Indian Health Service (IHS)

National HIV/AIDS Administrative Work Plan

2008 - 2011

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Executive Summary

The IHS Mission... to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level.

The IHS Goal... to assure that comprehensive, culturally acceptable personal and public health services are available and accessible to American Indian and Alaska Native people.

Over the past 25 years, UNAIDS estimates well over 60 MILLION people worldwide have been afflicted by HIV/AIDS. Currently, the number of people living with HIV/AIDS globally has increased to nearly 40 million.

American Indian/Alaska Natives (AI/AN) make up roughly 1% of the United States population. This population includes over 557 federally recognized tribes that maintain 250 distinct languages. According to CDC data, over the past 6 years, prevalence and incidence of HIV/AIDS in the AI/AN population has either continued to remain stable or has increased. When population size is taken into account, AI/AN rank third in the US (among all ethnicities) in rates of HIV/AIDS cases[1]. The rates have not decreased significantly since the late 1990s. HIV/AIDS exists among both urban and rural populations (and on or near reservations), a large portion of whom are estimated to be untested.

The AI/AN population is also one of known health disparities including lower health status when compared with other Americans, lower life expectancy and disproportionate disease burden. Access to health care is a problem for American Indians and Alaska Natives, who are second only to Hispanics in lacking health insurance.[2] IHS is funded at about 60% of what a comparable population with standard health insurance spends on individual health care. This can result in the inability of AI/AN patients to access health care[3], which is of critical importance given the missed opportunities for HIV screening and the level of health system adherence necessary for those patients living with HIV/AIDS. Per capita spending for the IHS is about $1,914 per year while spending for federal prisoners is roughly $3,803. Compared against the rest of the population, AI/AN have more than six times the rate of alcoholism, nearly three times the rate of diabetes and a 62 percent higher rate of suicide[4]. In 2004, reported cases of chlamydia, gonorrhea, and syphilis among AI/AN were 2 to 6 times higher than comparable rates for whites.[5] These health disparities contribute both directly and indirectly to the risk of HIV transmission in the AI/AN populations.

Evidence-based research and epidemiological data also demonstrate the inter-relationships between established disproportionate HIV co-risk factors in the AI/AN population (such as substance use, frequency of sexually transmitted infections, domestic violence, stigma, etc.) and the proven dynamics of HIV transmission subsequently put this population at a much higher risk for the spread of HIV. Based on these dynamics and disparities, guiding principles behind development of this document are founded upon a preventive paradigm of increased *risk* of HIV transmission (risk-based) and not solely based upon the current number of AI/AN cases, prevalence or incidence.

Therefore, *HIV/AIDS poses a serious and mounting risk to AI/AN.* Given these risks and current trends, we must persevere even more diligently in our efforts to openly discuss HIV (and STDs), prevent transmission, provide appropriate access and treatment, and promote screening and healthy behaviors that reduce the risk of acquiring HIV. The IHS National HIV/AIDS Administrative Work Plan, referred hereto within as the 'Work Plan', will assist in these efforts.

This Work Plan will be considered integrative with the IHS Strategic Plan (http://www.ihs.gov/NonMedicalPrograms/PlanningEvaluation/documents/IHS_StrategicPlan_2006-2011.pdf) which includes similar concepts surrounding:

1. Building and sustaining healthy communities. (Relative to HIV this may include reducing risk of transmission, opening discussion to reduce stigma and improving on health disparities that affect the HIV and at-risk community.
2. Providing accessible, quality health care. (Improving upon screening efforts, monitoring quality of care for people living with HIV or AIDS.)
3. Fostering collaboration and innovation across the Indian Health network. (Utilizing interagency partnerships as well as fostering relationships with Native organizations, tribal government and Native communities.)

HIV/AIDS is a disease that transcends traditional prevention and treatment paradigms and involves programmatic facets of behavioral health, chronic infectious disease and the need for health promotion and disease prevention (HPDP). Therefore, this Work Plan specifically supports the Director's Three Initiatives found at: (http://www.ihs.gov/NonMedicalPrograms/DirInitiatives/index.cfm?module=dr_message)

The Work Plan will follow its Guiding Principles and Assumptions for implementation and attempt to mitigate and prevent progressive effects of HIV/AIDS in the AI/AN communities. These progressive effects can include further stigmatization, increases in morbidity and mortality, economic impact and loss of family structure.

The Indian Health Service (IHS) HIV/AIDS program is a multi-health sector collaborative cultivated from a myriad of services and projects. It is a culturally fluent effort based upon a comprehensive public health approach. Although IHS focuses primarily on care of individuals, responsibility exists to also be a public health system – very different in nature than individual health delivery, yet mutually synergistic to improve population health. With HIV/AIDS, it is critical to consider a preventive, public health approach given a relatively lower number of HIV/AIDS cases and disproportionate co-risk factors. Although there is no direct HIV funding for this initiative, the word *program* will be utilized to demonstrate the integration of initiatives and strategic planning. Strategic and administrative planning is essential to effective and efficient response to HIV/AIDS and for the development of a comprehensive program serving its population. Integration of the program and planning process is a key factor of outcome success as information sharing, surveillance; capacity building and data collection are dispersed within this decentralized system. It is important to reinforce that all priority areas of this developing program (i.e. capacity building, treatment/care, prevention, policy, advocacy, monitoring, evaluation and

research) should be addressed. Multi-health sector, interagency and community input are gathered for gap analysis, needs assessment and for further strengthening of the program across multiple levels of influence. There still exists a critical and substantial need for enhanced prevention program efforts. Additionally, given current epidemiological trends and known vulnerabilities to HIV/AIDS in the AI/AN population, it is critical we consider the larger preventive public health and population approach.

The HIV/AIDS program is implemented through collaborations among multi-health sectors, both internal and external to the agency. It attempts to encompass all types of service delivery 'systems' including IHS, Tribal and Urban facilities. The HIV/AIDS Principal Consultant, part of the Division of Clinical and Community Services, Office of Clinical and Preventive Services (located at IHS Headquarters in Rockville, MD) orchestrates the program and serves as a national level principal consultation point within the IHS. Input for the Work Plan has been gathered from multiple sources and is discussed under the Work Plan Development section.

Within the Work Plan, the seven priority areas of intervention include:

1. Advocacy
2. Policy
3. Capacity Building
4. Prevention
5. Treatment and Care
6. Monitoring and Evaluation
7. Research and Epidemiology.

Each of these priority areas will contain projects and initiatives with specific objectives supporting overall goals of the program.

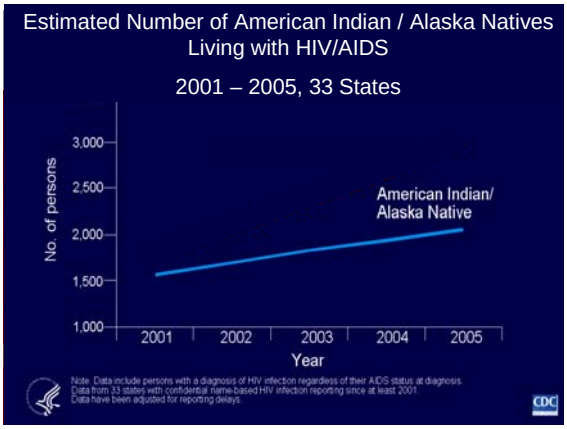
References (p.3-5):

1. CDC. *HIV/AIDS Surveillance Report, 2005*. Vol. 17. Atlanta: US Department of Health and Human Services, CDC: 2006:1–46. Available at Accessed March 15, 2007 at http://www.cdc.gov/hiv/topics/surveillance/resources/reports/
2. US Department of Health and Human Services. Indian Health Service. Regional differences in Indian health 1998-99. Rockville, MD: Department of Health and Human Services. Indian Health Service; 2000. Available from: URL: http://www.ihs.gov/PublicInfo/Publications/trends98/region98.asp
3. US Department of Commerce. Bureau of the Census. Selected social and economic characteristics by race and Hispanic origin for the United States. American Indian population by tribe for the United States, regions, divisions, and states: 1990. Washington, DC: Government Printing Office; 1992. CPH-L-99.
4. Martin, P. Healthcare for Indian Tribes in Need of Increase in Funding. *The Hill*. March 21, 2007. Accessed online July 22, 2007 at: http://thehill.com/op-eds/healthcare-for-indian-tribes-in-need-of-increase-in-funding-2007-03-21.html
5. Indian Health Service. *Sexually Transmitted Disease 2004*. US Department of Health and Human Services, CDC: November 2006.

Background Epidemiology

Although AI/AN currently make up only 0.3% of cumulative AIDS cases reported nationally, proportionally this population is now ranked third in rates of AIDS diagnoses, after African Americans and Hispanics.[1] It has been higher than that of whites since 1995 and has not had any substantial decrease in rates since that time. This suggests that the number of AI/AN living with HIV/AIDS continues to increase.

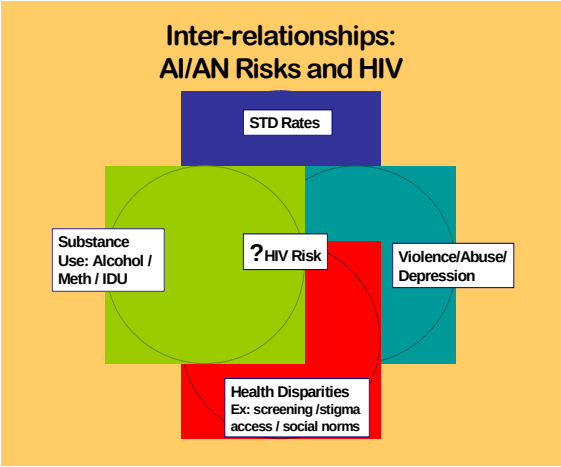
Figure 1: *Estimated Number of American Indian/Alaska Natives Living with HIV/AIDS.*



- AI/AN ranked third in rates of AIDS diagnoses[1];
- Greater than whites since 1995[1];
- Number of AI/AN living with HIV/AIDS continues to increase[1].

