

# Tennessee HIV/AIDS Jurisdictional Plan

Tennessee Department of Health  
HIV/STD Program  
September 2012

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# PREVENTION PLANNING EFFORTS

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Since 1994, HIV prevention activities funded by the State have been developed in collaboration with the Tennessee Community Planning Group (TCPG). This group—now also identified as the HIV Planning Group [HPG]—collaborates with the Health Department in a process referred to as the Jurisdictional Plan Development. The planning group has been populated to represent the diversity of HIV-infected populations and to make certain that other key stakeholders in HIV prevention and care have been brought to the table. The planning group meets bi-annually to assure a results-oriented engagement process in which the goals of seamless access to a continuum of care and prevention services are achievable. The planning group is a principal partner in planning statewide meetings which bring stakeholders outside the planning group, with broad and diverse perspectives on care and treatment needs, to advise and provide input into HIV prevention planning.

The Jurisdictional Plan includes a description of existing resources, reviews the HIV/AIDS disease burden in Tennessee, outlines unmet needs and gaps in services, and outlines prevention activities to be undertaken. In addition, the planning group oversees a process of creation of a Comprehensive Program Plan which describes in detail the plan for addressing the gaps and needs identified in the Jurisdictional Plan.

The planning group's core members consist of the health department co-chair [representing TDH], the community co-chair, and the two co-chairs from each of the five Regional Community Planning Groups [RCPGs]. Members of the RCPGs are qualified to become TCPG members as long as they actively participate and have their TCPG application accepted. Additional members are added as needed to meet parity, inclusion and representation. The TCPG works in conjunction with the RCPGs to synthesize work done at the regional level and identify populations and interventions that would best suit the citizens of Tennessee. In addition to the core members of the planning group, a statewide MSM Task Force has been established as an ad hoc committee of the statewide group and often attends [though not voting at] planning group meetings.

Every effort is made in all regions and in the statewide effort to work collaboratively with the Ryan White Planning Councils in the regions to ensure effective stewardship of resources. Many members of the CPGs also populate the Ryan White planning groups which oversee the execution of and funding for HIV services in Tennessee. The Part B program also makes extensive efforts to include key stakeholders in the process of planning for HIV care services and assuring the continuum of seamless

prevention, treatment, and care services is accessible to all Tennesseans. Working through the planning bodies at the Regional level and through its agreements with consortia, the Part B program assures that a diverse group of stakeholders, including representatives from all Ryan White Parts in Tennessee, as well as, prevention, substance abuse, mental health, and correctional health staff are engaged in the planning process.

In addition to the statewide efforts of TDH and the TCPG, it should be noted that the cities of Memphis and Nashville are funded by HRSA as Part A cities. The Memphis and Nashville Part A programs conduct HIV medical care and case management activities extraneous to the efforts of the Tennessee Department of Health [TDH]. That said, all efforts to encourage collaboration and cooperation are made. Members of the Part B staff regularly participate in relevant Part A planning activities and representatives from both Part A cities have been involved in the creation of the Tennessee AIDS Strategy. The collaboration on HDAP and in the surveillance programs have made not only seamless care possible, but also result in significant cost savings to the Part A grantees.

## DESCRIPTION OF EXISTING RESOURCES

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The Tennessee Department of Health receives approximately \$8 million dollars in HIV prevention funding to support HIV prevention and HIV rapid testing from the Centers for Disease Control and Prevention [CDC]. The State of Tennessee contributes an additional \$900,000 to the budget. In turn, the HIV/STD Prevention Branch provides formula-based HIV prevention funding to the five regions based on the numbers of cases of HIV/AIDS within the region, i.e. regions with the highest rates of infection receive the largest funding awards. Each year, HIV Prevention Services provides funding to more than 15 community-based organizations and to all 6 metro health departments to support high impact prevention activities as well as conventional and rapid HIV testing programs.

The Health Department—advised by the Tennessee Community Planning Group [TCPG]—provides the majority of HIV prevention activities in Tennessee. In addition, the state collaborates with a number of prevention providers including WOMEN—the CDC directly-funded CBO in Nashville—and twelve agencies funded by the Substance Abuse and Mental Health Services [SAMHSA] to deliver HIV testing in substance abuse facilities. Finally, HIV prevention services in minority communities are coordinated through the Minority AIDS Initiative Office in the Health Department.

Ongoing internal collaborations with the Tennessee Department of Corrections and the Tennessee Department of Education are designed to increase coordination of

prevention and education activities with these key stakeholders.

The Ryan White Part B Program, administered in the HIV/STD Program, is funded by the Health Resources and Services Administration [HRSA] to provide care and HIV medications to Tennesseans who are without health insurance and are below 300% of the Federal Poverty Limit. The Ryan White Part B Lead Agencies and Care Consortia—five non-profit entities across the State—are the single coordinating body charged with planning, developing, and assuring the delivery of services for individuals with HIV/AIDS within the geographic area served.

Medical Case Managers (MCM) are the point of entry into the system of care; they will assess clients' eligibility for this program when they apply for Part B coverage. The program primarily covers procedures directly or indirectly associated with HIV/AIDS and related illnesses. A fee schedule of covered procedures and the amounts paid is updated each year and sent to all authorized providers. For a health care provider to be authorized by the program, they must complete and submit a state "Authorization to Vendor Form" each year, and agree to accept the Fee Schedule amount as payment in full. The total Federal government support for the program is approximately thirty-two million dollars; more than half of that total covers drug assistance through the HIV Drug Assistance Program [HDAP]. The State of Tennessee supports HDAP with an additional seven million dollars. The remaining Federal resources—nearly fifteen million dollars—are primarily used to fund core medical services which include:

- Outpatient and ambulatory health services
- Pharmaceutical assistance, including medications provided through ADAP
- Oral health care
- Early intervention services
- Health insurance premium and cost-sharing assistance for low-income individuals
- Home health care
- Medical nutrition therapy
- Hospice services
- Home and community-based health services
- Mental health services
- Outpatient substance abuse care
- Medical case management, including treatment adherence services

# DISEASE BURDEN IN TENNESSEE

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Key terminology and notes are located in the appendix.

## EXECUTIVE SUMMARY

As of December 31, 2010, a cumulative total of 23,891 cases of HIV infection, regardless of the stage of disease at diagnosis, have been reported among Tennessee residents. Of these cases, 16,483 people are living with the HIV infection through the end of 2010. There were a total of 18,282 males (76.6%) and 5,584 females (23.4%) diagnosed with HIV infection (with or without AIDS) while there were a total of 11,565 males (79.1%) and 3,048 females (20.9%) with AIDS.

In the past thirty years, most cases of HIV infection were found in the 15-44 age groups and most cases of AIDS were in the 25-54 age groups for both males and females. Fifty-seven percent (57%) of HIV infections were among African Americans and 40% were among Whites compared to AIDS diagnoses, where 53% were among African Americans and 44% were among Whites. Within the adults and adolescents groups, 63% were diagnosed with HIV infections attributed to male-to-male sexual contact, and among females, 63% were attributed to heterosexual contact.

In 2010, there were 886 newly diagnosed HIV infection cases in Tennessee, and among them, 504 cases were AIDS. The majority of people newly diagnosed with HIV infection (77.5%) and with AIDS (75.8%) were male. The highest percentage (26.6%) and the highest rate (42.1) of new infections were among males in the 15-24 age group, in comparison to females who had the highest percentage (27.6%) and highest rate (13.4 per 100,000) of new infections among those in 25-34 age group. HIV infection diagnosis rate of Tennessee was 14.1 per 100,000 in 2010. The rate in the African American population was 54.5, which is 2.8 times more than that in the Hispanic population (19.7) and 11.2 times higher than that in the White population (4.9). Rates among males were significantly higher than those among females (21.3 vs. 6.1).

Comparing 2001 to 2010, the percentage of Hispanic Americans diagnosed with HIV infection in Tennessee increased 256%, while Whites decreased 32% and African Americans decreased 4 percent.

In Public Health Regions, the highest rate of new HIV infection diagnosed in 2010 occurred among residents of the Metro Davidson Public Health Region (40.1). Several other health regions had new HIV diagnosis rates higher than the overall state rate of 13.8. In descending order, they are the counties of: Shelby (35.0), Madison (20.1), and

Hamilton (15.5).

Since the beginning of the epidemic (1981) through the end of 2010, cumulatively at least 7,408 persons with HIV infection and 6,576 with AIDS have died in Tennessee. Among the HIV infection-related deaths 1,339 (18.1%) were female and 6,069 (81.9%) were male.

Of the people currently living with a diagnosis of HIV infection in Tennessee in 2010, 58.2% were African American, approximately 37.9% were White, 3.0% were Hispanic, and the remaining 0.9% was distributed among Asian, American Indian/Alaska Natives, Native Hawaiian/Pacific Islanders and Multiple Race/Unknown.

Among those individuals living with HIV infection at the end of 2010, the exposure category, men who have sex with men (MSM), accounted for 46.4% of cases statewide. Heterosexual contact was the second highest category of exposure in 23.2% of all living cases.

The ratio of females to males living with HIV infection continuously increased from 0.33 in 2001 to 0.35 in 2010, while the ratio of females to males living with AIDS diagnosis also increased from 0.25 in 2001 to 0.31 in 2010. This illustrates a growing trend of HIV/AIDS within the female population that can be attributed to increased exposure via heterosexual contacts.

### *The Sociodemographic Characteristics of the General Population in Tennessee*

**Population:** In the 2010 census, the total population reported for Tennessee was 6,346,105 people. Tennessee comprises 95 counties with populations ranged from a low of 5,077 people (Pickett County) to a high of a million people in (Shelby). Metropolitan areas in order of greatest populations are: Memphis, Nashville, Knoxville, Chattanooga, Sullivan, and Jackson, with populations ranging from 927,644 to 98,294.

**Public Health Regions and Consortia Regions:** The Tennessee Department Health is divided into six (6) Metro Public Health Regions and seven (7) other Public Health Regions, for the purpose of public health planning. A public health region comprises 7 to 19 counties. The Department is also divided into 5 Consortia Regions (including Metro Public Health Regions) which comprise 3 to 40 counties.

**Demographic Composition:** According to the U.S. Census Bureau's 2010 data, the racial and ethnic composition of the state was estimated to be 75.6% White, 16.6% African American, 1.5% Asian, 4.5% Hispanic origin, and 1.8% other.

**Age and Sex:** In 2010, the median age of Tennessee residents was 38 years. Those younger than 18 years of age comprised 24.6% of the population while 13.4% of the population was 65 or older. The proportion of females in the overall population was slightly higher than that of males (51.3% vs. 48.7%).

## **SECTION 1: OVERVIEW OF CHANGES IN THE HIV/AIDS EPIDEMIC IN TENNESSEE**

This HIV Surveillance Report is intended to provide a basic understanding of the HIV/AIDS epidemic in Tennessee by combining different indicators such as incidence, deaths, prevalence by sex, age, race, and modes of transmission. Therefore, this document uses multiple measures to provide a comprehensive picture of HIV infection (with or without AIDS) and AIDS in Tennessee, its regions, and counties.

### **HIV Infection (including AIDS) in Tennessee from 1981 to 2010**

As of December 31, 2010, a cumulative total of 23,891 cases of diagnosed HIV infection (with or without AIDS) have been reported among Tennessee residents. Of these, 16,483 were living with the HIV infection and 7,408 were deceased (Table I-1).

The HIV/AIDS epidemic has affected people of all genders, ages and racial/ethnic groups within all counties in Tennessee. The surveillance data on diagnosis of HIV infection (with or without AIDS) in Tennessee suggests that the annual number of new diagnosed infections increased steadily from the beginning of the epidemic in the early 1980s, and reaching a peak of 1,641 cases in 1992. Beginning in 1996, the number of newly diagnosed HIV infections continued to decline (with some fluctuations) at approximately 1,000 cases per year. In 2010, the number of newly diagnosed cases was down to 886 (Table I-1).

The number of people living with a diagnosis of HIV infection in Tennessee (HIV prevalence) is higher than ever before. It has increased steadily overtime from 3,657 in 1992 to 16,483 individuals in 2010, representing a 4.5 times increase, with a yearly average increase of 713 individuals since 1992.

Despite increases in the total number of people living with HIV infection, the annual number of deaths has decreased from 585 in 1995, its peak year. Deaths decreased to 495 in 1996 and continually decreased below 400 from 1997 through 2005. The number of deaths continued trending downward to below 300 in 2006 and 2007, then below 200 in 2008 and 2009, and even below 100 in 2010. While the one-year HIV infection case fatality rate was 21.3% in 1986, it continued to decline to 0.6% in 2010 (Table I-1).

**Table I-1. Number of HIV infection diagnoses, people living with the infection, related deaths from the infection, and one-year case fatality rate (%) in Tennessee from 1981 to 2010**

Year of Diagnosis	HIV Infection		Living with HIV Infection	Deaths from Related HIV Infection		
	Cases	Cumulative		Cases	Cumulative	One-year case fatality rate (%)
Up to 1985	203	203	167	36	36	21.6
1986	203	406	305	65	101	21.3
1987	368	774	586	87	188	14.8
1988	459	1,233	929	116	304	12.5
1989	543	1,776	1,323	149	453	11.3
1990	686	2,462	1,799	210	663	11.7
1991	784	3,246	2,322	261	924	11.2
1992	1,641	4,887	3,657	306	1,230	8.4
1993	1,290	6,177	4,508	439	1,669	9.7
1994	1,285	7,462	5,300	493	2,162	9.3
1995	1,367	8,829	6,082	585	2,747	9.6
1996	1,196	10,025	6,783	495	3,242	7.3
1997	1,169	11,194	7,613	339	3,581	4.5
1998	1,062	12,256	8,324	333	3,914	4.0
1999	968	13,224	8,996	314	4,228	3.5
2000	1,075	14,299	9,731	340	4,568	3.5
2001	975	15,274	10,337	369	4,937	3.6
2002	1,013	16,287	10,953	397	5,334	3.6
2003	940	17,227	11,523	370	5,704	3.2
2004	974	18,201	12,110	387	6,091	3.2
2005	959	19,160	12,673	396	6,487	3.1
2006	949	20,109	13,328	294	6,781	2.2
2007	970	21,079	14,062	236	7,017	1.7
2008	997	22,076	14,885	174	7,191	1.2
2009	929	23,005	15,696	118	7,309	0.8
2010	886	23,891	16,483	99	7,408	0.6
<b>Total</b>	<b>23,891</b>	--	--	<b>7,408</b>	--	--

As of December 31, 2010, a cumulative total of 14,615 diagnosed cases of AIDS have been reported. Of these cases, 8,037 people were living with an AIDS diagnosis in 2010, with 6,576 cumulative deaths occurring through 2010 (Table I-2).

**Table I-2. Number of diagnosed cases of AIDS, people living with AIDS, deaths related to AIDS, and one-year case fatality rate (%) in Tennessee from 1981 to 2010**

Year of Diagnosis	AIDS		Living with AIDS (# of cases)	Deaths from AIDS Related		
	Cases	Cumulative		Cases	Cumulative	One-year case fatality rate (%)
Up to 1985	74	74	38	36	36	94.7
1986	80	154	82	65	101	79.3
1987	182	336	149	87	188	58.4
1988	226	562	259	116	304	44.8
1989	292	854	403	149	453	37.0
1990	361	1,215	575	210	663	36.5
1991	426	1,641	768	261	924	34.0
1992	772	2,413	1,194	295	1,219	24.7
1993	832	3,245	1,607	419	1,638	26.1
1994	693	3,938	1,837	463	2,101	25.2
1995	829	4,767	2,126	540	2,641	25.4
1996	822	5,589	2,502	446	3,087	17.8
1997	716	6,305	2,931	287	3,374	9.8
1998	746	7,051	3,399	278	3,652	8.2
1999	639	7,690	3,782	256	3,908	6.8
2000	631	8,321	4,125	288	4,196	7.0
2001	639	8,960	4,456	308	4,504	6.9
2002	739	9,699	4,869	326	4,830	6.7
2003	703	10,402	5,261	311	5,141	5.9
2004	690	11,092	5,624	327	5,468	5.8
2005	785	11,877	6,076	333	5,801	5.5
2006	615	12,492	6,445	246	6,047	3.8
2007	566	13,058	6,813	197	6,244	2.9
2008	516	13,574	7,186	143	6,387	2.0
2009	538	14,112	7,618	104	6,491	1.4
2010	503	14,615	8,037	85	6,576	1.1
<b>Total</b>	<b>14,615</b>	--	--	<b>6,576</b>	--	--

The number of AIDS cases increased from the beginning of the epidemic and peaked in 1993 with 832 cases, and has since dropped to 503 cases in 2010. The number of persons living with AIDS increased yearly to 8,037 in 2010, while the number of deaths decreased from 540 in 1995, to 85 in 2010. The one-year AIDS case fatality rate was down from 79.3% in 1986 to 1.1% in 2010.

For the same time period, there was a total of 18,282 males (76.6%) and 5,584 females (23.4%) who were diagnosed with HIV infection, and a total of 11,565 males (79.1%) and

3,048 females (20.9%) who were diagnosed with AIDS. Most cases of HIV infection were in the 15-44 age groups and most cases of AIDS were in the 25-54 age groups for both males and females (Table I-3).

**Table I-3. Number of HIV/AIDS diagnoses by age and sex in Tennessee, 1981-2010**

Age	HIV Infection						AIDS					
	Male		Female		Total		Male		Female		Total	
	Cases	%	Cases	%	Cases	%	Cases	%	Cases	%	Cases	%
<13	85	0	87	2	172	1	36	0	24	1	60	0
13-14	12	0	14	0	26	0	5	0	1	0	6	0
15-24	2,548	14	1,236	22	3,784	16	590	5	309	10	899	6
25-34	6,752	37	1,909	34	8,661	36	3,928	34	1,020	33	4,948	34
35-44	5,686	31	1,418	25	7,104	30	4,281	37	1,013	33	5,294	36
45-54	2,325	13	636	11	2,961	12	2,014	17	481	16	2,495	17
55-64	695	4	219	4	914	4	557	5	153	5	710	5
≥65	179	1	65	1	244	1	154	1	47	2	201	1
<b>Total</b>	<b>18,282</b>	<b>100</b>	<b>5,584</b>	<b>100</b>	<b>23,866</b>	<b>100</b>	<b>11,565</b>	<b>100</b>	<b>3,048</b>	<b>100</b>	<b>14,613</b>	<b>100</b>
<b>%</b>	<b>76.6</b>		<b>23.4</b>			<b>100</b>	<b>79.1</b>		<b>20.9</b>			<b>100</b>

Among racial/ethnic groups, African Americans have the greatest burden of HIV/AIDS in Tennessee. Fifty-seven percent (57%) of diagnosed HIV infections were among African Americans and 40% were among Whites while 53% of diagnosed AIDS cases were among African Americans and 44% were among Whites. Of the 23,866 total cases of HIV infection, 172 were children less than 13 years old and of the 14,613 total cases of AIDS, 60 were less than 13 years of age (Table I-4).

**Table I-4. Number of diagnoses of HIV/AIDS by race/ethnicity and adult/children group in Tennessee, 1981-2010**

Race/Ethnicity	HIV Infection						AIDS					
	Adult & Adolescent		Children (<13 yrs)		Total		Adult & Adolescent		Children (<13 yrs)		Total	
	Case	%	Case	%	Case	%	Case	%	Case	%	Case	%
American Indian/Native Alask.	19	0	0	0	19	0	15	0	0	0	15	0
Asian	29	0	0	0	29	0	17	0	0	0	17	0
African American	13,370	56	119	69	13,489	57	7,736	53	37	62	7,773	53
Hawaiian/Pacific Islander	42	0	0	0	42	0	21	0	0	0	21	0
Hispanic	572	2	4	2	576	2	338	2	1	2	339	2
Multi-race	113	0	1	1	114	0	84	1	0	0	84	1
White	9,549	40	48	28	9,597	40	6,342	44	22	37	6,364	44
<b>Total</b>	<b>23,694</b>	<b>100</b>	<b>172</b>	<b>100</b>	<b>23,866</b>	<b>100</b>	<b>14,553</b>	<b>100</b>	<b>60</b>	<b>100</b>	<b>14,613</b>	<b>100</b>

Within the adult/adolescent groups, 63% of males who were diagnosed with HIV infection attributed their exposure to MSM contact, and 63% of females who were diagnosed with HIV infection attributed their exposure to heterosexual contact. The same form of exposure held true for males diagnosed with AIDS (64%) as well as females diagnosed with AIDS at 65% (Table I-5). The following acronyms define the transmission categories listed in Tables I-5 and I-6:

- H/C disorder – Hemophilia/coagulation disorder
- MHIV – Mother with/at risk for HIV infection
- Receipt BCT – Receipt of blood, components, or tissue
- ORF – Other risk factor reported
- NIR – No Identified risk factor
- NRR – No risk factor reported

**Table I-5. Number of diagnoses of HIV/AIDS among adults and adolescents by transmission category and sex in Tennessee, 1981-2010**

Transmission Category	HIV Infection						AIDS					
	Male		Female		Total		Male		Female		Total	
	Case	%	Case	%	Case	%	Case	%	Case	%	Case	%
MSM	11,430	63	0	0	11,430	48	7,400	64	0	0	7,400	51
IDU	1,751	10	830	15	2,581	11	1,274	11	590	20	1,864	13
MSM & IDU	952	5	0	0	952	4	723	6	0	0	723	5
H/C disorder	115	1	4	0	119	1	103	1	2	0	105	1
Heterosexual	1,603	9	3,462	63	5,065	21	983	9	1,959	65	2,942	20
Receipt BCT	81	0	46	1	127	1	63	1	37	1	100	1
Perinatal exposure	1	0	0	0	1	0	1	0	0	0	1	0
ORF	1	0	0	0	1	0	1	0	0	0	1	0
NIR	975	5	461	8	1,436	6	444	4	190	6	634	4
NRR	1,287	7	694	13	1,981	8	527	5	244	8	771	5
<b>Total</b>	<b>18,196</b>	<b>100</b>	<b>5,497</b>	<b>100</b>	<b>23,693</b>	<b>100</b>	<b>11,519</b>	<b>100</b>	<b>3,022</b>	<b>100</b>	<b>14,541</b>	<b>100</b>

Eighty-four percent (84%) of children less than 13 years old who were diagnosed with HIV infection, and 87% of children less than 13 years old who were diagnosed with AIDS, attributed the cause to mother-to-child transmission. In this category, there were more males (36) than females (24) who were diagnosed with AIDS (Table I-6). The cases listed below were diagnosed from January 1, 1981 through December 31, 2010, and exclude cases missing age information at diagnosis.

**Table I-6. Number of diagnoses of HIV/AIDS among children <13 years by transmission category and sex in Tennessee, 1981-2010**

Transmission Category	HIV Infection						AIDS					
	Male		Female		Total		Male		Female		Total	
	Case	%	Case	%	Case	%	Case	%	Case	%	Case	%
H/C disorder	14	16	0	0	14	8	6	17	0	0	6	10
MHIV	64	75	80	92	144	84	28	78	24	100	52	87
Receipt BCT	3	4	1	1	4	2	2	6	0	0	2	3
ORF	0	0	0	0	0	0	0	0	0	0	0	0
NIR	1	1	2	2	3	2	0	0	0	0	0	0
NRR	3	4	4	5	7	4	0	0	0	0	0	0
<b>Total</b>	<b>85</b>	<b>100</b>	<b>87</b>	<b>100</b>	<b>172</b>	<b>100</b>	<b>36</b>	<b>100</b>	<b>24</b>	<b>100</b>	<b>60</b>	<b>100</b>

### **Estimated HIV/AIDS Rate, a Comparison of Tennessee to Other States, 2008**

Based on CDC's 2009 *HIV Surveillance Report*, comparing 40 states and 5 U.S. dependent areas in 2008, Tennessee ranked 12<sup>th</sup> with an estimated HIV infection diagnosis rate of 17.2 per 100,000 population (Table I-7). This means that an estimated 17 people per 100,000 population were diagnosed with HIV infection in Tennessee in 2008. Florida, with an HIV infection rate of 33.0, had the highest rate in the nation.

*Note: This is not a complete national comparison of HIV infection rates since some states have recently implemented confidential name-based HIV case reporting. A complete national comparison of HIV infection rates will not be available until 2013.*

**Table I-7. Cases, estimated cases, and estimated rates (per 100,000 population) of HIV infection in Top 15 State/Dependent Areas of the U.S., 2008**

Area of Residence	Cases	Estimated Cases	Estimated Rate
Florida	5,775	6,120	33.0
Georgia	2,073	3,229	32.9
US Virgin Islands	25	35	31.4
New York	4,649	5,765	29.5
Louisiana	1,247	1,295	28.8
Puerto Rico	671	909	22.9
New Jersey	1,252	1,986	22.8
Mississippi	559	630	21.3
South Carolina	789	906	19.9
North Carolina	1,719	1,844	19.7
Texas	4,291	4,563	18.4
Virginia	997	1,359	17.2
<b>Tennessee</b>	<b>999</b>	<b>1,080</b>	<b>17.2</b>
Alabama	690	788	16.7
Nevada	368	418	15.8
<b>United States (Total)</b>	<b>45,202</b>	<b>42,995</b>	<b>17.4</b>

With an estimated AIDS diagnosis rate of 11.1 per 100,000 population, Tennessee ranked 12<sup>th</sup> in the nation while the USA average rate was 11.2 (Table I-8). Washington D.C. had the highest estimated AIDS rate at 120 per 100,000 population followed by New York (24.6), and Florida (23.7).

**Table I-8. Cases, estimated cases, and estimated rates (per 100,000 population) of AIDS in top 15 State/Dependent Areas of the U.S., 2008**

Area of Residence	Cases	Estimated Cases	Estimated Rate
District of Columbia	462	718	119.8
New York	3,379	4,799	24.6
Florida	3,907	4,392	23.7
Maryland	783	1,134	19.9
Louisiana	814	869	19.4
Delaware	120	159	18.0
New Jersey	917	1,475	16.9
South Carolina	613	713	15.6
Georgia	988	1,391	14.1
Mississippi	323	385	13.1
North Carolina	964	1,088	11.6
<b>Tennessee</b>	<b>613</b>	<b>697</b>	<b>11.1</b>
Texas	2,346	2,652	10.7
Nevada	238	281	10.6
California	2,811	3,760	10.2
<b>United States (Total)</b>	<b>27,662</b>	<b>34,993</b>	<b>11.2</b>

## SECTION II: NEW HIV/AIDS CASES

### New HIV/AIDS Cases in Tennessee by Sex

In 2010, there were 886 newly diagnosed HIV infections (including AIDS diagnoses) in Tennessee, with 504 of those cases determined to be with AIDS. Males comprised the majority of people newly diagnosed for both HIV infection (77.5%) as well as AIDS (75.8%).

