

**INDIANA
JURISDICTIONAL
HIV PREVENTION
PLAN
2013 - 2015**

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Executive Summary

The 2013-2015 Indiana Statewide HIV Prevention Plan is designed to establish the roadmap for HIV services that will have the greatest impact on communities at highest risk for acquiring and/or transmitting HIV. The HIV Prevention Plan contains information related to the HIV prevention needs in Indiana. The plan includes: the description of the Indiana State Department of Health (ISDH) HIV Prevention Programs, Epidemiologic Profile Executive Summary, Prevention and Care Resources for the State of Indiana, and the description and history of the Indiana HIV Prevention Community Planning Group (CPG).

Epidemiologic Profile Executive Summary

Demographics

The demographic information for Indiana used throughout this report is based on the 2010 Census Bureau population estimate. Indiana is a mostly rural state with several urban and metropolitan centers that had an estimated population of 6,483,802 people. The majority of the population (84.0%) is White and Non Hispanic, followed by Blacks (9.1%). The rest is comprised of people of Asian/ Pacific Islander and American Indian/Alaskan Native origin. The population is predominantly Non Hispanic (94.0%), with a small, but fast growing Hispanic minority. According to the 2010 Census Estimates, 6.0% of the population selected Hispanic as their Ethnicity.

Prevalence

By the end of December 2010, a total of 9,893 persons were living with HIV/AIDS (PLWHA) in the state of Indiana, up from 9,646 persons by the end of 2009. The disease continues to be male dominated, with the number of diagnosed males almost four times higher than that of females. The rate of infection was at 249.3 for males and 58.9 for females per 100,000 people of the general population. The majority of PLWHA are in their middle ages, ranging from 40 to 49 years of age. However, the majority of people are diagnosed for the first time at the ages of 20 to 29 years of age. Around a third of all PLWHA are Black (35.1%), while about five out of ten people with HIV/AIDS are White (54.6%). Based on the smaller number of Blacks in the general population, the prevalence rate of that racial group (587.3/100,000) is exceeding the rate of the Hispanic (182.4/100,000) and White group (98.8/100,000). HIV/AIDS continues to affect Black males disproportionately more than their White counterparts.

Each PLWHA is associated with a risk category of how they most likely were diagnosed with the disease. The overwhelming majority of risk categories were Men Having Sex with Men (MSM). Its rate of 155.0 per 100,000 people of the population is between 6 to 10 times higher than the other risk categories for all diagnosed people. It is the single largest category of risk for all race and ethnicity groups, and it is especially pronounced for Blacks. Heterosexual risk is the second highest risk category at 26.7 per 100,000 people.

Geographically, the vast majority of people that were diagnosed in Indiana are also living here (80%). Within the state of Indiana, most PLWHA are concentrated in the urban areas of the State. The majority are living in Health Region 5, corresponding to Central Indiana and the Indianapolis Metropolitan area, with 275.0 per 100,000 diagnosed people. Other regions with large numbers of PLWHA include Region 1 (168.6/100,000) and Region 2 (121.7/100,000) which corresponds to the northern part of the state adjacent to Chicago, and Region 7 (111.9/100,000) located in Southwestern Indiana.

New Diagnosis

In 2010, the number of newly diagnosed persons in Indiana was 496, slightly up from 2009, which had 489 newly diagnosed persons. The diagnosis rate remained relatively the same in

2010 at 7.6 slightly down from 7.7 per 100,000 people in 2009. The highest rate of new diagnosis in 2010 occurred among males between the ages of 25 to 29 years of age. This is slightly higher than in 2009 when the majority of new cases were found among those 20 to 24 years of age. Males continue to outrank females more than three times. The male diagnosis rate of 12.4/100,000 in 2010 has increased from a rate of 12.1 in 2009. The female new diagnosis rate remained around 3.0/100,000 in 2010 and the previous year.

For the first time, close to half of all diagnosed people is Black (45.8%), while in comparison the percentage of Whites shows a decrease (42.3%). The gap between races is starting to show a shift in the populations affected as shown by the previous year, 2009 (41.7% Black vs. 47.9% White). Blacks continue to have a rate (38.4) that is almost three times the rate of Hispanics (10.8), and more than eight times that of Whites (3.8). New diagnosis among males is predominant for all racial and ethnic groups. The rate of new diagnosis with HIV/AIDS among Black males (61.4) is especially high, compared to their Hispanic (16.1) and White (6.6) counterparts. The majority of new diagnosis can be found in the MSM risk category, with a diagnosis rate of 7.2 per 100,000 people. The main contributors are Whites (111), Blacks (99), and Hispanics (13). Heterosexual risk is the second highest category representing Blacks (43), Whites (23), and Hispanics (16).

Geographically, nearly five out of ten newly diagnosed persons live in Health Region 5 in Central Indiana, while regions 1, 2, and 7 come in close seconds of one another. Within the leading regions, Marion county and Lake county had the most new diagnosis in the reported time period.

Mothers with HIV

The cumulative number of reported cases of children born to HIV positive mothers, 1982 through 2010 in Indiana was 826, up from 728 in 2009. More than half of all children are Black (51.0%), less than one in three is White (31.0%), and the remaining is Hispanic (9.4%). In 2010, three new cases of pediatric HIV diagnosis were reported. Of all the children that were born to diagnosed mothers, 19.0% tested positive for HIV or were diagnosed with AIDS. Please note that these numbers are cumulative and include all children, including those that were born before medication to prevent the spread of the HIV virus from mother to child was available.

Mortality

The number of people that died of HIV/AIDS-related complications in Indiana peaked around the year 1995 and started to drop sharply thanks to the widespread availability of antiretroviral medications. However, in 2007, the number of persons that were diagnosed with HIV/AIDS and that died was 210, up from 121 in 2006. The Office of Clinical Data and Research completed a death match in early 2008. The Vital Statistics department provides information on any deaths of persons for a given time period which is used to match against the surveillance data base to identify persons with HIV/AIDS that have deceased. This may account for the increase in deaths associated with persons that have HIV/AIDS. From 2008-2009, the number dropped to 119 deaths. This decrease may in part be due to the development of a new Vital Records system established in early 2009. Many submitters were back logged with submittal of mortality reports. In 2010, it went back up to 149 deaths. This is likely a result of another death match with Vital Records and a comparison with the National Death Index. The majority of diagnosed people that

died were males (79.2%). Among the racial and ethnic groups the death rate was highest for Blacks (1.7/100), followed by Whites (1.4/100), and Hispanics (1.1/100). The highest number of deaths occurred among persons aged 40 to 49 (absolute number of 62). The majority of deaths are connected to the MSM and Hetero risk group, with mortality numbers of 66 and 22 respectively. Geographically, the highest mortality numbers occurred in Regions 5 (Central Indiana) at 67 deaths.