- As of 2005, an estimated 1595 AI/AN AIDS cases have been reported among AI/ANs in the United States and its territories[1];
- In 2005, an estimated 81 AI/AN with AIDS died[1].
- From the beginning of the epidemic through 2005, an AIDS estimated 32 AI/AN children under the age of thirteen years have been diagnosed with AIDS[1].
- Per the CDC, rates of AIDS diagnosis for AI/AN average 10.6 cases per 100,000 population per year.[1]

Figure 2: *Inter-relationships of HIV and Other Transmission Risk Factors.*



- AI/AN second highest rates of chlamydia, gonorrhea than any other race/ethnicity[2];
- More likely than any other ethnicities/races to have past year alcohol use disorder[3];
- Relative to non-Native peers, about ½ as likely to use contraceptives.[6]

Transmission co-risk factors and their inter-relationships are some of the most critical epidemiological aspects of HIV in the AI/AN population. Drug and alcohol use, sexually transmitted infections (STD), violence, depression and other health disparities all contribute to risk of HIV transmission. Surveys of STD clinics and alcohol and drug abuse treatment programs have proven the vulnerability for HIV in virtually all AI/AN communities, even the most remote. People already infected with an STD are two to five times more likely to become infected with HIV. Additionally, and possibly more important, is that the presence of any STD suggests sexual risk behaviors, which increase the chance of HIV transmission. As of 2004, AI/AN were nearly five times more likely than whites to contract chlamydia, over four times more likely to contract gonorrhea, and twice as likely to contract syphilis. AI/AN have the second highest rates of chlamydia and gonorrhea and third highest rate of Syphilis among all ethnicities/races.[2]

Additionally, those that are substance users (illicit drug use, alcohol) are more likely to engage in risky behavior under the influence. Current data indicate AI/AN had a higher rate of illicit drug use than persons of other races or ethnicities and were more likely than other racial groups to have a past year alcohol use disorder (10.7 vs. 7.6 percent) than persons of other races or ethnicities.[3] A growing epidemic in AI/AN communities is methamphetamine use, which can increase sexual drive and risky behavior as well as diminishing response to therapy. The data suggest that AI/AN have a higher rate of methamphetamine use than any other race/ethnicity.

HIV/AIDS cases are potentially increasing on tribal reservations and communities. In one large Southwestern tribe, the incidence of HIV/AIDS rose 60% from 2002 to 2003. Transmission of HIV on this reservation was recently documented for the first time, a significant change from previous transmission patterns in which infection was acquired off-reservation in urban settings.

While reporting of HIV among AI/AN to state health departments is generally accurate and complete, HIV screening of AI/AN may be inadequate and there are many missed opportunities for screening. Currently, the agency's only HIV related Government Performance Results Act (GPRA) measure is for prenatal HIV screening. Recent reports indicate IHS Areas are prenatal screening at about 65%, which indicates tremendous progress over the past two years, however must continue to stress 100% prenatal screening.

As discussed in the Executive Summary, health disparities can play a significant role in HIV co-risk factors and transmission. Health disparities also create challenges for prevention strategies and treatment and care - given the complexities of risk behavior (tied to sexual activity, social norms, stigma, etc) and clinical management of HIV/AIDS (need for optimal adherence, continuity of care, etc.). Lower life expectancy and the disproportionate disease burden exist perhaps because of inadequate education, disproportionate poverty, discrimination in the delivery of health services, and cultural differences. These are broad quality of life issues rooted in economic adversity and poor social conditions.[7] These disparities include the fact that although approximately 55% of AI/AN rely on the IHS to provide access to health services, the IHS appropriated funding provides only 55% of the necessary federal funding to ensure

mainstream personal health care services to AI/AN using that system[7]. Thirty-three percent (33%) of the AI/AN population is less than eighteen years old versus 26% nationally[5]. This is critically relevant since HIV disproportionately affects younger populations. Finally, the IHS service population is predominately rural, which can affect access, continuity of care and follow-up. Additional data to consider:

- During 1997–2000, 50.5% of AI/AN who responded to the Behavioral Risk Factor Surveillance System survey reported that they had never been tested for HIV.
- Since 1995, AI/AN have survived HIV for a shorter time than Asians and Pacific Islanders, whites, and Hispanics[1];
- Of any race or ethnicity except African Americans, AI/AN have the shortest time from diagnosis until death – suggesting late diagnosis;
- Of any race or ethnicity, AI/AN have the highest percentage of Men who have sex with Men/Injection Drug User (MSM/IDU) combination transmission group[1]. This specifically reflects transmission of HIV and is not known to be generalizable to the overall population;
- Racial misclassification and underreporting (e.g. Los Angeles 56%) miss a portion of the AI/AN population in potentially high risk areas[4];
- ;
- Evidence that HIV transmission is increasing in rural areas;
- Higher rates of AI/AN without high school degree
- Lower rate of AI/AN graduating from college;
- Of any race or ethnicity, AI/AN have a higher rate unemployment and underemployment.

These risk factors are all critical in developing targeted interventions. Regardless of the sheer number of estimated HIV/AIDS cases (or unknown cases) that exist in the AI/AN population, the IHS will continue to enhance surveillance to identify the epidemic trends and prevent further spread due to these disproportionately high risk factors.

Purpose of Work Plan

The IHS National HIV/AIDS Administrative Work Plan will hereunto be referred to as the "Work Plan". This Work Plan is intended for use by the IHS HIV/AIDS Program and IHS personnel. Although not required, this plan may also be utilized by Tribal and Urban programs as well as Native organizations and multiagency leads involved with HIV/AIDS activities for the American Indian / Alaska Native (AI/AN) population. The IHS will utilize this HIV/AIDS work plan to:

- Serve as the model for the planning process that can be referenced, reproduced, evaluated, and adjusted;
- Identify components and priority areas needed for this comprehensive HIV/AIDS working document;
- Assist in guiding IHS / Tribal / Urban (I/T/U) health personnel with activities that are both collaborative and integrative;
- Develop a focused process to enhance efficiency and avoid redundancy of initiatives within and external to IHS;
- Develop a consistent process for strategic planning;
- Enumerate foundational framework for future planning;
- Serve as a monitoring and evaluation tool to be reviewed on an ongoing basis;
- Achieve the highest quality program that serves the mission and supports Director's initiatives;
- Serve as a 3-year administrative blueprint for further development and progression of the IHS HIV/AIDS Program in the case of potential staff turnover;
- Develop an IHS HIV/AIDS Task Force to review content of the Work Plan and serve as a planning committee for activities to ensure consistency, sustainability and accountability.

Work Plan Development

The development of this Work Plan was initiated by the IHS HIV/AIDS Principal Consultant in 2006, based on needs assessments and input from various IHS and non-IHS sectors and stakeholders. The Work Plan may be utilized to challenge our system to mobilize resources, follow the guiding principles enumerated and be accountable for actions. Consensus of overall goals was first developed by a number of key personnel having multiple years of HIV/AIDS experience within IHS. Subsequent 'priority area' enumeration was based on a comprehensive HIV/AIDS program with a public health and preventive focus with input from multiple sources.

The Work Plan is dynamic and therefore subject to change based on new information or data, new initiatives, collaborations, and progression toward achieving the goals. Initially, a multi-health sector IHS team developed and reviewed the draft document. From this, an HIV/AIDS Task Force was developed for more comprehensive review. This Task Force includes:

- Key working group with senior staff holding years of experience in HIV/AIDS and related areas to include behavioral health, information technology, epidemiology, clinical care, urban health and global health.

- Principal Consultants in the Office of Clinical and Preventive Services (e.g. Maternal Child Health, Women's Health, Health Promotion/Disease Prevention (HPDP), Dental, Pharmacy, Nursing, etc) and other IHS Offices (e.g. Office of Information Technology (OIT) and Office of Public Health Support (OPHS) involved with key priority areas within the comprehensive HIV program.

- Collaborating external agency leads (i.e. Health Resources and Services Administration (HRSA), Substance Abuse and Mental Health Services Administration (SAMHSA), National Institutes of Health (NIH), etc);

- AI/AN living with HIV/AIDS (PLWH/A). This group is also involved with the entire planning and implementation process.

- Input for the Work Plan followed a systems model and the stated guiding principles that also included key points of contact from the multiple levels of influence listed below:
    - AI/AN Community members (i.e. Activists, Advocates, researchers, those having family members or friends affected by HIV/AIDS, etc.)
    - Tribal Representation (i.e. Behavioral Health Initiative Task Force)
    - Urban Health leadership
    - Traditional Service Providers (Traditionalists working with HIV clients)

Following initial Task Force review and input from key interagency points of contact, the Work Plan was circulated more widely amongst various senior IHS staff, IHS

Principal Consultants and public health advisors and non-IHS AI/AN advocates and recognized Native health organizations (i.e. NIHB) to ensure a comprehensive and culturally fluent product. Native HIV/AIDS organizations include representation from the CDC-funded Native Capacity Building Assistance provider's Network:

- National Native American AIDS Prevention Center (NNAAPC)
- Inter Tribal Council of Arizona (ITCA)
- Center for Applied Studies in American Ethnicity (CASAE)

Links to more information about this network can be found at the following url: http://www.ihs.gov/MedicalPrograms/HIVAIDS/index.cfm?module=links&option=cba#top

Guiding Principles

- ***Risk-Based***
  The AI/AN population is one of known health disparities as well as critically disproportionate co-factors of risk for HIV transmission. Consequently, it is a population that is at higher risk for the spread of HIV. This is demonstrated by evidenced-based research within those co-factors of risk. This Work Plan - and mobilization to action - is founded upon an increased *risk* of HIV transmission (risk-based) in the AI/AN population and not solely based upon actual number of cases, prevalence or incidence.

- ***Comprehensiveness***
  The IHS model for its HIV/AIDS program is based upon a comprehensive public health approach. It employs interventions at multiple levels of influence and priority areas. These levels of influence follow a systems/ecological model and consider broad sociocultural, environmental, community, clinical, and individual factors.

- ***Collaborative and Integrative***
  The IHS HIV/AIDS Program will coordinate its activities with multiple entities from various sectors within and external to the government. Federal agencies, Native health organizations and communities have ongoing HIV initiatives and activities that are innovative and effective. In addition, and to improve effectiveness and efficiency, this program execution will strive for integration and synergistic use of resources, activities and planning. Collaboration will be seen as the first step toward integration.

- ***Community Involvement / Involvement of People Living with HIV or AIDS (PLWH/As)***
  Following the comprehensive model, members of the AI/AN community as well as People Living with HIV/AIDS (PLWH/A) will be encouraged to participate in all levels of activities, planning, and execution of program. These unique perspectives are necessary for a comprehensive and ecological approach.

- ***Confidentiality***
  Confidentiality is critical when dealing with a topic such as HIV where there is still misunderstanding and stigma attached to it. It is imperative not only for the individual, but for preservation of Native communities and population health. Reducing HIV transmission involves engaging and empowering those afflicted, those at risk and those that are unaware of their status. A perception of lack of confidentiality in the system only alienates those who may wish to present for prevention, counseling or care. Confidentiality is absolutely necessary and should be ensured and enforced at all levels, especially at the local level, to prevent further spread of disease and preserve population health. All individuals in the healthcare delivery system are to be held accountable for this.