From 2001 to 2010, on average yearly, 881 people were diagnosed with HIV infection and 629 with AIDS. The ratio of females to males newly diagnosed with the disease in the same year remained stable at about 1:4 for both HIV/AIDS (Table II-1).

**Table II-1. Number of people diagnosed with HIV/AIDS by year of diagnosis and sex**

	Sex	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	Average	%
<b>HIV Infection</b>	Female	272	287	249	273	266	286	261	276	254	199	241	27.2
	Male	703	726	691	701	693	663	709	721	675	687	640	72.8
	<b>Total</b>	<b>975</b>	<b>1,013</b>	<b>940</b>	<b>974</b>	<b>959</b>	<b>949</b>	<b>970</b>	<b>997</b>	<b>929</b>	<b>886</b>	<b>881</b>	<b>100</b>
<b>AIDS</b>	Female	174	181	201	170	209	205	183	150	146	122	174	27.8
	Male	465	558	502	520	576	410	382	366	390	382	455	72.2
	<b>Total</b>	<b>639</b>	<b>739</b>	<b>703</b>	<b>690</b>	<b>785</b>	<b>615</b>	<b>565</b>	<b>516</b>	<b>536</b>	<b>504</b>	<b>629</b>	<b>100</b>

### New HIV/AIDS Cases in Tennessee by Sex and Age Group

New HIV infection by sex and age show some differences among males and females. Among males, the highest percentage (26.6%) of new infections was within the 15-24 age group. Among females, the highest percentage (27.6%) of new infections was within the 25-34 age group (Table II-2). Without accounting for sex, the infection was higher in the 25-34 age group (24.9%) and the next high percentages were the same in two age groups: 15-24 and 35-44 (24.3%).

**Table II-2. Number of people diagnosed with HIV infection – by sex and age at diagnosis, 2010**

Age (yrs)	Male		Female		Total	
	Case	%	Case	%	Case	%
<13	2	0.3	3	1.5	5	0.6
13 – 14	0	0.0	0	0.0	0	0.0
15 – 24	183	26.6	32	16.1	215	24.3
25 – 34	166	24.2	55	27.6	221	24.9
35 – 44	161	23.4	54	27.1	215	24.3
45 – 54	120	17.5	36	18.1	156	17.6
55 – 64	44	6.4	16	8.0	60	6.8
≥65	11	1.6	3	1.5	14	1.6
<b>Total</b>	<b>687</b>	<b>100.0</b>	<b>199</b>	<b>100.0</b>	<b>886</b>	<b>100.0</b>

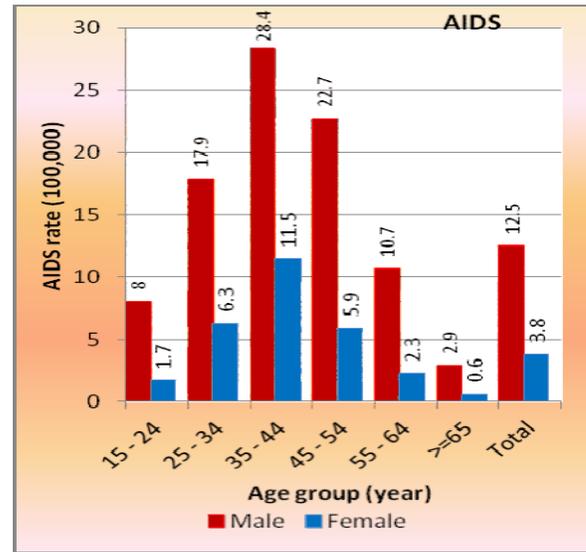
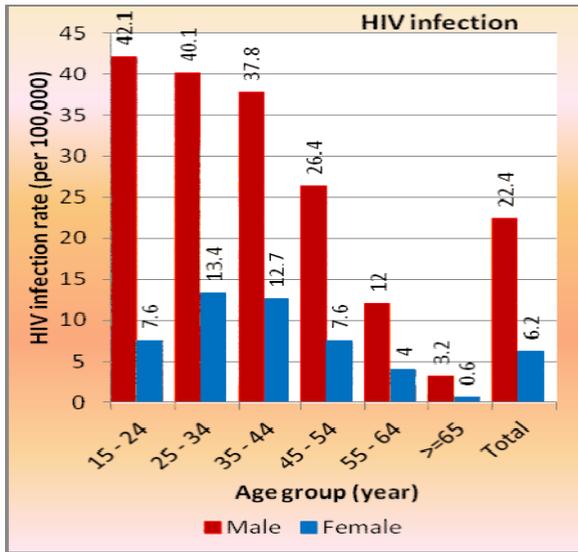
Different from the finding in Table II-2, the age group of 15-24 in Table II-3 had a low AIDS diagnosis percentage (8.3%). The age group of 35-44 years of age had the highest percentage of AIDS diagnosis (33.7%).

**Table II-3. Number of people diagnosed with AIDS cases – by sex and age at diagnosis, 2010**

Age (yrs)	Male		Female		Total	
	Case	%	Case	%	Case	%
<13	0	0.0	0	0.0	0	0.0
13 – 14	0	0.0	0	0.0	0	0.0
15 – 24	35	9.2	7	5.7	42	8.3
25 – 34	74	19.4	26	21.3	100	19.8
35 – 44	121	31.7	49	40.2	170	33.7
45 – 54	103	27.0	28	23.0	131	26.0
55 – 64	39	10.2	9	7.4	48	9.5
≥65	10	2.6	3	2.5	13	2.6
<b>Total</b>	<b>382</b>	<b>100.0</b>	<b>122</b>	<b>100.0</b>	<b>504</b>	<b>100.0</b>

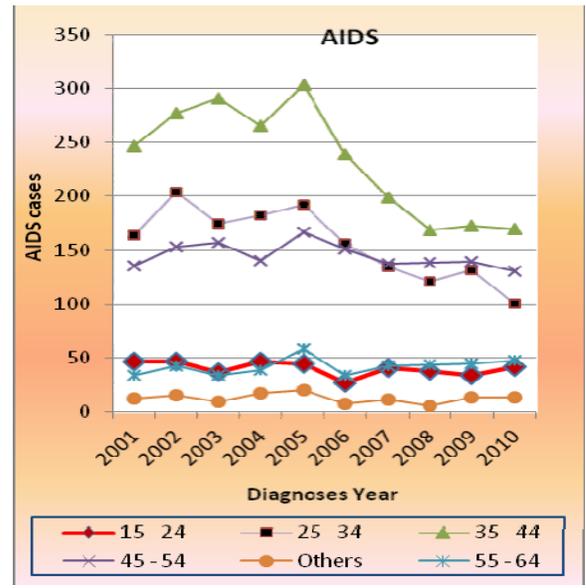
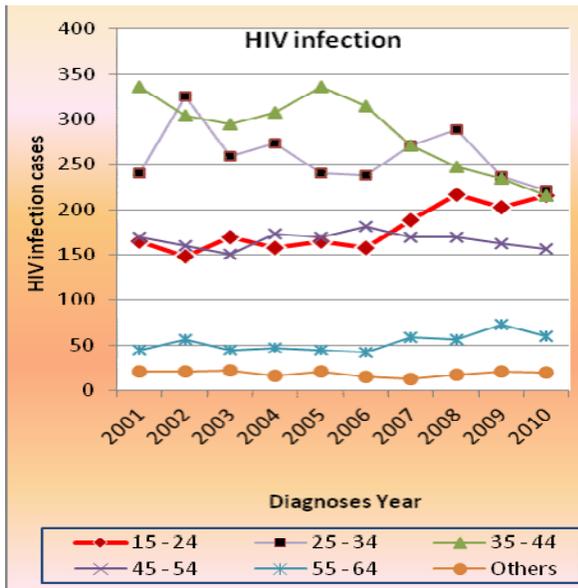
Table II-4 shows the HIV infection (with or without AIDS) and AIDS diagnosis rates (per 100,000 population) by age group in Tennessee for 2010. Among males, the HIV infection rate was higher in the 13-24 age group (42.1) and declined with age (from 42.1 to 3.2). Among females, the highest HIV infection rate was in the 25-34 age group (13.4) and declined as age increased. For both males and females, the highest AIDS diagnosis rates were in 35-44 age group (28.4 for males and 11.5 for females) and declined with age.

**Table II-4. HIV/AIDS diagnosis rate (per 100,000) by age group in Tennessee, 2010**



In Tennessee during the decade of 2001-2010, the majority of people (28.9%) diagnosed with HIV infection was among those in the 35-44 age group even though there was a downward trend in that age group. Recent data trends suggest an increase in HIV infection among those 15-24 years of age. AIDS diagnosis for people in age groups of 25-34, 35-44, and 45-54 has been declining substantially since 2005; however, as shown in Table II-5, AIDS diagnosis occurs more frequently in those same older age populations.

**Table II-5. Trends in number of people diagnosed with HIV/AIDS by age group, 2001-2010**



### New HIV/AIDS Cases in Tennessee by Sex and Race/Ethnicity

In 2010, the majority of new HIV infection cases were among African Americans than other races/ethnicities in Tennessee. African Americans accounted for 65% of all cases of HIV infection diagnosis while only comprising 16.6% of Tennessee’s population. Hispanics were also disproportionately impacted by HIV infection, and accounted for 6.4% of all new cases of while only comprising 4.5% of Tennessee’s population in 2010. Among females, African Americans had 4.2 times the number of HIV infection cases as Whites, while among males African Americans had 2.1 times the number of HIV infection as Whites (II-6).

African Americans accounted for 58.9% of all people diagnosed with AIDS in 2010, Whites accounted for 33.5% and Hispanics accounted for 4.8% (II-7).

**Table II-6. Number of people diagnosed with HIV infection by sex and race/ethnicity, 2010**

Race	Male		Female		Total	
	Case	%	Case	%	Case	%
Am Indian/Native Alaskan	1	0.1	0	0.0	1	0.1
Asian	4	0.6	3	1.5	7	0.8
African American	429	62.4	147	73.9	576	65.0
Hawaiian/ Pacific Islander	1	0.1	0	0.0	1	0.1
Hispanic	43	6.3	14	7.0	57	6.4
Multiple Race	5	0.7	0	0.0	5	0.6
White	204	29.7	35	17.6	239	27.0
<b>Total</b>	<b>687</b>	<b>100.0</b>	<b>199</b>	<b>100.0</b>	<b>886</b>	<b>100.0</b>

**Table II-7. Number of people diagnosed with AIDS by sex and race/ethnicity, 2010**

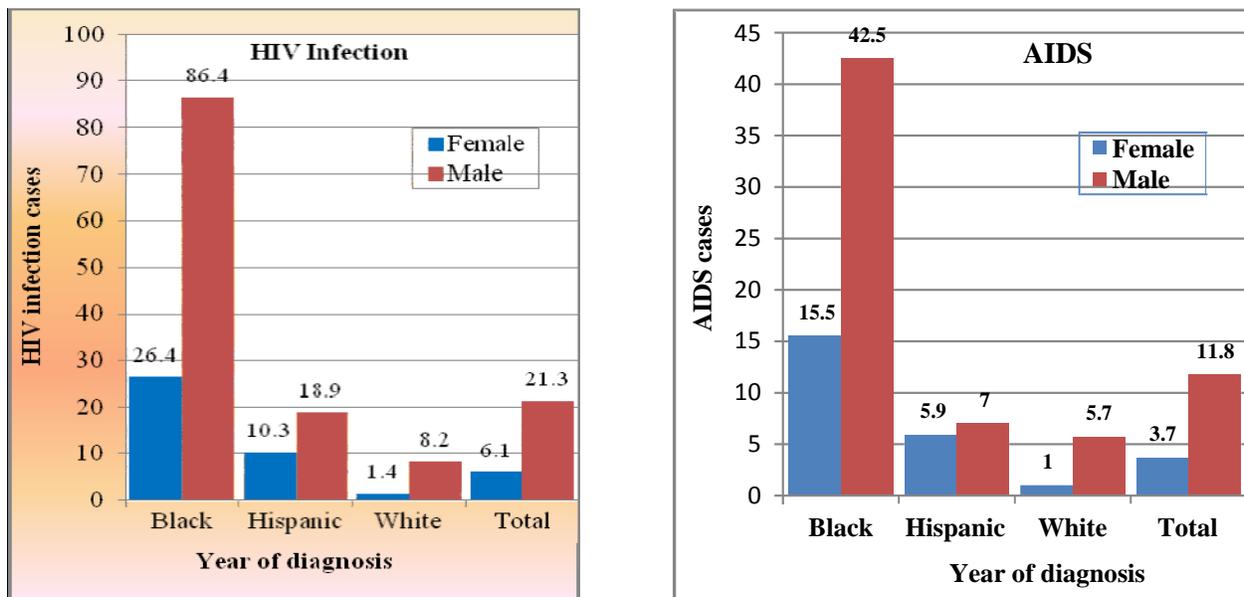
Race	Male		Female		Total	
	Case	%	Case	%	Case	%
Am Indian/Nat. Alaskan	0	0.0	0	0.0	0	0.0
Asian	4	1.0	1	0.8	5	1.0
African American	211	55.2	86	70.5	297	58.9
Hawaiian/ Pacific Islander	1	0.3	0	0.0	1	0.2
Hispanic	16	4.2	8	6.6	24	4.8
Multiple Race	7	1.8	1	0.8	8	1.6
White	143	37.4	26	21.3	169	33.5
<b>Total</b>	<b>382</b>	<b>100.0</b>	<b>122</b>	<b>100.0</b>	<b>504</b>	<b>100</b>

Table II-8 compares diagnosis rates for both HIV/AIDS in 2010 by sex and race/ethnicity. Among the male group, the highest HIV infection diagnosis rate (per 100,000) was in African Americans (86.4), the second in Hispanics (18.9), and then in Whites (8.2).

Among these same races/ethnicities, the rates for HIV infection were much lower among females than in males.

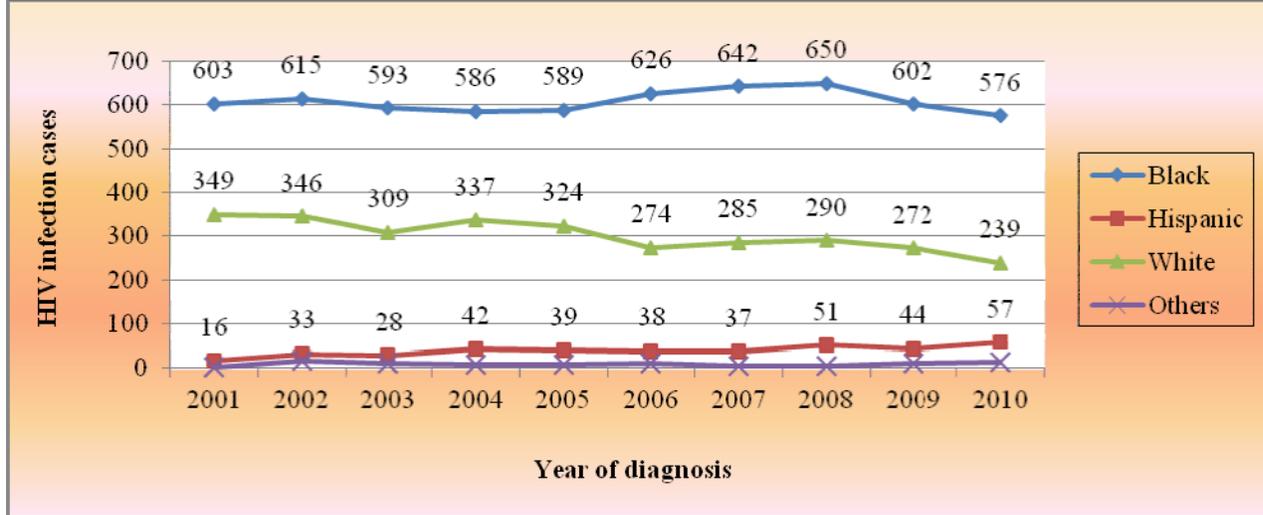
The diagnosis rate for AIDS was 42.5 for African American males, 7.0 for Hispanic males, and 5.7 for White males, compared to 15.5 for African American females, 5.9 for Hispanic females, and 1.0 for White females. The rate of diagnosis of HIV infection for African American males was more than 3 times the rate for African American females (86.4 vs. 26.4, respectively). In contrast, the rate of diagnosis of HIV infection for White males was almost 6 times the rate for White females (8.2 vs. 1.4, respectively).

**Table II-8. HIV/AIDS diagnosed rate (per 100,000) by sex and race/ethnicity, 2010**



Comparing 2001 and 2010, the percentage of Hispanic Americans diagnosed with HIV infection in Tennessee increased 256% from 16 in 2001 to 57 in 2010, while Whites decreased 32% from 349 to 239, and African Americans decreased 4% from 603 to 576. The ratio of African Americans to Whites increased from 1.7 (603/349) in 2001 to 2.4 (576/239) in 2010 (Table II-9).

**Table II-9. Trends of numbers of people diagnosed with HIV infection by year of diagnosis and race/ethnicity, 2001 – 2010**



**New HIV/AIDS Cases in Tennessee by Race/Ethnicity and Transmission Category**

The distribution of risk differs by race/ethnicity. For male-to-male sex, injection drug use, and heterosexual contact, proportions of HIV infections in 2010 were respectively: 58%, 3.8%, and 7.5% among Whites; 31%, 1.7%, and 19% among African Americans; 30%, 0%, and 26% among Hispanics; 14%, 0%, and 43% among Asians. In the whole state, the diagnosed infections attributed to male-to-male sexual contact were at 38% and infections attributed to heterosexual contact were at 17%, while missing risk information or unknown was at 42%. Exposure through male-to-male sex was much higher (58%) while heterosexual contact was much lower (7.5%) for Whites than that for other racial/ethnic groups (Table II-10).

**Table II-10. Number of people diagnosed with HIV infection by race/ethnicity and transmission category, 2010**

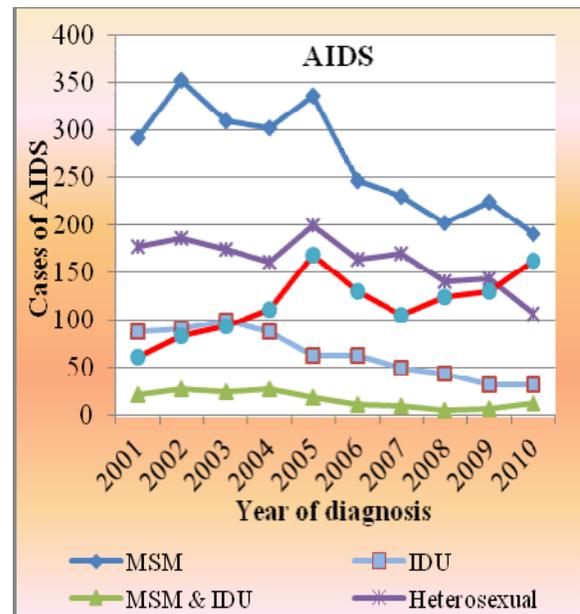
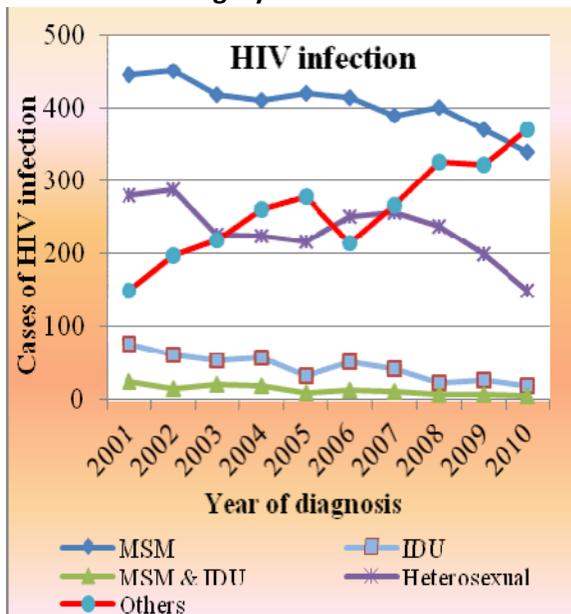
Transmission category	White		African American		Hispanic		Asian		Others		Total	
	Case	%	Case	%	Case	%	Case	%	Case	%	Case	%
Men who have sex with men (MSM)	138	58	181	31	17	30	1	14	3	43	340	38
Injection drug use (IDU)	9	3.8	10	1.7	0	0.0	0	0.0	0	0	19	2.1
MSM & IDU	1	0.4	4	0.7	0	0.0	0	0.0	0	0	5	0.6
Heterosexual contact	18	7.5	110	19	15	26	3	43	3	43	149	17
Perinatal exposure	0	0.0	2	0.3	0	0.0	0	0.0	0	0	2	0.2
Other/unknown	73	31	269	47	25	44	3	43	1	16	371	42
<b>Total</b>	<b>239</b>	<b>100</b>	<b>576</b>	<b>100</b>	<b>57</b>	<b>100</b>	<b>7</b>	<b>100</b>	<b>7</b>	<b>100</b>	<b>886</b>	<b>100</b>

Among Whites, the most common transmission category (60%) for AIDS was male-to-male sexual contact. Among African Americans, Hispanics, and Asians the most commonly reported response was other (missing risk information/unknown transmission) (Table II-11).

**Table II-11. Number of people diagnosed with AIDS by race/ethnicity and transmission category, 2010**

Transmission category	White		African American		Hispanic		Asian		Others		Total	
	Case	%	Case	%	Case	%	Case	%	Case	%	Case	%
Men who have sex with men (MSM)	101	60	78	26	4	17	2	40	5	55	190	38
Injection drug use (IDU)	16	9.5	16	5.4	0	0.0	0	0.0	0	0	32	6.3
MSM & IDU	5	3.0	7	2.4	0	0.0	0	0.0	0	0	12	2.4
Heterosexual contact	11	6.5	85	29	8	33	1	20	2	22	107	21
Perinatal exposure	0	0.0	0	0.0	0	0.0	0	0.0	0	22	0	0.0
Other/unknown	36	21	111	37	12	50	2	40	2	0	163	32
<b>Total</b>	<b>169</b>	<b>100</b>	<b>297</b>	<b>100</b>	<b>24</b>	<b>100</b>	<b>5</b>	<b>100</b>	<b>9</b>	<b>100</b>	<b>504</b>	<b>100</b>

**Table II-12. Trends of number of people diagnosed with HIV/AIDS by year of diagnosis and transmission category**



The annual number of diagnosed HIV infections attributed to male-to-male sexual contact decreased from 446 in 2001 to 340 in 2010; heterosexual contact dropped from 280 in 2001 to 149 in 2010; and injection drug use also decreased from 76 in 2001 to 19 in 2010. However, the number of infections listed under missing risk information or unknown increased from 173 in 2001 to 374 in 2010. The annual numbers of diagnosed

AIDS attributed to the risk exposure categories have the same pattern as that for diagnosed HIV infection (Table II-12).

### **New HIV/AIDS Cases by Selected Characteristics in Public Health Regions, 2010**

Table II-13 provides the number of diagnosed HIV infections (with or without AIDS) and Table II-14 shows the number of diagnosed AIDS cases in the six (6) Metro Public Health Regions and the seven (7) Public Health Regions in 2010, by selected characteristics including sex, age group, race/ethnicity, and transmission category.

### **Cumulative Number of People Diagnosed with HIV/AIDS by County through 2010**

Table II-15 provides cumulative cases of diagnosis of HIV infection (with or without AIDS) and cases of AIDS only by the State's 95 counties through December 31, 2010. The three counties with the highest number of cases are: Shelby (9,706 HIV infections, 5,674 AIDS); Davidson (6,073 HIV infections, 3,911 AIDS); and Hamilton (1,484 HIV infections, 989 AIDS). The three counties with the lowest cases are: Pickett (1 HIV infection, 0 AIDS); Stewart (4 HIV infections, 0 AIDS); and Moore (2 HIV infections, 2 AIDS).