Mobility

Of the total number of diagnosed people in Indiana as of December 31, 2010, a relatively small number has migrated. At the end of 2010, a total of 849 persons that were diagnosed with HIV/AIDS in Indiana and were still alive had moved out of the state, compared to 774 in 2009. At the same time a total of 1,963 people had moved to Indiana that were diagnosed with the disease in another state and that were alive at the time of this report, compared to 1,885 persons in 2009. Of the diagnosed persons that moved into the state in 2009, the majority were White (54.1%), compared to 54.4% in 2009. Over one-third of all persons that moved to Indiana in 2010 were Black (34.0%), virtually unchanged from 34.0% in 2009. Diagnosed persons of Hispanic ethnicity remain stable as a percentage of all persons moving to Indiana. They comprised 8.0% in 2010, compared to 7.8% in 2009. Of those that moved to Indiana, more than a third (39.5%) settled in central Indiana's Health Region 5, and 13.1% in Health Region 1, the northern part of the state. The rest was distributed more or less equally among the other health regions of the state.

Counseling and Testing

In 2010, a total number of 17,459 HIV/AIDS tests were administered in Indiana by the state, federally funded sites, compared to 31,826 in 2009. Out of those 17,459 tests, 135 (0.8%) had a positive result, slightly higher than the numbers of 2009 (190 or 0.5%) and 2008 (212 or 0.7%). Slightly more tests were administered to males (54.7%) than to females (45.2%). In addition, sixteen tests were administered to Transgender persons in 2010. The positive test results for males (10.3/1,000) were almost six times the number of female test results (1.6/1,000). Blacks (8.2) had a higher positivity rate per 1,000 tests as compared to Whites (5.5) followed by Hispanics (4.9). This changed from the previous year when Whites (6.1) and Blacks (6.2) were close to the same. The largest number of positives came from the 20-29 age groups (69) with 40-49 year olds (27) as runner-up.

Youth Risk Behavior Survey

The Youth Risk Behavior Survey (YRBS) surveys the health-risk behaviors of young people every two years in six domains: (1) behaviors which facilitate unintentional injuries and violence, (2) tobacco use, (3) alcohol and drug uses, (4) sexual behaviors related to pregnancy and sexually transmitted diseases, (5) unhealthy dietary behaviors, and (6) physical inactivity and being overweight. The information gathered from the 2009 YRBS reveals that three-quarters of adolescents have used alcohol and over a third had used marijuana. Almost half of adolescents in Indiana (49.2%) have had sexual intercourse, while about a third is currently sexually active. An encouraging 89.6% of Indiana adolescents have been taught about HIV and AIDS infection in school, yet only 58.0% used a condom during the last sexual intercourse.

Behavioral Risk Factor Surveillance System

In 2010, a survey (respondents=6,231) was conducted to assess the indicators of risk for HIV/AIDS in Indiana. The survey asked specific questions to a representative group of Indiana residents. Approximately, 34.6% of all interviewees have ever been tested for HIV, down from 37.9% in 2009. Of those tests, the majority were done in a hospital (41.1%) or a private doctor/HMO (40.4%). Respondents with a higher percentage of HIV testing were more likely to be among the 25-34 and 35-44 age groups (47.6% vs. 45.2%). Blacks have the largest share of HIV tests among each racial and ethnic group with 60.9%. However, only 30.5% of men had been tested for HIV compared to 38.8% of women. A higher percentage of respondents (43%) with an income of \$24,999 or less indicated they've been tested for HIV.

STD

In 2010, Chlamydia continued to be the most frequently reported sexually transmitted disease in Indiana, with 22,825 reported cases, 21,759 cases in 2009, and 21,744 in 2008. Gonorrhea cases were reported at 6,496 cases in 2010, 6,812 in 2009 and 8,489 in 2008. Primary and Secondary Syphilis was reported to be 175 in 2010, up from 152 in 2009, and 140 reported cases the year prior. Females continued to outnumber males for both Chlamydia and Gonorrhea while Syphilis is more prevalent among males. Both Blacks (43.4%) and Whites (36.0%) make up the majority of all STD cases in the last year.

In 2010, Indiana had 66 cases of acute Hepatitis B, up from 63 in 2009. The total number of chronic Hepatitis C infections for the state was reported to be 5,954 cases in 2009. Finally, 100 cases of Tuberculosis (TB) were reported in Indiana in 2011, up from 90 in the previous year. Of those 100 TB cases six persons were also HIV positive.

Care Issues

In the fiscal year that ran from April 1, 2010 to March 31, 2011, the funding for Part B of the Ryan White CARE Act added up to a total of \$12,215,957. The majority of that budget (90.2%) financed the AIDS Drug Assistance Program (ADAP) and the Health Insurance Assistance Programs (HIAP), while the rest was used for other administrative costs.

Of the 660 persons enrolled in ADAP in the same period, more than half (53.5%) were White. The share of Blacks among ADAP recipients grew to 36.8%. The majority of recipients (62.8%) continued to select MSM as their main risk category. In this report period, 1,830 persons were enrolled and received assistance through HIAP, an increase of 32% compared to 1,384 two years ago.

As of March 31, 2011, Indiana had a prevalence of 9,927 PLWHA. Annually, the HIV Care Services program uses the total PLWHA to estimate an Unmet Need population. Unmet Need is defined as service needs and gaps for diagnosed individuals who know their HIV positive status and are not receiving primary care. To calculate this estimation, persons found to have a CD4 or viral load test between April 1, 2010 and March 31, 2011 were identified as receiving care based on records kept by the electronic HIV AIDS Reporting System (eHARS). Also, individuals found to have Medicaid service or antiretroviral drug claims within this time frame were determined to be in care. Persons with the requirements listed above were removed and as a result, 3,282 (33.1%) PLWHA were found to represent those with Unmet Need. Demographically, Whites represented 47.0%, Blacks represented 41.0%, and Hispanics

represented 9.0% of the Unmet Need population. Most persons fell into the 40 – 49 age groups (40.0%). Of those with Unmet Need, a higher percentage of persons identified as Homosexual (45%) while Heterosexual (15.0%) and IDU (6.0%) followed.