- ***Sustainability***
  As initiatives are implemented, long term effectiveness will be fully considered. Routinization of services and programs stabilizes initiatives and will result in less volatility and more sustainability as human and financial resources change.

- ***Leadership***
  Advocating for any initiative takes recruitment of leadership from multiple sectors. This includes community champions, tribal leaders and those community members with the knowledge and commitment to create change. It is the intent of the Plan to open discussion about HIV/AIDS at the highest level in all sectors and disseminate among all AI/AN communities. Active and ongoing leadership will be needed from tribes, facilities, programs, the IHS and partnering agencies.

- ***Respect / Cultural Awareness and Fluency***
  With hundreds of federal and state recognized tribes, initiatives are implemented amongst a population rich in tradition and cultural diversity including unique languages, beliefs, values and norms. Individuals also vary in their cultural orientation to their ancestral communities. Respect is considered one of the most important values defining the nature of relationships in this society. Health care practitioners learn to blend Western strategies along with traditional culture and values when working with AI/AN clients. HIV/AIDS is historically charged with much sensitivity and both stigma and discrimination are common. It is recognized that these create unacceptable barriers to program implementation. This program will make diligent efforts to both recognize and learn from the cultural beliefs and values of the AI/AN population, the environment of those at risk and the potential challenges facing PLWH/A. It will be stressed within the program and to collaborating entities to raise awareness and act accordingly.

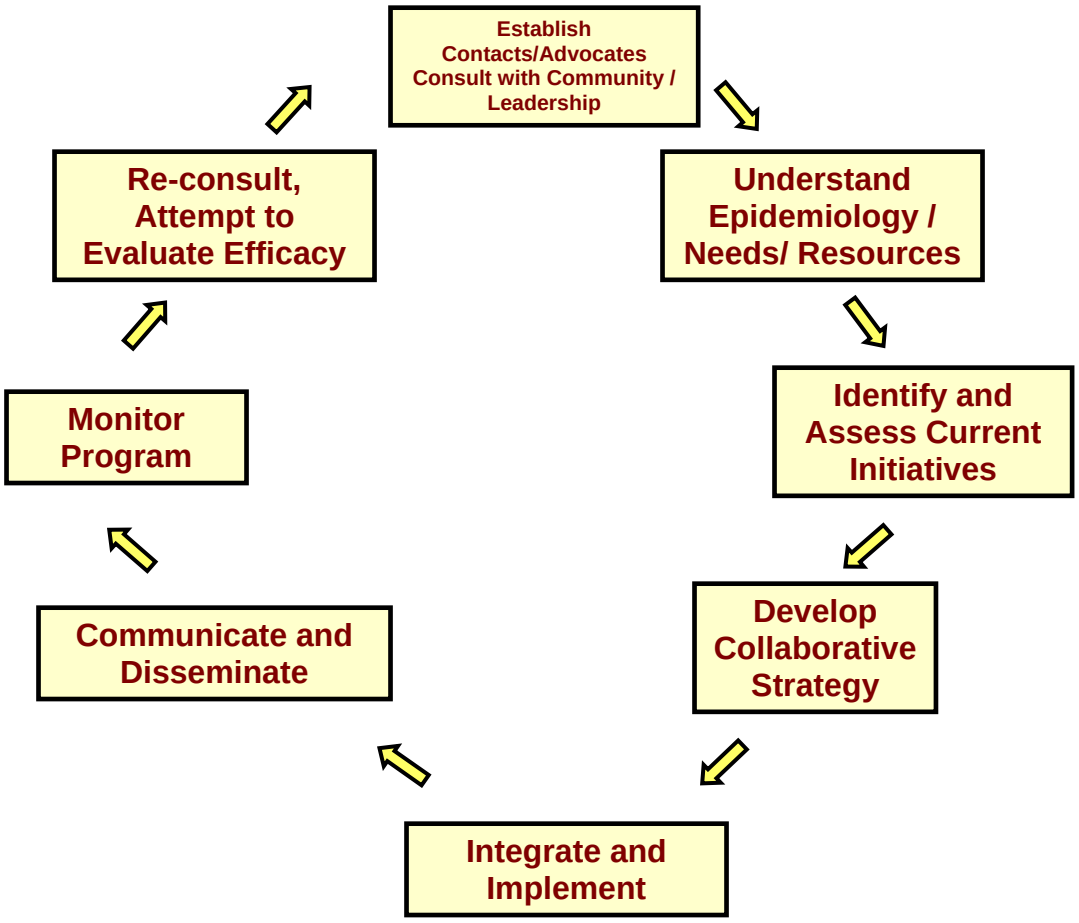
- ***Accountability***
  All interventions will be subject to evaluation and assessment. Design of programs, activities or interventions will include the best use of the limited resources and will incorporate a results-oriented and impact-monitored approach.

- ***Progressive***
  Many ‘at-risk’ groups are not being reached by prevention, treatment, and care programs. These ‘at-risk’ groups include (but are not limited to) drug and alcohol users, men who have sex with men, and sex offenders. There is anecdotal evidence that HIV/AIDS issues are not publicly discussed due to the sensitive nature of the topic and diagnosis. Initiatives will include the promotion of an atmosphere and environment where these barriers are eliminated, facilitating open discussion.

- ***Enabling / autonomous***
  Effective, culturally sensitive preventive and treatment programs require involvement of key community resources, people and elders. This principle also necessitates the best possible integration of initiatives across the IHS 'system' to include Tribal and Urban programs and leadership.

Implementation Process

Diagram 1: *Planning and Implementation Cycle at National level*



Commitment to Implementation

This Plan provides a unique and new opportunity to maintain a transparent, integrative and collaborative approach to address HIV/AIDS within the IHS. It is anticipated that other organizations, individuals and agencies will assume similar leadership roles relative to actions falling within the purview of their respective missions and expertise and assist in implementation of any / all of the various initiatives and projects.

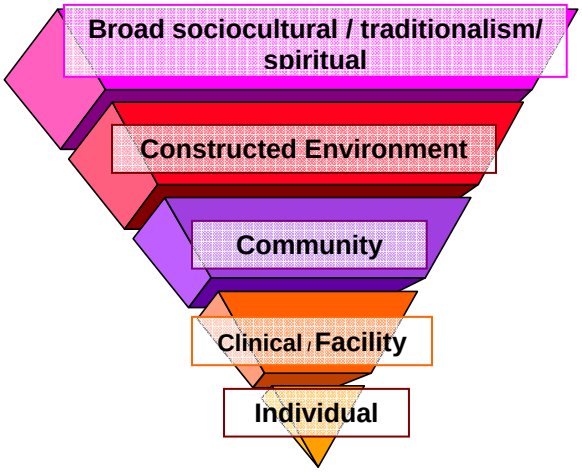
Having initiated this project, the IHS HIV/AIDS Program also accepts responsibility of a coordination role of IHS activity and support of others' efforts to implement activities as well as to monitor and report on the overall progress of its agency undertakings.

What are the Actual and/or Perceived Barriers to Program Implementation?

- HIV/AIDS stigma in facilities and communities
- Perceived lack of confidentiality within healthcare system
- Jurisdiction in certain situations at the state or local level
- Anecdotal evidence of certain tribal leadership not open to discussion
- Lack of human resources with HIV/AIDS expertise at the local level
- Lack of data sharing in the Indian health system
- Perception that HIV/AIDS is rare in AI/AN communities
- Financial and human resources commonly directed towards other appropriate and competing priorities (i.e. Diabetes, Cardiovascular Disease, Injury Prevention, etc)
- Expenses and complexity of treatment and care for smaller facilities
- Human capacity to devote time to and promote HIV specific projects
- Lack of transparency of government initiatives and reluctance of uptake due to any historical or potential distrust
- Lack of open discussion, misperceptions and sensitivities surrounding sexuality, social norms and stigma
- Health education system dealing with sensitivities around HIV and STDs
- Proven prevention strategies such as harm reduction programs and sex/sexuality education incur many challenges due to sensitivity of topic and legal / political issues

Ecological Model

Figure 4: *Levels of Influence: Socio-cultural Ecological Model of Intervention*



All mitigation models and strategies require an environment that encourages people to seek out or adhere to messages about reducing and eliminating risky behavior and to adopt actual behavior change without fear of stigma, discrimination or consequence. However, we must be mindful of levels of influence behind behavior change and the socio-cultural elements of behavior via implementation of an ecological or systems public health approach. Figure 4 depicts 'ecological' levels of influence in this approach designed for indigenous populations with strong cultural and traditional ties.

The goal of the program is to attempt to address, develop, and monitor initiatives at each level. In addition, there may be a priority area (discussed above) in some or all of the levels shown here. Often, we end up focusing on the lower levels of influence (Individual, clinic, etc), yet the "influence" for behavior change often comes from the higher tiered levels (i.e. Broad sociocultural). If we utilize interventions developed from each priority area and apply them to this model, we may be able to logically discuss where there are gaps / needs / resources, etc. Additionally, it may contribute to affirmation of a more culturally fluent program and plan that builds an environment of trust, transparency and open dialogue. For examples within each level, see below:

- Broad socio-cultural (traditionalism, spiritual, economy, violence, risk, etc) - Ex. Social and cultural mores/norms about sexual activity, sexuality and stigma
- Constructed environment (systems, laws, policies) – Ex. I/T/U, state, federal, resources, tribal law or policy, state law or policy
- Community (social epidemiology within community, local stigma, support structure, confidentiality, etc.) – Ex. Homophobia within communities

- Clinical / Facility (Clinics, support structure, expertise, resources, traditional healing, etc) – Ex. Are there treatment and care resources in a facility
- Individual (biological/genetic, individual behavior, barriers to treatment, etc)