*Note: For all tables, incident (new) cases less than 5 at the county level or below have been suppressed (replaced) with an asterisk (\*) in order to protect patient confidentiality.*

Table II-13. Number of people diagnosed with HIV Infection by selected characteristics in Metro & Public Health Regions, 2010

Characteristics		Chattanooga	Jackson	Knoxville	Memphis	Nashville	Sullivan	East	Cumberland	Mid East	North Central	South East	Upper Cumberland	West
Sex	Female	*	13	6	43	85	*	7	14	1	7	3	1	14
	Male	*	36	29	196	243	*	26	72	11	10	5	5	34
Age Group (Years)	<13	0	0	*	*	*	0	0	2	0	0	0	0	0
	13 - 14	0	0	0	*	*	0	0	0	0	0	0	0	0
	15 - 24	11	14	5	56	79	0	4	25	1	3	1	1	15
	25 - 34	5	9	7	53	97	0	6	26	3	4	1	2	8
	35 - 44	*	10	11	63	68	*	16	17	5	4	2	1	12
	45 - 54	*	10	6	48	55	*	4	11	2	5	3	2	7
	55 - 64	0	6	*	12	25	0	3	4	1	1	1	0	6
	≥65	0	0	*	6	*	0	0	1	0	0	0	0	0
Race	Am Indian/Nat. Alaskan	0	*	0	0	0	0	0	0	0	0	0	0	0
	Asian	0	0	*	*	0	0	0	0	0	0	0	0	0
	African American	17	20	9	144	297	*	5	5	2	7	3	0	36
	Nat. Hawaiian/Pacific Isld	0	*	0	0	0	0	0	0	0	0	0	0	0
	Hispanic	*	5	0	14	14	*	5	5	1	1	1	1	2
	Multiple race	*	*	*	*	*	*	0	0	0	1	0	0	1
	White	2	22	23	79	16	*	23	23	9	8	4	5	9
Transmission	Men who have sex with men (MSM)	11	17	23	119	82	0	15	50	4	3	2	2	12
	Injection drug use (IDU)	0	*	*	11	0	*	2	1	0	1	0	1	1
	MSM & IDU	*	*	*	*	*	*	0	0	1	1	0	0	0
	Heterosexual contact	*	6	*	25	75	*	3	11	1	4	0	2	16
	Perinatal exposure	0	0	0	*	*	0	0	1	0	0	0	0	0
	Other/unknown	7	26	6	83	170	*	13	23	6	8	6	1	19
<b>Total</b>		<b>49</b>	<b>20</b>	<b>35</b>	<b>328</b>	<b>239</b>	<b>4</b>	<b>33</b>	<b>86</b>	<b>12</b>	<b>17</b>	<b>8</b>	<b>6</b>	<b>48</b>

Table II-14. Number of people diagnosed with AIDS by selected characteristics in Metro & Public Health Regions, 2010

Characteristics		Chatanooga	Jackson	Knoxville	Memphis	Nashville	Sullivan	East	Mid	North	South Central	South	Upper	West
Sex	Female	*	8	7	24	52	*	24	27	9	11	7	7	29
	Male	*	21	27	86	122	*	4	6	2	2	2	2	9
Age Group (Years)	<13	0	0	0	0	0	0	0	0	0	0	0	0	0
	13 - 14	0	0	0	0	0	0	0	0	0	0	0	0	0
	15 - 24	*	0	5	9	15	0	1	4	0	0	0	0	5
	25 - 34	*	5	5	20	37	0	3	9	2	3	2	2	8
	35 - 44	*	11	16	32	62	*	17	7	4	3	2	2	9
	45 - 54	*	9	*	34	40	0	4	11	3	6	5	5	8
	55 - 64	0	*	5	10	15	0	3	2	2	1	0	0	8
	≥65	0	*	*	5	5	0	0	0	0	0	0	0	0
Race/Ethnicity	Am Indian/ Nat. Alaskan	0	0	0	0	*	0	0	0	0	0	0	0	0
	Asian	0	*	0	0	0	0	0	3	0	0	0	0	0
	African American	9	9	18	66	147	0	2	14	2	4	3	0	22
	Nat. Hawaiian/Pacific Isld	0	0	1	0	0	0	0	0	0	0	0	0	0
	Hispanic	*	*	*	*	7	0	3	3	1	2	0	2	0
	Multiple race	0	0	*	*	*	*	0	0	0	1	0	0	4
	White	*	17	12	42	18	*	23	13	8	6	6	7	12
Transmission	Men who have sex with men (MSM)	*	14	15	47	50	*	15	16	3	2	5	5	12
	Injection drug use (IDU)	0	*	*	9	*	0	6	2	0	3	0	0	6
	MSM & IDU	0	*	0	6	*	0	0	0	1	1	0	0	2
	Heterosexual contact	*	0	5	19	62	*	1	5	0	2	0	1	7
	Perinatal exposure	0	0	0	0	0	*	0	0	0	0	0	0	0
	Other/unknown	*	10	*	29	60	0	6	10	7	5	4	3	11
<b>Total</b>		<b>34</b>	<b>12</b>	<b>29</b>	<b>174</b>	<b>110</b>	<b>2</b>	<b>28</b>	<b>33</b>	<b>11</b>	<b>13</b>	<b>9</b>	<b>9</b>	<b>38</b>

**Table II-15. Cumulative number of people diagnosed with HIV/AIDS by County through December 31, 2010**

County	HIV infection	AIDS	County	HIV infection	AIDS	County	HIV infection	AIDS
Anderson	103	74	Hamilton	1484	989	Morgan	35	21
Bedford	47	29	Hancock	5	4	Obion	31	48
Benton	15	10	Hardeman	62	37	Overton	4	2
Bledsoe	10	7	Hardin	34	23	Perry	8	6
Blount	148	98	Hawkins	39	26	Pickett	1	0
Bradley	178	117	Haywood	142	95	Polk	14	9
Campbell	27	21	Henderson	24	16	Putnam	91	58
Cannon	20	6	Henry	40	31	Rhea	23	16
Carroll	32	23	Hickman	28	21	Roane	47	39
Carter	48	31	Houston	7	6	Robertson	147	93
Cheatham	76	43	Humphreys	14	11	Rutherford	427	237
Chester	10	7	Jackson	11	7	Scott	10	5
Claiborne	18	14	Jefferson	55	41	Sequatchie	15	12
Clay	7	5	Johnson	27	20	Sevier	133	98
Cocke	41	27	Knox	1,358	861	Shelby	9,706	5,674
Coffee	67	45	Lake	18	10	Smith	24	16
Crockett	16	12	Lauderdale	117	64	Stewart	4	0
Cumberland	36	29	Lawrence	42	34	Sullivan	191	127
Davidson	6,073	3,911	Lewis	4	3	Sumner	228	161
De Kalb	34	28	Lincoln	42	29	Tipton	123	79
Decatur	18	12	Loudon	46	31	Trousdale	16	8
Dickson	61	41	Macon	17	10	Unicoi	13	8
Dyer	47	37	Madison	308	184	Union	9	5
Fayette	94	49	Marion	37	31	Van Buren	5	5
Fentress	12	10	Marshall	36	25	Warren	60	46
Franklin	28	22	Maury	140	93	Washington	265	171
Gibson	84	60	McMinn	71	52	Wayne	19	9
Giles	42	27	McNairy	17	11	Weakley	23	17
Grainger	21	14	Meigs	13	8	White	26	21
Greene	78	55	Monroe	49	35	Williamson	179	106
Grundy	14	9	Montgomery	297	167	Wilson	139	92
Hamblen	74	50	Moore	2	2	<b>Total</b>	<b>23,891</b>	<b>16,483</b>

Among the public health regions, the highest rate of new HIV infections diagnosed in 2010, occurred among residents of the Metro Nashville Public Health Region (40.1). Several other health regions had new HIV diagnosis rates higher than the overall state rate of 13.8. The highest are: Shelby (35.0), Madison (20.1), and Hamilton (15.5).

## SECTION III: DEATHS AMONG PEOPLE DIAGNOSED WITH HIV/AIDS

The State allows at least 18 months (until June 30, 2012) for all 2010 deaths to be reported. Because of this, the reported death data is accurate through the end of 2009. Those deceased in 2010 will be removed from the list of people living with a diagnosis of HIV infection for that year. While this report does not intend to interpret the death numbers in 2010, it will provide the cumulative death figures through the end of 2010 in the state, regions and counties by selected characteristics.

### Deaths among People Diagnosed with HIV/AIDS by Sex

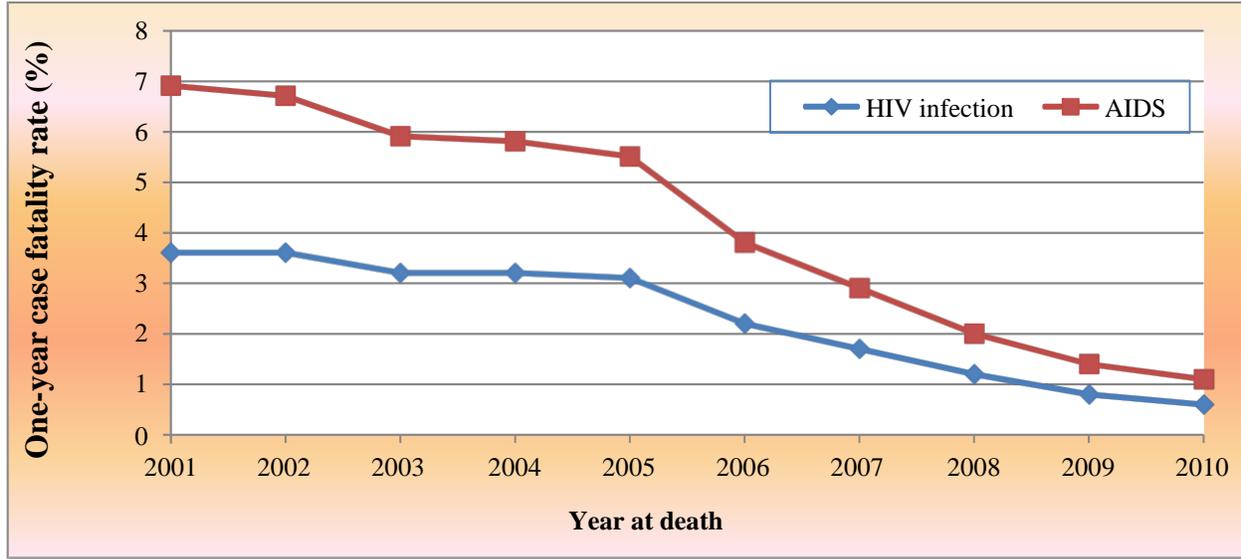
Since the beginning of the epidemic through the end of 2010, at least 7,408 persons with a diagnosis of HIV infection (with or without AIDS) have died in Tennessee. Of these, there were 6,576 with an AIDS diagnosis. Among the HIV infection-related deaths, 1,339 (18.1%) were females and 6,069 (81.9%) were males. The death ratio of females to males was very similar for HIV and AIDS: 1 to 4.5 for HIV and 1 to 4.7 for AIDS. In the last decade, the number of deaths among people with HIV infection and with AIDS declined steadily in both males and females. Among males, HIV infection-related deaths declined 73.5% from 268 in 2001, to 71 in 2010. Among females, deaths declined 72.2% from 101 in 2001, to 28 in 2010 (Table III-1).

**Table III-1. Death trends among people diagnosed with HIV/AIDS by sex**

	Sex	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	Cumulative through 2010	
												Number of Cases	%
HIV infection	Female	101	106	90	103	101	83	62	47	32	28	1,339	18.1
	Male	268	291	280	284	295	211	174	127	86	71	6,069	81.9
	<b>Total</b>	<b>369</b>	<b>397</b>	<b>370</b>	<b>387</b>	<b>396</b>	<b>294</b>	<b>236</b>	<b>174</b>	<b>118</b>	<b>99</b>	<b>7,408</b>	<b>100.0</b>
AIDS	Female	82	91	78	96	82	73	54	39	29	26	1,164	17.7
	Male	226	235	233	231	251	173	143	104	75	59	5,412	82.3
	<b>Total</b>	<b>308</b>	<b>326</b>	<b>311</b>	<b>327</b>	<b>333</b>	<b>246</b>	<b>197</b>	<b>143</b>	<b>104</b>	<b>85</b>	<b>6,576</b>	<b>100.0</b>

One-year case fatality rates are calculated annually by the year of diagnosis. The one-year HIV infection case fatality rate is calculated by the number of deaths related to the infection in a year divided by the number of persons living with the infection in the same year, multiplied by 100. Similarly, a one-year AIDS case fatality rate is calculated by the number of deaths related to AIDS in a year divided by the number of persons living with AIDS in the same year, multiplied by 100. The deaths might be for other reasons, but HIV/AIDS was the major cause. The one-year HIV infection case fatality was 3.6% in 2001 down to 0.6% in 2010, while the one-year AIDS case fatality rate also continued down from 6.9% in 2001 to 1.1% in 2010 (Table III-2).

Table III-2. One-year case fatality rates (%) among people with HIV/AIDS, 2001-2010



### Deaths among People Diagnosed with HIV/AIDS by Age

Among people diagnosed with HIV/AIDS in Tennessee, the number of persons who died each year from 2001-2010 is listed in Table III-3 and III-4 below. It should be noted that these deaths are not necessarily a result of being infected with HIV/AIDS, but include all causes of deaths, including cardiac arrest, vehicular accidents, and homicide. Cause of death data is listed on death certificates in all states, but may accurately reflect a person's true cause of death.

Table III-3. Death trends among people with a diagnosis of HIV infection by age group

Age (years)	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	Cumulative through 2010	
											Total	%
<13	0	0	0	0	0	0	0	0	0	0	32	0.4
13 - 14	0	0	1	0	0	0	0	0	0	0	2	0.0
15 - 24	19	7	6	9	4	1	3	1	1	2	179	2.4
25 - 34	74	70	55	56	68	30	33	24	11	7	2,039	27.5
35 - 44	148	158	163	137	123	108	84	52	43	32	2,813	38.0
45 - 54	90	114	102	121	118	103	87	55	40	35	1,572	21.2
55 - 64	22	37	34	47	66	37	23	27	14	15	555	7.5
≥65	16	11	9	17	17	15	6	15	9	8	216	2.9
Total	369	397	370	387	396	294	236	174	118	99	7,408	100.0

**Table III-4. Death trends among people diagnosed with AIDS by age group**

Age (years)	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	Cumulative through 2010	
											Total	%
<13	0	0	0	0	0	0	0	0	0	0	31	0.5
13 - 14	0	0	1	0	0	0	0	0	0	0	2	0.0
15 - 24	17	5	5	8	4	1	1	1	1	1	158	2.4
25 - 34	61	61	49	45	61	26	28	21	9	6	1,880	28.6
35 - 44	122	134	140	126	109	94	76	45	36	29	2,533	38.5
45 - 54	76	87	78	102	93	86	73	44	37	31	1,350	20.5
55 - 64	19	30	29	34	49	29	14	20	13	12	446	6.8
≥65	13	9	9	12	17	10	5	12	8	6	176	2.7
<b>Total</b>	<b>308</b>	<b>326</b>	<b>311</b>	<b>327</b>	<b>333</b>	<b>246</b>	<b>197</b>	<b>143</b>	<b>104</b>	<b>85</b>	<b>6,576</b>	<b>100.0</b>

**Deaths among People Diagnosed with HIV/AIDS by Race/Ethnicity**

Among cumulative deaths with HIV infection, 3,908 (52.8%) were African American and 3,363 (45.4%) were White. From 2001 through 2010, the annual deaths among people with HIV/AIDS decreased for both African Americans and Whites (Table III-5).

**Table III-5. Death trends among people diagnosed with HIV infection by race/ethnicity**

Race/Ethnicity	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	Cumulative through 2010	
											Total	%
American Indian/Nat. Alaskan	0	0	0	0	1	0	1	0	0	0	7	0.0
Asian	0	0	0	0	0	0	0	0	0	1	1	0.0
African American	246	265	241	255	260	202	172	105	58	48	3,908	52.8
Hawaiian/ Pacific Islander	0	0	0	0	0	0	0	0	0	0	0	0.0
Hispanic	2	2	3	9	9	4	3	4	1	5	88	1.2
Multiple Race	1	0	7	2	5	5	0	3	1	3	33	0.4
White	120	130	119	120	120	82	60	62	58	42	3,363	45.4
<b>Total</b>	<b>369</b>	<b>397</b>	<b>370</b>	<b>387</b>	<b>396</b>	<b>294</b>	<b>236</b>	<b>174</b>	<b>118</b>	<b>99</b>	<b>7,408</b>	<b>100.0</b>

Among the cumulative deaths with AIDS, 3,367 (51.2%) were African American and 3,078 (46.8%) were White (Table III-6).

**Table III-6. Death trends among people diagnosed with AIDS by race/ethnicity**

Race/Ethnicity	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	Cumulative through 2010	
											Total	%
American Indian/Nat. Alaskan	0	0	0	0	1	0	1	0	0	0	7	0.1
Asian	0	0	0	0	0	0	0	0	0	1	1	0.0
African American	196	230	207	214	210	170	142	87	55	40	3,367	51.2
Hawaiian/Pacific Islander	0	0	0	0	0	0	0	0	0	0	0	0.0
Hispanic	2	2	2	8	9	5	3	4	1	5	84	1.3
Multiple Race	1	0	6	3	5	5	0	3	1	3	32	0.5
White	109	94	96	101	107	66	51	49	47	36	3,078	46.8
<b>Total</b>	<b>308</b>	<b>326</b>	<b>311</b>	<b>327</b>	<b>333</b>	<b>246</b>	<b>197</b>	<b>143</b>	<b>104</b>	<b>85</b>	<b>6,576</b>	<b>100</b>

### Deaths among People Diagnosed with HIV/AIDS by Transmission Category

Cumulatively, men who identified themselves as having sex with other men (MSM) accounted for more than half (51.1%) of all deaths, and heterosexual contact accounted for 16.8% of all deaths among people with a diagnosis of HIV infection or with a diagnosis of AIDS in Tennessee (Table III-7).

**Table III-7. Deaths among people diagnosed with HIV infection by transmission category**

Transmission Category	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	Cumulative through 2010	
											Total	%
Men who have sex with men (MSM)	15	16	14	15	15	11	96	53	47	38	3,785	51.1
Injection drug use (IDU)	73	67	79	65	63	56	39	24	26	18	1,177	15.9
MSM & IDU	17	22	22	16	22	7	6	6	8	2	474	6.4
Heterosexual contact	88	105	80	102	97	63	59	45	24	24	1,247	16.8
Perinatal exposure	0	0	1	0	0	0	0	0	0	0	27	0.4
Other/unknown	36	43	42	48	62	53	36	46	13	17	698	9.4
<b>Total</b>	<b>369</b>	<b>397</b>	<b>370</b>	<b>387</b>	<b>396</b>	<b>294</b>	<b>236</b>	<b>174</b>	<b>118</b>	<b>99</b>	<b>7,408</b>	<b>100.0</b>

## **SECTION IV: PERSONS LIVING WITH A DIAGNOSIS OF HIV/AIDS**

The number of persons living with a diagnosis of HIV infection (HIV infection prevalence) and the number of persons living with a diagnosis of AIDS (AIDS prevalence) are higher than ever before. These increases are due to the fact that while people are still infected with HIV/AIDS, less people die each year with HIV infection or AIDS.

### **Number of People Living with a Diagnosis of HIV/AIDS by Sex in 2010**

As of December 31, 2010, 16,483 people were reported to be living with a diagnosis of HIV infection (with or without AIDS), and 8,027 people were diagnosed with AIDS in Tennessee. There were approximately three times as many males as females living with a diagnosis of HIV infection and living with an AIDS diagnosis (Table IV-1). The number of people diagnosed with HIV/AIDS is underestimated because it excludes people with HIV/AIDS who have not yet been tested or who have only been tested anonymously.

### **Number of People Living with a Diagnosis of HIV/AIDS by Age Group in 2010**

At the end of 2010, the majority of people (78.9%) living with HIV infection were 25-54 years old. Those 24 years old and younger comprised 5.0%, and adults 55 years old and older consisted of only 16.0% of all individuals with HIV infection. By comparison, the percentage of people living with AIDS who were 25-54 years old was 78.7%. Those 24 years old and younger comprised just 1.7%, and adults 55 years old and older comprised up to 19.6% (Table IV-1).

### **Number of People Living with a Diagnosis of HIV/AIDS by Race in 2010**

Of the people living with a diagnosis of HIV infection in Tennessee in 2010, 58.2% were African American, 37.9% were White, 3.0% were Hispanic, and the remaining 0.9% was distributed among Asian, American Indian/Native Alaskan, Native Hawaiian/Pacific Islander and Multiple Race/Unknown. Of the people living with an AIDS diagnosis in 2010, approximately 54.8% were African American, 40.9% were White, 3.2% were Hispanic, and the remaining 0.9% was distributed among Asian, American Indian/Native Alaskan, Native Hawaiian/Pacific Islander and Multiple Race/Unknown, indicating a similar pattern as that of HIV infection (Table IV-1).

### **Number of People Living with a Diagnosis of HIV/AIDS by Transmission Category in 2010**

Among those individuals living with HIV infection at the end of 2010, the transmission category, MSM, accounted for near half (46.4%) of individuals statewide. Heterosexual contact was the second highest transmission category with 23.2% of all living cases, third was other/unknown with 13.6%, and the fourth was injection drug users who comprised 8.5% of those people living with HIV infection. The transmission categories

for people living with AIDS showed the same pattern (Table IV-1).

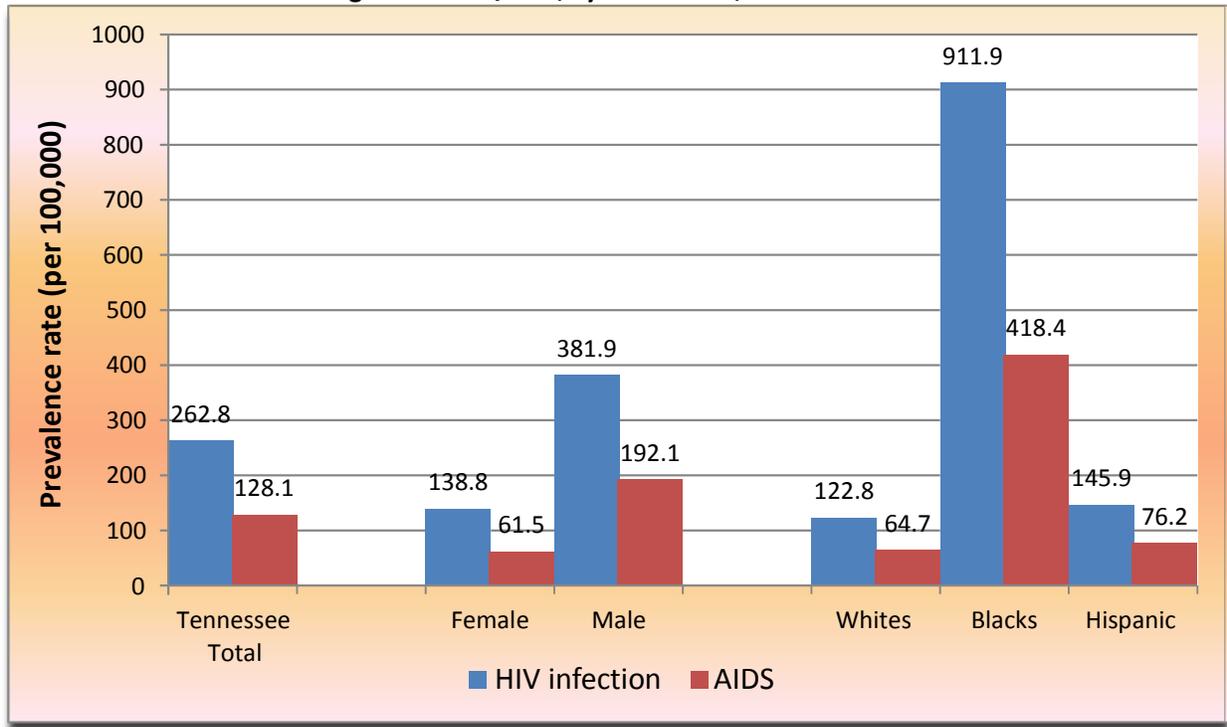
**Table IV-1. Prevalence percentage among people living with HIV/AIDS, by selected characteristics in Tennessee, 2010**

Characteristics		HIV infection		AIDS	
		Prevalence	%	Prevalence	%
Sex	Female	4,248	25.8	1,883	23.4
	Male	12,235	74.2	6,154	76.6
Age Group (years)	<13	57	0.3	5	0.1
	13 - 14	11	0.1	2	0.0
	15 - 24	759	4.6	127	1.6
	25 - 34	2,726	16.5	895	11.1
	35 - 44	4,881	29.6	2,390	29.7
	45 - 54	5,403	32.8	3,043	37.9
	55 - 64	2,112	12.8	1,263	15.7
	≥65	534	3.2	312	3.9
Race/Ethnicity	Am Indian/Nat. Alaskan	12	0.1	8	0.1
	Asian	28	0.2	16	0.2
	African American	9,597	58.2	4,404	54.8
	Nat. Hawaiian/Pacific Isld	10	0.1	2	0.0
	Hispanic	488	3.0	255	3.2
	Multiple Race	79	0.5	51	0.6
	White	6,245	37.9	2,641	32.9
Transmission Category	Men who have sex with men (MSM)	7,648	46.4	3,945	49.1
	Injection drug use (IDU)	1,407	8.5	839	10.4
	MSM & IDU	478	2.9	285	3.5
	Heterosexual contact	3,820	23.2	1,851	23.0
	Perinatal exposure	117	0.7	26	0.3
	Other/unknown	3,013	18.3	1,091	13.6
<b>Total</b>		<b>16,483</b>	<b>100</b>	<b>8,037</b>	<b>100</b>

### Prevalence Rates of Diagnoses of HIV/AIDS in 2010

At the end of 2010, the prevalence rate (per 100,000 population) of diagnoses of HIV/AIDS in Tennessee was at 263.1 and 192.1, respectively. The prevalence rate of HIV infection for males was 381.9, which was three times that of females (138.8). Among race, the rates of HIV infection were 911.9 for African Americans, 145.9 for Whites and 122.8 for Hispanics. The AIDS prevalence rate for sex and race is also provided (Table IV-2).

Table IV-2. Prevalence rate of diagnoses of HIV/AIDS, by sex and race, 2010



### Trends in the Number of People Living with a Diagnosis of HIV/AIDS by Sex, 2001-2010

The number of people living with a diagnosis of HIV infection has increased steadily during the past ten years from 10,337 in 2001 to 16,483 in 2010, representing a 160% increase. Residents living with an AIDS diagnosis also increased each year from 4,456 in 2001 to 8,037 in 2010, representing a 180% increase. The ratio of females to males living with HIV infection continued to increase from 0.33 in 2001, to 0.35 in 2010, as did the ratio of females to males living with an AIDS diagnosis (from 0.25 in 2001 to 0.31 in 2010). This illustrates an upward trend in HIV/AIDS among females that is attributed to increased exposure via heterosexual contact (Table IV-3).

**Table IV-3. Trends in the number of people living with HIV/AIDS by sex, 2001-2010**

	Sex	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
HIV infection	Female	2,549	2,730	2,889	3,059	3,224	3,427	3,626	3,855	4,077	4,248
	Male	7,788	8,223	8,634	9,051	9,449	9,901	10,436	11,030	11,619	12,235
	F/M	0.33	0.33	0.33	0.34	0.34	0.35	0.35	0.35	0.35	0.35
	<b>Total</b>	<b>10,337</b>	<b>10,953</b>	<b>11,523</b>	<b>12,110</b>	<b>12,673</b>	<b>13,328</b>	<b>14,062</b>	<b>14,885</b>	<b>15,696</b>	<b>16,483</b>
AIDS	Female	884	974	1,097	1,171	1,298	1,430	1,559	1,670	1,787	1,883
	Male	3,572	3,895	4,164	4,453	4,778	5,015	5,254	5,516	5,831	6,154
	F/M	0.25	0.25	0.26	0.26	0.27	0.29	0.30	0.30	0.31	0.31
	<b>Total</b>	<b>4,456</b>	<b>4,869</b>	<b>5,261</b>	<b>5,624</b>	<b>6,076</b>	<b>6,445</b>	<b>6,813</b>	<b>7,186</b>	<b>7,618</b>	<b>8,037</b>

*F/M = ratio of number of cases of females to the number of cases of males*

### Trends in the Number of People Living with a Diagnosis of HIV/AIDS by Age Group, 2001-2010

Over the past decade, persons living with a diagnosis of HIV infection numbered the most among those 35-54 years old at the time of diagnosis (Table IV-4). When comparing the number of people living with HIV infection in 2010 to those in 2001, there was a statewide increase 1.6 times (16,483 vs. 10,337), while those 15-24 years old increased the most by 5.2 times (759 vs. 146), and those 65 years or older increased 2.5 times (534 vs. 216).

**Table IV-4. Trends in the number of people living with a diagnosis of HIV infection by age group 2001-2010**

Age	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
<13	48	53	60	66	71	41	43	46	52	57
13 - 14	11	11	11	11	11	11	11	11	11	11
15 - 24	146	213	301	408	554	172	262	407	559	759
25 - 34	1,661	1,892	2,122	2,340	2,530	1,717	1,974	2,256	2,505	2,726
35 - 44	4,299	4,501	4,672	4,861	5,058	4,076	4,291	4,512	4,700	4,881
45 - 54	3,077	3,158	3,205	3,280	3,307	4,879	5,001	5,135	5,280	5,403
55 - 64	879	905	929	931	931	1,924	1,957	1,996	2,062	2,112
65 +	216	220	223	213	211	508	523	522	527	534
<b>Total</b>	<b>10,337</b>	<b>10,953</b>	<b>11,523</b>	<b>12,110</b>	<b>12,673</b>	<b>13,328</b>	<b>14,062</b>	<b>14,885</b>	<b>15,696</b>	<b>16,483</b>

People living with a diagnosis of AIDS also numbered the most among those 35-54 years old at the time of diagnosis (Table IV-5). When comparing the number of people living with AIDS in 2010 to those in 2001, the whole State increased 1.8 times (8,037 vs. 4,456), while those 15-24 years of age increased the most by 4.9 times (127 vs. 26), and those 65 years of age and up increased 2.4 times (312 vs. 132).