Based on the information above, the following populations have been identified as populations that are at greatest risk for transmission and acquisition of HIV in the state of Indiana:

1. People Living with HIV/AIDS
2. Black Men who Have Sex with Men (MSM)
3. White Men who Have Sex with Men (MSM)
4. Hispanic Men who Have Sex with Men (MSM)
5. Black Heterosexual Women

Purpose of the Jurisdictional HIV Prevention Plan

The Purpose of the Jurisdictional HIV Prevention Plan (Plan) is to provide a blueprint for HIV planning and provide flexible direction. The Plan is structured to:

1. Support the implementation of High-Impact Prevention programs;
2. Ensure that HIV planning is efficient and focused on results-oriented processes;
3. Encourage collaboration and coordination across HIV prevention, care and treatment services;
4. Reduce reporting documentation;
5. Engage a broader group of stakeholders; and
6. Focus on streamlining communication, coordination and implementation of needed services, including mental health and substance abuse, across the continuum of HIV prevention, care and treatment services

The Indiana State Department of Health has chosen to incorporate the state's three-year funding cycle into the planning cycle and create a plan every three years, and update the existing plan annually or as needed.

Indiana State Department of Health HIV Prevention Programs

HIV prevention is the best strategy for reducing the human and economic toll from HIV/AIDS. Comprehensive HIV prevention is a broad term that incorporates tracking the epidemic through HIV/AIDS Surveillance system, research to identify causes and solutions, implementing effective, evidence based prevention intervention programs; building capacity of state and local programs; and program evaluation and policy development.

The goal of the Indiana HIV Prevention Program is to increase public understanding of, involvement in, and support for HIV prevention in an effort to reduce the number of new infections. The focus is on eliminating racial and ethnic disparities in new infections and prevention with HIV-positive individuals. Programs are implemented statewide through designated health departments and community based organizations (CBOs). These agencies provide education, information, and services to initiate modification of behavior patterns or practices that put persons at risk for HIV infection.

Adult Viral Hepatitis Prevention

The mission of this program is to decrease transmission of hepatitis viruses, increase hepatitis A & B immunizations among adults and those at increased risk, increase resources to identify and treat persons with chronic hepatitis, increase identification of those living with viral hepatitis, and increase awareness among healthcare providers and laboratories as to their roles in prevention, detection, management, and treatment of viral hepatitis.

Perinatal Hepatitis B Prevention Program (PHBPP)

The Indiana Perinatal Hepatitis B Prevention Program (PHBPP) is a resource for the surveillance and control of perinatal hepatitis B infection. The primary goal of the program is to prevent perinatal transmission of hepatitis B infection by identifying and providing case management to HBsAg-positive pregnant women to ensure initiation of post-exposure prophylaxis to their newborns.

Perinatal HIV Project

The *One Test Two Lives: Prevent HIV Indiana* campaign is an effort of multiple partners to increase awareness and promote practices that will result in prevention of HIV transmission from mothers to their babies. The campaign is a multi-pronged outreach designed for those who provide care to and interact with women of childbearing age and the general public to make sure everyone is knowledgeable regarding mother-to-child-transmission of HIV. In addition to providing this education firsthand to those that the campaign has the ability to reach, it is also an objective to ask those who receive this important message to join in the prevention efforts.

Capacity Building Assistance Program

The goal of the Capacity Building Assistance program is to improve the performance of Indiana's HIV prevention workforce in the following areas: Strengthening Organizational Infrastructure, Strengthening Interventions for HIV Prevention, Strengthening Community Access to and Utilization of HIV Prevention Services, and Strengthening Community Planning for HIV Prevention. This is done by assisting community based organizations and local health

departments to increase and sustain their ability to deliver effective HIV prevention services. Once a need has been identified, program staff initiates a request for local and national providers to assist with meeting the provider's capacity building needs.

Training and Development Program

This program initiates, coordinates, and provides trainings related to HIV prevention. These trainings are provided by program staff as well as through collaborations with national providers. The program holds monthly HIV Prevention Counseling Certification Training for employees and volunteers of community partners.

Needs Assessment and Gap Analysis

Needs Assessment

Needs assessment is the process of obtaining and analyzing findings to determine the type and extent of unmet needs in a particular population or in a community.

Gap Analysis

A gap analysis is used to identify and describe the gaps in services for defined high-risk populations determined by the needs assessment. A gap analysis is usually conducted following any needs assessment activities that have taken place. The needs assessment committee then utilizes this document in order to make recommendations to the state of Indiana.

As a result of these activities, the ISDH and CPG have identified the following populations to watch: black heterosexual men, commercial sex workers, Hispanic women, injection drug users (IDU) and transgender persons. The numbers of new HIV infections for these groups is on the rise locally. These groups have been shown to be at extremely high risk in the United States. They also have unique needs in regard to HIV prevention services.

Additional work is needed in this area to more fully identify needs and gaps with regard to HIV prevention, care and services in the state of Indiana. The CPG, in partnership with the Division, Indiana Minority Health Coalition and Policy Resource Group, LLC, created *Moving Forward Together: A Needs Assessment Research Agenda for HIV Prevention in Indiana*, (<http://policyresourcegroup.com/IndianaHIVPreventionNeedsAssesment.asp>). This agenda will guide future needs assessment work in the state.

HIV Prevention Resources

Counseling, Testing, and Referral (CTR) Program

The mission of this statewide program is to provide and facilitate disease intervention and prevention. This is accomplished through counseling, testing, and client referrals to other service needs. This program also serves to promote early detection of HIV infection and facilitate access to health care. This will be done through collaboration between agencies that have been funded to provide HIV prevention and services. According to the CDC, testing is one of the several critical services needed to get people into care. Providing linkage to services when and where HIV screening services are provided to help overcome barriers to obtaining care is essential.