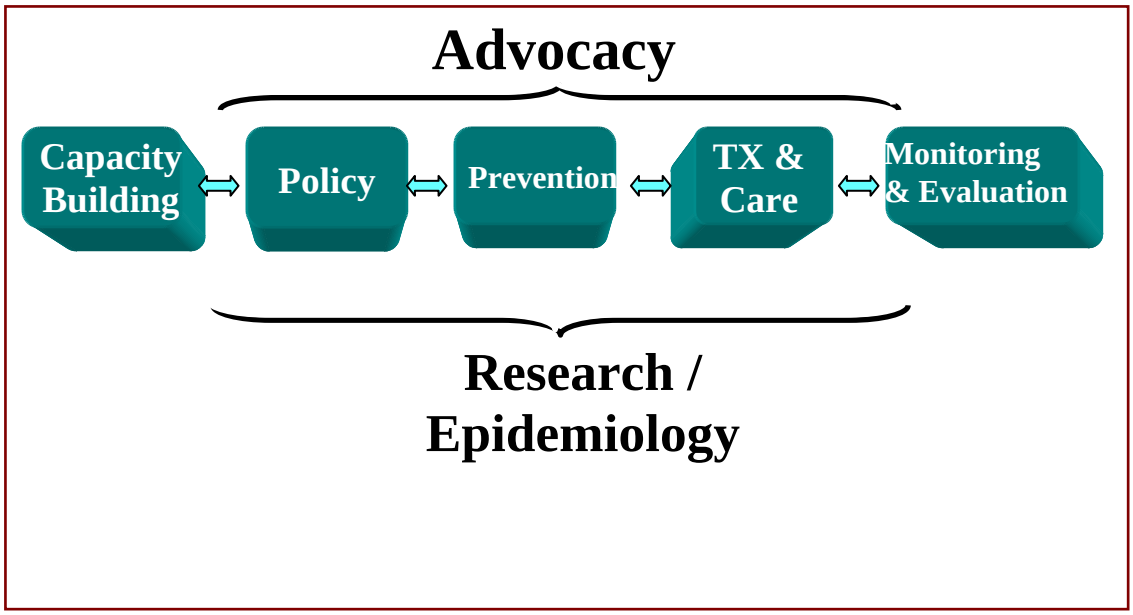
As well, support and 'protective factors' may be realized within this model. The community and individual levels include family members, relatives, extended family and traditionalists which can and should be included (where appropriate) in support structures and cultural connectedness. For example, there is evidence among American Indian youth that family communication acts as a protective factor against HIV risk by lowering reported substance use during last sexual encounter.[6]

References:

1. CDC. *HIV/AIDS Surveillance Report, 2005*. Vol. 17. Atlanta: US Department of Health and Human Services, CDC: 2006:1–46. Available at Accessed March 15, 2007 at http://www.cdc.gov/hiv/topics/surveillance/resources/reports/
2. CDC. *Sexually Transmitted Disease Surveillance 2004*. Atlanta: US Department of Health and Human Services, CDC; September 2005: Tables 11B, 21B, 34B. Also available at http://www.cdc.gov/std/stats/toc2004.htm. Accessed April 6, 2006.
3. Substance Abuse and Mental Health Services Administration. Results from the 2004 National Survey on Drug Use and Health. Available at http://oas.samhsa.gov/nsduh/2k4nsduh/2k4results/2k4results.htm Accessed April 10, 2006.
4. Hu YW, Yu Harlan M, Frye DM. Racial misclassification among American Indians/Alaska Natives who were reported with AIDS in Los Angeles County, 1981–2002. National HIV Prevention Conference; August 2003; Atlanta. Abstract W0-B0703.
5. US Census Bureau. The American Indian, Eskimo, and Aleut population. 2001. Available at http://www.census.gov/population/www/pop-profile/amerind.html. Accessed April 6, 2006.
6. Marsiglia F, Nieri T, Stiffman AR. HIV/AIDS Protective Factors among Urban American Indian Youths. *Journal of Health Care for the Poor and Underserved*. Pg 745-8. Vol 17. 2006.
7. Indian Health Service. Facts on Indian Health Disparities. January 2007.Accessed July 18, 2007 from http://info.ihs.gov/ .

Priority Areas

Figure 3: *Work Plan Priority Areas*



Advocacy is needed in each priority area. Advocating for any initiative takes recruitment of leadership from multiple sectors. The mainstreaming of HIV/AIDS issues will be more challenging without advocacy and leadership from all sectors.

Capacity building includes the training of personnel, the identification of human and financial resources and the development of collaborative relationships for sustainable programs as well as implementation of programs and models. Partnerships should include resource-sharing, integration and collaborations with other federal agencies and native organizations that focus on community capacity building for integrative purposes. Certain sites, given the magnitude of HIV care delivered and economies of scale, may serve as select sites for implementation of multiple initiatives and serve as referral centers within IHS for smaller facilities.

Policy involves evaluation and development of existing and new recommendations as well as the review and implementation of appropriate IHS Policy. State public health policy and law as well as any relevant tribal policies must be considered under this priority area as jurisdiction often resides at the state and/or local level and with tribal government.

Prevention programs are supported by many activities, some of which may be contained within other priority areas. Currently, funding for HIV services is focused on the treatment and care delivery system. Given resource constraints, prevention activities are often incorporated into other programs such as Health Promotion / Disease Prevention (HPDP), Maternal Child Health (MCH) and Health Education, however these activities are not only important to prevent transmission of HIV, but also for risk assessment. Prevention

programs can also be implemented through Native organizations, Community Based Associations (CBAs), and smaller health centers that do not have the capacity for treatment and care.

Treatment and care initiatives are largely limited to I/T/U hospitals or major medical referral centers. These facilities have the volume of patients necessary, the human and financial resources to manage them and the in-house expertise required to care for this population along the HIV/AIDS continuum of care. Treatment and care projects will support delivery of quality care and more effectively routinize HIV services. Additionally, the plan intends integration of behavioral health initiatives and the chronic care model within primary care to optimize quality of care.

Monitoring and evaluation is an essential part of planning and accountability. Without effective monitoring, it is not possible to evaluate progress and manage further implementation. Development of performance indicators, measurable outcomes, coordinated goals and the dissemination of information are all critical elements of monitoring and evaluation.

Research and Epidemiology are also cross-cutting priority areas. Research is needed not only in the areas of treatment and care, but also in prevention, policy implementation, and behavioral health sciences – all specific to the AI/AN population. This also includes appropriate data collection methods, technical assistance and validity and fidelity of information. Epidemiologic surveys allow for the monitoring of the spread of HIV through sub-populations and geographic areas. Tracking the impact of the virus will also allow for targeted interventions and the ability to evaluate care within our healthcare system and perform gap analysis.

Note: In some instances, initiatives enumerated below may overlap multiple priority areas. They will be placed in one of the appropriate areas as best possible.

Program Goals

Overarching National Goal

To prevent new infections of HIV

1. Reduce the transmission of HIV through behavior modification, prevention education and other proven prevention methods;

2. Ensure access (and linkages) to quality healthcare services for those individuals at risk for and those living with HIV/AIDS;

    - Increase individual awareness of personal HIV serostatus;
    - *Routinize* HIV/AIDS testing and linkages to care; ensure quality HIV/AIDS services are delivered at IHS direct, Tribal and Urban (I/TU) sites;

3. Address stigma and discrimination surrounding HIV/AIDS through open discussion internal and external to the health sector as a step toward *normalization* of this health topic;

4. Interpret and implement best practices and national guidelines;

5. Integrate approaches (i.e. STD, substance use and HIV prevention integration) to build capacity and maximize resources for surveillance, prevention, research, treatment and mitigation through sustainable collaborations.

6. Enhance an 'intervention environment' that facilitates dialogue, shares knowledge, demonstrates transparency and builds trust among I/T/U and the community to create a cultural partnership and mutual learning environment surrounding the issues of HIV/AIDS.

Program Objectives

Overarching National Objectives and Timeline

These overall objectives will be supported and expanded by specific objectives and projects/activities within priority areas.

Advocacy

1. By 2008, release the "IHS HIV/AIDS Administrative Work Plan" (via email, listserv and webpage) to all IHS Area Offices, interagency points of contact and other non-IHS collaborators) as an integrating and fluid document.

2. By 2008, create an integrated network of HIV providers, advocates and leaders connected through distribution lists and an IHS HIV/AIDS internet website.

Capacity Building

3. By 2009, strengthen the capacity nationwide to develop and implement effective prevention programs by developing and integrating a number of interagency and I/T/U collaborations and resource mobilization opportunities.

Policy

4. By 2010 interpret and implement up-to-date guidelines through national IHS policy development and recommendations.

Prevention

5. By 2010, increase the number of user population aware of their HIV status by routinizing screening and adapting appropriate policy/process in IHS facilities.

6. By 2010, routinize prenatal screening and reporting to 100%

7. Prevent all cases of Maternal to Child Transmission (MTCT).

Treatment and Care

8. By 2011, develop and disseminate established processes across the HIV continuum of care including best practices, improved access to screening, quality management and care, effective treatment (and linkages to treatment) and palliative care services.

Monitoring and Evaluation

9. By 2009 develop methods for evaluation of initiatives and tracking program outputs across priority areas.

Epidemiology and Research

10. By 2011, integrate HIV/AIDS and STD services and strengthen processes to monitor disease through various effort and collaborations with Area offices and IHS Divisions, most specifically the Division of Epidemiology and Disease Prevention.

Additional Program Objectives

Advocacy

- Expand Information Dissemination to I/T/U facilities and native health organizations
- Expand tribal representation and activities
- Advocate through interagency collaborations and publications
- Integrate behavioral health into primary care and other HIV initiatives
- Reduce stigma and discrimination across all priority areas
- Catalyze workforce involvement and maintain resources already established
- Outreach to AI/AN communities and Native health organizations
- Identify and recruit traditionalists working with HIV/AIDS

Capacity Building

- Expand specific I/T/U training and education around HIV/AIDS topics
- Through training and education, link community with Indian health system
- Expand capacity to screen for HIV and improve access to testing in I/T/U sites
- Identify / obtain new funding streams through partnerships and new initiatives
- Develop sustainable collaborations with other federal agencies involved
- Build capacity in IHS sites to address HIV/AIDS treatment and care
- Expand human resources within funding constraints
- Obtain grant funding for credentialing or coordination of health professionals

Policy

- Ensure current and appropriate HIV/AIDS policy within IHS
- Ensure policy reflects appropriate interpretation and implementation of current national clinical guidelines
- Ensure patient confidentiality through policy, protocols, adherence to standards
- Assist in shaping state policies / laws with regards to assisting AI/AN care for HIV/AIDS
- Reduce stigma and discrimination through open discussion about HIV, policy review and measures that help assure accountability regarding confidentiality
- Ensure Occupational Health of employees is addressed (i.e. PEP protocols, etc)

Prevention

- Enhance health promotion/disease prevention message by integrating HIV message in other health topic areas
- Ensure preventive health education on HIV/AIDS to youth through inter-divisional and interagency collaboration
- Enhanced/earlier screening of higher risk groups (co-existing risk factors)
- Ensure vertical transmission is prevented through prenatal screening and surveillance
- Ensure access to and awareness of individual preventive measures and prophylaxis