**Table IV-5. Trends in the number of people living with a diagnosis of AIDS by age group, 2001-2010**

Age	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
<13	6	8	8	10	11	4	4	4	5	5
13 - 14	4	4	4	4	4	2	2	2	2	2
15 - 24	26	39	52	80	117	33	46	68	92	127
25 - 34	454	557	659	781	911	508	599	692	799	895
35 - 44	1,826	2,011	2,178	2,322	2,513	1,859	1,986	2,121	2,259	2,390
45 - 54	1,529	1,607	1,703	1,765	1,843	2,632	2,720	2,811	2,932	3,043
55 - 64	479	504	520	525	539	1,115	1,151	1,188	1,224	1,263
≥65	132	139	137	137	138	292	305	300	305	312
<b>Total</b>	<b>4,456</b>	<b>4,869</b>	<b>5,261</b>	<b>5,624</b>	<b>6,076</b>	<b>6,445</b>	<b>6,813</b>	<b>7,186</b>	<b>7,618</b>	<b>8,037</b>

### **Trends in the Number of People Living with a Diagnosis of HIV/AIDS by Race/Ethnicity, 2001-2010**

Increases in the number of people living with HIV infection were also demonstrated in each racial/ethnic category. While the number of African Americans living with HIV infection increased 167.7% from 5,724 in 2001 to 9,597 in 2010, and the number of Whites increased 143.2% from 4,362 in 2001 to 6,245 in 2010, the number of Hispanics tripled (306.9%) from 159 in 2001, to 488 in 2010 (Table IV-6).

**Table IV-6. Trends in the number of people living with a diagnosis of HIV infection by race/ethnicity, 2001-2010**

Race/Ethnicity	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Am Indian/Nat. Alaskan	7	8	8	8	8	8	8	9	11	12
Asian	0	0	3	4	6	12	14	17	22	28
African American	5,724	6,074	6,426	6,757	7,086	7,510	7,980	8,525	9,069	9,597
Nat. Hawaiian/Pacific Isld	1	2	5	5	7	8	8	8	9	10
Hispanic	159	190	215	248	278	312	346	393	436	488
Multiple race/unknown	60	74	71	77	74	73	76	75	77	79
White	4,362	4,578	4,768	4,985	5,189	5,381	5,606	5,834	6,048	6,245
<b>Total</b>	<b>10,337</b>	<b>10,953</b>	<b>11,523</b>	<b>12,110</b>	<b>12,673</b>	<b>13,328</b>	<b>14,062</b>	<b>14,885</b>	<b>15,696</b>	<b>16,483</b>

Hispanics living with AIDS more than tripled (314.8%), while African Americans living with AIDS almost doubled (192.4%) from 2001 to 2010. There was an increase of 160.9% among Whites living with AIDS in the same time period (Table IV-7).

**Table IV-7. Trends in the number of people living with a diagnosis of AIDS by race/ethnicity, 2001-2010**

Race/Ethnicity	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Am Indian/ Nat. Alaskan	5	5	5	5	5	5	5	6	8	8
Asian	0	0	1	1	3	5	6	10	12	16
African American	2,289	2,523	2,753	2,958	3,233	3,452	3,655	3,864	4,147	4,404
Nat. Hawaiian/Pacific Isld	0	0	1	1	1	1	1	1	1	2
Hispanic	81	96	107	125	148	166	185	211	236	255
Multiple race	24	34	33	36	35	35	40	42	46	51
White	2,048	2,200	2,349	2,487	2,641	2,771	2,910	3,040	3,156	3,289
<b>Total</b>	<b>4,456</b>	<b>4,869</b>	<b>5,261</b>	<b>5,624</b>	<b>6,076</b>	<b>6,445</b>	<b>6,813</b>	<b>7,186</b>	<b>7,618</b>	<b>8,037</b>

### **Trends in the Number of People Living with a Diagnosis of HIV/AIDS by Transmission Category, 2001-2010**

People living with a diagnosis of HIV infection decreased among IDUs from 1,477 in 2001 to 1407 in 2010. The number did not change among men who self-identified as having sex with men and who were also injection drug users. The numbers increased among MSM, those reporting heterosexual contact, perinatal exposure and other/unknown (Table IV-8).

**Table IV-8. Trends of number of people living with a diagnosis of HIV infection by transmission category**

Transmission Category	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Men who have sex with men (MSM)	4,988	5,280	5,553	5,809	6,078	6,378	6,673	7,022	7,346	7,648
Injection drug use (IDU)	1,477	1,471	1,446	1,438	1,407	1,403	1,406	1,405	1,406	1,407
MSM & IDU	478	471	470	473	461	468	474	475	475	478
Heterosexual contact	2,365	2,548	2,695	2,817	2,938	3,127	3,325	3,519	3,695	3,820
Perinatal exposure	81	86	91	97	102	105	107	110	115	117
Other/unknown	948	1,097	1,268	1,476	1,687	1,847	2,077	2,354	2,659	3,013
<b>Total</b>	<b>10,337</b>	<b>10,953</b>	<b>11,523</b>	<b>12,110</b>	<b>12,673</b>	<b>13,328</b>	<b>14,062</b>	<b>14,885</b>	<b>15,696</b>	<b>16,483</b>

People living with AIDS trended upwards in all transmission categories in the past ten years (Table IV-9). Among people living with AIDS, the number exposed through heterosexual contact doubled from 928 in 2001 to 1,851 in 2010. This change is higher than in any other transmission category except for other/unknown.

**Table IV-9. Trends of number of people living with a diagnosis of AIDS by transmission category, 2001-2010**

Transmission Category	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Men who have sex with men (MSM)	2,344	2,572	2,764	2,937	3,145	3,295	3,445	3,602	3,789	3,945
Injection drug use (IDU)	662	694	722	753	767	781	796	815	824	839
MSM & IDU	243	253	257	270	268	273	276	275	274	285
Heterosexual contact	928	1,021	1,126	1,200	1,316	1,424	1,545	1,646	1,766	1,851
Perinatal exposure	20	22	21	23	24	25	25	25	26	26
Other/unknown	259	307	371	441	556	647	726	823	939	1,091
<b>Total</b>	<b>4,456</b>	<b>4,869</b>	<b>5,261</b>	<b>5,624</b>	<b>6,076</b>	<b>6,445</b>	<b>6,813</b>	<b>7,186</b>	<b>7,618</b>	<b>8,037</b>

**Number of People Living with a Diagnosis of HIV/AIDS by Selected Characteristics in Public Health Regions, and Counties, 2010**

Table IV-10 provides the number of people living with a diagnosis of HIV infection (with or without AIDS), and Table IV-11 provides the number of people living with a diagnosis of AIDS in six (6) Metro Public Health Regions, and seven (7) Public Health Regions in 2010, by selected characteristics.

Table IV-12 gives the number of people living with a diagnosis of HIV infection (with or without AIDS) and the number of people with a diagnosis of AIDS by county through December 31, 2010. The three counties with the greatest number of people living with HIV/AIDS are: Shelby (6,794 HIV infections, 3,126 AIDS); Davidson (4,208 HIV infections, 2,197 AIDS); and Hamilton (975 HIV infections, 519 AIDS).

*Note: Small cell sizes less than 5 at the county level of below are not reportable due to confidentiality concerns. These cells have been replaced with an “\*” and should be interpreted as “less than 5”.*

Table IV-10. Number of people living with a diagnosis of HIV Infection (prevalence) by selected characteristics in Public Health Regions, 2010

Characteristics		Chatanooga	Jackson	Knoxville	Memphis	Nashville	Sullivan	East	Mid Cumber-land	North East	South Central	South East	Upper Cumber-land	West
Sex	Female	243	58	165	908	2,079	21	92	241	64	94	57	40	184
	Male	723	164	743	3,233	4,571	99	412	934	261	231	210	193	447
Age Group (years)	<13	0	*	*	*	32	0	2	4	0	0	1	0	5
	13 - 14	0	*	*	*	7	0	0	0	0	0	0	3	0
	15 - 24	46	20	20	143	378	*	9	63	9	12	4	8	42
	25 - 34	132	41	124	527	1,366	20	53	209	45	41	33	22	110
	35 - 44	284	62	285	1,212	1,973	29	180	316	107	86	93	67	181
	45 - 54	315	71	326	1,544	1,941	38	174	390	109	110	87	95	198
	55 - 64	153	19	113	580	759	25	70	150	44	56	41	31	70
	≥65	36	8	38	124	194	*	16	43	11	20	8	7	25
Race/Ethnicity	Am Indian/ Nat. Alaskan	*	0	0	*	*	0	0	3	1	2	0	0	0
	Asian	*	0	*	10	*	0	1	7	0	0	0	0	0
	African American	449	152	240	2,144	5,547	24	46	409	49	102	36	19	375
	Nat. Hawaiian/Pacific Isld	*	0	*	*	*	0	1	1	0	0	0	0	0
	Hispanic	33	12	22	153	102	*	25	56	11	19	8	25	17
	Multiple race	*	*	7	12	34	*	1	3	0	2	0	2	12
	White	471	56	630	1,811	955	91	430	691	264	200	223	187	226
Transmission	Men who have sex with men (MSM)	484	108	531	2,165	2,636	68	276	604	177	130	148	112	202
	Injection drug use (IDU)	81	24	89	601	267	11	47	88	35	38	25	21	79
	MSM & IDU	*	*	*	139	129	*	21	40	18	15	7	18	32
	Heterosexual contact	161	49	117	844	1,994	21	72	163	38	72	38	48	201
	Perinatal exposure	*	*	*	19	61	*	5	8	4	0	2	3	7
	Other/unknown	213	32	144	373	1,563	16	83	272	53	70	47	31	110
<b>Total</b>		<b>966</b>	<b>222</b>	<b>908</b>	<b>4,141</b>	<b>6,650</b>	<b>120</b>	<b>504</b>	<b>1,175</b>	<b>325</b>	<b>325</b>	<b>267</b>	<b>233</b>	<b>631</b>

Table IV-11. Number of people living with a diagnosis of AIDS (prevalence) by selected characteristics in Public Health Regions, 2010

Characteristics		Charltonoog <sup>a</sup>	Jackson	Knoxville	Memphis	Nashville	Sullivan	East	Cumber	Mid	North	Central	South	East	Upper	West
Sex	Female	106	27	79	437	841	7	42	116	27	46	26	30	96		
	Male	398	75	373	1,640	2,039	54	261	475	148	157	136	111	269		
Age Group (years)	<13	0	*	0	*	*	0	0	0	0	0	0	0	0	0	
	13 - 14	0	0	0	*	*	0	0	0	0	0	0	1	0		
	15 - 24	11	*	5	30	47	0	5	12	1	0	1	4	7		
	25 - 34	54	16	38	182	410	*	21	67	18	14	10	13	47		
	35 - 44	159	29	140	565	914	19	91	154	54	57	54	39	109		
	45 - 54	163	40	175	871	1,000	23	122	243	67	76	61	58	137		
	55 - 64	100	7	70	358	404	13	54	88	27	42	29	20	46		
	≥65	17	7	24	69	101	*	10	27	8	14	7	6	19		
Race/Ethnicity	Am Indian/ Nat. Alaskan	*	0	*	*	*	0	1	1	0	2	0	0	0		
	Asian	*	0	*	*	*	0	1	4	0	0	0	0	0		
	African American	235	68	115	1,076	2,342	8	31	203	25	59	22	11	202		
	Nat. Hawaiian/Pacific Isld	*	0	0	0	0	0	0	1	0	0	0	0	0		
	Hispanic	17	5	12	73	48	*	15	27	7	13	4	20	12		
	Multiple race	*	0	5	8	21	0	0	0	0	1	0	2	11		
	White	244	29	314	911	464	52	255	354	143	128	136	107	139		
Transmission	Male sex male (MSM)	263	45	275	1,093	1,276	40	165	302	102	82	99	69	126		
	Injection drug use (IDU)	57	15	53	321	160	5	37	57	21	28	10	11	61		
	MSM & IDU	*	6	*	87	76	*	11	20	10	8	5	10	23		
	Heterosexual contact	87	27	55	421	883	9	40	98	17	47	21	32	110		
	Perinatal exposure	*	0	*	7	8	*	3	2	1	0	1	1	0		
	Other/unknown	80	9	56	148	477	5	47	112	24	38	26	18	45		
<b>Total</b>		<b>504</b>	<b>102</b>	<b>452</b>	<b>2,077</b>	<b>2,880</b>	<b>61</b>	<b>303</b>	<b>591</b>	<b>175</b>	<b>203</b>	<b>162</b>	<b>141</b>	<b>365</b>		

**Table IV-12. Number of people living with a diagnosis of HIV/AIDS by county, 2010**

County	HIV Infection	AIDS	County	HIV Infection	AIDS	County	HIV Infection	AIDS
Anderson	65	37	Hamilton	975	519	Morgan	27	13
Bedford	33	18	Hancock	*	*	Obion	25	12
Benton	10	5	Hardeman	45	21	Overton	*	*
Bledsoe	9	6	Hardin	23	12	Perry	7	5
Blount	94	50	Hawkins	25	13	Pickett	*	0
Bradley	126	72	Haywood	92	55	Polk	11	6
Campbell	18	12	Henderson	16	9	Putnam	65	33
Cannon	17	3	Henry	26	17	Rhea	17	10
Carroll	24	15	Hickman	17	10	Roane	27	21
Carter	38	21	Houston	6	5	Robertson	92	45
Cheatham	60	27	Humphreys	8	6	Rutherford	347	165
Chester	7	5	Jackson	8	*	Scott	8	*
Claiborne	7	3	Jefferson	28	15	Sequatchie	7	*
Clay	5	3	Johnson	15	8	Sevier	87	53
Cocke	24	13	Knox	920	451	Shelby	6,794	3,126
Coffee	42	24	Lake	13	5	Smith	17	10
Crockett	6	*	Lauderdale	90	43	Stewart	3	0
Cumberland	19	14	Lawrence	28	21	Sullivan	119	59
Davidson	4,208	2,197	Lewis	2	1	Sumner	159	96
De Kalb	27	21	Lincoln	25	14	Tipton	83	44
Decatur	12	6	Loudon	32	19	Trousdale	12	*
Dickson	46	29	Macon	9	*	Unicoi	9	5
Dyer	28	18	Madison	226	109	Union	7	*
Fayette	67	24	Marion	26	21	Van Buren	5	5
Fentress	6	*	Marshall	23	14	Warren	40	27
Franklin	15	10	Maury	110	66	Washington	191	105
Gibson	54	34	McMinn	44	26	Wayne	15	6
Giles	31	19	McNairy	9	6	Weakley	13	7
Grainger	14	8	Meigs	10	5	White	14	13
Greene	44	25	Monroe	31	17	Williamson	135	66
Grundy	7	*	Montgomery	231	109	Wilson	102	58
Hamblen	49	26	Moore	*	*	<b>Total</b>	<b>16,771</b>	<b>8,390</b>

## SECTION V: SEXUALLY TRANSMITTED DISEASES

While the previous section addressed the level of HIV infection in various groups affected by HIV, the following section will focus on Sexually Transmitted Diseases (STDs) in Tennessee. There are three notifiable sexually transmitted diseases for which there are federally-funded control programs: Chlamydia, gonorrhea, and syphilis.

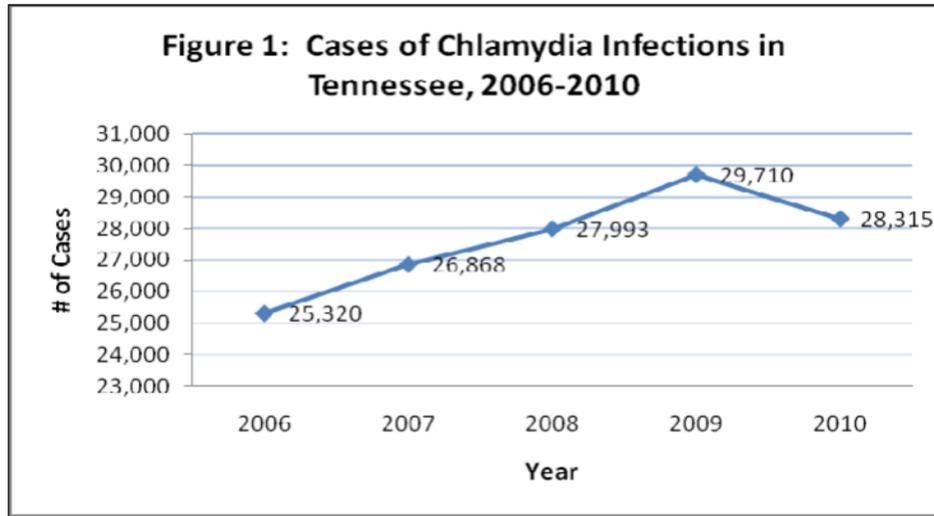
### Chlamydia

Chlamydia is a common sexually transmitted disease (STD) caused by the bacterium, *Chlamydia trachomatis*, which can damage a woman's reproductive organs. It is the most frequently reported bacterial sexually transmitted disease in the United States. Chlamydia affects both males and females, although it is most prevalent among young women.

Chlamydia can be transmitted during vaginal, anal, or oral sex. It can also be passed from an infected mother to her baby during vaginal childbirth. The majority of people infected with chlamydia have no symptoms. If symptoms do occur, they usually appear within 1-3 weeks after exposure. Women who have symptoms of chlamydia might have an abnormal vaginal discharge or a burning sensation when urinating. Men with symptoms may also have a burning sensation when urinating or a discharge from the penis, as well as burning or itching around the opening of the penis. Fortunately, chlamydia can be easily treated and cured with antibiotics. If untreated, it can progress to serious reproductive and other health problems, such as pelvic inflammatory disease in women and epididymis in men.

### Statistical Data

Reported cases of chlamydia in Tennessee steadily increased from 2006 to 2009. However, in 2010 Tennessee reported 28,315 cases of chlamydia, which was a 4.7% decrease from the number of cases reported in 2009 (Figure 1). Of these 28,315 reported cases, 140 were found to be co-infected with HIV. The rate of chlamydia also experienced a decline in 2010. There were 451.9 cases of chlamydia per 100,000 population in 2010, which was a 5.6% decrease from the 2009 rate of 478.9 cases per 100,000 population.

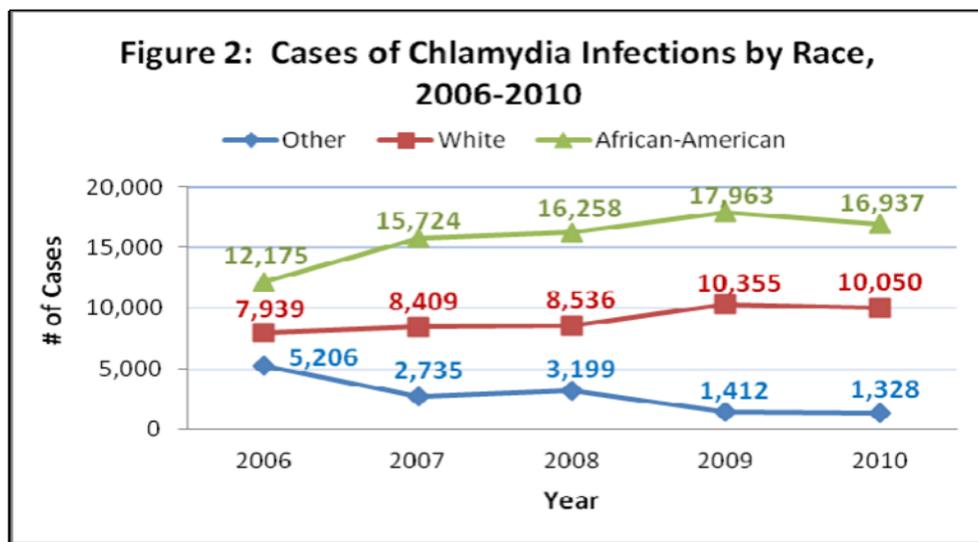


Tennessee is divided into six metropolitan health regions and seven rural health regions. The Nashville/Davidson and Memphis/Shelby metropolitan regions typically report the highest number of cases. In 2010, these two regions together reported 48% of the total number of chlamydia cases in Tennessee. Among the metropolitan regions, the Memphis/Shelby region had the highest rate of chlamydia with 1,063.3 cases per 100,000 population (Table 1). West Tennessee had the highest rate among the rural regions with 463.4 cases per 100,000 population (Table 2).

<b>Table 1: Chlamydia - 2010 Reported Cases and Rates</b>		
<b>Metropolitan Regions</b>		
<b>Region</b>	<b>Cases</b>	<b>Cases per 100,000 Population</b>
Memphis/Shelby	9,976	1,063.3
Jackson/Madison	690	694.6
Nashville/Davidson	3,495	586.6
Chattanooga/Hamilton	1,537	484.9
Knoxville/Knox	1,597	376.6
Sullivan	294	190.8
<b>Total</b>	<b>17,589</b>	<b>695.7</b>

Table 2: Chlamydia - 2010 Reported Cases and Rates		
Rural Regions		
Region	Cases	Cases per 100,000 Population
West	2,504	463.4
Mid-Cumberland	3,280	310.7
South Central	1,095	282.6
Southeast	914	282.2
East	1,655	222.4
Upper-Cumberland	702	208.1
Northeast	576	166.0
<b>Total</b>	<b>10,726</b>	<b>287.1</b>

Chlamydia screening in Tennessee is primarily conducted among females younger than 26 years of age. Consequently, there are almost 3 times as many females than males with reported cases of chlamydia, and morbidity is highest among this age group. Table 3 on the next page summarizes demographic information for chlamydia in 2010.



Since 2006, African Americans have consistently represented the highest numbers of chlamydia cases. In 2010, there were 16,937 cases of chlamydia among African Americans, which represented 60% of all cases reported. Additionally, chlamydia morbidity has increased among both Whites and African Americans since 2006. There was a 26.6% increase in cases among Whites from 2006-2010, while cases among African Americans increased 39.1% during this period (Figure 2).

**Table 3: Chlamydia - Reported cases by Race, Sex, and Age Group  
Tennessee, 2010**

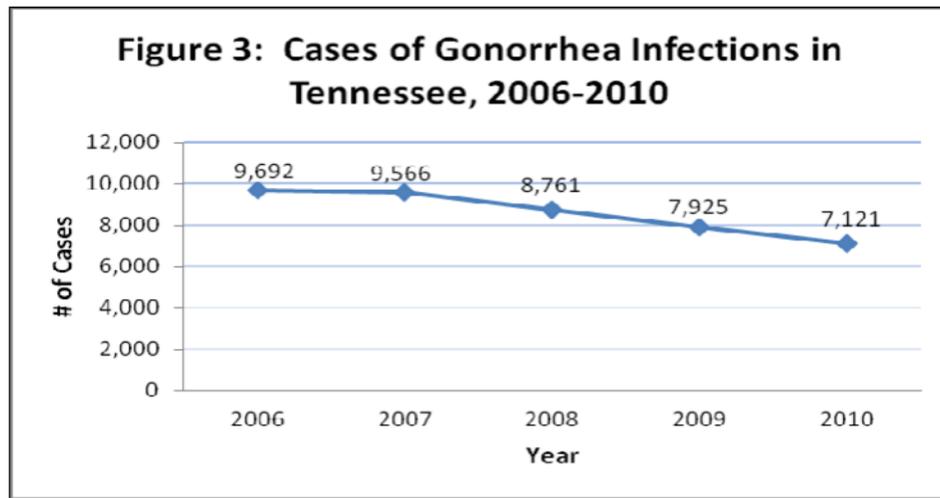
Age Group	White		Black		Asian/Pacific Islander		American Indian/Alaskan Native	
	Male	Female	Male	Female	Male	Female	Male	Female
10-14	3	80	15	183	0	0	0	0
15-19	512	2,840	1,454	5,022	3	22	0	8
20-24	1,072	3,045	1,878	4,387	5	27	2	8
25-29	478	1,036	836	1,398	5	11	1	1
30-34	186	364	401	533	1	4	0	3
35-39	80	135	189	191	2	4	0	0
40-44	34	75	91	111	1	0	0	0
45-54	30	45	86	91	1	0	1	1
55-64	10	5	25	26	0	0	0	0
65+	5	1	5	2	0	0	0	0
<b>TOTAL</b>	<b>2,410</b>	<b>7,626</b>	<b>4,980</b>	<b>11,944</b>	<b>18</b>	<b>68</b>	<b>4</b>	<b>21</b>

## Gonorrhea

Gonorrhea is caused by the bacterium *Neisseria gonorrhoeae*. It is a very common infectious disease and is spread through contact with the penis, vagina, mouth, or anus. It can also be spread from mother to baby during delivery. Most men and women with gonorrhea have no symptoms at all. When men have signs or symptoms, they may appear one to fourteen days after infection, and could include a burning sensation when urinating, or a white, yellow, or green discharge from the penis. When a woman has symptoms they are often mild, and may include a painful or burning sensation when urinating, increased vaginal discharge, or vaginal bleeding between periods. Antibiotics can successfully cure gonorrhea in adolescents and adults. As with chlamydia, untreated gonorrhea can cause serious and permanent health problems in both men and women, such as pelvic inflammatory disease and epididymis.

## Statistical Data

There were 7,121 reported cases of gonorrhea in 2010. Following a peak of diagnosis in 2006 with 9,692 cases, gonorrhea morbidity has declined over the past 5 years. There was a 26.5% decrease in cases from 2006-2010, and numbers are the lowest they have been in five years (Figure 3). Furthermore, the 2010 rate of gonorrhea in Tennessee was 113.7 cases per 100,000 population, which is a 29.1% decrease from the 2006 rate of 160.4 cases per 100,000 population.



In 2010, the Memphis/Shelby metropolitan region accounted for 48.9% of all gonorrhea cases in Tennessee. This region also had the highest rate, with 370.9 cases per 100,000 population (Table 4). Among the rural regions, West Tennessee had the highest rate of gonorrhea, with 94.9 cases per 100,000 population (Table 5).