The CDC estimates that approximately 1.1 million adults and adolescents in the United States are living with HIV and many are unaware of their infection. The primary purpose of CTR is to increase clients' knowledge of their HIV status; encourage and support risk reduction; and secure needed referrals for appropriate services (medical, social, prevention, and partner services).

There are crucial activities that may be tailored to fit different agencies and at-risk populations. These are parts of the strategy that can be adapted to meet the needs of the organization or target population:

1. Provide information and education about testing in 1 of 3 ways:
 - a. Individual session
 - b. Small or large group sessions.
 - c. Brochures, handouts, videos, or audiotape, or other non-personalized information.
2. Deliver client-focused counseling and test results in an individual, face-to-face session.
3. Use a variety of specimen types and test types for HIV antibody testing, depending on the setting in which testing is conducted and the needs of the organization and the client.
4. Provide service referrals to client's self-identified priority needs (increases likelihood that referrals will be completed), if possible.
5. For clients whose test results are positive, priority is placed on referrals for medical care, partner services, and other prevention and support services.

Partner Services (PS)

The goal of PS is to notify the sex and/or needle-sharing partners, including spouses, of HIV-infected individuals of their possible exposure to HIV and to recommend that they seek health care to include counseling and testing. The goal of this is to help prevent HIV transmission and to ensure that partners have the opportunity to implement prevention strategies while gaining access to counseling, testing, and other services as appropriate.

Comprehensive Risk Counseling and Services (CRCS) Program

The goal of CRCS is to promote the adoption and maintenance of HIV risk-reduction behaviors by clients who have multiple, complex problems and risk-reduction needs. The ISDH has set the following guidelines for those individuals who should be referred to this public health strategy:

1. Any HIV-negative client who presents for repeated testing with no signs of change in behavior.

2. Any HIV-positive client who demonstrates an unwillingness to adhere to the “duty to warn” law.
3. Any client who demonstrates an unwillingness to engage in some level of risk reduction behavior.
4. Any client who is in a serodiscordant relationship and expresses a desire to learn more about transmission prevention or is putting him/herself or his/her partner at risk.
5. Any client who reports wanting or needing assistance or additional support to make behavior change associated with risk.
6. Any client who reports having been diagnosed with two or more sexually transmitted infections in the last 12 months.

This public health strategy provides several sessions of client-centered HIV risk-reduction counseling. CRCS helps clients initiate and maintain behavior change toward HIV prevention while addressing competing needs that may make HIV prevention a lower priority. This strategy addresses the relationship between HIV risk and other issues such as substance abuse, mental health, social and cultural factors, and physical health.

CRCS has the following 7 Core elements:

1. Provide CRCS as intensive, client-centered HIV risk-reduction counseling, and include conventional case management services only when the client does not have access to those services.
2. Base CRCS services on the premise that some people may not be able to prioritize HIV prevention when they face problems perceived to be more important and immediate.

For HIV-positive individuals

3. Focus on persons living with HIV who have multiple, complex problems and risk-reduction needs who are having, or are likely to have, difficulty initiating or sustain practices that reduce or prevent HIV transmission.

For HIV-negative individuals

4. Consider persons whose HIV status is negative or unknown to be eligible if they have a recent history (past 6 months) of 1 or more of the following:
 - unprotected sex with a person who is living with HIV.
 - unprotected sex in exchange for money or sex.
 - multiple (e.g., more than 5) or anonymous sex partners.
 - multiple or anonymous needle-sharing partners.
 - a diagnosis of a sexually transmitted disease.
5. Recruit persons who expressed some degree of commitment to participating in ongoing risk-reduction counseling.
6. Hire prevention counselors with the appropriate training and skills to complete the CRCS activities within their job description.
7. Develop clear procedures and protocol manuals for the CRCS program to ensure effective delivery of CRCS services and minimum standards of care.

Evidence-Based Behavioral Interventions

- **Mpowerment** is a community building program designed to reduce the frequency of unprotected anal intercourse among young gay and bisexual men ages 18–29. The Mpowerment intervention is based on an empowerment model in which young gay men take charge of the project. The project draws on the theory of diffusion of innovations, which suggests that people are most likely to adopt new behaviors that have already been accepted by others who are similar to them and whom they respect.
- **Healthy Relationships** is a multisession, small-group, skills-building program for men and women living with HIV/AIDS. The program is designed to reduce participants' stress related to safer sexual behaviors and disclosure of their serostatus to family, friends, and sex partners. The program is based on Social Cognitive Theory, which states that persons learn by observing other people successfully practice a new behavior.
- **Popular Opinion Leader (POL)** is an intervention based on a program that identifies, trains, and enlists the help of key opinion leaders to change risky sexual norms and behaviors in the gay community. The target population is men who frequent gay bars. The program is based on diffusion of innovation/social influence principles, which states that trends and innovations are often initiated by a relatively small segment of opinion leaders in the population. Once innovations are visibly modeled and accepted, they then diffuse throughout a population, influencing others.
- **VOICES/VOCES** is a single-session, video-based HIV/STD prevention program designed to encourage condom use and improve condom negotiation skills. The target population is African-American and Latino adult men and women clinic clients. The program is based on the theory of reasoned action, which explains how behaviors are guided by attitudes, beliefs, experiences, and expectations of other persons' reactions. VOICES/VOCES is grounded in extensive formative research exploring the culture- and gender-based factors that can facilitate behavior change.

For a list of 2012 HIV Prevention Service Providers, see Appendix A.

Expanded HIV Testing in Medical Settings Program

In September 2007, Wishard Hospital, an urban inner city hospital located in Indianapolis, began collaborating with Midwest AIDS Training and Education Center (MATEC) to create a combined task force comprised of hospital staff, representatives from community based organizations, and ISDH in an effort to implement an Emergency Department (ED) based routine HIV screening pilot project. Execution of routine HIV testing in the Wishard ED began in September of 2008, and continues with plans for expansion to Blackburn Community Health Center in Marion County with a start date in August of 2012. The Methodist Hospital in Lake County plans to begin ED testing in the Fall of 2012.

Special Populations Support Program (SPSP)

The Special Populations Support Program (SPSP) is designed to deliver two distinct but complementary services: disease prevention and supportive care. SPSP employs certified HIV testing counselors who have been specially trained to perform comprehensive risk assessments, pre-test counseling, testing, and post-test counseling with the substance using population. The testing counselors conduct their testing activities in a variety of venues where the target population can be found, including the statewide DMHA treatment facilities.