- Support ‘harm reduction’ and behavioral health strategies in IHS where appropriate

Treatment and Care

- Expand access to care in IHS facilities
- Ensure multidisciplinary team approach for HIV/AIDS treatment and care
- Adapt Chronic Care Model to HIV/AIDS continuum of care
- Reduce stigma and discrimination from IHS care delivery system
- Ensure access and linkages to screening, medications and care services
- Understand role and programming of Ryan White (RW) and RW funding for IHS facilities**.** Enhance by dissemination of information and collaborations with HRSA
- Ensure standardization and quality of HIV/AIDS care (Also see M&E)
- Optimize adherence of HAART (also see Priority Are 7: Research #5)
- Make disease management system available to sites with appropriate capacity

Monitoring and Evaluation

- Ensure networking availability
- Ensure efficient use of resources and collaborative nature of initiatives
- Establish review process for reimbursable funding sources
- Monitor quality of care in health care delivery system
- Monitor and evaluate implementation of overall program with development of tracking mechanism(s)
- Utilization of Epi Centers in collaborations
- Respond to Government Inquiries (i.e. Government Accountability Office)
- Inventory Current capacity / resources
- Identify resources at Area level

Research and Epidemiology

- Expand research initiatives (and funding) for Native-focused HIV/AIDS Research utilizing internal and external resources to include academia
- Identify and coordinate Epidemiology resources external to IHS (i.e. CDC, HRSA, NIH, etc)
- Collect and analyze accurate Epidemiology data within IHS
- Collect data from RPMS and national database via HMS, CRS and GRPA
- Enhance effective system-wide integration of STDs and HIV
- Ensure virilogic success of HAART through research

Initiative Matrix (by Priority Areas)

Advocacy

Objective	Activity and/or Action Steps	Responsible Person/Body	Indicator/Output Goal(s)
Identify and recruit traditionalists working with HIV/AIDS	Behavioral Health Traditionalist Working group and Summit • Establish relationship with key traditionalists during DBH trainings • Assist with development of traditionalist working group and progression to summit • Relay process and rationale of traditionalist inclusion into systems / chronic care model within HIV • Explore and potentially identify a traditional model of care for HIV	IHS HIV and DBH	• Number of traditionalists engaged and participating • Completion of Summit • Process established for infusion of traditionalists into HIV program • Goal 3, 6
Integrate behavioral health into HIV initiatives	Review priority areas and develop areas of collaboration including Director's Initiative – Behavioral Health • Maintain listserv of Area Behavioral Health Consultants; include contacts in HIV/AIDS listserv	IHS HIV and DBH	• Number of DBH collaborations • Area-wide Listserv • Goal 1,3,5
Expand Information Dissemination	Develop and launch IHS HIV/AIDS Webpage • Maintain page currency and engage other IHS staff to contribute. • Develop and maintain "ARV Corner" on HIV/AIDS Webpage • Collect AI/AN specific HIV research and develop 'library' within webpage. • Identify model practices • Utilize website as interagency tool for communication and planning • Develop and document a more formalized process for dissemination of information to IHS, Tribal and Urban entities as well as tribal leadership and	IHS HIV All	• Information dissemination • Confirmed 'hits' • Confirmed 'visits' • Number of ARV corner articles • Goal 1,2,4,5,6

	communities		
	Develop HIV listserve to network I/T/U staff/stakeholders • Maintain and expand email distribution list	IHS HIV	• Number of members • Expanded 'reach' of program into I/T/U facilities • Goal 5,6
	Author articles in various publications • Chief Clinical Consultants Corner – monthly opportunities to author articles • IHS *Primary Care Provider* • Encourage other IHS personnel to publish on current HIV work	IHS HIV IHS MCH	• Number of articles published • Number of types of publications • Goal 2, 3, 4, 5
	Continue speaking engagements nationwide and at annual national meetings of significance, Area meetings and Interagency presentations (HRSA, CDC, NIH, SAMHSA, Combined Councils, NIHB, etc)	IHS HIV	• Number of formal presentations at least at Area level or higher • Types of venues • Goal 2,3,4,5
	Collaborate with HHS National Mobilization Campaign • Obtain additional resources/info • Development and training of speaker's bureau. Recommend advocates/tribal and community members.	IHS HIV HHS / OHAP	• Speakers nominated and trained • Events staffed / presentations made • Goal 2, 3, 6
	Disseminate informational manuals, CDs, funding opportunities, guidelines via multiple modes of communication (internet, SharePoint, meetings, email)	IHS HIV	• Messages sent, materials distributed • Monitor geographic reach • Goal 2,3,4,5,6
	Raise awareness amongst other Agency leads, project officers, etc • Include stakeholders in listserv • Advocate for combined TDY and host travel into IHS Areas		• Travel to IHS Areas with key interagency leadership • Number of stakeholders /agencies included in listserv
	Infuse and utilize new technologies to advance information dissemination and reach more target sub-groups • Internet, podcasting, blogging, social networking, mobile applications	IHS HIV OHAP	• Number / Types of new media used • Cross coordination with HHS
Expand tribal HIV network	Establish panel of native researchers	IHS HIV NIH	• Completion of Researcher Meeting

and activities	• Identify funding source and potential IAA to support activity • Support native research meetings on HIV and foster integration with NARCH initiative • Utilize Epi-Centers where appropriate • Utilize for planning and needs assessments	IHS NARCH	• Attendance/advocacy at annual meeting • Financial resources / opportunities • Goal 3,6
	Sensitize and raise awareness for tribes about eligibilities (i.e. RWMA), care options, confidentiality laws, reporting structure, etc through interagency MOUs, listserv, etc.	IHS HIV and interagency collaborators	• Goal 2,3,5,6
	Include potential opportunity for training of Tribal providers/care workers in all initiatives	IHS HIV	• Goal 2,3,4,5,6
Reduce stigma and discrimination across all priority areas	Foster environment that supports open discussion about gender issues, sexuality and social/sexual norms	All	• Sessions / trainings that include discussion on this issue • Integration of cultural approach and open dialogue to augment message • Goal 1,3,5,6
	Infuse message into all trainings and health education messages	All	
	Provide information / access to trainings for I/T/U providers and tribal leadership on these issues.	All	
	Create / Locate model programs that discuss sexual norms/sexuality/ etc. and provider resources / tools	All	
	Utilize traditionalists and elders in dissemination of these messages	All	
Catalyze workforce and maintain resources of those already involved	Develop recognition process /program for appropriate personnel • Potential awards for staff • Potential civilian recognition for work in this field • Email / webpage recognition of model programs and personnel	IHS HIV	• Goal 6
	Serve on the CDC/HRSA Advisory Committee on HIV and STD Prevention and Treatment. • Two meetings / year. • Maintain IHS as having alternating Ex-Officio positions on committee between two IHS senior staff	IHS HIV and Division of Epidemiology	• Collaborations with CDC • Goal 5,6

	Serve on Minority AIDS Initiative Steering Committee • Maintain seat on committee and actively participate	IHS HIV	• Goal 2,5,6
Outreach to AI/AN Communities	Establish partnerships with active Native health organizations, native HIV organizations and native health leadership • Communication to Executive Directors and representatives of major Native health and Native HIV organizations. • Interview with/for organizations requesting program information	IHS HIV	• Number of organizations supported / outreach • Goal 1,3,5,6
	Annual support of National Native Awareness Day, March 20 • Coordination of HHS Leadership Campaign with IHS and Native organizations • Engage IHS Director -draft Press Statement and Public Service Announcement for him/her. • Coordinate with IHS Public Affairs • Support and prepare announcements for National Testing Day, June 27	IHS HIV HHS / OHAP IHS IHS	• Number of Media outlets, radio stations • Director's Press Statement and Public Service Announcement • Principal Consultant email • Goals 1,3,5,6

Capacity Building

Objective	Activity and/or Action Steps	Responsible Person/Body	Indicator/Output Goal(s)
Expand Training and Education around HIV/AIDS topics	Execute trainings and obtain funding for Behavioral Health regional trainings • Progress trainings to appropriate participants and meet objectives • Facilitate and augment current networking opportunity	IHS HIV and DBH	• Cadre of HCWs that integrate behavioral health within HIV initiatives; • Number of staff trained in behavioral health; • Traditional Service Provider network to enhance quality care • Goal 1,3,4,5,6
	Link I/T/U staff with HRSA clinical training opportunities; • Through listserv • Develop and maintain partnerships (AETC- portion of MOU) and DBH regional training above • Assist with integration of MAI initiatives and FY funding	IHS HIV HRSA/AETC	• Part of signed MOU stating intent to collaborate with AETC • Integration with websites • Number of trainings with partnering staffs • Goal 1-6
	Link CDC testing / counseling training with IHS • Explore collaboration with CDC or SAMHSA to train I/T/U personnel in testing/rapid testing / counseling • Integrate into MAI SAMHSA Collaboration	IHS HIV SAMHSA CDC	• Number of Trainings • Personnel trained • Resources from CDC, SAMHSA • Goals 1-6
Through training and education, link community with health system	Execute training for Community Health Representatives (CHR) with MAI funds • Gain assistance from PHN • Develop listserv /network • Maintain MAI funding • Track extended impact	IHS CHR IHS HIV	• CHRs/PHNs trained or participated • improve linkages from prevention to tx • Number of trainings • Listserv/network of trusted healthcare workers • Goals 1-6
	Develop Training of Trainer methodology for all trainings to expand extended impact	IHS HIV DBH, CHR	• Trainings with ToT format
Expand access to testing in Urban sites	Propose and obtain funding from MAI for Urban programs. Plus-up funds from FY05 initiatives.	Office of Urban Indian Health	• Identify barriers of implementation. • Increased services

