, obstacles, and/or legal imposed bans based solely on a history of addiction and HIV stigma should be evaluated and reconsidered if they interfere with people seeking treatment or recovery from substance abuse disorder.

During the 2005 RICPG Conference, the following issues were raised that provide insight into the effects of stigma and cultural barriers to treatment:

- There is stigma associated with IDUs that includes fear, a history of criminality, abuse/trauma, and family discord.
- It is hoped that providers are past the stigma issues, but clients' experiences with providers do not always reflect that.
- There is a stigma associated with methadone treatment among IDUs as well as the non-using community. There is a need to lower the stigma associated with methadone treatment for IDUs.
- Treatment is a window of opportunity for education with substance users. It is a time during which learning can take place.
- Overcoming client and staff stigma and biases would facilitate the treatment process.
- Clients need to be counseled by people who look like them and with whom they can identify; who know the community; and who can provide compassion, love, honesty, and trust in a non-judgmental way.
- Sexual orientation (gay, lesbian, and transgender) needs to be addressed with specific programs for that population.

Guiding Principle 4: In order to meet the complex needs of individuals with substance abuse disorders and their families, a holistic approach to HIV and addiction treatment and recovery should be widely implemented.

During the 2005 RICPG Conference, the following issues were raised that provide insight into the need for a holistic approach:

- When considering this population, providers need to consider the addictive process and the overpowering nature of the drug use. When actively using, a client's priority is procuring drugs.

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- There needs to be “one stop” mental health and substance abuse treatment that includes the client’s medication and more interagency referrals and coordinated care across all the client’s needs.
- IDU are represented in hidden populations too. Substance use is associated with complex issues such as homelessness, poverty, domestic violence and mental illness.
- Systemic changes are needed to bring the “services to the street” where substance users are located.
- The community has not been able to consistently provide evidence-based interventions for clients with a chronic, relapse-based disease who need frequent attempts at treatment.
- Case management of clients is needed to overcome the fragmentation of services and care for this vulnerable population.

Recommendations

- Insurance coverage and access to treatment for substance abuse disorders should be at parity with that for other chronic illnesses.
- The syringe exchange program needs to make programmatic changes to meet the needs of injecting drug users on the street where the behavior is taking place.
- Increase the capacity for physicians to provide methadone treatment in private practice.
- Treatment for alcohol or other drug disease should be individualized for each patient, based on the best science and standards of care, including the use of appropriate medications, behavioral therapies, and ancillary services that significantly enhance the likelihood of success.
- Substance abuse disorder care coordination must include housing, vocational rehabilitation, education, mental health, hepatitis C treatment, and/or access to other social and health services.
- Advocate for building the capacity of the community to develop and implement science-based models that can be evaluated for effectiveness.
- Advocate for implementation of the Office of Minority Health-mandated standards:
 - *Standard 4: Qualified language assistance services (mandate)*

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Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.

- *Standard 5: Notices to patients/consumers of the right to language assistance services (mandate)*
Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.
- *Standard 6 – Qualifications for bilingual and interpreter services (mandate)*
Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).
- *Standard 7 – Translated materials (mandate)*
Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

Priority 3: Women engaging in unprotected sex with men

The Women's Task Force created 2005 goals with 2004's accomplishments in mind. The Task Force continued meeting and working together as a team and developing a plan for service delivery for women in Rhode Island. The Task Force's 2005-2006 goals are as follows:

- Create a participant survey for women accessing HIV services to get feedback to give providers information on how to better service women.
- Pilot the tool with both constituents and providers; document feedback.
- Share tool and findings with RICPG to get input.
- Organize a Women's Task Force retreat.
- Implement tool and interpret data.
- List recommendations and present them to RICPG.

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The Women's Task Force created the participant survey tool and has piloted the tool with over 25 women. The provider tool will be piloted in the fall of 2005. The Task Force is working on organizing a retreat. We continue to move obstacles and jump over barriers placed in our way by systems set up to keep women oppressed.

The primary message that Task Force seeks to convey is that the Women's Task Force, in its planning process, has run up against as many obstacles in trying to gather data and assess needs as many of the clients do who cannot access the services. However, the Task Force still remains optimistic and will continue to work toward turning obstacles into opportunities to better increase both quantity and quality of services for these women.

The Task Force focused on the lack of appropriate questions on current forms when gathering information about HIV, and the same discovery surfaced when the group began to look at STDs as a risk factor for HIV. Some of the flaws in current data collection included making the connection around violence. Examples from professionals serving women included the fact that even using the word violence may not connect with some of the women. If a woman has vaginal sex, being forced into anal sex may not occur to them as violence. They rarely ask a person if they are in an abusive relationship. They often don't ask about sexual orientation. Critical information is being missed due to poor instruments and insufficient field training in gathering information. The above mentioned continues to exist and continues to create barriers to women accessing services and women being served with dignity and respect.