**Table 4: Gonorrhea - 2010 Reported Cases and Rates**

**Metropolitan Regions**

Region	Cases	Cases per 100,000 Population
Memphis/Shelby	3,480	370.9
Jackson/Madison	186	187.2
Nashville/Davidson	965	162.0
Chattanooga/Hamilton	442	139.4
Knoxville/Knox	336	79.3
Sullivan	41	26.6
<b>Total</b>	<b>5,450</b>	<b>215.5</b>

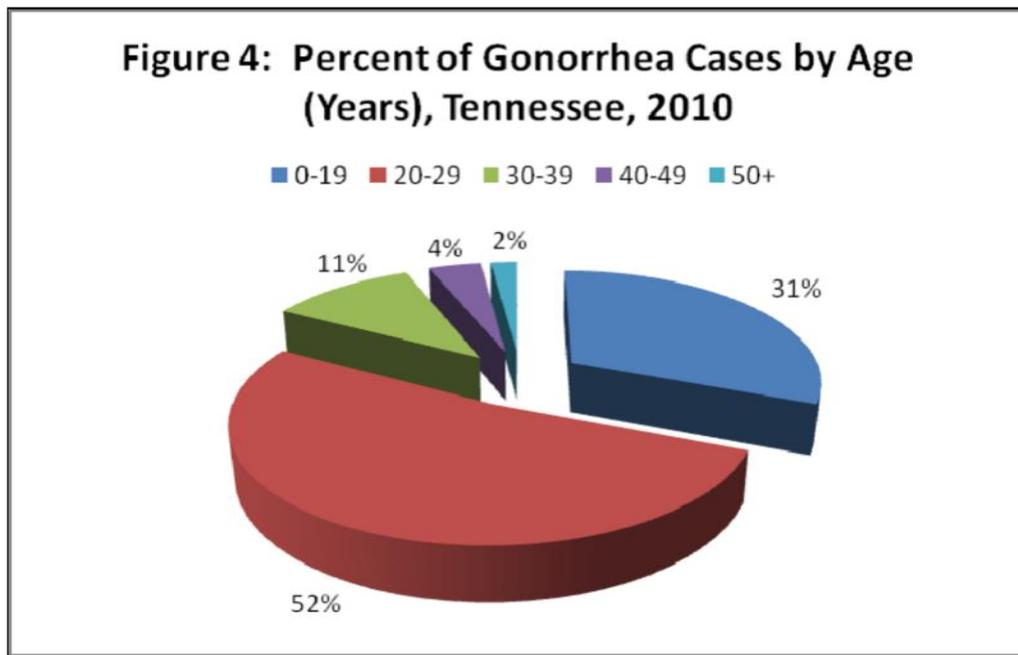
**Table 5: Gonorrhea - 2010 Reported Cases and Rates**

**Rural Regions**

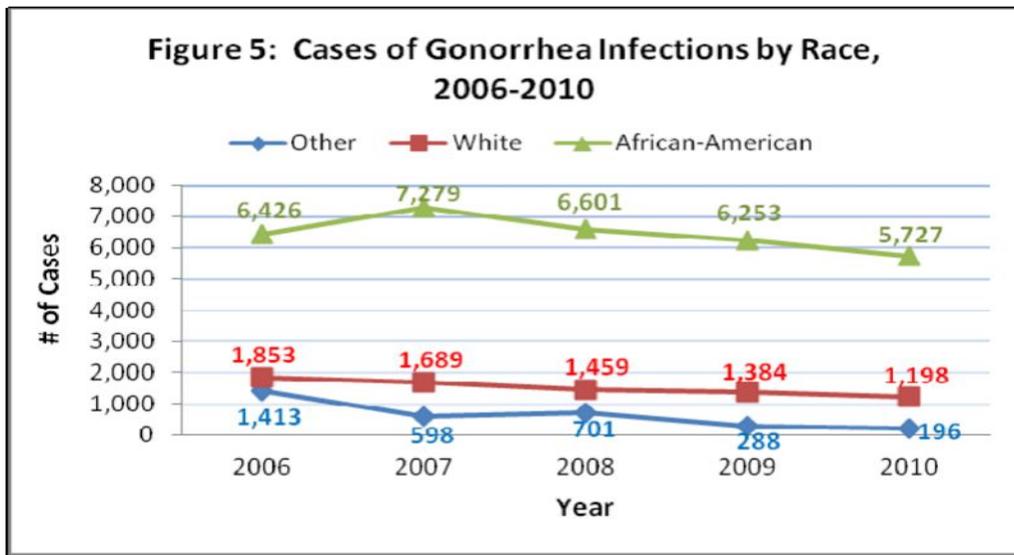
Region	Cases	Cases per 100,000 Population
West	513	94.9
Mid-Cumberland	540	51.1
South Central	175	45.2
Southeast	108	33.3
Northeast	109	31.4
Upper-Cumberland	72	21.3
East	154	20.7
<b>Total</b>	<b>1,671</b>	<b>44.7</b>

Tennessee utilizes a dual screening test for gonorrhea and chlamydia; consequently, all patients are screened for both tests. Screening for chlamydia is performed primarily on women; therefore, cases of gonorrhea are higher among females, but only slightly. In 2010, females constituted 55% of the 7,121 cases reported in Tennessee.

Similar to chlamydia, young persons were infected with gonorrhea at a much higher rate than older persons. People aged 20-29 had the highest proportion of gonorrhea cases with 52%; those aged 0-19 years had the second highest proportion of cases with 31%. These two age groups comprised 83% of the overall infection rate for 2010 (Figure 4).



African Americans have historically represented the highest number and rate of gonorrhea cases. In 2010, there were 5,727 cases of African Americans with gonorrhea, which represented 80% of the total number of cases. There were 1,198 cases of Whites with gonorrhea, while the remaining 196 cases were comprised by other races (Figure 5). In 2010, the rate of African Americans with gonorrhea was 544.1 cases per 100,000 population, which was significantly higher than the rate for Whites, which was 23.6 cases per 100,000 population. However, the case numbers and rate for both African Americans and Whites continues to decrease each year.



## Syphilis

Syphilis is caused by the bacterium *Treponema pallidum*, and is spread through direct contact with a syphilis sore. These sores occur mainly on the external genitals, vagina, anus, or in the rectum. However, they can also occur in the lips and in the mouth. Syphilis is transmitted during vaginal, anal, or oral sex. Additionally, pregnant women with syphilis can pass it on to the babies they are carrying. The course of syphilis is divided into different stages, each with their own signs and symptoms.

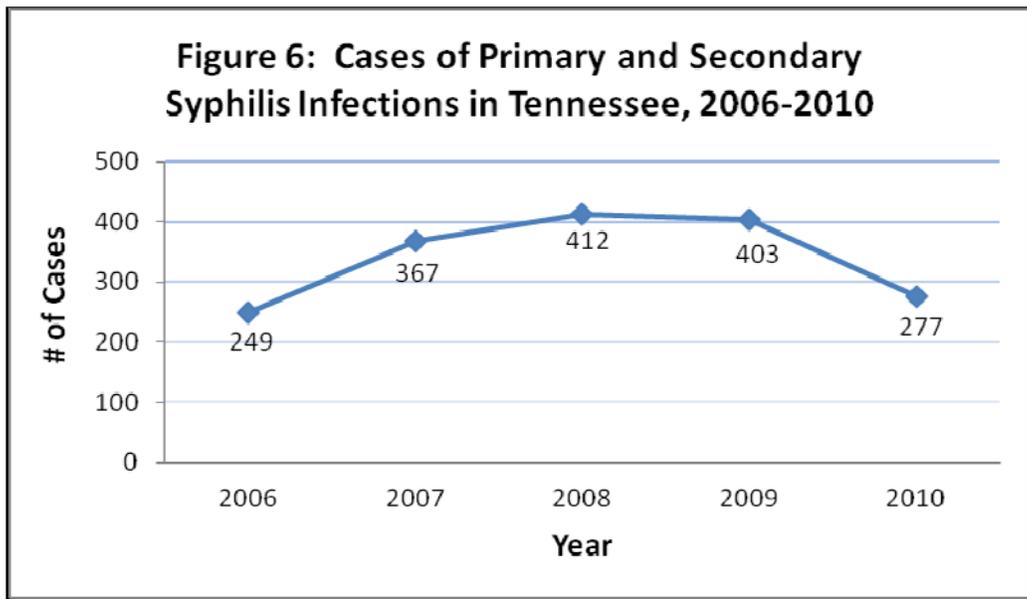
- **Primary Syphilis** is the most infectious stage of the disease. It is usually marked by the appearance of a single sore (called a chancre), but there may be multiple sores. The chancre is usually firm, round, small, and painless, and appears at the spot where Syphilis enters the body. The chancre lasts 3 to 6 weeks, and it heals without treatment. However, if adequate treatment is not administered, the infection progresses to the secondary stage.
- **Secondary Syphilis** is characterized by skin rash and mucous membrane lesions. The rash develops on one or more areas of the body and typically appears on the palms of the hands and soles of the feet. However, rashes with a different appearance may occur on other parts of the body. Other symptoms of secondary syphilis include fever, swollen lymph glands, weight loss, and fatigue. The symptoms will resolve with or without treatment. Without treatment, the infection progresses to the latent stages.
- The latent stage of syphilis begins when primary and secondary symptoms disappear. This is stage can be divided into early and late subcategories. When initial infection has occurred within the previous 12 months, latent syphilis is

classified as **Early Latent**. When the initial infection has occurred greater than 1 year previously, it can be classified as **Late Latent**. In the late latent stage of Syphilis, paralysis, numbness, gradual blindness, and dementia may occur, and the disease can damage the internal organs. This damage may be serious enough to cause death.

A single intramuscular injection of penicillin, an antibiotic, will cure a person who has had syphilis for less than a year. Additional doses (up to three doses, given over a three week period) are needed for someone who has had Syphilis for longer than a year.

### Statistical Data

In 2010, there were 277 cases of primary and secondary syphilis reported in Tennessee. This was a 31.3% decrease from the 403 cases reported in 2009, and numbers are the lowest they have been in 4 years (Figure 6). The rate of primary and secondary syphilis in 2010 was 4.4 cases per 100,000 population, which is a 32.3% decrease from the 2009 rate of 6.5 cases per 100,000 population. The most significant change in morbidity was in the Knoxville/Knox metropolitan region, with a 77.5% decrease of cases in 2010.



The Memphis/Shelby and Nashville/Davidson metropolitan regions encompassed the majority of cases. These two regions together comprised 72% of the total number of primary and secondary syphilis cases in 2010. The Memphis/Shelby region had the highest rate, with 15.0 cases per 100,000 population (Table 6). Among the rural regions, Southeast Tennessee had the highest rate of primary and secondary syphilis, with 1.9

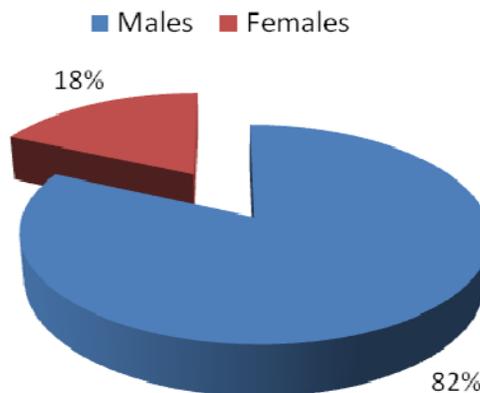
cases per 100,000 population. Northeast Tennessee reported no cases of primary and secondary syphilis in 2010 (Table 7).

<b>Table 6: Primary and Secondary Syphilis - 2010 Reported Cases and Rates</b>		
<b>Metropolitan Regions</b>		
<b>Region</b>	<b>Cases</b>	<b>Cases per 100,000 Population</b>
Memphis/Shelby	141	15.0
Nashville/Davidson	59	9.9
Knoxville/Knox	18	4.2
Chattanooga/Hamilton	10	3.2
Jackson/Madison	3	3.0
Sullivan	1	0.6
<b>Total</b>	<b>232</b>	<b>9.2</b>

<b>Table 7: Primary and Secondary Syphilis - 2010 Reported Cases and Rates</b>		
<b>Rural Regions</b>		
<b>Region</b>	<b>Cases</b>	<b>Cases per 100,000 Population</b>
Southeast	6	1.9
Mid-Cumberland	19	1.8
West	9	1.7
South Central	4	1.0
East	6	0.8
Upper-Cumberland	1	0.3
Northeast	0	0.0
<b>Total</b>	<b>45</b>	<b>1.2</b>

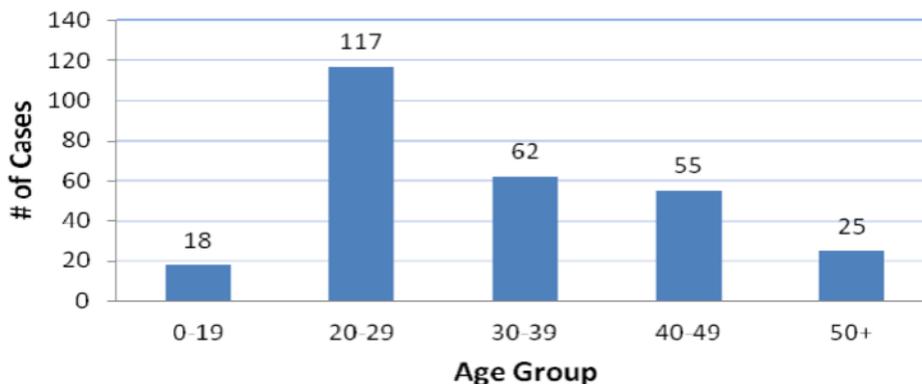
Males overwhelmingly represented the highest proportion of primary and secondary syphilis cases in 2010. Of the 277 cases of primary and secondary syphilis reported, 82% were males. Females comprised only 18% of the number of cases reported (Figure 7).

**Figure 7: Percent of Primary and Secondary Syphilis Cases by Gender, Tennessee, 2010**



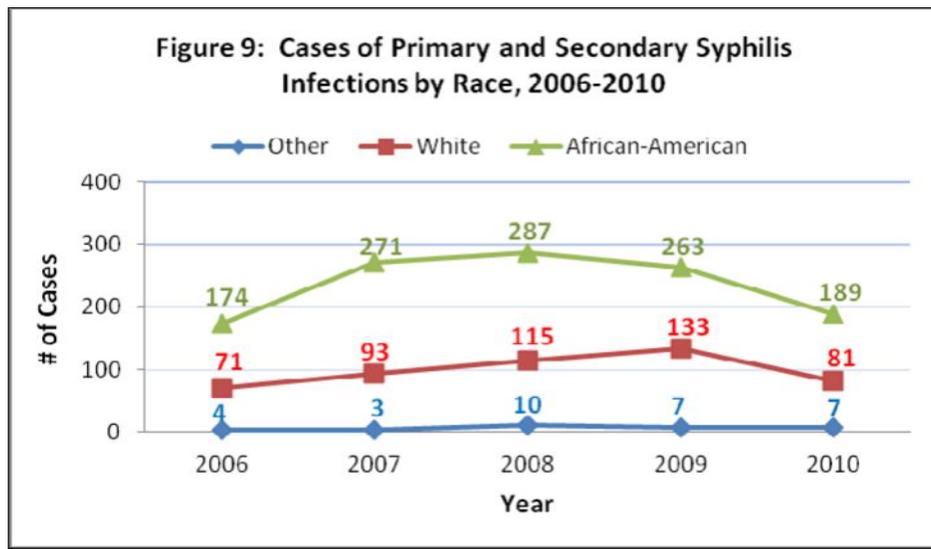
The highest number of primary and secondary syphilis cases in 2010 was among the 20-29 age group, which comprised 117 of the 277 cases reported. However, unlike chlamydia and gonorrhea, the 30-39 age group had the second highest number of reported primary and secondary syphilis with 62 cases. Following closely behind with the third highest reported number was the 40-49 age group with 55 cases. Primary and secondary syphilis cases were lowest in the 0-19 and 50+ age groups (Figure 8).

**Figure 8: Cases of Primary and Secondary Syphilis Infections by Age Group, Tennessee, 2010**



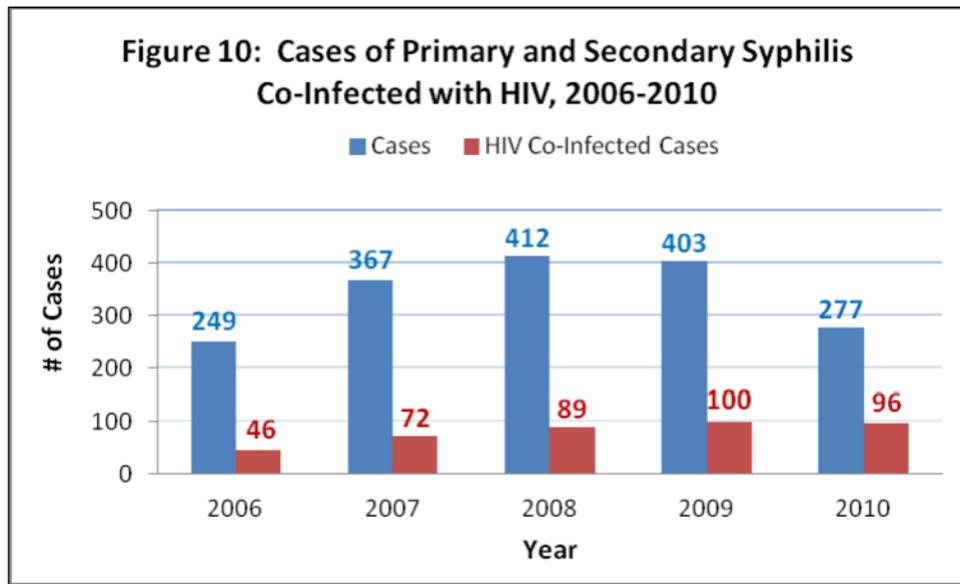
As with chlamydia and gonorrhea, cases of primary and secondary syphilis are highest among African Americans. In 2010, there were 189 reported cases of African Americans with primary and secondary syphilis, which represented 68% of the total number of cases reported. There were 81 cases of Whites with primary and secondary syphilis

while the remaining 7 cases were comprised by other races (Figure 9). Although cases and rates of primary and secondary syphilis decreased considerably in 2010, the rate of African Americans with primary and secondary syphilis continues to be significantly higher when compared to the rate for Whites. In 2010, the rate of African Americans with primary and secondary syphilis was 18.0 cases per 100,000 population, while the rate for whites was 1.6 cases per 100,000 population.



### HIV and Syphilis Co-Infection

Although there was a decline in the number of cases of primary and secondary syphilis in 2010, the proportion of cases co-infected with HIV continues to increase each year. In 2006, 18.5% of individuals diagnosed with primary and secondary syphilis were co-infected with HIV, while 34.7% were co-infected in 2010. There were 96 cases of co-infection in 2010, which is a 108.7% increase from the 46 cases of co-infection in 2006 (Figure 10).



Only 5 of the 96 cases co-infected with both HIV and primary and secondary syphilis in 2010 were women. Additionally, there were 85 co-infected men who claimed to have had sex with other males. Of these 85 men, 80% were African American.

## SECTION VI: EMERGING POPULATIONS

Among the risk factors for HIV/AIDS in Tennessee, rates of infection continue to impact the men who have sex with men (MSM) population, who represent the largest percentage of individuals living with HIV/AIDS (47%) and the largest number of new cases (38%) in 2010. New cases among African American MSM accounted for 31% of new cases during this same period. The following six groups have been identified as emerging populations (not in priority order): African Americans, African American MSM, youth, immigrants/non-English speaking populations, formerly incarcerated individuals, and persons living in rural areas.

**African Americans** – African Americans represent 16.7% of Tennessee’s population, but represent 46% of Tennessee’s prison population. Thirty-four percent live in poverty, and 26.8% report poor mental health. Tennessee faces several unique challenges when attempting to identify, link and keep this population in care. Denial, stigma, poverty, distrust of the medical community, and substance abuse (primarily alcohol or crack cocaine) are among the mitigating factors. Fifty-five percent of individuals living with HIV disease in the state are African American, despite the fact that this demographic group tests for HIV less frequently or not at all and upon entering the care system are often sicker and in need of additional services. Intensive case management services are often needed to keep them in actively engaged in care. Barriers to care include

transportation, affordable housing, lack of child care (particularly for women), and financial issues. Cultural competency and sensitivity are on-going issues with the African American community.

*Estimated annual cost of providing medical care, medications and support services for African Americans is \$12,000 per person annually.*

**African American Males who have Sex with Males (MSM)** – The number of individuals living with HIV who identified male-to-male sex as an exposure category represent 47.4% of those living with HIV disease in Tennessee as of December 2010. African American MSM are disproportionately represented when taking race-specific population size into account. In 2010, African American MSM accounted for 53% (or 181) of MSM newly diagnosed with AIDS (340 total) in the state. The rates of syphilis infection in Tennessee among HIV-infected MSM indicate a need for continued health education and risk reduction interventions. During 2010, there were 277 cases of primary and secondary syphilis. Ninety-six of those cases were co-infected with HIV. There were 85 co-infected men who claimed to have had sex with other males. Eighty percent of those men were African American. A five-city CDC study of MSM found that Black MSM were two times as likely to be infected with HIV as other MSM. Individuals who are not open about their same-sex activities or do not identify as gay or bi-sexual are difficult to reach. Denial, stigma, and substance abuse issues seem to exacerbate the barriers to care experienced by this population. Service gaps for this population also include culturally appropriate services, affordable housing, access to substance abuse and mental health services, and transportation.

*Estimated annual cost of providing medical care, medications, and support services for African Americans MSM is \$12,000 per person annually.*

**Youth** – Slightly less than 46% of Tennessee’s population is 34 or younger. Twenty-two percent of Tennessee’s HIV/AIDS infected population is under age 35. National data support concern about the increasing rates of HIV infection in young African American MSM. A CDC fact sheet indicates that there are more new HIV infections among young Black MSM (aged 13- 29) than among any other age and racial group of MSM, with infections rates “roughly twice that of their white and Hispanic counterparts”. According to this same fact sheet, among young Hispanic MSM most new infections occur in the same age group as young Black MSM. The rate of HIV infection among young African American MSM in the Memphis TGA is startling. Anecdotally, it appears that stigma about sexuality and particularly homophobia, complacency about risk, substance abuse, and lack of knowledge are all factors attributing to the infection rates in this population.

Services gaps for this group include health education and risk reductions, affordable housing, and access to substance abuse services.

*Estimated annual cost of providing medical care, medications, and support services for youth is \$12,000 per person annually.*

**Immigrants** – According to the United States Census Bureau’s *American Community Survey*, 4.4% of the people living in Tennessee were foreign born. According to 2010 United States Census data, 6.2% of the households in Tennessee has a language other than English spoken in it. Most reported Spanish as the language most spoken. Hispanics are 4.6% of the state’s population. Thirty-five percent of the Hispanic population lives in poverty. The Nashville TGA has one of the largest Kurdish populations in the United States with the city being one of Catholic Charities refugee resettlement sites.

Challenges to providing services to the immigrant population include: language barriers, cultural differences, increased mobility, and often the lack of family or social support. Hispanics represent 3.3% of PLWHA in the state of Tennessee. However, the continued anti-immigration movement in entire state, Nashville/Davidson County’s use of the 287 (G) program which checks the immigration status of individuals coming through the jail, and frequent media reports about undocumented worker raids makes finding these individuals, as well as keeping them in care, extremely difficult. Navigating health care systems without the additional complication of English being a second language is very daunting. Cost studies conducted in health department clinics have determined that if patients require a translator, the cost of medical care increases by 30%. Language-appropriate and culturally sensitive services, as well as knowledge of community resources, are barriers that must be addressed in order to increase immigrant utilization of HIV/AIDS care.

*Estimated annual cost of providing medical care, medications, and support services to the immigrant population is \$15,600 per person annually.*

**Formerly Incarcerated Individuals** – According to *Bureau of Justice Statistics*, between 2007-2008, Southern states held more than twice the number of PLWHA prisoners than those states in the Northeast. In 2010, 181 PLWHA were reported in Tennessee’s state prison system during this same period. Persons living with HIV/AIDS who have been previously incarcerated often require intensive case management services. Challenges include finding stable housing, employment, and social support to assist in linking them to and keeping them in care. Tennessee has a dedicated prison liaison program in place which focuses on working with this population in pre-release stages to address services access barriers that may be encountered once released or paroled. Liaison staff is

located in the three Tennessee Department of Corrections intake facilities (West Tennessee State Penitentiary, Henning, TN; Tennessee Prison for Women, Nashville, TN; and Morgan County Correctional Facility, Wartburg, TN). The program provides the individual with information on, and linkages to, services in the area the recently released PLWHA chooses to locate.

*Estimated annual cost of providing medical care, medications, and support services for formerly incarcerated individuals is \$12,333 per person annually.*

**Persons Living in Rural Areas** – CDC data indicates that southern states comprise 68% of all AIDS cases among rural populations. African Americans represent over 50% of rural AIDS cases, with rates among African American women increasing, according to this same report. People in rural areas are less likely to have access to information and health services and therefore may be less likely to know how to negotiate safer sex or have access to safe sex education and materials. Tennessee is a mainly agricultural state and is geographically expansive with three Grand Divisions – West, Middle, and East, often referred to as the three states of Tennessee. Within each of these Grand Divisions, there are population pockets in the urban areas of Memphis, Nashville, Knoxville, Chattanooga, and Jackson. AIDS Service Providers are concentrated mainly in Memphis and Nashville TGAs. Providers are located in the remaining areas, but are not necessarily geographically convenient to clients in rural areas. Centers of Excellence Clinics, however, are strategically located across the state allowing for greater access to HIV medical care for clients in rural areas.

The annual consortia needs assessment documents from Middle and East Tennessee both state that many PLWHA in rural areas do not access services due to a lack of knowledge of resources in their respective areas. For persons in rural areas, stigma and confidentiality, lack of social support, housing, and transportation to medical services are the greatest challenges.

*Estimated annual cost of providing medical care, medications, and support services for persons living in rural areas is \$12,000 per person annually.*

## **SECTION VII: PRIORITY POPULATIONS** **(POPULATIONS DISPROPORTIONALLY IMPACTED IN TN)**

Stigma remains a universal challenge that prevents many from knowing their HIV status. The disproportionate impact of HIV in African-American population of the state is a deeply troubling concern. Tennesseans with HIV continue to be unequally poor and

have challenges related to access, affordability, and trust in the health system. Among that population, a disturbing number of individuals with HIV are homeless or marginally housed. In the rural areas of the state, concerns exist about staff members at the local health department, community clinic, and local pharmacy knowing one's status and *that* information trickling into the community causing individuals to be ostracized about their disease status and/or lifestyle.

Barriers to reaching Tennessee's disproportionately-impacted populations by population include:

- ***African-American MSM***—lack of information, or misinformation, about HIV transmission, prevention, and treatment; impact of homophobia, especially in health-seeking behavior; lack of access to health care generally; and lack of awareness and/or denial of risk.
- ***Young MSM***—misperceptions about HIV risk; denial associated with being a late adolescent; difficulties comprehending the seriousness of HIV infection.
- ***High-risk Heterosexuals***—lack of perceived risk; poverty and poor access to health care and health information; acting as care givers in families; and financial dependency on a partner.
- ***Incarcerated individuals***—stigma (isolation due to HIV status, potential for violence due to HIV status); lack of or misinformation about HIV transmission, prevention, and treatment (situational sex/"gay for the stay"); and lack of awareness or access to testing and/or health care services upon release.