	• Utilize Urban Indian Health Institute (UIHI, Seattle) to assist in coordination of reporting/analysis • Develop consistent and timely reporting plan with detailed indicators/outputs for data collection • Assist Urban Health Director with MAI proposal, announcements, implementation of proposal	IHS HIV	• Number of individuals tested. • Number of seropositive/(-) • Number of refusals • Number linked to care/treatment • Other qual. outputs • Goal 1-6
Identify new funding streams for information dissemination and/or capacity building	Coordinate/collaborate with NIH Office of AIDS Research (OAR) • Sustain information dissemination projects and research group to gather info on needed action steps • Link NARCH and Epi-Centers with OAR • Disseminate research information collected	NIH OAR and IHS HIV IHS HIV IHS NARCH	• Potential funding for needs/assessment • number of meetings • Tribal representation • Potential AI/AN research through NIH OAR • Goals 5,6
Develop sustainable collaborations with other federal agencies involved with HIV in AI/AN	Coordinate/collaborate with HRSA • Develop MOU • Explore new legislation and eligibility for IHS facility to be a direct grantee for RWMA Title III and IV. • Disseminate timely policy changes / new information on Ryan White • Update website links • Update PowerPoint brief on RWMA and disseminate • Ryan White Fact sheets on webpage o Policy/Program o ADAP • Look into ADAP research on AI/AN • Work with SPNS on new AI/AN initiative	IHS HIV HRSA / HAB	• Signed MOU with HRSA • Facilities that are Part III, IV grantees • Goal 2,5,6
	Coordinate / collaborate with NIH OAR (see above) • Develop MOU with NIH for initiative and sustainable collaboration	IHS HIV NIH / OAR	• MOU • Goals 2,5,6

Expand human resources with limited/no funding	Engage Emerging Leaders (ELs), students and universities (multidisciplinary, MPH, etc) at HQ, Area level or HQ-West to work on initiatives • Develop Agreements with Univ. to have consistent student rotation in HIV/AIDS program • Accept residents when appropriate • Engage and obtain services of emerging leaders	IHS HIV	• Number of students • Universities involved • MOUs with other federal agencies • Involved Emerging Leaders • Goals 5,6
Obtain grant funding for credentialing or coordination of health professionals	American Pharmacists Association Grant for work in HIV/AIDS with pharmacists. Awarded 2007 grant • Coordinate network of RPh from I/T/U sites • Promote NCPS and get RPh certified nationally	IHS HIV and I/T/U RPhs	• Number of pharmacists certified • Number of presentations at regional/national meetings • Goals 2,4,5,6
Document capacity building efforts	• Identify and document best practices and disseminate information	IHS HIV Potentially Native CBA network	• Documentation

Policy

Objective	Activity and/or Action Steps	Responsible Person/Body	Indicator/Output Goal(s)
Ensure current and appropriate HIV/AIDS Policy within IHS	Policy review and development. • Assess current need for updated HIV policy - survey key working group from field	IHS HIV	• Policies reviewed, recommended, developed • Goal 2,3,4
	Removal of outdated policy and forms. • Follow process for rescinding policy (SGMs) • Cancellation of out-dated forms	IHS HIV	• Number of policies rescinded / forms cancelled • Goal 2,3,4
	Identify successful local policy "models". • Disseminate widely for uptake. • Current changes in HIV testing recommendations may yield opportunity for local best practice (i.e. Sells Service Unit HIV testing policy)	IHS HIV IHS facilities	• Goals 2,3,4
Ensure patient confidentiality	Review any policy related to confidentiality/stigma/discrimination • Determine need for specific policy related to confidentiality. • Discuss with key working group and garner community input as well as input from PLWH/A	IHS HIV	• Development of new policy if warranted • Goal 2,3,6
Assist in shaping state policies / laws with regards to assisting AI/AN care for HIV/AIDS	Maintain awareness of state law/policy surrounding HIV. • Monitor websites and daily listservs. • Coordinate with CDC leads on uptake of revised testing recommendations. • Coordinate with native orgs involved with similar policy interest	IHS HIV CDC	• Goal 1-6
	Assist with State relationships • Work with/support CDC on revised testing recommendations • Work with NASTAD on Native HIV Report/ requested as consultant to edit/review • Review any other Native "reports" on policy / needs	IHS HIV CDC Community members	• Increase in state uptake of testing recommendation • Accurate report • Goal 1-6
Reduce stigma and	See #2 above. • Assess need for policy related to	IHS HIV	• Related local and/or national

discrimination	stigma and discrimination. • Review related current service unit policy.		policy • Goal 3,6
Ensure Occupational Health addressed	Occupational Exposure Policies in place locally. • Coordinate and confirm inventory with Sheila Warren (OCPS) policy exists to deal with occupational exposure and PEP • Provide up-to-date guidelines via webpage, listserv and to OCPS leads	IHS HIV IHS Occupational Health	• Facilities with up-to-date HIV PEP policy • Goals 4,5

Prevention

Objective	Activity and/or Action Steps	Responsible Person/Body	Indicator/Output Goal(s)
Enhance health promotion/disease prevention message	Coordinate with HPDP director and submit HIV information for materials distributed • Annual HPDP resources guide • Area coordinators • Establish link to HPDP Director's Initiative	IHS HIV / HPDP	• Updated HIV information / resources contained in guide • Listserv • Goals 1,3,5
	Youth Leadership Initiative through HPDP	IHS HIV and IHS HPDP	• Development of youth leaders with knowledge of HIV/AIDS issues • Goal 1,3,5
	Collaborate with HPDP on community mobilization project • Involves training a community "team" with a model to mobilize against health topics, one of which is HIV. Methods / Model / Network	IHS HIV and IHS HPDP	• 3-person team completing training • Goals 1,3,5,6
	Combine prevention strategies • Integrate HIV prevention message into Substance use, STD, sexual abuse/violence messages / counseling / care	IHS HIV IHS/DBH IHS / Epi	• Number of areas linked to HIV prevention messages • Goals 1,5,6
Ensure health education on HIV/AIDS to youth	Collaborate with Health Education (DCCS) on best method to get prevention message to youth	IHS HIV HPDP Health Education	• Goal 1,5
	Contact BIA P.O.C and coordinate /reassess Circle of Life curriculum and status as well as potential new collaborative	IHS HIV Health Education Bureau of Indian Education (BIE)	• Programs and/or schools involved • Curriculum developed / updated • Curriculum disseminated • Goals 1,5,6
	Boys and Girls club f/u from 2005 MAI initiative	IHS HIV	• Report filed
Enhanced/earlier screening of higher risk groups (co-existing risk factors)	Partner with SAMHSA • Recent approval/funding of MAI initiative – substance use and HIV/AIDS in AI/AN • DBH Regional Trainings • Rapid Testing Initiative • Draft MOU to formalize	IHS HIV SAMHSA	• Signed MOU • Goals 1,2,5,6

	collaboration		
	Continue to routinize prenatal screening in opt-out format	IHS HIV / OIT/ EPI	• % screened (GPRA) • Gap analysis via Epi study • Goals 2,3,4,5
	Promulgate recommendations and action based on gap analysis	IHS HIV EPI	• Recommendations
	Develop CRS 8.0 measure to screen for HIV in STD diagnosed population. Assess new CRS performance measure via reports	IHS HIV OIT	• % screened for HIV with STD • CRS Reports • Goals 2,4,5
	Explore potential to stage this into GRPA measure 2009		• Goal 2
Ensure vertical transmission is prevented	Refer to #2 above as well as prevention education and f/u after L&D with post partum education	IHS HIV / Women's Health	• Goals 2,5
	Co-factors of risk for HIV infection in women: • Monitor risk areas such as substance use, depression/violence, teen pregnancy, sexual abuse • Ensure screening according to revised CDC recommendations (i.e. opt out / initial and 3rd trimester)	IHS HIV Women's Health Epi	• Goals 2,5
Ensure access to and awareness of individual preventive measures of prophylaxis	• Evaluate accessibility • Review uptake and KAB about prophylaxis • HPDP messages • Assess procurement process for prophylaxis	IHS HIV HPDP IHS Supply	• Goals 1,2,3
Support 'harm reduction' strategies in IHS	• Perform Assessment from POCs • Review state laws regarding needle exchange programs • Identify and highlight model harm reduction programs	IHS HIV	• State law data on needle exchange policy • Assessment of IHS programs • Goals 1,4,5

Treatment and Care

Objective	Activity and/or Action Steps	Responsible Person/Body	Indicator/Output Goal(s)
Expand access to care in IHS facilities	Continue to obtain funds and build telemedicine program with Center of Excellence. • Provide supportive consultation to providers in I/T/U facilities • Maintain MAI funding as needed	IHS HIV IHS Facility / HIV CoE	• Number of providers who can provide access points for care • MAI Funds obtained • Goals 2,4
Ensure multidisciplinary team for tx and care	Obtain APhA grant funding for national Pharmacist credentialing in HIV/AIDS tx and care • Coordinate for lectures at IHS Quad in Phoenix • Coordinate with NCPS to develop official HIV NCPS	HIV CoE IHS HIV	• Funding from APhA • Credentialed HIV IHS Pharmacists • Lecture delivered at Quad • Goals 2,4
Adapt Chronic Care Model to HIV/AIDS Care	• Apply Self-Management, Decision Support, Clinical Information, Delivery System, Organization of Health, and Community to HIV continuum of care • Seek MAI funding to support project and develop collaborative model to implement	All	• MAI funding • Implementation of proposed model into select sites • Dissemination of information / model • Goal 2,5,6
	Infuse behavioral health into primary and chronic care model via DBH trainings	IHS HIV IHS DBH	• Best practice model • Goal 2,5
See #4 box in M&E			
Reduce stigma and discrimination from IHS delivery system	DBH trainings for providers on stigma and discrimination reduction skills	IHS HIV IHS DBH	• People trained in stigma reduction • Goals 2,3,6

Ensure access and linkages to screening, antiretroviral medications and tx /care services	HRSA collaboration and MOU development. • Multiple POCs for activities with RWMA, policy and ADAP, SPNS, which all contribute to linkages to care and potential collaborations. • Identify HRSA referral system in each area outside I/T/U system.	IHS HIV HRSA	• MOU to formalize ongoing collaborations and sharing of resources/expertise • Goals 2,5
Understand role and programming of Ryan White (RW) and RW funding for IHS Facilities for treatment and care	Ryan White eligibility now includes IHS direct facilities • Assess funding for current language (no assurance of RW funding) • Apply to RW as grantee • Document process of application /edits/ review information from RW	IHS HIV IHS Facilities	• Facilities applying as RW direct grantee • Funding acquired • Disseminate simple materials to discuss RW for AI/AN. • Goal 2,5,6
	Identify model linkages of care for ADAP and disseminate best practice information. Continue to collaborate with ADAP	IHS HIV CoE	• Best practice models for establishing linkages and referrals • Goals 2,6
	Augment functional referral system at Area level within IHS for smaller facilities.	IHS HIV IHS Facilities	• Linkages or referral centers • Goals 2,6
	Dental providers as access point for screening • Training opportunities • Rapid testing	IHS HIV IHS Dental	• Goal 2
Ensure standardization of care (Also see M&E)	Utilize HMS / CRS / GPRA as a potential ‘standardizing protocol’ via RPMS. Uptake of HMS or CRS based on need-limited to facilities with high case load	IHS HIV IHS OIT IHS EPI	• Quality assurance indicators • Goals 2,4
Optimize adherence of HAART (also see Priority Are 7: Research #5)	Review literature and any specific AI/AN research related to adherence	HIV RPhs	• Goals 2,4
Make disease management system available to site with appropriate capacity	Continue to work on optimization of HMS for uptake in more facilities	IHS HIV IHS OIT IHS EPI	• HMS versions • Goal 2