This Task Force has identified a need for building the capacity of professionals in the field to interview and counsel in a way that will sensitively collect some of the data that is known but not sufficiently documented. In addition, the Task Force ran into union bargaining obstacles when considering who might best provide such training.

The work of the Task Force revealed that many of the HIV interviewing forms were not specific and were more often a guidance tool. This flaw assumes that the professional interviewers will ask the needed questions. This Task Force's experience with this population is that it often does not happen.

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One of the highlights of the Task Force's insights and discoveries was that the free clinics in both HIV testing and STD testing are not deemed responsive to the needs of the specific population that needs them. The hours for testing are Monday through Friday 9-4. People who might be using this service would most likely not be able to take a day off of work. Even if individuals were not working, one of the known characteristics of this population is that it takes courage to motivate to go for testing and that individuals need to be able to access it as soon as possible after they make the decision. Because of daily crises and stressful demands, they may not be motivated or able to do it later. Therefore, it is the conclusion of this group that more services need to be offered with a more frequent and flexible schedule to include evenings and weekend hours. It is known that for a free HIV testing appointment one may be asked to wait three to four weeks. In families where crises and distractions permeate daily life, this wait is a missed opportunity for service providers. The Task Force concludes that testing should be made available immediately upon request.

The Task Force agreed that anything short of addressing these access issues is insufficient and does not respond to the needs of the population. The Task Force will work to continue to remedy this problem.

The Task Force further explored the area of consumer friendliness and cultural competence in services for high-risk women. The Task Force has key informant information and observations indicating that some organizational climate issues alienate consumers from getting the services they deserve.

The Task Force has struggled with the issue of creating a consumer-friendly climate instrument to substantiate the key informant information that concerns this group. In addition, the issue of how to implement the instrument has also been an obstacle.

The RICPG is organized as a partner with HEALTH-RI; non-HEALTH-RI vendors may not always welcome efforts in this behalf. Even HEALTH-RI-funded vendors may not greet this work with open arms. The Task Force has discovered similar obstacles even working

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directly with HEALTH-RI. The Task Force will continue to work toward enhancing collaboration in these efforts.

The Task Force further discussed that free HIV testing should be offered by a variety of organizations. Competition to offer the best free service is good for Rhode Island. It increases the motivation to offer quality services; it increases the options for referring organizations while ensuring quality care, and provides options for deserving women and other consumers of these services.

The Task Force identified that Chlamydia is the number one sexually transmitted disease. If Chlamydia exists, it is a sign that a woman is at risk for HIV. The need to focus on STD data to determine risk factors has resurfaced many times in the discussions of this group.

In addition to data collection needs, the group discussed the need for more evidence-based prevention strategies in Rhode Island.

The Task Force is currently getting a more broad-based perspective and soliciting feedback through invitations to guest professionals to participate in meetings.

Finally, the Task Force has explored the option of creating a resource guide for women as a tool to help them access services available.

The work of this Task Force is not to negate or disregard the work and services of many qualified and caring professionals working in the service of women. The charge of the RICPG Women's Task Force is to gather data, identify gaps, and recommend a strategy for improvement.

Priority 4: Youth engaging in unprotected sex and alcohol and other drug use

Much progress has been made in organizing the RICPG Youth Task Force. REACH has offered a training event on getting youth on board, and the Task Force is now up and running. The RICPG Facilitator is co-chairing the group until an adult co-chair is designated. The group does, however, have a youth Co-Chair, who has just received the

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Youth Community Involvement Award from Destiny House. In addition, this youth has much experience working as mentor for Planned Parenthood Rhode Island.

The Task Force has seven members, two of which are youth. The youth members include one Latino female and one gay, African American male. In addition, the group has the benefit of a HEALTH-RI staff person on board. The group continues to place recruitment strategies on the active agenda.

The group has been able to secure meeting space that is accessible to youth, follows two brainstorming meetings on strategy.

Activities in progress include:

- Sponsorship of a successful “Youth Cultural Competency” training, with plans to offer a follow-up that will out reach to parents as well.
- Developing a Task Force orientation packet with the help of the HEALTH-RI staff person.
- The Department of Education member has developed a PowerPoint Training/Orientation and HIV IQ Test. RICPG members can review and comment via a Youth Task Force web event. The same presentation will be used to disseminate information through youth mentors.
- In addition, the youth Co-Chair and two members will be panel presenters raising awareness on the local cable TV network Soap Box Television talk show with Planned Parenthood of Rhode Island.
- The Task Force has interfaced with the Department of Education member to submit the HIV awareness quiz for publication in the Health Schools! Healthy Kids! School Health Chronicle. Finally, the Task Force has reviewed the Task Force workbooks and has discussed the option of having them available electronically, so that Task Forces would be able to progress through the workbook more efficiently. Our Department of Education member took the lead on these projects.
- The group has summarized activities to include as follow-up to the 2005 RICPG Conference breakout session needs and gaps discussion.