### **Linking New Diagnoses to Care**

There are systematic efforts used to find people and get them into care. When individuals are newly diagnosed, the Disease Intervention Specialist (DIS) who investigates the case also discusses the importance of medical care and refers the person to a Medical Case Manager in the area. Changes to the e-HARS system, described above, now allow electronic tracking of whether or not the person attended the first medical visit. Monthly reports can be generated by geographic area (including TGAs) of persons who did not keep their appointments and who need additional follow up. For persons who drop out of care, there are mechanisms in place to notify Medical Case Managers (MCM) when patients appear to be out of care. The contracted mail order pharmacy notifies the MCM any time a patient fails to re-order his prescriptions. The ADAP coordinator also notifies MCMs when patients are past due for the 6 month eligibility determination. The MCMs then try to locate the patients and get them to return to care. Finally, Minority AIDS Initiative funding is being used to fund specialists/coordinators in rural areas (West, Southeast) who try to find persons who have dropped out of care and assist them in returning. Both the Memphis and Nashville

TGAs have implemented Early Intervention Services in their respective geographic areas to find people and get them into care.

## **SECTION VIII: SOCIAL DETERMINANTS OF HEALTH AND STRUCTURAL FACTORS**

The term *social determinants of health* (SDH) refers to the complex, integrated, and overlapping social structures and economic systems that include social and physical environments and health services. These determinants are shaped by the level of income, power, and resources at global, national, and local levels. They are also often influenced not only through personal choices, but through policy choices as well. CDC proposes in its White Paper ***“Establishing a Holistic Framework to Reduce Inequities in HIV, Viral Hepatitis, STDs, and Tuberculosis in the United States”*** that there are five determinants of population health generally recognized in the scientific literature: (1) biology and genetics (e.g., sex), (2) individual behavior (e.g., alcohol or injection drug-use, unprotected sex, smoking), (3) social environment (e.g., discrimination, income, education level, marital status), (4) physical environment (e.g., place of residence, crowding conditions, built environment [i.e., buildings, spaces, transportation systems, and products that are created or modified by people]), and (5) health services (e.g., access to and quality of care, insurance status).

In the Tennessee needs assessment, issues around the disproportionate effect of HIV on African Americans are the most pronounced initial impression. While African Americans make up approximately 17% of the Tennessee general population, they account for approximately 65% of the new HIV cases in Tennessee each year.

To address this challenge, the Ryan White MAI project has a two-pronged approach that focuses on minorities, primarily African American former Ryan White clients who have dropped out of medical care. The outreach component will consist of one outreach case manager in each of Tennessee’s three grand divisions, whose primary job responsibility will be to find clients who have dropped out of care. The outreach case managers assist clients in making medical appointments while in the field, and work with Ryan White Medical Care Managers to re-enroll clients in ADAP or any other drug program for which the client is eligible. Grantees provide outreach services, as appropriate, to targeted African American and Hispanic populations. Minorities within each region who have fallen out of care or have not received a Ryan White Service in the past twelve months are located and referred to a Medical Care Manager (MCM). The MCM will assist those

individuals in returning to medical care and enrolling in the HIV Drug Assistance Program (HDAP).

The educational component of the MAI activity consists of a Minority AIDS Initiative Coordinator housed in the Central Office. This person works in conjunction with staff from the Office of Minority Health, providing material and educational opportunities, in the form of workshops, seminars and health fairs to minority agencies, churches, and communities in Middle Tennessee. These activities are designed to increase awareness and understanding of the importance of medical care for persons infected with HIV. The goal is to dispel myths, decrease stigma and increase community support for persons living with HIV/AIDS.

Historically, many public health efforts have focused on individual behaviors. SDH typically refers to the latter three categories mentioned above (i.e., social environment, physical environment, and health services), which *are not* controllable by the individual but affect the individual's environment. A thoughtful analysis of the data on HIV in Tennessee reveals a devastating impact of HIV on sexual minority persons—specifically MSM. More than 60% of cumulative cases of HIV are among men who report sexual contact with other men as a risk factor.

For many vulnerable individuals, homophobia presents a potent barrier to effective HIV prevention and to compassionate care. The health department, through the MSM Task Force, is undertaking an initiative to reduce stigma in this population and promote broader acknowledgment of HIV as a public health problem. Grantees in each of the six regions have been actively involved in development of media campaigns to address the impact of homophobia on people at risk for, or living with, HIV.

Environmental factors, such as housing conditions, social networks, and social support are also key drivers for infection with HIV, viral hepatitis, STDs, and TB. The health department is committed to working closely with HOPWA providers in Tennessee to address and solve the challenges posed to individuals living with HIV who are homeless or marginally housed.

Importantly, income inequities serve as proxy measures for other socio-economic inequities. The CDC emphasizes the impact of social exclusion on health and well-being, with social exclusion being a shorthand term for what can happen when people suffer from a combination of linked problems, such as unemployment, poor skills, low incomes, poor housing, high crime environments, bad health and family breakdown. To that end, the HIV prevention and care activities conducted by the health department are driven by collaboration with individuals living with HIV and representatives of

communities most impacted. To the extent that this sensitivity brings about effective strategies to address possible barriers to inclusion and strives to consistently link planned activities to the needs of the most vulnerable populations seems logically to be one strategy for substantive community engagement.

In addition to other factors, a final important factor must be addressed in responding to the disparities faced by individuals with HIV in Tennessee: the obstacles for rural health care provision. Clearly, *access to high-quality medical care* is a challenge in rural America because of distances to large hospitals and health facilities. Moreover, this distance combined with *generally poorer economic conditions* creates a huge concern in accessing care. Even further compounding these issues is *stigma of HIV in rural Tennessee* which has been consistently reported in needs assessment activities as a major barrier for effective prevention of HIV and of compassionate response.

To address this challenge, the health department relies heavily on the Regional consortia around the state. Partnering with these entities allows agencies developing service plans to build on the relative strengths and challenges in their communities to guide prevention and care activities in ways that address stigma and increase access. The Centers of Excellence model, while not perfect, has been designed to assure that high-quality medical care is available throughout Tennessee to those impacted by HIV. While progress has been made to address disparities in Tennessee, much work remains. The HIV/AIDS Branch is committed to the goal of reducing disparities and addressing social determinants of health in the next several years.

**Source:** Centers for Disease Control and Prevention. (October 2010). Establishing a Holistic Framework to Reduce Inequities in HIV, Viral Hepatitis, STDs, and Tuberculosis in the United States. Atlanta (GA): U.S. Department of Health and Human Services, Centers for Disease Control and Prevention.

# NEEDS ASSESSMENT AND GAPS IN SERVICES

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This section summarizes the efforts of the Tennessee Department of Health to analyze unmet needs in HIV prevention and care. In the spirit of the National HIV/AIDS Strategy, a decision was made to conduct an assessment which addressed both the prevention and care gaps in services which would lead to a plan that addressed both prevention and care goals in one document. This document is referred to as the Tennessee HIV/AIDS Strategy and builds on the strengths in the National HIV/AIDS Strategy.

This process was initiated by convening a working group to oversee the process. This working group was composed of stakeholders representing a broad range of Tennesseans. Representatives included HIV prevention providers, HIV care providers, representatives from both Ryan White Part A cities, Part C representatives, and the Part F grantee. In addition to HIV-serving organizations, representatives from Education, Corrections, Mental Health, and Substance Abuse Services, along with a broad range of consumers, formed the Needs Assessment Work Group.

An initial plan for the Statewide Coordinated Statement of Need (SCSN) was proposed by the health department and was presented to the Work Group for comment. Once agreement on a plan was reached, the process for discovering gaps in services and unmet needs has been conducted in several distinct phases.

Initially, a review of past HIV care documents [e.g., previous SCSNs, prior comprehensive plans] and HIV prevention documents [e.g., prior needs assessments, previous comprehensive plans] was conducted. Following this review, a series of key informant interviews was conducted to gather preliminary information about current challenges. This data—gathered from consumers and providers—was used to guide the next phases of the process.

The initial inquiry of stakeholders led to the creation of a statewide web-based survey which was distributed across Tennessee to consumers and providers, as well as, to interested community members. A total of 131 survey responses were obtained—more than one-fifth of responses came from individuals living with HIV disease.

These findings led to a meeting in March 2012 at which the Needs Assessment Work Group came together to prioritize identified needs. At this statewide meeting, a process

was facilitated that allowed for unmet needs to be prioritized and for suggestions to meet these unmet needs.

Final input was obtained via a series of focus groups conducted during a meeting of the Tennessee Community Planning Group [TCPG].

## **INITIAL NEEDS ASSESSMENT**

Interviews were conducted with a wide variety of stakeholders. Key informant interviews with prevention and care providers, as well as, consumers were conducted in late February/early March 2012 to identify issues affecting service delivery. HIV positive consumers were engaged and their input was factored into the later assessment activity.

In terms of assessment findings, ongoing themes in discussion of barriers to HIV prevention included stigma and fear of discrimination, lack of access to health care (especially in rural areas), lack of information about HIV, and poor sense of perceived risk.

Efforts to assess care needs focused on heavy case loads for case managers, challenges with substance-using and mentally-ill consumers, and lack of key medical sub-specialty referral. Significant regional differences were noted and were explored in the Statewide meeting.

The findings from the initial assessment activity led to the development of the web-based survey. A draft of this survey was developed and then distributed after feedback was obtained from the Needs Assessment Work Group. The process of administering the survey and results from the survey follow.

## **STATEWIDE SURVEY AND FINDINGS**

As one component of data collection for the Statewide Coordinated Statement of Need, a web-based needs assessment questionnaire was deployed in March, 2012. The state Part B coordinator shared the website link with possible respondents, and sent one reminder email. Postcards with information about the website were also distributed at the March statewide meeting.

The web-based survey received 131 total responses, with 60 of those respondents identifying themselves as living outside of Memphis or Nashville. In order to explore potential differences in needs and gaps in services among those living in the regions

The web-based survey received 131 total responses, with 60 of those respondents identifying themselves as living outside of Memphis or Nashville.

outside of Memphis or Nashville, the summary of survey data is broken down into two parts. Part One is the summary of data from all respondents across Tennessee (n=131). Part Two is the summary of data from just the survey respondents living outside of Memphis and Nashville (n=60).

As stated previously, this report highlights findings from the needs assessment survey. These results will be triangulated with the results from the focus groups and discussions to provide a broader and deeper picture of the needs across Tennessee.

## PART 1: ALL RESPONDENTS FROM ACROSS TENNESSEE

One hundred of the one hundred and thirty-one survey respondents identified their primary role. Of that one hundred, twenty-eight (28%) identified as individuals living with HIV; eighteen (18%) identified as HIV Care Providers; seventeen (17%) identified as administrators; fourteen (14%) identified as HIV Prevention Providers; seven (7%) identified as community members; and sixteen (16%) identified as “other.”

### *Why don't individuals who need HIV testing access counseling and testing services?*

**Stigma/discrimination** clearly emerged as the most “highly likely” reason why individuals do not access HIV counseling and testing services, with 74% of respondents choosing this as a “highly likely” reason.

One hundred and nine individuals responded to the series of questions intended to address the question above. From those respondents, *stigma/discrimination* clearly emerged as the most “highly likely” reason that individuals did not access HIV counseling and testing services, with 74% of respondents choosing that reason as “highly likely” on a 4 point scale from “highly likely” to “not very likely.”

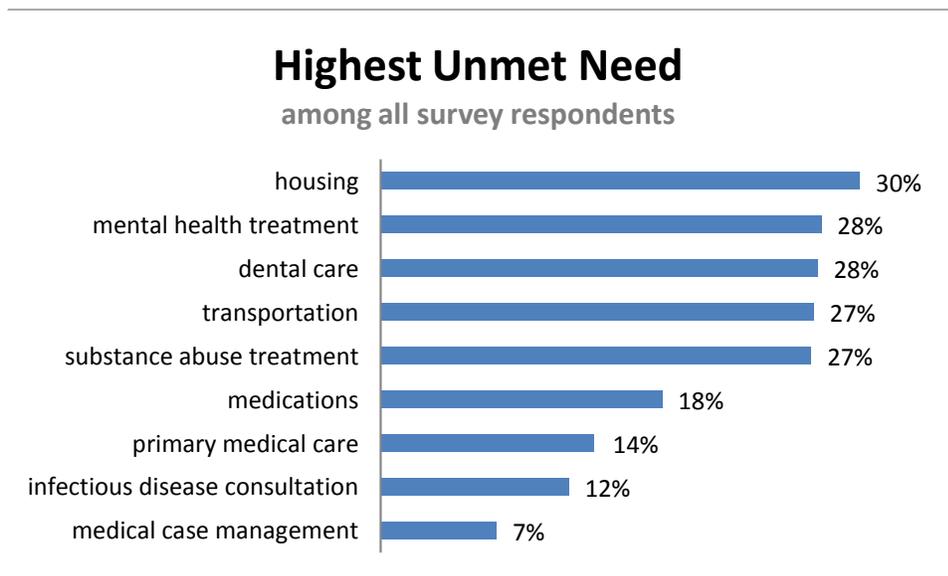
Nearly one-half (45%) of respondents selected *lack of perceived risk* as a highly likely reason why individuals who need HIV testing do not access those services. Further, approximately one-third of respondents cited *distrust of health care systems* (38%) and *fatalism* (32%) as highly likely reasons for not accessing counseling and testing services. One-quarter (25%) of respondents selected the reasons of *lack of information about HIV transmission* and *lack of knowledge about HIV testing* as highly likely reasons for lack of access.

### *Which services are perceived most difficult for an individual with HIV to access in Tennessee?*

One hundred and twenty-one individuals responded to this series of questions. Each respondent was given a list of services and asked to rate each service on a 4-point scale

ranging from “highest unmet need” to “need mostly met.” Reported percentages reflect the amount of respondents who indicated that the specific service had the highest unmet need on this scale.

No specific service emerged as a standout critical unmet need. Rather, about one in three respondents (27-30%) reported that the highest unmet needs spread across five areas – housing, mental health treatment, dental care, transportation and substance abuse treatment. Nearly one in five respondents (18%) believed that medications were the highest unmet need among Tennesseans.



*Some respondents suggested that rather than eliminating services, services should be **coordinated** or **combined** to save resources.*

### Streamlining HIV Care/Support Services

#### *What services are overlapping or duplicated?*

Seventy- one survey participants responded to this open-ended question. Over one-third (38%) of the total respondents to this question stated that there was no overlap or duplication of HIV care/support services. However, the rest of the respondents offered the following areas of overlap/duplication:

- Case management (most common response)
- EIS
- Lead agents for each region
- Too many interviews before given/approved for services
- Too many administrators
- Prevention and distribution of condoms
- MAI and Prevention overlap

- Housing and food vouchers
- Parts A & D
- Infectious disease services

Some individuals offered the following solutions in their responses to address overlap/duplication:

**Case management** was the most commonly cited area where respondents saw overlap and duplication of HIV care/support services.

- Have medical case managers and non-medical managers located with each other to best coordinate services
- Conduct medical case management where one receives medical care
- Need online data communication system to link medical and supportive service providers to avoid duplication
- One organization in each city to coordinate HIV care services
- Cut out the middle men

### *Are there specific services that might be eliminated or combined?*

Of the sixty-eight individuals responding to this question, forty individuals offered comments on specific services that might be eliminated or combined, or simply suggested that rather than eliminating services, services should be *coordinated* or *combined* to save resources. Below are types of services offered as areas to be combined:

**Substance abuse and not understanding the importance of regular care** were both described by 50% or more of respondents as “strongly contributing” to why individuals were currently out of care.

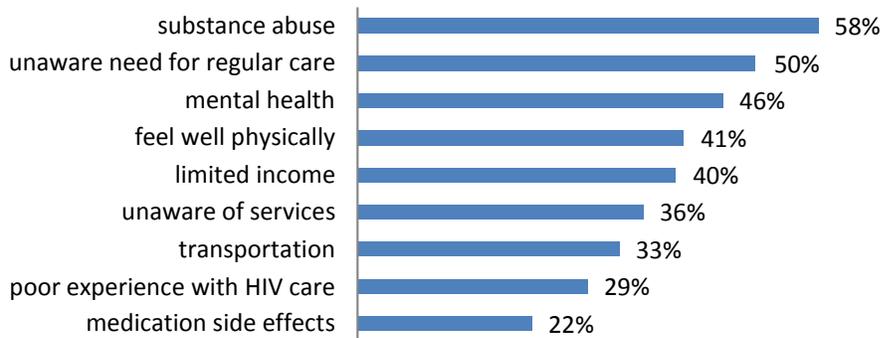
- Case management (combine general, nursing, medical, etc.)
- HIV testing and community events
- Transportation and housing
- Link Ryan White programs to non-Ryan White programs (e.g. dental, mental health)
- Minority AIDS Initiative and Prevention

Types of services offered as areas to be eliminated are below:

- Duplicate adherence counseling by medical case manager and other providers
- Duplication of interviews – “clients should be screened for services (dental, food, EFA, etc.) by their MCM and referred to the appropriate service provider, who should not need to ‘interview’ the client again.”
- Eliminate regional lead agent and have one fiscal agent for the state
- Administration
- Prevention and education to no more than two organizations
- Pharmacy consultation may reiterate treatment plans and education but just makes for a longer doctor’s visit for patients

## Strong Contributors Keeping People Out of Care

among all survey respondents



### Which factors contribute most to individuals being out of care in Tennessee?

*“Saturate the community with education - computer access is one thing - but we must remember those who need help, (often) don't have computers, nor a TV...”*

One-hundred and nine individuals responded to this series of survey questions. Respondents were given a list of possible contributors, or reasons why people may be currently out of care. For each reason, respondents were asked to indicate, on a 4-point scale ranging from “strongly contributes” to “probably doesn’t contribute,” how strongly they thought each contributed to people being out of care. *Substance abuse* and *not understanding the importance of regular care* were both described as “strongly

contributing” to individuals being out of care by 50% or more of respondents. The percentage of respondents indicating each of the other factors as strong contributors ranged between 22% and 46%.

Some respondents contributed “other” contributing factors not previously listed in the survey. These include:

- Fear/Shame/Stigma of HIV (family, church, providers and staff)
- Lack of personal touch or caring feeling by care providers
- Linguistic barriers
- Politics and favoritism
- Lack of susceptibility by young people
- Lack of coverage for hospitalization

### Ideas to Enhance HIV Care and Support Services

Seventy individuals provided comments on how to enhance care and support services for individuals living with HIV in Tennessee. Comments covered a wide range of issues with the most commonly suggested responses calling for an increase in awareness about services, an increase in education on HIV issues within the community, and efforts

to decrease stigma. Other frequently noted comments included the need to coordinate services and provide more resources.

Other suggestions made by respondents are summarized below:

- Meet the need for specific services (dental, fitness/nutrition counseling, peer support, and sexual abuse counseling)
- *Normalize HIV testing* (focus on routine testing, have role modeling by community leaders [e.g., politicians and pastors] getting tested, and provide more advertising of HIV testing service sites)
- *Enhance service delivery* (more communication between providers across regions, more collaboration between Ryan White Parts, improve multidisciplinary provider relationships, garner input from infected clients, have staff/volunteers *especially* represent HIV infected individuals, have more caring staff, reduce turnover of staff and create uniform practices across agencies)

## PART 2: SUBSETS OF RESPONDENTS LIVING OUTSIDE MEMPHIS/NASHVILLE

All sixty respondents living outside of Memphis or Nashville responded to this question. One-third of the total respondents living outside Memphis or Nashville identified themselves as individuals living with HIV. The remaining respondents were administrators (12%), community members (7%), HIV care providers (17%), HIV prevention providers (13%) and others (18%).

### *Why don't individuals who need HIV testing access counseling and testing services?*

Just as with the larger group of all respondents across Tennessee (n=131), those living outside of Memphis or Nashville (n=60) identified **stigma/discrimination** as the most “highly likely” reason that individuals did not access HIV counseling and testing services.

Fifty-two individuals living outside of Memphis or Nashville responded to the series of questions intended to address the question above. Just as with the larger group of all respondents across Tennessee (n=131), *stigma/discrimination* clearly emerged as the most “highly likely” reason that individuals did not access HIV counseling and testing services, with 71% of respondents choosing that reason as “highly likely” on a 4 point scale from “highly likely” to “not very likely.”

Approximately one-third of respondents selected *lack of perceived risk* (37%) and *distrust of the health care system* (31%) as “highly likely” contributing factors to individuals not accessing HIV counseling and testing services. *Transportation, lack of knowledge and legal issues* were considered “highly likely” by 14% or less of respondents.

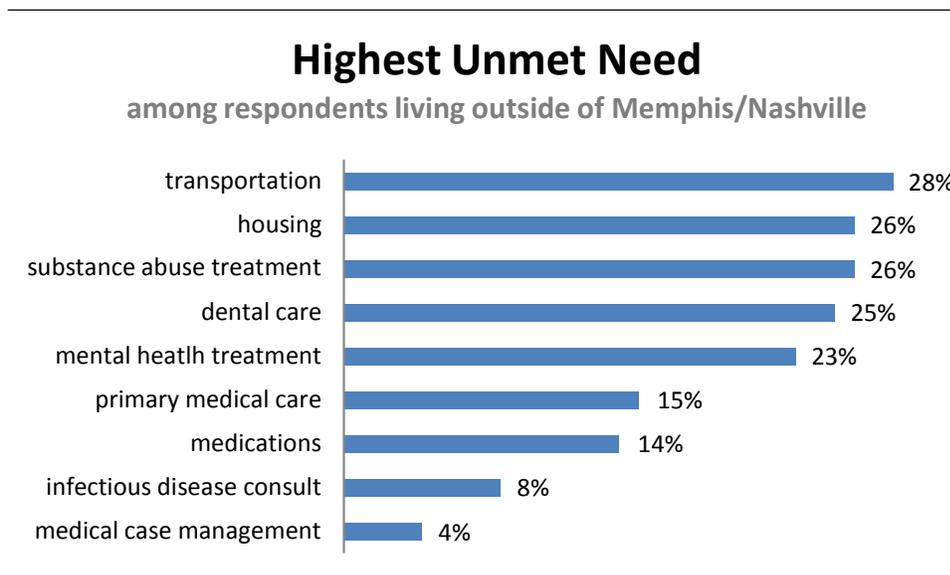
### *Which services are the most difficult for an individual with HIV to access?*

*No one specific service emerged as a standout critical unmet need. Rather, the unmet needs spread evenly across five areas:*

***Transportation, housing, substance abuse treatment, dental care, and mental health treatment.***

Fifty-seven individuals living outside of Memphis or Nashville responded to this series of questions to address the overreaching question above. Each respondent was given a list of services and asked to rate each service on a 4-point scale ranging from “highest unmet need” to “need mostly met.” Reported percentages reflect the amount of respondents who indicated that the specific service had the highest unmet need on this scale.

Just as with the larger group of respondents from all over Tennessee (n=131) reported in Part 1 of this survey report, those living outside of Memphis and Nashville indicated no one specific service as a critical unmet need. Rather, again, just as with the larger group of survey respondents across Tennessee, those items identified with the most unmet need spread across five areas— *transportation, housing, substance abuse treatment, dental care, and mental health treatment*. More than 10% believed that *primary medical care and medications* were the highest unmet needs.



Twelve respondents (21%) shared comments in the “other” category of unmet need. These spanned an array of services, including: vision care, linkages to other resources in the community, hospitalization, more responsive lead agency, non-medical case management, nutrition counseling, medication counseling, personal hygiene products, sexual abuse counseling, social/educational support group activities and follow-up for abnormal pap smears. One person noted that service needs are more pressing in rural communities.

### PART 3: STREAMLINING HIV/CARE SUPPORT SERVICES

#### *Where are overlapping or duplicated services?*

Sixteen of the thirty-five individuals responding to this open-ended question felt that there was no duplication, especially in this rural part of the state. However, the rest of the respondents felt there were overlapping or duplicated services. Their responses are summarized below:

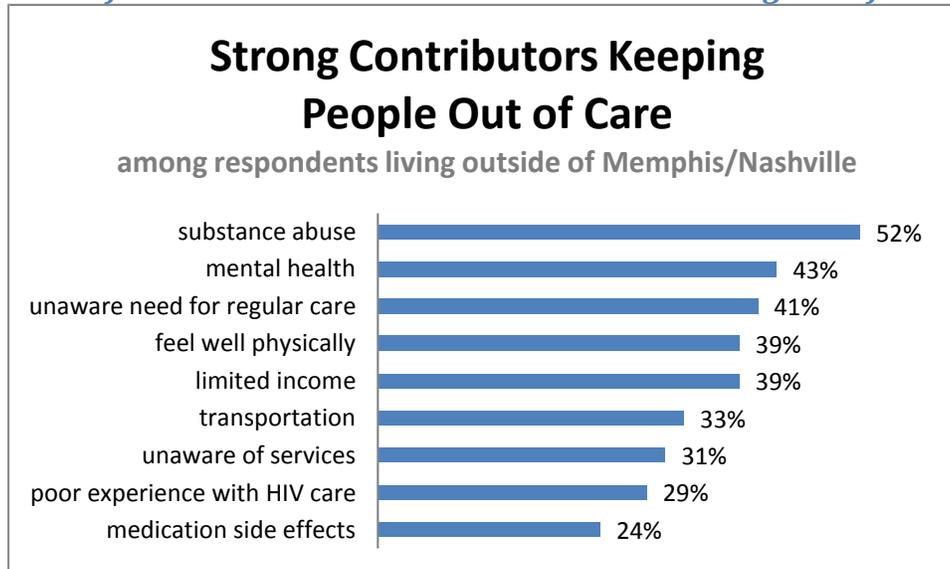
- Coordination of services, specifically between: support services, types of case management, medical care and EIS services, and condom distributors/prevention
- Case management
- One lead agency for state rather than regional

#### *Are there specific services that might be eliminated or combined?*

*Substance abuse was the only factor chosen by over 50% of respondents as “strongly contributing” to individuals being out of care.*

Most of those commenting on this question believed that rather than eliminating services, services should be *coordinated* or *combined* to save resources, e.g., “If we ran ‘one-stop shops,’ the service delivery would be much more seamless and cost-effective.” Two individuals specifically suggested eliminating regional lead agents and keeping just one for the state. Additionally, two individuals believed that separate adherence counseling could be eliminated.

#### *Which factors contribute most to individuals being out of care?*



Fifty-two individuals responded to this survey question. Substance abuse was the only factor chosen by over 50% of respondents as “strongly contributing” to individuals being out of care. All other factors were chosen as strong contributors by 24% to 43% of respondents.