Monitoring and Evaluation

Objective	Activity and/or Action Steps	Responsible Person/Body	Indicator/Output Goal(s)
Ensure networking availability	• Maintain and expand current listserv and webpage • Continue to network and request points of contact	IHS HIV	• Active listserv users • Hits tracked on website • Goal 3,5,6
Ensure efficient use of resources and collaborative nature of initiatives	• Promote synergistic decision making processes among collaborators of partnered initiatives • Garner input on strategic planning activities	IHS HIV interagency collaborators	• Agencies engaged • MOUs signed • Goal 6
Establish review process for reimbursable funding sources	• Minority AIDS Initiative coordination • Regular updates and teleconferences. - Timely reporting and proposals. • Maintain MAI project listserv • Strengthen transparency and accountability in fund management, movement, process	IHS HIV Project Officers of MAI projects	• Timely submission of reports and proposals to MAI • Goals 5,6
Monitor quality of care in health care delivery system	Continue ongoing CRS indicators and develop new ones: • Quality of care (QOC) indicators • Request and review OIT 2 QOC measures (viral load and CD4) • Share QOC report via HMS	IHS HIV IHS OIT IHS Facilities	• QOC indicators compared against accepted standards • Goals 2,5,6
	• New CRS indicator CRS 8.0: STD/HIV Screening • Review reports • Support through funding	IHS HIV IHS OIT	• Number of persons with STD screened for HIV • Funding obtained • Goals 2,4,5
	GPRA Indicators • Monitor, evaluate and progress on GPRA indicator(s) relevant to HIV • Potential staged approach: CRS STD/HIV screen progress to GRPR	IHS HIV IHS GPRA	• Number of pregnant women screened for HIV • Progression of GRPRA

			measure • Goals 2,4,5
	Annual Area reporting if possible (or by major service unit/provider/POC) • Coordinate with POC from GIMC, PIMC, ANMC, and OKC for reports	IHS Facilities	• Reports submitted • Goals 2,5,6
	Assess new CRS 8.0 STD/HIV performance measure via reports	IHS OIT	• % screened for HIV with STD • CRS Reports • Goals 2,5,6
	Explore potential to stage CRS measure and/or universal screening into pilot project or GRPA draft measure 2009	IHS HIV IHS OIT IHS EPI	• Goal 2
Monitor and evaluate implementation of overall program	• Review steps of program implementation and assess current status	IHS HIV	• Goals 1-6
	• Develop an implementation model of HIV program through diagrams and/or narrative. Reproducible process that depicts methodology for other staff	IHS HIV	• Process document included in Work Plan • Goals 6
	• Develop spatial mapping to map HIV / AIDS by state/county from CDC data overlay on major I/T/U facilities, Native CBAs and IHS Telemed network as well as possibly RW providers	IHS HIV	• Spatial map • Goal 6
Utilization of Epi Centers	• MAI proposal for HIV testing KAB opinion survey to go through Epi-centers FY08 • Establish points of contact in each of 12 Epi-centers; place on listserv	IHS HIV	• Number of Epi-centers actively engaged • Goals 1,2,3,6
Respond to Government Inquiries	GAO inquiry • Multiple activities: Reporting, questionnaires, telecons, emails, site visits.	IHS HIV GAO IHS	• Timely reporting, bridge-building • Number of telecons, emails, reports, meetings • Goals 2,6
	OMB inquiry (as section of MAI PART) • Reporting data and data	IHS HIV MAI Project leads	• Timely and accurate reporting

	elements to MAI		• Goal 2,6
Inventory Current capacity / resources	Work with reporting bodies, GAO, and Area POCs to survey / enumerate/identify local capacity	IHS HIV GAO Area CMOs/POCs	• Documentation of capacity • Goals 2,5,6
Identify resources at Area level	Assist with enhancing Area level knowledge and awareness of available resources and HQ activities	Giberson Area POCs	• Goals 2,3,5,6

Research and Epidemiology

Objective	Activity and/or Action Steps	Responsible Person/Body	Indicator/Output Goal(s)
Expand research initiatives for AI/AN HIV/AIDS Research	• Collaborate with NIH and NARCH • Engage Epi-Centers • IRB review and approval for research initiatives	IHS HIV IHS NARCH NIH / OAR Tribal Epi-Centers	• Number of Initiatives • IRB Approval • Goals 2,5
	• Collaborate with academia to enhance / augment research initiatives through MOUs	IHS HIV	• MOU with Academic institution • Linkages to HIV research activities for AI/AN
	• Identify and disseminate culturally specific Effective Behavioral Interventions (EBI) • Diffusion of EBIs (DEBI)	IHS DBH IHS HIV External collaborators	• Culturally specific DEBIs
	• Collaborate with CDC on Native research initiatives	IHS HIV CDC	
Identify and coordinate Epi resources external to IHS	Coordinate with CDC on Annual AI/AN HIV Fact Sheets	IHS HIV CDC	• Yearly fact sheet obtained in a timely manner • Goals 1,3,5,6
Collect and analyze accurate Epi data in IHS	Prenatal Screening surveillance • Site visits to evaluate and develop interventions to improve screening, transmittal and development of site • National data base development • Measures and process developed for future HIV data collection	IHS HIV IHS EPI	• Number of sites recruited • Increased screening rates • Goals 1-6
	Engage and recruit Tribal Epi Centers and develop collaborative data collection /survey(s) and analysis efforts	IHS HIV Tribal Epi Centers	• Number of tribal Epi-centers engaged and active • Goals 5,6
	Execute national survey related to HIV testing through Epi-centers		• Survey results • KAB survey of providers and population • Goals 1,3,5,6
	Streamline process and identify/resolve barriers to prenatal	IHS HIV IHS EPI	• Facilities with bundled HIV

	screening (i.e. bundling of panel) • Create /develop policy or statement on recommendations • Publish information		screen • Goals 1,2,4
	Annual Epidemiology report on HIV/AIDS (potential incorporation into annual STD report or stand alone)	IHS HIV IHS EPI	• Annual report • Goal 5
Collect data from RPMS and national database	Develop more streamlined process to acquire data within IHS and between statistics, epi, OCPS, etc. • Potential for data access agreement	IHS HIV IHS OPHS	• Improved protocol for collecting data • Data access agreement • Goals 5,6
	Collect baseline and subsequent data on HIV testing, seropositivity, etc	IHS OPHS	• Data generated • Goals 2,5,6
	Continue to collect GPRA data on prenatal screening and consider new GPRA measure for 2009 or beyond	IHS HIV	• Progression of HIV GPRA measure • Goals 2,5,6
	Collect national data on antiretroviral use and distribution as both a baseline measure and comparative data	IHS HIV IHS OPHS	• Report on antiretrovirals • Goals 2,4
Expand funding for research initiatives	Identify potential funding resources for research (i.e. NARCH)	IHS HIV NIH OAR IHS NARCH	• New funding streams for research • Goal 5
Enhance effective system-wide integration of STD and HIV	Collaborate with Division of Epidemiology on strategic planning integration between STD and HIV. • Obtain STD strategic plan. Discuss plan with Epi program and potential for integrative strategies at the national level.	IHS HIV IHS EPI	• Goals 4,5
	Attend STD regional conferences/trainings and integrate HIV message	IHS HIV	• Goal 1,5
Ensure virilogic success of HAART through research	Potential for grant proposals surrounding medication adherence, access and support for HAART	IHS RPhs	• Goals 2

The Way Forward

American Indians and Alaska Natives (AI/AN) are at higher risk of transmission of HIV than other races and ethnicities. The health disparities are apparent and the linkages between HIV risk factors and transmission have been demonstrated. The number of AI/AN living with HIV/AIDS is increasing and the rates per 100K population have not decreased. The following elements should also be considered as principles in all future planning:

- Strategic Planning and networking should be continuous;
- Avoid any complacency that may be based on sheer number of AI/AN PLWH/A and/or classification of HIV/AIDS as a 'chronic' disease;
- ***Routinize*** HIV services;
- Open discussion and decrease stigma around this health topic in all health and non-health sector venues;
- Continue to integrate programs and messages to build sustainable capacity;
- Unless prevalence increases substantially, a preventive paradigm is still warranted;
- Advocacy from tribal leadership and traditionalists will be necessary since ***normalization*** of the disease will be heavily influenced within non-health sector;
- Demonstrate program transparency and build trust among and between the federal / tribal / urban partners and the community advocates to create a cultural partnership and mutual learning environment surrounding the issues of HIV/AIDS for AI/AN.

Catalyzing change is important to turn the tide of transmission. This Work Plan addresses some pieces of the puzzle that can increase the coverage, scale and intensity of the impact – and make a difference in the AI/AN population served. The health sector has shown the capacity to have significant impact in many populations around the world. Strong links exist between the opportunities offered by, and resources available for prevention messages, access and linkages to care, and knowledgeable staff, which illuminates this comparative advantage for the health sector. Good public health also involves utilizing other sectors; however this should not become a barrier to implement a health-sector response – which is the responsibility of our IHS healthcare delivery system. The health sector includes a multidisciplinary team that can address not only the physiological manifestations of a person living with HIV/AIDS, but also the psychosocial and behavioral issues that are encountered with co-existing risk factors, prevention programs, treatment, care and support. It is imperative we avoid complacency and continue our resolve against HIV/AIDS.