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Progress since last year's HIV Prevention Plan submission

Group readiness was an issue for the Task Force, but much progress has been made, with a consensus a working Task Force can be developed. The full RICPG, which meets once a month in the evening, is more youth-friendly and has the capacity to involve youth in a more meaningful way; as a result, the Latino female from the Youth Task Force is now in the process of joining the full RICPG as an active member.

Prevention for Positives

The case manager survey has been handed over to the Quality Assurance Consultant Team working with the Provision of Care. Activities between prevention and care include:

- Prevention staff serve on case management quality assurance working group to advocate for health education/risk reduction to be included in standards of care.
- Prevention staff attend the Provision of Care meetings.
- Ryan White funded programs attended the Bridge Committee to share information on services and gaps in services. The Bridge Committee includes RICPG members.
- Funding from Ryan White Care Act Title II was awarded for HIV prevention project and included in the comprehensive HIV prevention RFP issued in 2004.

| Needs Assessment | | | | |
|---|--|----------------------|---|--|
| Objective | Activities | Output | Immediate Outcome (2006) | Intermediate Outcome (2009) |
| To continue to conduct a needs assessment based on the priority population/ behaviors using coordinated community assessment strategies | <ul style="list-style-type: none"> • Continue to facilitate a plan to conduct a community assessment • Facilitate the priority population/ behavior Task Force meetings • Conduct activities associated with each Task Force plan • Train staff and RICPG in community assessment strategies | Task Force Report(s) | The RICPG has additional information to assist in the priority setting process. | RICPG members are prepared to act on the tasks associated with community planning. |

Resource Inventory

The RICPG Strategy Planning Committee has assumed the responsibility for the development of a new process for collecting data for a resource inventory that can service both providers and consumers. Prior efforts at the resource inventory were inefficient in managing and updating the data. The old inventory was based on the responses to a survey sent to agencies throughout Rhode Island. Because of the time-consuming nature of this process and the low return rate of surveys, a process to update the inventory in a more cost-effective manner was necessary. In addition, it was important that the survey include all the services for HIV prevention and treatment (Ryan White, all Titles), HCV testing, and HCV treatment resources.

In 2005, HEALTH-RI continues to develop new approaches to the resource directory through the following steps:

- Monitoring other directories, websites, and resources in the state and nationally. Sites and materials of interest are shared with vendors and staff via email.
- Updating the HEALTH-RI web pages devoted to HIV/AIDS, including services for prevention and care. The web pages were included in a public health campaign for HIV testing and advertised heavily in the community.
- Contracting with a consultant (SAS) to design an interactive web page that the community can use to query information. A sole source agreement has been issued and HEALTH-RI is finalizing the criteria for the interactive sites. The site will be completed by December 2005.

| Resource Inventory | | | | |
|--|---|--|---|--|
| Objective | Activities | Output | Immediate Outcome (2006) | Intermediate Outcome (2009) |
| To continue to conduct a resource inventory of services associated with HIV/AIDS prevention and treatment. | <p>Explore cost-effective methods of gathering inventory information.</p> <p>Conduct resource inventory update for 2005.</p> <p>Make inventory available on HEALTH-RI web site.</p> | <p>Updated resource inventory to include Ryan White services and substance abuse treatment centers offering HCV testing.</p> | The RICPG has additional information to assist in the priority setting process. | RICPG members are prepared to act on the tasks associated with community planning. |

Gap Analysis

2002 was the year that the RICPG Strategic Planning Committee initiated the gaps analysis process. In 2003 the process was revised to include:

1. Review of the priority population/behavior determined by the RICPG.
2. Review of the current set of HEALTH-RI funded HIV prevention programs, Ryan White-funded programs and community partners.
3. Identifying gaps by type of intervention and location of services for each priority population/behavior identified by the RICPG.

Beginning in 2004 and continuing in 2005, Task Forces have used a gaps analysis process set forth in the RICPG Task Force Workbooks.

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Gaps that have been identified by Task Forces are indicated in the chart the follows. Please note that the key to all strategies and services is as follows:

- **ILI**—individual level intervention
- **GLI**—group level intervention
- **PCM**—HIV Prevention Case Management
- **TO**—Targeted outreach
- **CTR**—HIV counseling, testing and referral and partner notification services
- **PI**—public information/education

Identified Gaps by Priority Populations/Behaviors

Gaps Priority 1 MSM:

Intervention: PCM, CTR, ILI, TO, GLI
Geography: State wide

Gaps Priority 2 IDU:

Intervention: PCM, GLI, TO
Geography: Woonsocket, Newport, non-urban areas

Gaps Priority 3 Women:

Intervention: ILI, GLI, PCM, TO
Geography: Woonsocket, Newport, non-urban areas

Gaps Priority 4 Youth:

Intervention: ILI, GLI, CTR, PCM
Geography: Woonsocket, non-urban areas

Gaps Priority 5 Don't Know Status:

Intervention: CTR, TO
Geography: Woonsocket, non-urban areas