*The most commonly suggested response called for increasing awareness about services and education on HIV issues within the community.*

### **Ideas to Enhance HIV Care/Support Services**

Thirty-five individuals provided comments on how to enhance care and support services for individuals living with HIV in Tennessee. Comments covered a wide range of issues. The most commonly suggested response called for increasing awareness about services and education on HIV issues within the community. Other frequent comments included the need to coordinate services, provide more resources, end stigma and address insurance/payment issues.

Other comments made by respondents are summarized across three categories:

- *Meet the need for specific services* (dental, fitness counseling, peer support, sexual abuse counseling and getting a clinic in Chattanooga)
- *Change HIV care focus* (on client responsibility, routine testing with role modeling by community leaders getting tested, adherence to treatment, and disclosure of status)
- *Enhance service delivery* (garner input from infected clients, have staff/volunteers represent HIV infected individuals, have more caring staff, reduce turnover of staff and create uniform practices across agencies)

## **PART 4: STATEWIDE PRIORITIZATION PROCESS**

As a follow-up to the preceding activity, the Needs Assessment Work Group was convened in March with the goals of analyzing assessment activity and beginning the process of making recommendations regarding strategies to address unmet needs. In response to the three core assessment questions, the following were the most commonly occurring responses when participants were asked to suggest interventions:

### ***How can we identify those individuals unaware of their status?***

- Engage peer navigators
- Advertise in media/social media
- Expand testing/increase testers
- ‘Bundle’ HIV with other medial services/mobile medical services

### ***How do we address gaps in services for individuals aware of their status and in care?***

- Improve coordination [e.g., shared forms, processes, medical identification]
- Centralize health service organizations—‘one-stop’ for care

- Train health care providers in sensitivity/cultural topics
- Increase transportation

*What strategies can help with linkage to care/retention in care?*

- Use peers to assist with both linkage and retention
- Enhance ‘marketing’ of services/patient education material
- Expand Early Intervention Services [EIS]
- Introduce anti-retroviral treatment and services (ARTAS)

As part of the Statewide meeting, a focus group among Medical Case Managers was held, which focused on issues of retention in care. Suggestions from case managers on enhancing retention include the following:

- Remove barriers/create a ‘one-stop’ care center
- Provide training on cultural sensitivity for Ryan White providers
- Collaborate with medical/dental schools
- Provide training for medical case managers
- Increase number of case managers/lower case loads
- Develop ‘What to Expect’ brochure
- Use peers in treatment settings
- Enhance collaborations between CBOs and care sites
- Increase availability of primary care in Part B settings

Both consumers and case managers were asked to identify gaps in services by region. The following summarizes their input:

Regional Gaps in Services by Region

East	
Consumers	Case Managers
<ul style="list-style-type: none"> <li>• Centralized services</li> <li>• Vision</li> <li>• Food and Transportation</li> <li>• HIV Specialists [ID]</li> <li>• Mental Health/Substance</li> <li>• Abuse treatment</li> </ul>	<ul style="list-style-type: none"> <li>• Specialty providers [primary care/mental health]</li> <li>• Substance abuse treatment</li> <li>• Transportation/knowledge of resources</li> <li>• Education in schools</li> <li>• Survival needs [food, housing]</li> <li>• Hours of operation of existing clinics</li> </ul>

## Southeast

### Consumers

- Preventive health services
- Transportation
- Dental
- Rural access
- Money for medications

### Case Managers

- Mental health
- Substance abuse
- Affordable housing
- Transportation
- Prescription drug costs

## Middle

### Consumers

- Dental care
- Patient assistance programs
- Transportation reimbursement
- Cultural sensitivity
- Support for housing but not utilities

### Case Managers

- Transportation
- Housing
- Mental health
- Substance abuse treatment
- Access from rural areas to Davidson Co.
- Medication costs

## West

### Consumers

- Transportation
- Housing
- Dental
- Need for more AIDS-service organizations
- Food

### Case Managers

- Transportation
- Mental health/substance abuse treatment
- Eligibility requirements
- Confidentiality

## Southwest

### Consumers

- Housing
- Eligibility requirements
- Mental health
- Home health
- Substance abuse treatment

### Case Managers

- Need for inter-agency communication
- Consumer education
- Housing
- Transportation
- Services for Youth

## **PART 5: PREVENTION NEEDS/FACTORS AFFECTING HIV TESTING**

Focus groups were held at the March statewide meeting and at the Tennessee Community Planning Group [TCPG] in an effort to articulate unmet prevention needs and issues for individuals not aware of their status. The following summarizes some of the qualitative information concerning issues for individuals unaware of their status:

- Stigma
- Access to care/testing
- Lack of perceived risk
- Denial
- Desensitized to the issue
- Psychosocial issues [e.g., self-efficacy, stigma, shame]
- Lack of awareness of available services
- Isolation [poverty, geography, culture]
- Mistrust of the health care system/fear of deportation
- Poor response from the Black Church
- Lack of health insurance
- Lack of HIV being incorporated into routine medical care

Finally, at the TCPG meeting, strategies to enhance linkages to care and collaboration were discussed. The following summarize recommendations for collaboration and linking to care:

### **Identified Gaps in Linkage to Care**

- Individuals testing in health departments may not be referred to care setting
- Prevention settings don't plan on care
- Clients lost when preliminary positive
- Transient clients/clients lost to follow-up
- Care and testing providers being territorial
- Lack of peer navigators
- Lack of transportation
- Information not readily accessible

### **Strengths in Existing Services**

- Communication from state to providers
- DIS are committed and do a good job
- Good mix of current providers
- Most regions have good prevention and care
- Centers of Excellence model great collaboration
- Memphis/Nashville peer navigators are doing a great job

## Recommendations for Enhancing Linkage to Care

- Expedite Western blot testing
- Enhance communication between partners
- Training prevention in care services
- Replicate EIS model in other parts of the State
- Expand use of peer navigators
- Test counselors need to make EIS a priority
- Enhanced transportation

# The Jurisdictional Plan

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The following represent the key activities in the Jurisdictional Plan for Tennessee. The specific activities and evaluation plans are outlined in the next section of this document, the Comprehensive Plan. These key activities represent the HIV/STD Program's commitment to high-impact prevention activities and to implementing interventions which can reach affected populations on a large scale.

Highlighted activities to be included in the FY 2012 plan are:

- **HIV Testing Activity** - The focus of this activity will be on reaching individuals living with HIV who are not aware of their status through enhanced HIV testing in non-healthcare settings. The Health Department will continue to collaborate with funded agencies to identify those individuals most at risk; support targeted testing, monitor positivity rates to ensure return rates > 1% HIV prevalence.
- **Comprehensive Prevention for Positives** - This strategy will focus on individuals in Memphis and Nashville who are living with HIV and also contracted syphilis. These individuals will be referred by Disease Investigation Specialist to community-based organizations where intensive risk-reduction counseling can be employed.
- **Condom Distribution** - This goal is to be implemented by targeting most vulnerable populations and improving access to condoms. Ongoing support for ordering, tracking, monitoring utilization and evaluation of distribution activity will be in place.
- **Policy Initiatives** - The intended policy activity will focus on a system-wide HIV testing program in the Tennessee Prison system. The HIV/STD Program Medical

Director will lead the initiative to integrate HIV testing into routine care using an opt-out method.

- **HIV Planning Group [HPG]** - The focus will be on assuring a results-oriented engagement process is in place. The group will be encouraged to explore partnerships outside the current planning group, develop new collaborations, and review elements in the Jurisdictional HIV Prevention Plan to ensure they are in place.
- **Capacity-Building** - New capacity-building activities will focus on resource development training for community organizations in Memphis. Given the disease burden, targeting the Memphis CBOs for this TA may be among the most scalable interventions possible.
- **Monitoring and Evaluation** - The plan for enhanced M & E will include more regular site visits from HIV Program staff.
- **Behavioral Interventions for High-Risk Negative Clients** - Focused on Memphis and Nashville, the two highest disease burden cities, four community level interventions addressing African-American MSM will be implemented.

## SCALABILITY

The activities highlighted above present a significant opportunity to reach individuals in need—both living with HIV and who are at high risk for HIV—in a way that will allow us to demonstrate population-level impact. Significant resources will be devoted to testing high risk individuals and comprehensive prevention for positives in order to identify infection, link people to care, help them to protect their own health and help them to prevent the spread of HIV to others. This will be accomplished as more people know their status, adhere to their medical care regimen, and are given the tools to prevent the transmission of HIV.

In addition to testing and prevention for positives, behavioral interventions are focused in the areas with the greatest morbidity in highest risk populations in order to reach those most at risk in the population.

Lastly, through continued use of enhanced monitoring and evaluation measures TDH is able to better understand where the greatest need lies and who is able to best meet those needs. This involves actively monitoring our epidemiological data and the process and outcome measures of our program. This continuous monitoring allows TDH to shift

our limited resources and effort to areas most in need in order to have the highest impact.

### **CAPACITY BUILDING EFFORTS**

The State is committed to meeting the capacity-building needs of its partners. Under an agreement with the Southeast Tennessee Development Corporation, a comprehensive needs assessment survey is being conducted. Following the analysis of these survey results, a comprehensive prevention and care capacity-plan will be implemented.

Working closely with local and Federally-funded capacity-building agencies, the Prevention branch plans to provide TA on multiple activities. The branch will be committed to providing or obtaining technical support on community-level interventions to be implemented in Memphis and Nashville. There will also be support for grant-writing capacity development in Memphis. The Prevention staff closely monitors grantee input in the CRIS system and use this tool to request and track Prevention training needs which can be provided as part of the agreement with CDC's capacity-building Branch.

In addition to the above prevention activities, there are plans to provide capacity-building in a range of Positive Prevention interventions. Working with the CBA providers for Tennessee, it is anticipated that training in the ARTUS intervention will be available to a number of grantees by mind-2012. In addition, there are plans to collaborate with the AIDS Education and Training Center at Vanderbilt [Part F grantee for TN] to implement Partnership for Health in at least one clinic setting.

There are additional plans to increase training for minority and minority-serving care providers. Again in collaboration with the Part F grantee, a series of clinical trainings and preceptorships in both Memphis and Nashville are planned. The outcome of these is intended to be an increase in the number of minority providers working in the field of HIV care, and enhanced capacity of those providers providing care to minority patients in Tennessee.

In addition to formal capacity-building efforts, the commitment to quality improvement offers an important opportunity for informal feedback, coaching, and strategizing to resolve performance challenges. Each care site will be visited at least annually, and prevention grantees are often visited annually though informal support and TA happens often via phone and email.

## **THE COMPREHENSIVE PLAN**

Based on Tennessee's 2009 Comprehensive Plan, a great deal of success was noted in achieving planned targets. Highlights of the progress on the following goals and objectives are identified below:

### *HIV Drug Assistance Program (HDAP)*

- **Goal** – Administer the HIV Drug Assistance Program (HDAP) and add new medications as necessary to the program's drug formulary, as funding permits.
- **Progress** – Tennessee's formulary includes all FDA-approved antiretrovirals, 21 drugs to treat opportunistic infections, and 15 miscellaneous drugs.

### *Health Insurance Assistance*

- **Goal** – Provide, through an Insurance Benefits Management contract, an Insurance Assistance Program for the purpose of continuing consumer's private health insurance. Services will include payment of premiums, co-pays and/or deductibles as needed within the program maximum monthly expenditure cap.
- **Progress** – IAP services are provided through a contracted vendor. In FY 2010, 1,647 clients received over \$7M in premium, co-pay, and deductible assistance.

### *Outpatient Medical Care*

- **Goal** - Continue to utilize the AIDS Centers of Excellence model, consisting of a coordinated network of clinics and private practitioners across the state, which will provide a comprehensive approach to AIDS and HIV therapy.
- **Progress** – In FY 2010, 3,806 clients received outpatient medical care services and 4,151 accessed medical case management services through a Centers of Excellence site.

### *Case management (medical and non-medical)*

- **Goal** - Add additional Case Management services, as funding allows during this grant cycle.
- **Progress** – Through a network of strategically placed case managers (medical and non-medical), more than 4,500 clients received case management services. Twenty-nine case managers (either full or partially funded through Part B) proved over 103,000 units of service during the last grant cycle. The Part B program will add two additional medical case managers in the middle and southeastern regions of the state in the upcoming grant cycle.

### *Transportation*

- **Goal** - Provide adequate transportation to afford clients access to care.

- **Progress** – In FY 2010, 438 clients received medical transportation assistance in the form of bus passes, gas vouchers, or agency-based transportation.

#### Food and Nutritional Services

- **Goal** - Provide essential nutritional supplements and food/home-delivered meals to improve or maintain good health during this grant cycle.
- **Progress** – During FY 2010, 745 clients received food assistance (either through grocery vouchers or home-delivered meals); 83 clients received nutritional counseling through a registered dietician; and over 100 clients received nutritional supplements.

#### Oral Health Care/Dental Services

- **Goal** – Add new providers to the network and additional services as funding allows during this grant cycle.
- **Progress** – During FY 2010, 781 clients received oral health care services through a network of almost 50 dentists in either private practice or county health departments.

### **GOALS AND OBJECTIVES**

The 2012 plan strives to build on successes begun in the 2009 plan, attempts to address ongoing unmet needs, and strives to respond to anticipate emerging needs as they are identified. The goals and objectives of the 2012-2014 Jurisdictional Plan are indicated on pages 77-100. The four goals of the Plan are:

- Goal 1 – Reduce new infections in high incidence areas
- Goal 2 – Increase access to health care and improve health outcomes
- Goal 3 – Reduce HIV disparities and health inequalities
- Goal 4 – Increase internal and external collaboration between HIV prevention and care providers to ensure a seamless system of care is available to individuals with HIV/AIDS

The responsible party is indicated by the color of the objective according to the following key:

- Red - Prevention Unit
- Green - HOPWA
- Yellow - Ryan White
- Orange - Prevention and Ryan White Collaboratively

## GOAL 1: REDUCE NEW INFECTIONS IN HIGHEST INCIDENCE AREAS

<b>Priority: Using innovative approaches identify HIV-positive individuals, who are unaware of their status, provide HIV testing, and link to care.</b>			
<b>Objective</b>		<b>Monitoring/Evaluation Question</b>	<b>Data Source</b>
<b>By December 31, 2014, at least 1,000 HIV-positive individuals unaware of their status will be tested, given results, and linked to care</b>		<ul style="list-style-type: none"> <li>• How many HIV + individuals have been identified?</li> <li>• How many of those with a confirmed positive test have been linked to care?</li> </ul>	PTBMIS PRISM Evaluweb Ryan White Eligibility System TennCare e-HARS
<b>Activity</b>	<b>Time Frame</b>	<b>Monitoring/Evaluation Question</b>	<b>Data Source</b>
At least nine community based organizations, six metro health departments, and eighty-nine rural county health departments will be awarded funds to deliver HIV testing services in communities at high-risk.	January 1, 2012- December 31, 2014	<ul style="list-style-type: none"> <li>• Have community organizations/health departments been identified and awarded funds?</li> <li>• How many HIV tests has each agency delivered?</li> </ul>	Completed contracts PTBMIS PRISM Evaluweb
Staff will be trained on TDOH HIV testing guidelines.	January 1, 2012 -ongoing	<ul style="list-style-type: none"> <li>• How many staff members have been trained in HIV testing curricula?</li> <li>• Have quality assurance</li> </ul>	Training logs Staff reports

		standards been put in place in testing agencies?	
CBOs will send in data via Evaluweb. Health departments will send in data via PTBMIS.	Ongoing	<ul style="list-style-type: none"> <li>Have community organizations sent complete counseling and testing data?</li> </ul>	Evaluweb reports PTBMIS reports
Tennessee Department of Health will monitor positivity rates at funded organizations monthly.	Ongoing	<ul style="list-style-type: none"> <li>What percent of test results are delivered to individuals who are HIV-positive?</li> </ul>	Evaluweb reports.
If positivity rates below 1%, TDOH will provide technical assistance on targeted testing strategies.	January 1, 2012 – December 31, 2014	<ul style="list-style-type: none"> <li>Has technical assistance been provided to agencies that have a positivity rate less than 1%?</li> </ul>	Staff reports
Monitor PRISM to ensure Partner Services has been conducted.	Ongoing	<ul style="list-style-type: none"> <li>Have HIV-positive individuals been linked to partner services?</li> </ul>	PRISM reports
<b>Activity</b>	<b>Time Frame</b>	<b>Monitoring/Evaluation Question</b>	<b>Data Source</b>
Compare e-HARS and PRISM data to ensure accuracy of reporting.	Ongoing	<ul style="list-style-type: none"> <li>Have individuals in e-HARS also been entered into PRISM?</li> </ul>	e-HARS records PRISM reports
<b>Activity</b>	<b>Time Frame</b>	<b>Monitoring/Evaluation Question</b>	<b>Data Source</b>

Continue to actively work with Partner Services to refer known contacts and high-risk negative persons into HIV testing.	Ongoing	<ul style="list-style-type: none"> <li>How many contacts of HIV + individuals have been referred for HIV testing?</li> <li>How many additional contacts have been referred for HIV testing?</li> </ul>	PTBMIS reports
<b>Activity</b>	<b>Time Frame</b>	<b>Monitoring/Evaluation Question</b>	<b>Data Source</b>
Collaborate with TB and Hepatitis screening programs to screen individuals for HIV.	Ongoing	<ul style="list-style-type: none"> <li>Have individuals being seen for TB testing and treatment been referred for HIV testing?</li> <li>Have individuals being screened or treated for hepatitis been referred for HIV testing?</li> </ul>	PTBMIS reports
<b>Priority: Deliver comprehensive HIV prevention services targeted toward individuals living with HIV.</b>			
<b>Objective</b>	<b>Time Frame</b>	<b>Monitoring/Evaluation Question</b>	<b>Data Source</b>
<b>By December 31, 2014, at least 1500 individuals living with HIV will have successfully participated in behavioral interventions.</b>		<ul style="list-style-type: none"> <li>How many individuals living with HIV have received the behavioral interventions?</li> </ul>	Participant logs Participant assessments
<b>Activity</b>	<b>Time Frame</b>	<b>Monitoring/Evaluation Question</b>	<b>Data Source</b>
Sites will be identified to implement behavioral	April 1, 2012 – December 31, 2013	<ul style="list-style-type: none"> <li>How many community sites have agreed to</li> </ul>	Completed contracts

Interventions.		participate in the behavioral	
<b>Activity</b>	<b>Time Frame</b>	<b>Monitoring/Evaluation Question</b>	<b>Data Source</b>
Work with CDC Capacity Building Assistance providers to ensure training for individuals delivering interventions.	October 1, 2012 - December 31, 2013.	<ul style="list-style-type: none"> <li>Have providers been trained in funded interventions?</li> </ul>	Training records
<b>Objective</b>	<b>Time Frame</b>	<b>Monitoring/Evaluation Question</b>	<b>Data Source</b>
<b>By December 31, 2014, recruit and train at least 10 peer advocates as patient navigators to assist newly identified HIV+ individuals.</b>		<ul style="list-style-type: none"> <li>Have peer advocates been recruited?</li> <li>Have peer advocates received training on patient advocacy?</li> </ul>	CBO reports Training logs
<b>Activity</b>	<b>Time Frame</b>	<b>Monitoring/Evaluation Question</b>	<b>Data Source</b>
Peers identified in the linkage to care activity will be trained in patient advocacy	April 1, 2013-December 31, 2014	<ul style="list-style-type: none"> <li>Have peers been identified and trained?</li> </ul>	Training logs

techniques.		<ul style="list-style-type: none"> <li>• Are peers assisting with linkage to care?</li> </ul>	
<b>Priority: Conduct targeted condom distribution efforts to most vulnerable populations, prioritizing individuals who are aware of their HIV status.</b>			
<b>Objective</b>	<b>Time Frame</b>	<b>Monitoring/Evaluation Question</b>	<b>Data Source</b>
<b>By December 31, 2014, at least a million condoms will be distributed to individuals at high risk for HIV through a network of 60 condom distribution sites.</b>		<ul style="list-style-type: none"> <li>• Have condoms been distributed?</li> </ul>	CBO, HIV testing sites, and Health department quarterly reports
<b>Activity</b>	<b>Time Frame</b>	<b>Monitoring/Evaluation Question</b>	<b>Data Source</b>
Work with condom distribution sites to achieve targeted distribution of condoms to most vulnerable populations.	Ongoing	<ul style="list-style-type: none"> <li>• Have agreements been reached with agencies?</li> <li>• Are agencies reaching most vulnerable populations?</li> </ul>	CBO, HIV testing sites, and Health department quarterly reports
<b>Activity</b>	<b>Time Frame</b>	<b>Monitoring/Evaluation Question</b>	<b>Data Source</b>
Establish a distribution list in the TDOH electronic ordering system to assure ease of distribution.	Ongoing	<ul style="list-style-type: none"> <li>• Has distribution list been established?</li> </ul>	TDOH electronic ordering system records
<b>Activity</b>	<b>Time Frame</b>	<b>Monitoring/Evaluation Question</b>	<b>Data Source</b>
Work with condom manufacturer to drop ship condoms quarterly to distribution sites in the State.	Ongoing	<ul style="list-style-type: none"> <li>• Have condoms been shipped in a timely fashion to distribution sites?</li> </ul>	Reports from condom distributor

Objective	Time Frame	Monitoring/Evaluation Question	Data Source
<b>By December 31, 2014, at least 100,000 condoms will be distributed to individuals living with HIV.</b>		<ul style="list-style-type: none"> <li>Have condoms been distributed?</li> </ul>	COE quarterly reports
Activity	Time Frame	Monitoring/Evaluation Question	Data Source
Work with HIV care sites to ensure condom access in clinical care settings.	Ongoing	<ul style="list-style-type: none"> <li>Have agreements been reached with HIV care sites to provide condoms?</li> </ul>	Communication with care sites
Activity	Time Frame	Monitoring/Evaluation Question	Data Source
Add care sites to the condom distribution list and work with manufacturer to ensure quarterly shipping of condoms takes place.	Ongoing	<ul style="list-style-type: none"> <li>Have care sites been added to quarterly condom distribution plans?</li> </ul>	Invoices from purchasing system
<b>Priority: Develop and implement policies to assure identification of individuals living with HIV who are unaware of their status in correctional settings.</b>			
Objective	Time Frame	Monitoring/Evaluation Question	Data Source
<b>By December 31, 2012 all Tennessee Department of Corrections (TDOC) prison intake facilities will perform opt-out HIV testing.</b>		<ul style="list-style-type: none"> <li>Has a policy for opt-out testing been developed?</li> <li>Is HIV testing being offered in all intake facilities on all patients?</li> </ul>	Evaluweb
Activity	Time Frame	Monitoring/Evaluation Question	Data Source

TDOH to meet with TDOC to establish parameters for a system-wide opt-out HIV testing program.	January 2012	<ul style="list-style-type: none"> <li>• Have meetings occurred in which opt-out HIV testing has been discussed?</li> </ul>	Staff report
<b>Activity</b>	<b>Time Frame</b>	<b>Monitoring/Evaluation Question</b>	<b>Data Source</b>
TDOH to contract with agencies to provide testing and provide agencies with test kits.	January 1, 2012- June 30, 2012	<ul style="list-style-type: none"> <li>• Have agencies been contracted to do HIV testing?</li> <li>• Have test kits been supplied?</li> </ul>	Completed contracts Quarterly reports
<b>Activity</b>	<b>Time Frame</b>	<b>Monitoring/Evaluation Question</b>	<b>Data Source</b>
TDOH to monitor reporting of tests in Evaluweb.	Ongoing	<ul style="list-style-type: none"> <li>• Are tests being conducted?</li> <li>• What are the results of these HIV tests?</li> </ul>	Evaluweb reports
<b>Priority: Continue to facilitate a participatory process where individuals representing communities affected by HIV are involved in HIV prevention planning.</b>			
<b>Objective</b>	<b>Time Frame</b>	<b>Monitoring/Evaluation Question</b>	<b>Data Source</b>
<b>By October 1, 2012, convene and consistently work with a HIV Planning Group (HPG) that will advise TDOH on HIV prevention priorities.</b>		<ul style="list-style-type: none"> <li>• Has a HPG been convened?</li> <li>• Does the HPG meet regularly to advise TDOH on its prevention activities?</li> </ul>	TCPG meeting minutes
<b>Activity</b>	<b>Time Frame</b>	<b>Monitoring/Evaluation</b>	<b>Data Source</b>

		<b>Question</b>	
The existing HPG will make recommendations on recruitment, engagement, and retention of members.	Ongoing	<ul style="list-style-type: none"> <li>• Have HPG committees recommended recruitment, engagement and retention strategies?</li> </ul>	TCPG meeting minutes
<b>Activity</b>	<b>Time Frame</b>	<b>Monitoring/Evaluation Question</b>	<b>Data Source</b>
HPG to meet in April 2012 to consider enhancements to CDC-funded prevention activities.	April 2012	<ul style="list-style-type: none"> <li>• Did the HPG meet in April 2012?</li> <li>• Did the HPG advise the Health Department on the Jurisdictional Plan and Comprehensive Plan?</li> </ul>	HPG meeting notes Letter of Concurrence
<b>Priority: Assure that appropriate capacity building activities are planned in key jurisdictions to assist community-based partners in implementing proven public health strategies.</b>			
<b>Objective</b>	<b>Time Frame</b>	<b>Monitoring/Evaluation Question</b>	<b>Data Source</b>
<b>By September 30, 2013, training on grant writing will be conducted in Memphis.</b>		<ul style="list-style-type: none"> <li>• Was grant writing training conducted in Memphis?</li> </ul>	Training logs Staff notes
<b>Activity</b>	<b>Time Frame</b>	<b>Monitoring/Evaluation Question</b>	<b>Data Source</b>
TDOH to identify trainers, oversee development of materials, and secure training location in Memphis.	Spring 2013	<ul style="list-style-type: none"> <li>• Have trainers been identified?</li> <li>• Have materials been developed?</li> </ul>	Trainer contracts Review of curriculum materials Letter of confirmation with training location

		<ul style="list-style-type: none"> <li>Has a training venue been secured?</li> </ul>	
<b>Activity</b>	<b>Time Frame</b>	<b>Monitoring/Evaluation Question</b>	<b>Data Source</b>
TDOH will invite community partners—including current and potential grantees—to participate.	July 31, 2013	<ul style="list-style-type: none"> <li>Have partners been invited to participate?</li> </ul>	Confirmed RSVP emails
<b>Priority: Assuring that all Health Departments and CBOs are conducting high-quality, evidence-based HIV prevention activities.</b>			
<b>Objective</b>	<b>Time Frame</b>	<b>Monitoring/Evaluation Question</b>	<b>Data Source</b>
<b>By December 31, 2012, all funded CBOs and health departments will have received at least one quality assurance site visit.</b>		<ul style="list-style-type: none"> <li>Have all CBOs received site visits?</li> <li>Have health departments received site visits?</li> </ul>	Site visit reports
<b>Activity</b>	<b>Time Frame</b>	<b>Monitoring/Evaluation Question</b>	<b>Data Source</b>
Create a schedule for site visits.	Spring 2012	<ul style="list-style-type: none"> <li>Has a site visit schedule been developed?</li> </ul>	Site visit schedule
<b>Activity</b>	<b>Time Frame</b>	<b>Monitoring/Evaluation Question</b>	<b>Data Source</b>
Conduct site visits with program management staff.	June 1, 2012-December 31, 2012	<ul style="list-style-type: none"> <li>Have site visits been conducted?</li> </ul>	QA reports
<b>Activity</b>	<b>Time Frame</b>	<b>Monitoring/Evaluation Question</b>	<b>Data Source</b>
Review findings with	October 1, 2012-	<ul style="list-style-type: none"> <li>Were findings reviewed</li> </ul>	Staff report