HIV positive individuals are then referred to the program's support specialists who engage the consumer with interventions designed to minimize substance use and maximize compliance with all applicable treatment plans. The specialists work closely with the local HIV Care Coordination agency to ensure that the consumer receives comprehensive care.

For a list of 2012 SPSP Service Providers, see Appendix B

HIV Care Resources

Care Coordination Program

All persons testing HIV-positive who receive their test results at an ISDH sponsored facility are referred to the HIV Care Coordination Program. HIV Care Coordination is a specialized form of HIV case management. Its mission is to assist those living with HIV disease with the coordination of a wide variety of health and social services. Case Management services are available statewide at 16 regional sites (for a list of current Care Coordination service providers, see Appendix C). Care Coordination provides an individualized plan of care that includes medical, psychosocial, financial, and other supportive services, as needed. Care Coordination services are offered free of charge.

The primary goals of the program are to ensure the continuity of care, to promote self-sufficiency, and to enhance the quality of life for individuals living with HIV. Care Coordinators are trained professionals who can offer assistance in the following areas:

- Access to health insurance to obtain medications, including Medicaid, Medicare, Early Intervention Plan (EIP), AIDS Drug Assistance Plan (ADAP), Health Insurance Assistance Plan (HIAP), Indiana Comprehensive Health Insurance Association (ICHIA), Wishard Advantage, and the Ryan White Program (Parts A & C) offered through the Marion County Health Department, etc.;
- Access to housing programs such as Section 8, Housing Opportunities for Persons with AIDS (HOPWA), Shelter Plus Care, etc.;
- Access to emergency funds, such as Direct Emergency Financial Assistance (DEFA) to assist with rent, utilities, medications, etc.;
- Access to mental health and substance abuse programs;
- Referrals for optical and dental care;
- Referrals to community and government programs, such as Social Security;
- Referrals to local food pantries;
- Referrals to support groups;
- Referrals for legal assistance;
- Assistance with medication management and adherence;
- Assistance with transportation (e.g., bus passes);
- Access to HIV testing and prevention counseling services; and
- Access to HIV prevention and education services.

A referral for medical care is usually made following a full assessment of the client's needs and resources. Like all referrals made by the HIV Care Coordinator, those for medical care are closely monitored to ensure successful completion. HIV Care Coordination staff remind clients of upcoming appointments, confirm that transportation arrangements have been made, and immediately evaluate the success of the referral through direct contact with the client. In the event of incomplete or unsuccessful referrals, alternate arrangements can be made for the client.

HIV Medical Services Program

The HIV Medical Services Program provides assistance to individuals with HIV disease in need of therapeutic medications and medical services. It is designed to give an individual full access

to comprehensive health insurance at no cost to the person enrolled in the program. The program provides both short- and long-term benefit packages covering basic health care services as well as the range of HIV-related medical services and medications, including all FDA-approved highly active antiretroviral drugs. Four different plans are offered:

- **Health Insurance Assistance Plan (HIAP)**
This program pays the premium, deductible, co-pay and co-insurance costs to eligible individuals routed through Indiana's Comprehensive Health Insurance Association (ICHIA) Program.
- **AIDS Drug Assistance Plan (ADAP)**
The AIDS Drug Assistance Plan (ADAP) provides HIV-related prescription drugs to low-income people with HIV/AIDS who have limited or no prescription drug coverage if there is a waiting period before the HIAP/ICHIA insurance coverage begins. ADAP is a payer of last resort and only serves individuals who cannot get their medication needs met through their insurance payer.
- **Early Intervention Plan (EIP)**
This program covers the costs associated with medical services such as doctor visits, laboratory services, and specified vaccinations, including influenza. EIP provides funding for health care services during a possible waiting period of three months before their full HIAP/ICHIA benefits begin.
- **Medicare Part D Assistance Plan (MDAP)**
This program provides assistance toward the co-pay, co-insurance and deductible cost of a Medicare Part D prescription drug plan for qualifying individuals aged 65 and older.

HIV Prevention Community Planning Group

The Indiana HIV Prevention CPG is comprised of persons throughout the state of Indiana who are either infected with or affected by HIV/AIDS. The CPG works in partnership with the ISDH Division of HIV/STD/Viral Hepatitis (Division), HIV Prevention Program to monitor this Jurisdictional HIV Prevention Plan that best represents the needs of various communities at risk for or infected with HIV. The Indiana HIV Prevention CPG allows for a membership of 25 persons. Applications are accepted throughout the year with new members selected on an annual basis, during the month of October. Technical advisors are provided by the Division and recruited from associated fields. The CPG has the responsibility of reviewing the Epidemiological Profile, assessing community services, creating and submitting the letter of concurrence/non-concurrence/concurrence with reservations and evaluating planning activities. These tasks are completed by the following CPG committees: Executive/Budget Committee, Evaluations Committee, Membership/Stakeholder Identification Committee, and Engagement Committee. In addition to these committees there are Ad Hoc committees that focus on the following topics: Advocacy, Policies & Procedures, and Sexually Transmitted Disease.

For a description of these committees, see Appendix D.

History of HIV Prevention Community Planning

In 1993, CDC issued a directive for “*states and localities*” to receive special funds for HIV prevention to assist in the creation of HIV Prevention Community Planning Groups (CPG). Prior to 1993, communities were involved in carrying out HIV prevention services, but were not involved in the planning of comprehensive state and local prevention programs. Decisions regarding HIV prevention were either mandated by Congress or administered by the CDC through its Cooperative Agreement with State Health Departments regulating their grantees to adhere to CDC mandated criteria. Community Planning was developed to reflect the belief that it would bring state and local health departments down to community level and assist them with a more realistic point of view for determining how best to respond to local HIV prevention priorities and needs. Community Planning also assists in giving these entities a vehicle to determine how the CDC’s mandates and initiatives could be best carried out through local community decision making.

The Relevance of HIV Planning

The National HIV/AIDS Strategy (NHAS) is the driving force for combating the epidemic. It is estimated that 21 percent of people living in the United States are living with an unknown HIV status. It is critical that HIV planning be strengthened as a component in implementing the NHAS in Indiana. The collaboration of Indiana State Department of Health, community partners and stakeholders will result in the development and implementation of the engagement process and the jurisdictional plan, the execution of HIP program and activities and the achievement of the goals of NHAS.