Appendices

Appendix 1: HHS Interagency Collaboration Matrix

Department of Health and Human Services / Office of HIV-AIDS Policy (HHS/OHAP):	**National Institutes of Health (NIH)**	**Health Resources and Services Administration (HRSA)**
• Office of HIV/AIDS Policy (OHAP) / Minority AIDS Initiative. POC is Christopher Bates. Yearly proposal process to acquire MAI funding. Currently 6 projects within IHS • National Mobilization Campaign. Promote testing / screening / train speaker's bureau. (Names submitted) • National Native HIV/AIDS Awareness Day March 20, each year. Resources and materials available. Team will assist IHS with planning, coordination, execution of events o Podcasts o Press statement o Public Service Announcements o AIDS.gov spotlight o Presence of senior HHS staff at NNHAD event • Serve on MAI Steering Committee • Involvement of HHS Office of HIV/AIDS Policy on strategic planning initiatives and integrating all HHS initiatives into IHS planning.	• Gather and share information from and for AI/AN researchers. • Coordinate and integrate data collection and evaluation efforts relevant to AI/AN research. • Previously conducted and co-funded National conferences with IHS • Provided resources for support of the Tribal/Community Leadership Advisory Board (T/CLAB) developed subsequent to the 2006 *Embracing Our Traditions Conference* as part of the strategic planning process. • May conduct future AI/AN researcher meetings and/or T/CLAB meetings with NIH funds • Consider integration of NARCH initiatives with NIH funding potential • Draft Memorandum of Understanding (MOU) between NIH and IHS is in development	• Signed MOU with IHS for 3 years beginning 6/7/07 through 6/7/10 • HRSA HAB meets with IHS HIV Principal Consultant about 3-4 times/yr • HRSA Ryan White Policy POC to work with IHS on disseminating RWMA message in clear terms and multimedia. • HRSA AETC POC working with Behavioral Health Trainings • HRSA ADAP POC new contact is Douglas Morgan • HRSA HAB may also serve as TA for curriculum development or grants • Assist with webpage content if requested • Assist with IHS HIV Program strategic planning transparency between agencies

Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Substance Abuse Treatment: • Co-project officers of IHS /SAMHSA National Behavioral Health Conference (annual event and the largest Native American focused training event) HIV/AIDS related-issues are a key component of the conference. • Liaison assistance with Tribe, Tribal Organizations and Indian Health Center to increase capacity for Rapid HIV testing in tribal communities • Provide info / program on Rapid HIV Testing Initiative (RHTI) • Development of clinical skills training such as I/T/U-only testing and counseling training • Collaborating to help implement and disburse MAI funds for rapid testing in AI/AN urban populations • Working with SAMHSA and CDC on training of I/T/U personnel with SAMHSA MAI funding. • Assist with IHS HIV Program strategic planning transparency between agencies • Currently developing an MOU between SAMHSA and IHS to help minimize redundancy.	**Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Substance Abuse Prevention:** • Minority Education Institution Initiative (MEI) • Goal is to prevent the onset or reduce Substance abuse and related HIV and HIV transmission by 10% by 2008. • Working with multiple universities and colleges on this initiative, two of which are Tribal colleges: o Salish Kootenai College, MT o Southwestern Indian Polytechnic Institute, NM • Addresses campus capacity to address preventive health needs • Learned gender-specific interventions • Created collaborations with community partners and local government agencies.	**Centers for Disease Control and Prevention (CDC):** • Annual AI/AN Fact Sheet shared with IHS depicting HIV/AIDS epidemiology from data collected by state public health department. Fact-sheet will go to IHS HIV/AIDS webpage annually. • Division of Adolescent and School Health – Youth Risk Behavior Survey • Division of STD – - Detailed officers and/or to IHS Division of Epi - Red Talon Project, Northwest Portland Area Indian Health Board • CDC Division of HIV/AIDS Prevention Programs: - Fund CBO network of 6 Native Organizations: Alaska Native Tribal Health Consortium (AK), Indigenous Peoples Task Force (MN), Native American Health Center (CA), Life Foundation (HI), Native American Community Health Center (AZ) and Missoula AIDS Council (MT)

Centers for Disease Control and Prevention (continued):	**Dep. Of Health and Human Services – Office of Women's Health:**	**DHHS – Office of Minority Health:** AI/AN Health Disparities Program
• State Health Departments and Indirectly-Funded CBOs • 3 Capacity Building Assistance (CBA) Providers: – Colorado State University's Center for Applied Studies in American Ethnicities www.happ.colostate.edu – Inter Tribal Council of Arizona, Inc. www.itcaonline.com/nshapp – National Native American AIDS Prevention Center www.nnaapc.org • 3 HIV Rapid Testing Demonstration Projects • 3 United States Conference of Mayors' Grants • Aberdeen Area Tribal Chairmen's Health Board Capacity Building STD/HIV/Hepatitis Contract • OMH/IHS Collaborations with Tribal Epi Centers • Tribal Consultation Advisory Committee	• In Community Spirit - Prevention of HIV/AIDS for Native/ American Indian and Alaska Native Women Living in Rural[1] and Frontier Indian Country Program • This initiative is intended to pilot a collaborative partnership approach between the grantee and local health or social service providers, e.g., community health centers, rural health centers, family planning clinics, Indian Health Service (IHS) facilities • The grantees for In Community Spirit are: Navajo AIDS Network, University of South Dakota and Sault Saint Marie Tribe of Chippewa Indians. The 2 tribal colleges are: Southwestern Indian Polytechnic Institute and Salish Kootenai College	• Strengthen the capacity of Tribal Epidemiology Centers (TECs) to collect and manage date more effectively and to better understand and develop the links among public health problems and behavior, socioeconomic conditions, and geography. • TECs funded in FY07: Inter Tribal Council of Arizona, Inc.; Albuquerque Indian Health Board; Seattle Indian Health Board; Aberdeen Area Tribal Chairmen's Health Board; Oklahoma City Inter-Tribal Health Board; and Alaska Native Tribal health Consortium. OMH anticipates funding four additional TECs under in FY08.

Appendix 2: National HIV/AIDS Principal Consultant Functional Responsibilities

This 'reference' narrative and checklist functions to maintain consistency of, and process involved with the Principal Consultant position and orchestration of the IHS HIV/AIDS Program. This will seek to augment a sustainable and strategic implementation plan and process.

Position Title

National HIV/AIDS Principal Consultant

Basic Position Description

A senior member of IHS with extensive knowledge of subject matter (and other related topics), field experience and medical and/or public health background in a multidisciplinary role that can develop, implement, evaluate and coordinate a comprehensive HIV/AIDS program for the American Indian / Alaska Native population. The incumbent must also represent the Agency, Office and Program to the senior Federal, Tribal, State and/or local government agency or nongovernmental authorities as well as Native organizations and community members.

Functional Responsibilities to include (but not limited to):

- National consultant for agency level HIV/AIDS activities, responsible for coordinating, supporting, and/or developing the program for IHS. Serve as Agency technical lead.
- Directs/integrate all aspects of a comprehensive public health HIV/AIDS program
- Agency-level HIV liaison to all Federal, Tribal, State and/or local government agency or nongovernmental authorities and Native organizations and community members.
- Programmatic planning – strategize/shape future direction of national initiatives
- Collect, assess, and disseminate information as widely as possible
- Publish information (when appropriate)
- Develop or review IHS National HIV/AIDS Policy and Guidelines to reflect current guidelines and best medical access and care.
- Maintain subject matter expertise to serve as Agency's national consultant.
- Serve on interagency and departmental level committees
- Design or develop new and innovative ways to augment or enhance the program through analysis, data collection, and identification of successful intervention models.
- Development of curriculum of agency and /or collaborators
- Serve as trainer, faculty, and/or agency-level speaker at multiple regional and/or national venues.
- Manage budget through multiple funding streams and attempt collaborations to increase human and / or financial resources. Identify new funding resources.
- Expand funding streams and facilitate grant proposals and new initiatives to identify and grow limited financial resources within program.
- Develop a structured process of proposals, reporting, and strategic planning for Minority AIDS Initiative program. Maintain or increase funds and the number of approved proposals.

Appendix 3: Acronym List

Acronym	Expanded
ADAP	AIDS Drug Assistance Program
AETC	AIDS Education and Training Centers
AI/AN	American Indian / Alaska Natives
ANMC	Alaska Native Medical Center
APhA	American Pharmaceutical Association
ARV	Antiretroviral
BIA	Bureau of Indian Affairs
CASAE	Center for Applied Studies in American Ethnicity
CBA	Capacity Building Assistance
CBO	Capacity Building Organization
CDC	Centers for Disease Control and Prevention
CoE	Center of Excellence
CRS	Clinical Reporting System
DBH	Division of Behavioral Health
DEBI	Diffusion of Effective Behavioral Intervention
DCCS	Division of Clinical and Community Services
EBI	Effective Behavioral Intervention
EPI	Epidemiology
F/U	Follow-up
GAO	Government Accountability Office
GIMC	Gallup Indian Medical Center
GPRA	Government Performance Results Act
HAART	Highly Active Antiretroviral Treatment
HAB	HIV/AIDS Bureau (HRSA)
HCW	Healthcare workers
HHS	Department of Health and Human Services
HMS	HIV/AIDS Management System
HPDP	Health Promotion / Disease Prevention
HRSA	Health Resources and Services Administration
I/T/U	IHS / Tribal / Urban
IAA	Interagency Agreement
IHS	Indian Health Service
IRB	Internal Review Board
ITCA	Inter Tribal Council of Arizona
KAB	Knowledge / Attitude / Behavior

L&D	Labor and Delivery
M&E	Monitoring and Evaluation
MAI	Minority AIDS Initiative
MEI	Minority Education Institution Initiative
MOU	Memorandum of Understanding
MPH	Masters in Public Health
NARCH	Native American Research Centers for Health
NASTAD	National Alliance of State and Territorial Health Directors
NCPS	National Clinical Pharmacy Specialist
NIH	National Institutes of Health
NIHB	National Indian Health Board
NNAAPC	National Native American AIDS Prevention Center
OAR	Office of AIDS Research
OCPS	Office of Clinical and Preventive Services
OHAP	Office of HIV/AIDS Policy
OIT	Office of Information Technology
OPHS	Office of Public Health Support
POC	Point of Contact
PEP	Post-Exposure Prophylaxis
PIMC	Phoenix Indian Medical Center
PLWH / A	People Living with HIV/AIDS
QOC	Quality of Care
RHTI	Rapid HIV Testing Initiative
RPh	Registered Pharmacist
RPMS	Resource and Patient Management System
RW	Ryan White Program
RWMA	Ryan White Treatment Modernization Act 2007
SAMHSA	Substance Abuse and Mental Health Administration
SGM	Special General Memorandum
SPNS	Special Projects of National Significance
STD	Sexually Transmitted Disease
T/CLAB	Tribal / Community Leadership Advisory Board
TA	Technical Assistance
TDY	Temporary Duty
TEC	Tribal Epidemiology Centers
UIHI	Urban Indian Health Initiative
UNAIDS	Joint United Nations Programme on HIV/AIDS

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