Prevention Program management.	December 31, 2012	with Prevention Program staff?	
<b>Activity</b>	<b>Time Frame</b>	<b>Monitoring/Evaluation Question</b>	<b>Data Source</b>
Report findings to sites.	October 1, 2012-December 31, 2012	<ul style="list-style-type: none"> <li>Have findings and recommendations been shared with grantee?</li> </ul>	QA reports
<b>Activity</b>	<b>Time Frame</b>	<b>Monitoring/Evaluation Question</b>	<b>Data Source</b>
Conduct follow-up activity to sites with findings to assure recommendations have been implemented.	January 1, 2013-ongoing	<ul style="list-style-type: none"> <li>Have follow up activities been conducted?</li> </ul>	Staff report
<b>Priority: Deliver targeted behavioral interventions to HIV-negative individuals most at risk for HIV infection.</b>			
<b>Objective</b>	<b>Time Frame</b>	<b>Monitoring/Evaluation Question</b>	<b>Data Source</b>
<b>By December 31, 2012, four community-level interventions [two each in Nashville and Memphis] will be funded for African American MSM by the HIV Prevention Program.</b>		<ul style="list-style-type: none"> <li>Have new interventions been funded in Nashville and Memphis?</li> </ul>	Letters of Agreement
<b>Activity</b>	<b>Time Frame</b>	<b>Monitoring/Evaluation Question</b>	<b>Data Source</b>
The HIV Prevention Program will solicit proposals from community agencies for community-level, evidence-based behavioral interventions targeting	October 1, 2012-December 1, 2012	<ul style="list-style-type: none"> <li>Have proposals for EBIs been solicited from community-based organizations?</li> </ul>	CBO proposals

African-American MSM.			
<b>Activity</b>	<b>Time Frame</b>	<b>Monitoring/Evaluation Question</b>	<b>Data Source</b>
The HIV Prevention Program will fund proposals that demonstrate capacity to provide interventions with fidelity in these most-at-risk populations.	December 31, 2012	<ul style="list-style-type: none"> <li>• Have awards gone to agencies with demonstrated capacity?</li> </ul>	Completed contracts

## GOAL 2: INCREASE ACCESS TO HEALTH CARE AND IMPROVE HEALTH OUTCOMES

<b>Priority: Facilitate linkage to care of 85% of individuals within 90 days of their HIV diagnosis.</b>			
<b>Objective</b>	<b>Time Frame</b>	<b>Monitoring/Evaluation Question</b>	<b>Data Source</b>
<b>By December 31, 2014, at least 1,700 individuals will have successfully been linked to care.</b>		<ul style="list-style-type: none"> <li>How many individuals have been linked to care?</li> </ul>	e-HARS PRISM
<b>Activity</b>	<b>Time Frame</b>	<b>Monitoring/Evaluation Question</b>	<b>Data Source</b>
DIS will make referrals will make referrals to HIV care.	Ongoing	<ul style="list-style-type: none"> <li>Was referral made?</li> <li>Was appointment kept?</li> </ul>	PRISM e-HARS Ryan White Eligibility System
Conduct at least four regional ARTAS trainings.	June 1, 2012 - December 31, 2013	<ul style="list-style-type: none"> <li>Have trainers been secured for ARTAS training?</li> <li>Have training venues been established?</li> </ul>	Staff reports
<b>Activity</b>	<b>Time Frame</b>	<b>Monitoring/Evaluation Question</b>	<b>Data Source</b>
Participants will be recruited through CBO and clinic staffs to participate.	June 1, 2012 - December 31, 2013	<ul style="list-style-type: none"> <li>Have participants been recruited and invited to participate in ARTAS training?</li> </ul>	Letters of confirmation

<b>Activity</b>	<b>Time Frame</b>	<b>Monitoring/Evaluation Question</b>	<b>Data Source</b>
At least 75 trainees will successfully complete ARTAS training and be delivering the intervention.	June 1, 2012 - December 31, 2013	<ul style="list-style-type: none"> <li>How many participants have successfully completed ARTAS training?</li> </ul>	Completed training evaluations
<b>Objective</b>	<b>Time Frame</b>	<b>Monitoring/Evaluation Question</b>	<b>Data Source</b>
<b>Priority: Continue providing high-quality HIV core medical services in all Part B clinical settings.</b>			
<b>Objective</b>	<b>Time Frame</b>	<b>Monitoring/Evaluation Question</b>	<b>Data Source</b>
<b>By December 31, 2012, the Grantee will assure that all Part B core medical services are being conducted following PHS treatment guidelines.</b>		<ul style="list-style-type: none"> <li>Is medical care being delivered following PHS Guidelines?</li> </ul>	QA reports
<b>Activity</b>	<b>Time Frame</b>	<b>Monitoring/Evaluation Question</b>	<b>Data Source</b>
All medical care delivered in Part B settings will be in compliance with PHS Guidelines.	Ongoing	<ul style="list-style-type: none"> <li>Is medical care being delivered following PHS Guidelines?</li> </ul>	QA reports
<b>Activity</b>	<b>Time Frame</b>	<b>Monitoring/Evaluation Question</b>	<b>Data Source</b>
All Part B medical service providers will provide ART administration in compliance with ART guidelines.	Ongoing	<ul style="list-style-type: none"> <li>Is ART administration in compliance with ART guidelines?</li> </ul>	QA reports HDAP Pharmacy Issuance records
<b>Activity</b>	<b>Time Frame</b>	<b>Monitoring/Evaluation Question</b>	<b>Data Source</b>

All Medical Case Managers will provide services consistent with Tennessee Medical Case Management standards.	Ongoing	<ul style="list-style-type: none"> <li>Are case management services following MCM standards?</li> </ul>	QA reports
<b>Activity</b>	<b>Time Frame</b>	<b>Monitoring/Evaluation Question</b>	<b>Data Source</b>
All dental service providers will provide services consistent with Dental Guidelines for Part B providers.	Ongoing	<ul style="list-style-type: none"> <li>Is dental care being provided following HRSA guidelines for dental care?</li> </ul>	QA reports
<b>Activity</b>	<b>Time Frame</b>	<b>Monitoring/Evaluation Question</b>	<b>Data Source</b>
The Tennessee Ryan White program will be administered following program guidance issued by HRSA/ HAB.	Ongoing	<ul style="list-style-type: none"> <li>Is the TN Ryan White program following HRSA/HAB guidance?</li> </ul>	QA reports Audits
<b>Priority: Need for monitoring and effective program evaluation in HIV care settings.</b>			
<b>Objective</b>	<b>Time Frame</b>	<b>Monitoring/Evaluation Question</b>	<b>Data Source</b>
<b>By December 31, 2014, all Part B providers will have received annual site visits and feedback from the Part B staff.</b>		<ul style="list-style-type: none"> <li>Have all Part B care providers received site visit and feedback from program monitors?</li> </ul>	Monitoring schedule Site visit reports
<b>Objective</b>	<b>Time Frame</b>	<b>Monitoring/Evaluation Question</b>	<b>Data Source</b>

Quality assurance visits will be scheduled.	Ongoing	<ul style="list-style-type: none"> <li>Have QA visits been scheduled with grantees?</li> </ul>	Monitoring schedule
<b>Objective</b>	<b>Time Frame</b>	<b>Monitoring/Evaluation Question</b>	<b>Data Source</b>
Feedback will be provided to program staff on successes and improvement opportunities.	Ongoing	<ul style="list-style-type: none"> <li>Was feedback offered to grantee?</li> </ul>	Site visit report
<b>Priority: Foster mechanisms in care settings which promote medication adherence and enhance retention in care.</b>			
<b>Objective</b>	<b>Time Frame</b>	<b>Monitoring/Evaluation Question</b>	<b>Data Source</b>
<b>By December 31, 2014, rates of retention in Part B care settings will increase by at least 10%.</b>		<ul style="list-style-type: none"> <li>Have retention rates been increased?</li> </ul>	CAREWare Ryan White Eligibility system
<b>Activity</b>	<b>Time Frame</b>	<b>Monitoring/Evaluation Question</b>	<b>Data Source</b>
Medical case managers will be trained and supported in assisting with retention in care.	August 1, 2012-December 31, 2013	<ul style="list-style-type: none"> <li>Has medical case manager training on retention been conducted?</li> </ul>	Training logs
<b>Activity</b>	<b>Time Frame</b>	<b>Monitoring/Evaluation Question</b>	<b>Data Source</b>
TDOH to complete pilot at East Tennessee State University on retention in care and summarize findings.	December 31, 2013	<ul style="list-style-type: none"> <li>Has ETSU pilot been completed?</li> <li>Have findings been published or shared with TDOH partners?</li> </ul>	Written report from pilot COE distribution list

<b>Activity</b>	<b>Time Frame</b>	<b>Monitoring/Evaluation Question</b>	<b>Data Source</b>
Provide training to peer advocates and clinic sites on retention in care.	December 31, 2014	<ul style="list-style-type: none"> <li>• Have HIV + peers been identified?</li> <li>• Have peers been trained in retention strategies?</li> </ul>	Letters of commitment Training logs
<b>Priority: Capacity-development in HIV care settings.</b>			
<b>Objective</b>	<b>Time Frame</b>	<b>Monitoring/Evaluation Question</b>	<b>Data Source</b>
<b>By December 31, 2014 at least three trainings will be conducted targeting Part B providers.</b>		<ul style="list-style-type: none"> <li>• Have training for Part B providers been conducted in Tennessee?</li> </ul>	Training logs
<b>Activity</b>	<b>Time Frame</b>	<b>Monitoring/Evaluation Question</b>	<b>Data Source</b>
Collaborate with Part F grantee on annual statewide conference.	Ongoing	<ul style="list-style-type: none"> <li>• Were the training needs of Part B participants addressed in the statewide conference?</li> </ul>	Agenda Conference evaluation
<b>Activity</b>	<b>Time Frame</b>	<b>Monitoring/Evaluation Question</b>	<b>Data Source</b>
Review findings from Part F grantee needs assessment and develop a collaborative training/TA plan.	September 1, 2012	<ul style="list-style-type: none"> <li>• Was the Part F needs assessment conducted?</li> <li>• Did the Part B grantee review findings and</li> </ul>	Training Plan

		develop a collaborative training/TA plan?	
<b>Activity</b>	<b>Time Frame</b>	<b>Monitoring/Evaluation Question</b>	<b>Data Source</b>
Continue to work with Part F grantee on clinical preceptorship opportunities in Centers of Excellence.	Ongoing	<ul style="list-style-type: none"> <li>Were the number of preceptor opportunities available adequate for the needs of Part B providers?</li> </ul>	Preceptorships completed
<b>Priority: Coordinate with HOPWA providers to ensure access to affordable housing for all HIV-positive individuals in need.</b>			
<b>Objective</b>	<b>Time Frame</b>	<b>Monitoring/Evaluation Question</b>	<b>Data Source</b>
<b>By December 31, 2014, increase the percentage of Part B clients who are stably housed by 10%.</b>		<ul style="list-style-type: none"> <li>What is the percentage of Part B recipients who are stably housed?</li> </ul>	CAREWare Ryan White Eligibility system
<b>Activity</b>	<b>Time Frame</b>	<b>Monitoring/Evaluation Question</b>	<b>Data Source</b>
Work with HOPWA grantee on developing mechanisms to ease access to housing for individuals who are unstably housed.	Ongoing	<ul style="list-style-type: none"> <li>Have strategies been developed to identify Part B clients who are unstably housed?</li> <li>Have new mechanisms been developed to simplify access to housing?</li> </ul>	Staff reports

<b>Activity</b>	<b>Time Frame</b>	<b>Monitoring/Evaluation Question</b>	<b>Data Source</b>
Work with HOPWA grantee on messaging to consumers that will increase percentage who are aware of available housing.	Ongoing	<ul style="list-style-type: none"> <li>• Have consumer education materials been developed to disseminate to Part B clients?</li> </ul>	Materials

### GOAL 3: REDUCE HIV DISPARITIES AND HEALTH INEQUALITIES

<b>Priority: Conduct public information campaign aimed at reducing stigma of HIV infection.</b>			
<b>Objective</b>	<b>Time Frame</b>	<b>Monitoring/Evaluation Question</b>	<b>Data Source</b>
<b>By December 31, 2013, conduct five regional MSM public information campaigns to reduce stigma.</b>		<ul style="list-style-type: none"> <li>How many public information campaigns were conducted?</li> </ul>	MSM Task force meeting minutes
<b>Activity</b>	<b>Time Frame</b>	<b>Monitoring/Evaluation Question</b>	<b>Data Source</b>
Monitor progress of campaigns.	Ongoing	<ul style="list-style-type: none"> <li>Has the task force achieved deliverables?</li> </ul>	Task force reports
<b>Activity</b>	<b>Time Frame</b>	<b>Monitoring/Evaluation Question</b>	<b>Data Source</b>
Monitor and assess impact of campaigns.	Ongoing	<ul style="list-style-type: none"> <li>Have the goals of the campaign been achieved?</li> </ul>	Task force reports
<b>Priority: Conduct community-level HIV prevention activities designed to enhance perceived vulnerability and mobilize stakeholders.</b>			
<b>Objective</b>	<b>Time Frame</b>	<b>Monitoring/Evaluation Question</b>	<b>Data Source</b>
<b>By December 31, 2014, at least one implementation of D-Up and MPowerment and will be conducted by community-based organizations.</b>		<ul style="list-style-type: none"> <li>Have community-based interventions been conducted?</li> </ul>	Quarterly reports
<b>Activity</b>	<b>Time Frame</b>	<b>Monitoring/Evaluation Question</b>	<b>Data Source</b>
Ensure request for proposals are released to community-	January 1, 2013	<ul style="list-style-type: none"> <li>Have request for proposals been</li> </ul>	Proposal request

based partners.		released?	
<b>Activity</b>	<b>Time Frame</b>	<b>Monitoring/Evaluation Question</b>	<b>Data Source</b>
Ensure proposal review and selection at least one grantee for each of the two interventions to be delivered.	March 1, 2013	<ul style="list-style-type: none"> <li>• Have proposals been reviewed?</li> <li>• Have grantees been selected?</li> </ul>	Proposal review forms
<b>Activity</b>	<b>Time Frame</b>	<b>Monitoring/Evaluation Question</b>	<b>Data Source</b>
Provide technical assistance and support for grantees implementing the community-based interventions.	March 1, 2013-ongoing	<ul style="list-style-type: none"> <li>• Has technical assistance been provided?</li> </ul>	Training and technical assistance logs
<b>Activity</b>	<b>Time Frame</b>	<b>Monitoring/Evaluation Question</b>	<b>Data Source</b>
Monitor implementation of community-based interventions and assess compliance with grant proposal.	Ongoing	<ul style="list-style-type: none"> <li>• Have agencies complied with the plan in their proposal?</li> </ul>	Site visit reports
<b>Priority: Reduce HIV-related mortality.</b>			
<b>Objective</b>	<b>Time Frame</b>	<b>Monitoring/Evaluation Question</b>	<b>Data Source</b>
<b>By December 31, 2014, increase proportion of HIV positive MSM and African-American individuals with undetectable viral loads by 10%.</b>		<ul style="list-style-type: none"> <li>• What percentage of viral loads of MSM and African-Americans' viral loads</li> </ul>	Viral load data Ryan White Eligibility system e-HARS

		undetectable?	
Activity	Time Frame	Monitoring/Evaluation Question	Data Source
Establish baseline viral loads for MSM and African-American consumers in Part B clinics.	September 1, 2012-ongoing	<ul style="list-style-type: none"> <li>What are the baseline viral loads of MSM and African-American patients?</li> </ul>	Viral load reports Ryan White Eligibility system e-HARS
Activity	Time Frame	Monitoring/Evaluation Question	Data Source
Provide technical assistance to clinicians and medical case management providers to increase medication adherence.	January 1, 2013-December 31, 2014	<ul style="list-style-type: none"> <li>Has technical assistance been provided?</li> </ul>	Training logs
Activity	Time Frame	Monitoring/Evaluation Question	Data Source
Monitor viral load activity to assure success of medication adherence and successful suppression of viral load.	Ongoing	<ul style="list-style-type: none"> <li>What percent of viral load change has been demonstrated in this intervention?</li> </ul>	Viral load data Ryan White Eligibility system e-HARS
<b>Priority: Continue to engage individuals affected and infected with HIV in planning care and prevention policy.</b>			
Objective	Time Frame	Monitoring/Evaluation Question	Data Source
<b>By December 31, 2014, individuals living with HIV will continue to be substantively engaged in planning care and prevention policy.</b>		<ul style="list-style-type: none"> <li>Have individuals with HIV been engaged in planning HIV prevention and care?</li> </ul>	Meeting minutes
Activity	Time Frame	Monitoring/Evaluation	Data Source

		<b>Question</b>	
At least 25% of HIV Planning Group [HPG] will continue to be composed of individuals living with HIV.	Ongoing	<ul style="list-style-type: none"> <li>Do PLWHA comprise 25% of HPG?</li> </ul>	Membership roster
<b>Activity</b>	<b>Time Frame</b>	<b>Monitoring/Evaluation Question</b>	<b>Data Source</b>
At least 20% of HIV Care and Services Advisory Committee membership will continue to be individuals living with HIV.	Ongoing	<ul style="list-style-type: none"> <li>Do PLWHA comprise 20% of HIV Care and Services Advisory Committee?</li> </ul>	Membership roster
<b>Activity</b>	<b>Time Frame</b>	<b>Monitoring/Evaluation Question</b>	<b>Data Source</b>
The HIV/STD Program will continue to support Tennessee Association of Persons with AIDS [TAPWA] in meeting at least twice yearly.	Ongoing	<ul style="list-style-type: none"> <li>Has TAPWA been supported in at least two yearly meetings?</li> </ul>	Meeting agendas
<b>Priority: Need for highly-trained culturally-competent HIV providers.</b>			
<b>Objective</b>	<b>Time Frame</b>	<b>Monitoring/Evaluation Question</b>	<b>Data Source</b>
In collaboration with the Part F grantee, assure that at least 200 minority-serving health care workers achieve high-quality training on HIV management, antiretroviral therapy, or support services.		<ul style="list-style-type: none"> <li>Have minority-serving health care providers been trained in HIV care strategies?</li> </ul>	Training logs

Activity	Time Frame	Monitoring/Evaluation Question	Data Source
Continue collaboration with Project SAVED in middle and east Tennessee.	Ongoing	<ul style="list-style-type: none"> <li>Has collaboration with Project SAVED continued?</li> </ul>	Staff reports Training logs
<b>Priority: Increase number and diversity of HIV care providers in the State.</b>			
Objective	Time Frame	Monitoring/Evaluation Question	Data Source
<b>By December 31, 2014, at least three initiatives to expand diversity of providers in Tennessee will be successfully implemented.</b>		<ul style="list-style-type: none"> <li>Have new initiatives been implemented?</li> </ul>	Staff reports
Activity	Time Frame	Monitoring/Evaluation Question	Data Source
Create enhancements to the Tennessee Dept. of Health web site that facilitates provider's application to participate as Part B service providers.	Ongoing	<ul style="list-style-type: none"> <li>Has TDOH web site been enhanced to facilitate applications to participate as Part B providers?</li> </ul>	Number of applications submitted
Activity	Time Frame	Monitoring/Evaluation Question	Data Source
Provide support for community partners in training medical students and residents in HIV care and support?	January 2013-December 2014	<ul style="list-style-type: none"> <li>Has medical student training program been supported?</li> </ul>	Training logs

<b>Activity</b>	<b>Time Frame</b>	<b>Monitoring/Evaluation Question</b>	<b>Data Source</b>
Collaborate with Part F grantee in support of its training efforts to reach physicians in TN who serve minority populations.	Ongoing	<ul style="list-style-type: none"> <li>• Have continuing educations opportunities been provided for health professionals?</li> </ul>	Training logs

**GOAL 4: INCREASE INTERNAL AND EXTERNAL COLLABORATION BETWEEN HIV PREVENTION AND CARE PROVIDERS TO ENSURE A SEAMLESS SYSTEM OF CARE IS AVAILABLE TO INDIVIDUALS WITH HIV/AIDS**

<b>Priority: Collaborate with and coordinate services with all prevention and care providers in Tennessee.</b>			
<b>Objective</b>	<b>Time Frame</b>	<b>Monitoring/Evaluation Question</b>	<b>Data Source</b>
<b>By December 31, 2014, collaborations between HIV prevention, Ryan White Parts A, B, C, and D grantees in Tennessee will be enhanced.</b>		<ul style="list-style-type: none"> <li>• Have collaborations with partners been enhanced?</li> </ul>	Participation in respective planning groups
<b>Activity</b>	<b>Time Frame</b>	<b>Monitoring/Evaluation Question</b>	<b>Data Source</b>
Conduct statewide prevention and care meetings at least twice a year.	Ongoing	<ul style="list-style-type: none"> <li>• Have statewide meetings been conducted?</li> </ul>	Meeting agendas
<b>Activity</b>	<b>Time Frame</b>	<b>Monitoring/Evaluation Question</b>	<b>Data Source</b>
TDOH prevention and care staff will actively serve on planning groups.	Ongoing	<ul style="list-style-type: none"> <li>• Has staff actively served on planning groups?</li> </ul>	Meeting minutes Staff reports
<b>Activity</b>	<b>Time Frame</b>	<b>Monitoring/Evaluation Question</b>	<b>Data Source</b>
Department staff will support and participate in regional planning meetings.	Ongoing	<ul style="list-style-type: none"> <li>• Has HIV/STD program staff participated in regional consortia and regional prevention planning</li> </ul>	Meeting minutes Staff reports

		meetings?	
<b>Priority: Collaborate with all DHHS-funded HIV prevention providers in Tennessee to assure collaboration and coordination of prevention services.</b>			
<b>Objective</b>	<b>Time Frame</b>	<b>Monitoring/Evaluation Question</b>	<b>Data Source</b>
<b>By December 31, 2104, collaborations will be established or enhanced with all Federally-funded HIV initiatives in Tennessee.</b>		<ul style="list-style-type: none"> <li>Have collaborations with Federally-funded agencies been enhanced?</li> </ul>	Staff reports
<b>Activity</b>	<b>Time Frame</b>	<b>Monitoring/Evaluation Question</b>	<b>Data Source</b>
Continue collaborations with CDC directly-funded CBO by providing technical assistance.	Ongoing	<ul style="list-style-type: none"> <li>Has technical assistance been provided to WOMEN?</li> </ul>	Staff reports
<b>Activity</b>	<b>Time Frame</b>	<b>Monitoring/Evaluation Question</b>	<b>Data Source</b>
Collaborate with both TN Department of Mental Health and Substance Abuse Services and SAMHSA direct grantees.	Ongoing	<ul style="list-style-type: none"> <li>Have collaborative relationships been established?</li> </ul>	Staff reports Meeting minutes

# Appendix

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**AIDS (Acquired Immunodeficiency Syndrome):** Advanced stage (stage 3) of HIV infection characterized by severe immune deficiency. Diagnosis is made by presenting at least one of 26 opportunistic illnesses or a CD4 laboratory test less than 200 cells/ml of blood or 14% of the total white blood cells (lymphocytes).

**Case:** A condition, such as HIV infection (e.g., an HIV case) or AIDS (e.g., an AIDS case) diagnosed according to a standard case definition.

**Case Fatality:** The number of deaths among people with a diagnosis of the disease of interest. Usually expressed as a rate (number of deaths after disease onset or diagnosis divided by the number of people living with the disease times 100); measures the effect of the disease on people with a diagnosis.

**HIV (Human Immunodeficiency Virus):** A retrovirus that infects the helper T cells of the immune system, resulting in immunodeficiency. HIV infection is diagnosed by a positive confirmatory antibody test or positive/detectable viral detection test. HIV infection can be on its stage 1, stage 2 or stage 3 (AIDS).

**Incidence:** Refers to the number of new cases of a disease that occur in a population during a specified time, usually one year.

**Mortality:** The total number of people who have died of the disease of interest. Usually expressed as a rate, mortality (total number of deaths over the total population) measures the effect of the disease on the population as a whole.

**Place of Residence for HIV/AIDS Cases:** Data are presented based on a residence within Tennessee at the time HIV infection or AIDS was diagnosed. Therefore, these data do not contain people who are currently living with HIV infection in Tennessee, but were originally diagnosed in another state. Data presented on living cases reflect those originally diagnosed in Tennessee that are still presumed to be living, regardless of their current residence. The number of new HIV infections in Tennessee includes only people who were first reported with HIV infection while residing in Tennessee.

**Prevalence:** Refers to the total number of people with a specific disease or condition at a given time. HIV infection prevalence data are generally presented as “people living with a diagnosis of HIV infection.” AIDS prevalence data are generally presented as “people living with a diagnosis of AIDS.”

**Trend:** A long-term movement or change in frequency, usually upward or downward; may be presented as a line graph.

**Transmission Category:** To monitor how HIV is being transmitted, HIV/AIDS cases are classified as one of several exposure (risk) categories. Each case is only included in a single transmission category.

- **MSM:** Men who have sex with men; that is, homosexual or bisexual contact.
- **IDU:** Injection drug use, refers to the injecting nonprescription drugs.
- **MSM/IDU:** Men who have sex with men and also inject nonprescription drugs.
- **HRH:** High-Risk Heterosexual Contact: heterosexual contact with a partner who is at increased risk for HIV infection, i.e., a homosexual or bisexual man, an injection drug user, or a person with documented HIV infection.
- **Hemophilia/transfusion/transplant:** cases are those resulting from a transfusion of blood or blood products before 1985.
- **Perinatal:** Individuals born to a mother with HIV or a mother with an exposure history listed in the transmission category hierarchy.
- **NIR No Identified Risk (NIR)/Unspecified:** Individuals reporting no exposure history to HIV through any of the modes listed in the transmission category hierarchy.

**Vital Status:** People are assumed alive unless the HIV/STD Program has received notification of death. Current vital status information for cases is ascertained through routine site visits with major reporting sites, reports of death from providers, reports of death from other states' surveillance programs, routine matches with Tennessee death certificates and social security death master files.