Key Concepts of HIV Planning

Indiana HIV planning efforts will be guided by the five components of HIP:

- Effectiveness and cost

- Feasibility of full-scale implementation
- Coverage in the target population
- Interaction and targeting of interventions
- Emphasizing interventions that will have the greatest overall potential to reduce HIV infections

Importance of HIV Prevention Community Planning

CDC expects HIV prevention community planning to improve HIV prevention programs by strengthening the scientific basis, community relevance, and risk-based focus of HIV prevention interventions in each project area. The basic intent of the process has been threefold:

1. To increase meaningful community involvement in prevention planning
2. To improve the scientific basis of program decisions
3. To target resources to those communities at highest risk for HIV transmission/acquisition

The CPG will strive to engage a range of providers that cover the syndemics which co-occur with HIV and ensure that all CPG activities aim to reach the goals of the Indiana Jurisdictional plan and NHAS. The CPG will consider health inequities driving the epidemic, diversity of representation and communities that are most affected.

CPG members have a responsibility to ensure that HIV planning is truly a participatory process. CPG members are expected to participate in scheduled meetings and devote a number of hours to CPG-related activities.

Letter of Concurrence, Concurrence with Reservations or Non-Concurrence

The CPG will inform and review the Jurisdictional HIV Prevention Plan and submit a letter to CDC signed by the CPG co-chairs on behalf of the CPG membership. The letter can be one of concurrence, concurrence with reservations, or non-concurrence and will be submitted with the Jurisdictional HIV Prevention Plan. The letter will document the extent to which the CPG informed or did not inform the development of the Jurisdictional HIV Prevention Plan, a description of the process used to review the Jurisdictional HIV Prevention Plan, and whether or not the CPG concurs with the Jurisdictional HIV Prevention Plan developed by ISDH. In the case of concurrence with reservations, the letter will provide in detail the reason(s) why the group is submitting a concurrence with reservations. If the CPG does not concur, the letter will provide in detail the reason(s) why the group is submitting a non-concurrence.

APPENDIX A

2010-2012 HIV Prevention Directly Funded Sites

Agency Name	Intervention	Populations Served	Counties Served
African Community International www.africancommunity.net/	CTR	Hetero/African Females	Marion
AIDS Ministries AIDS Assist www.aidsministries.org/	CTR, Outreach	AA MSM, AA females	St. Joseph
AIDS Resource Group www.argevansville.org	CTR, Outreach, CRCS	People living with HIV/AIDS	Vanderburgh, Warrick, Knox, Dubois, Gibson
AIDS Task Force-Fort Wayne www.aidsfortwayne.org/	Street Smart, GLI, Outreach	Hetero AA-females, AA-males	Allen, Dekalb, Kosciusko, LaGrange, Noble, Steuben, Wabash, Whitley
The Aliveness Project www.thalivenessprojectnwi.org	CTR, CRCS	MSM, AA-females, IDU, Youth, People living with HIV/AIDS	Lake, Porter, LaPorte
The Bethlehem House www.thebethlehemhouse.org	Healthy Relationships	AA-MSM, AA-females	Marion
Brothers United Brothersunitedindy.org	CTR, CRCS, Outreach	AA-GLBT	Marion
Clark County Health Department Clarkcountyhealth.net/std.htm	CTR	Youth	Clark, Floyd, Washington, Orange, Scott, Crawford, Ohio, Harrison, Jackson, Ripley, Jennings, Jefferson, Switzerland, Dearborn
The Damien Center www.damien.org	CTR, CRCS	Youth	Marion, Johnson, Shelby, Hancock, Hamilton, Boone, Hendricks, Morgan
Elkhart Co. Health Department www.elkhartcountyhealth.org/communityhealth.php	CTR, Outreach	Youth, MSM, People living with HIV/AIDS, AA-females	Elkhart, Kosciusko, Marshall, Noble, St. Joseph
Fort Wayne-Allen County Health Department www.allencountyhealth.com/divisions/clinicalservices/	CTR, CRCS	MSM, Hetero AA-females, Youth-high risk males and females, People living with HIV/ADIS	Allen, Dekalb, Steuben, Jay, LaGrange, Noble, Whitley, Kosciusko, Wabash, Huntington, Wells, Adams
Imani Unidad www.imaniunidadinc.org/	CRCS	People Living with HIV/AIDS, High Risk males and females	St. Joseph, Elkhart
Indianapolis Urban League www.indplsul.org	I Need You To Listen, Hear, Understand Me	Youth	Marion
Madison County Health Department www.madcohealth.org/content/hiv-std-prevention.php	Voices POL	AA-females MSM ages 20-49 years	Delaware, Grant, Madison, Wayne
Northern Indiana Hispanic Health www.nihhc.com/	CTR, Outreach	Latino, MSM, Hetero Latina females, Youth	Elkhart, Noble, LaGrange, Kosciusko
Positive Link Iuhealth.org/Bloomington/for-patients/community-health-aids-positive-link	CTR, MPowerment, CRCS	MSM	Monroe, Bartholomew, Brown, Greene, Lawrence, Owen
Step-Up, Inc. www.stepupin.org	POL, SISTA, Youth Outreach “Understanding Risk	AA-MSM, Latina-youth	Henry, Johnson, Madison, Marion

	Sessions?		
Wayne County Health Department www.co.wayne.in.us/clinic/	CTR, Outreach	MSM, Hetero AA- female, Youth, IDU	Wayne

APPENDIX B

SPECIAL POPULATIONS SUPPORT PROGRAM ~ DIRECTORY FY 2011-2012

<p>AIDS MINISTRIES/AIDS ASSIST 201 South William Street South Bend, IN 46601 (574)234-2870 ext. 1103 or (800)388-2437 (574)232-2872 fax</p>	<p>CLARK COUNTY HEALTH DEPARTMENT 1301 Akers Ave. Jeffersonville, IN 47130 (812)283-2586 (812)288-1474 fax</p>
<p>IU HEALTH- Positive Link 333 East Miller Drive Bloomington, IN 47401 (812)353-3254 (812)353-3269 (800)245-0261 or (812)353-3226 fax</p>	<p>FT WAYNE/ ALLEN COUNTY HEALTH DEPT. 4813 New Haven Ave. Fort Wayne, IN 46803 (260)449-3021 (260)449-3507 fax</p>
<p>ASPIRE INDIANA-Central P.O. Box 304 Elwood, IN 46036 (765)552-5009 or (866)264-2020 (765)552-8347 fax</p>	<p>INDIANAPOLIS URBAN LEAGUE 777 Indiana Avenue Indianapolis, IN 46202 (317)693-7603 (317)693-7613 fax</p>
<p>ASPIRE INDIANA-West 133 N. 4th Street Suite 409 Lafayette, IN 47901 (765)742-4402</p>	<p>AIDS RESOURCE GROUP 201 NW 4th Street, Suite B7 Evansville, IN 47708 (812)421-0059 or (800)423-6255 (812)424-9059 fax</p>
<p>ALIVENESS PROJECT 5490 Broadway, Suite L3 Merrillville, IN 46410 (800)293-7312 or (219)985-6097 fax</p>	<p>ASPIRE INDIANA-East 2809 W. Godman Suite 5 Muncie, IN 47304 (765)286-4481</p>
<p>ASPIRE INDIANA-Southeast 1119 ½ N.W. 5th Street Richmond, IN 47374 (765)962-8778</p>	<p>IU HEALTH- Positive Link 333 East Miller Drive Bloomington, IN 47401 (800)245-0261 or (812)353-3226 fax</p>

APPENDIX C

2012 CARE COORDINATION PROVIDERS

Site	Location	County
AIDS Ministries/AIDS Assist	201 South William Street South Bend, IN 46601	St. Joseph County
AIDS Ministries/AIDS Assist - Satellite	616 South Main Street Elkhart, IN 46516	St. Joseph County
AIDS Resource Group of Evansville	201 NW 4th Street, Suite B-7 Evansville, IN 47708	Vanderburgh County
AIDS Task Force of Northeast Indiana	525 Oxford Street Fort Wayne, IN 46806	Allen County
Aliveness Project of Northwest Indiana	5490 Broadway, Suite L-3 Merrillville, IN 46410-0568	Lake County
Aliveness Project of Northwest Indiana - Satellite	301 East 8 th Street Michigan City, IN 46360	LaPorte County
Aspire Indiana – Central	2009 Brown Street Anderson, IN 46016	Madison County
Aspire Indiana – Southeast	600 East Main Street, Suite L-14 Richmond, IN 47374	Wayne County
Aspire Indiana – West	133 North 4 th Street, Suite 409 Lafayette, IN 47901	Tippecanoe County
Clark County Health Department	1301 Akers Avenue Jeffersonville, IN 47130	Clark County
Concord Center Association	1310 South Meridian Street Indianapolis, IN 46225	Marion County
Damien Center	26 North Arsenal Avenue Indianapolis, IN 46201	Marion County
Riley Hospital for Children - Satellite	702 Barnhill Drive Indianapolis, IN 46202	Marion County
St. Vincent Hospital - Satellite	2001 W. 86 th Street Indianapolis, IN 46260	Marion County
Housing Authority of Terre Haute	P.O. Box 3086 Terre Haute, IN 47803	Vigo County
LifeCare – Indiana University Health	1633 N. Capitol Avenue, Suite 700 Indianapolis, IN 46202	Marion County
Meridian Health Services Corporation	240 North Tillotson Muncie, IN 47304	Delaware County
Positive Link – Indiana University Health Bloomington	333 East Miller Drive Bloomington, IN 47401	Monroe County
Step Up Incorporated	850 N. Meridian Street Indianapolis, IN 46204	Marion County
Wishard Health Services	Infectious Disease Clinic West 1111 West 10 th Street Indianapolis, IN 46202	Marion County

APPENDIX D

HIV PREVENTION COMMUNITY PLANNING GROUP COMMITTEE DESCRIPTIONS

Advocacy Ad Hoc Committee

The Advocacy Ad Hoc Committee is responsible for researching, identifying and disseminating information related to policies, strategies, and/or legislation that affects or has the potential to affect HIV-positive people, those at highest risk for HIV, the spread of HIV, HIV prevention or care funding, or the response to the HIV/AIDS epidemic in Indiana.

Executive/Budget Committee

The Executive Committee is made up of the two co-chairs, the chairs of each standing committee and one at-large member. The Executive Committee functions as the leadership of the Community Planning Group by providing directional and functional guidance. The Executive Committee keeps the CPG informed on the status of the annual CPG budget and works closely with ISDH to propose a budget for the upcoming year.

Needs Assessment/Engagement Committee

The Needs Assessment/Engagement Committee is charged with working closely with ISDH and other CPG committees to achieve an engagement process that results in identifying specific strategies to ensure a coordinated and seamless approach to accessing HIV prevention, care, and treatment services for the highest-risk populations, particularly those disproportionately affected by HIV within the planning jurisdiction.

The Needs Assessment/Engagement Committee will work collaboratively to ensure that the engagement process addresses the following:

1. Development of services where they do not currently exist but the need is evident;
2. Enhancement of services in content, format, or delivery so consumers are more willing to access;
3. Removal or mitigation of various structural barriers that currently impede access to existing services.

Epidemiology/Populations Committee*

This committee was charged with the development, definition, and prioritization of targeted populations. Beginning in February of 2010, this committee began the development of the prioritization process that was eventually carried out in September of 2011.

Evaluation Committee

The Evaluation Committee will implement, evaluate and monitor the CPG process as mandated by the CDC to provide direction to the Community Planning Group regarding evaluation and monitoring of prevention efforts in general, but most specifically, in regards to the Jurisdictional HIV Prevention Plan. This mission will be carried out through the following functions:

1. Ensuring that service providers and other stakeholders who will best inform the coordination and collaboration of the HIV prevention, care and treatment services participate in the planning process.
2. Ensuring that the engagement process achieves a more coordinated, collaborative, and seamless approach to accessing HIV services for the highest risk populations.
3. Ensuring that input from CPG members, other stakeholders, and providers is used to inform and monitor the development and implementation (or update) of the jurisdiction plan.
4. Ensure that surveillance and service data/indicators are utilized to inform and monitor the development and implementation (or update) of the jurisdiction plan.
5. Working with Division staff and consultants to develop/update a survey tool and/or other methodologies to evaluate the community planning process.
6. Assist when necessary with implementing the evaluation process.
7. Report back to CPG the results and recommendations based on the evaluation.
8. Keep abreast of the evaluations methodology being utilized for the local funded prevention projects and national trends regarding evaluation.

Interventions Committee*

It has been the role of the interventions committee to identify appropriate interventions for the set targeted priority populations as well as to keep the full CPG updated on any and all information regarding newly created or revised interventions.

Membership/Stakeholder Identification Committee

The Membership/Stakeholder Identification Committee will work within the CPG to address the needs for representation, retention and functioning within the community planning process. The committee will maintain parity, inclusion and representation (PIR) by ensuring community input and access to the community planning process.

- **Recruitment and Selection**
The Membership/Stakeholder Identification Committee will recruit members that accurately reflect the HIV/AIDS epidemic in Indiana. Applications are accepted throughout the year with new members selected on an annual basis. To determine the representation gaps and needs the membership committee will work closely with the ISDH HIV Epidemiologist to review the data and get a clear depiction of the epidemic for each year. The committee will carefully review current applications and recommend members that satisfy the existing vacancies and gaps in representation.
- **Orientation**
The purpose of orientation is to help define the role of each CPG member. The orientation will also help to ensure that CPG members are engaged in the planning process, thus increasing the likelihood of retaining active members. During the orientation each CPG member will be educated on the history of the CPG, his/her role as a CPG member, the roles of the ISDH, CDC, and the shared responsibilities of each. Each new member will receive a copy of the Indiana CPG Charter by-laws and the Indiana CPG policies and procedures. An overview of the Indiana CPG Charter by-laws and the policies and procedures will be given during the orientation.

- **Participation**
Each CPG member will fulfill his/her attendance obligation in regard to the full-body CPG meetings. Participation of CPG members will be monitored at each face-to-face meeting and through the CPG Executive Committee meetings. CPG members that are not fulfilling their duties will be contacted by a CPG Membership Committee member to identify the barriers to participation. It is a requirement that CPG members attend two-thirds of the face-to-face full-body CPG meetings each year.
- **Inclusion**
To guarantee inclusion, the Membership/Stakeholder Identification Committee will work to remove any and all barriers that may prevent members from actively participating in the CPG process. This will be done by identifying any potential challenge to membership participation and creating policies to address the needs of the CPG members such as childcare, travel, meal reimbursement and paid lodging.

Policies & Procedures Ad Hoc Committee

The mission of the Policies and Procedures Ad Hoc Committee is to keep the CPG informed on the local, state, national, and international policies affecting the issue of HIV/AIDS/STD prevention and to make recommendations of policies and procedures to facilitate the planning and implementation process of the CPG. The expectations of this committee are as follows:

1. Recommend to the CPG, endorsement of position papers on HIV/AIDS/STD issues, and promote awareness among CPG membership of such issues.
2. Monitor any HIV/AIDS/STD activity, in an effort to keep the CPG updated and informed.
3. Solicit CPG co-chairs, committee chairs for immediate and/or future needs of Policy and Procedure needs.
4. Work with other appointed Committees (as needed by appointed committee) on compiling a draft recommendation for the Executive Committee.
5. Compile and disseminate draft policies and procedures to the CPG Executive Committee for preliminary approval.
6. Maintain and revise all necessary CPG policies and procedures.

Sexually Transmitted Disease (STD) Ad Hoc Committee

The mission of the STD Committee is to act as an advisory committee and provide input to the CPG regarding STD prevention activities as they relate to collaborations with HIV prevention.

This mission is carried out in the following functions:

1. Identify means to coordinate prevention activities of HIV and STDs.
2. Maintain and promote awareness of relationships between HIV and STDs including new prevention detection and treatment technologies.
3. Recommend statistical comparisons between STDs and HIV.

4. Work with the ISDH STD program manager to determine unmet STD intervention needs throughout the state.

**Both the Epidemiology/Populations Committee and the Interventions Committee have functioned as standing committees in previous years. The CPG is currently working on determining the functions these two committees will have in the upcoming year based on the new Guidance from CDC.*

APPENDIX E

Community Planning Group 2012 Committee Members List

Executive Committee

Latorya Greene, Community Co-Chair
Andrea Perez, ISDH Co-Chair
Ramon Morton, Evaluations Chair
Emily Brinegar, Member At-Large
Brian Revalee, Membership Chair
Angela Goode, Needs Assessment Chair
Tony Gillespie, Epi/Populations Chair
Nate Rush, Interventions Chair

Epidemiology/Populations Committee

Tony Gillespie, Committee Chair
Val Harvell
Ramon Morton
Dan Hillman, ISDH Technical Advisor
Anita Ohmit, Technical Advisor
Brenda Mason, ISDH Technical Advisor

Interventions Committee

Nate Rush, Committee Chair
Rico Nash
Thomas Sullivan
Mike Exom, Technical Advisor
Brenda Mason, ISDH Technical Advisor
Amanda Writt, ISDH Technical Advisor

Needs Assessment/Engagement Committee

Angela Goode, Committee Chair
Emily Brinegar, Committee Co-Chair
Andrea Perez, ISDH, Co-Chair
Tony Gillespie
Marissa Miller
Amanda Copeland, Technical Advisor
Anita Ohmit, Technical Advisor

STD Committee

Richard Nash, Committee Chair
Rochelle Feldheiser Keyes
Mike Exom, Technical Advisor
John Hon, ISDH Technical Advisor

Advocacy Committee

Emily Brinegar, Committee Chair
Derwin Gary
Tony Gillespie
Angela Goode

Evaluations Committee

Ramon Morton, Committee Chair
Derwin Gary, Committee Co-Chair
Alicia Barnes, ISDH Technical Advisor
Darin Foltz, ISDH Technical Advisor

Membership Committee

Brian Revalee, Committee Chair
Latorya Greene, CPG Co-Chair
Rochelle Feldheiser Keyes
Marissa Miller
Ramon Morton
Cena Bain, ISDH Technical Advisor

Policy & Procedures Committee

Latorya Greene, Community Co-Chair
Ramon Morton
Alicia Barnes, ISDH Technical Advisor