HIV Systems Assessment:
Consortium #1 (Cleveland) &
Cleveland Transitional Grant Area (TGA)

CUYAHOGA REGIONAL HIV SERVICES PLANNING COUNCIL

April 2007

Overview of HIV Systems Assessment

Agenda
Findings, Conclusions & Recommendations

I. Project Introduction
II. Impact of Ryan White Treatment Modernization Act of 2006
III. Background: Hypotheses
IV. Funding of HIV Care
V. Planning for HIV Care
VI. Service Delivery of HIV Care
    I. Focus on two (2) core services:
        a) Outpatient Primary Medical Care
        b) HIV Case Management
            I. Ramifications of Medical HIV Case Management
    II. Provider
        a) Capacity
        b) Accessibility
        c) Acceptability
VII. Conclusions & Recommendations

Project Introduction

HIV Systems Assessment: Consortium #1/Cleveland TGA

- Conducted Assessment of HIV Systems of Care (regardless of funding source) in the 6-county Cleveland TGA, with comparison to the 5-county Consortium #1, the other ten (10) Consortia, and Ohio. researched other funding sources including SAMHSA, Healthcare for the Homeless, SPNS, Medicaid, Medicare, and private insurance.
- Evaluated:
  - Impact of Ryan White Treatment Modernization Act
  - Funding Sources
  - Planning Processes/Bodies
  - Service Delivery System
    - Providers
      - Capacity
      - Accessibility
      - Acceptability
- Recommended possible resolutions to:
  - Retain TGA status post 2009
  - Maintain or Enhance Funding
  - Improve or Consolidate Planning process
  - Ensure Service Delivery System is
    - Sized to fit Capacity/Demand
    - Accessible to Clients
      - Measure by 3 Regions in Cleveland TGA
    - Acceptable to all Clients
- Determined client input (involved and not involved in Planning processes) regarding Funding; Planning; Service Delivery System (Capacity, Access, Acceptability) in all three (3) regions with participation by **66 PLWHA.**

CONSORTIA	AREA	# OF COUNTIES
1	Cleveland	5
2	Columbus	7
3	Cincinnati	16
4	Dayton	6
5	Toledo	8
6	Akron	3
7	Youngstown	4
8	Canton	6
9a	Rural counties: Lima area	11
9b	Rural counties: Mansfield area	10
9c	Rural counties: Athens area	20
TOTAL		88

Impact of Ryan White Modernization Treatment Act

- The Cleveland EMA became a Transitional Grant Area (TGA) (no hold harmless clause, lower funding pool, less access to Supplemental/Competitive funds).
- Danger to Ryan White eligibility if a TGA fails to clear the 1,000-1,999 bar for the past 5 years of newly diagnosed AIDS cases (Cleveland at 806, would be 947 if Summit & Portage counties were added to TGA).
- Current mandate to retain representative Planning Council, absolved for five (5) 'new TGAs' (were Emerging Communities under Ryan White Title II [Cincinnati & Columbus still ECs] – cumulative 5 years of AIDS cases between 500 and 999).
- In addition to newly diagnosed AIDS threshold of 1,000-1,999 to qualify as TGA, overall population must be 50,000 or over (was 500,000).
- Formula funding now is half of EMA/TGA (Title I) funds (was 2/3). Supplemental or competitive funds are reduced to 1/3 from 50% of total award.
- Formula award made at the beginning of the Fiscal or Grant Year (March 1), Supplemental now staggered to end of April and Minority AIDS Initiative to August (also MAI restricted to Capacity Building vs. apportioned to Treatment & Care)

Background

Hypotheses: Stated Issues

AREAS OF CONSENSUS	AREAS OF DISAGREEMENT	AREAS THAT ONE OR BOTH DON'T CARE ABOUT (BUT SHOULD)	NEW AREAS OF CONCERN
* PLWHA involvement throughout the process * Need to preserve funding for Ohio PLWHA * Use of Priority Setting process to allocate Resources * Need to place voice of consumer in process through annual Needs Assessment.	* Gatekeeper model * Emergency/ episodic care vs. continuous care model * Emergency Financial Assistance to allocate resources for services * Use of 'up-front' EFA by providers (Pot 15) * Audit/QM process * Unmet Need estimate	* Service unit definition of 'core' services (II) * Epidemiologic Profile as Foundation of Formula funding * Quantifiable QM (II) * Rules based ADAP qualification (II) * Severity of Need Index/ Severe Need Groups/ Stage of Disease. Complexity & Cost of Care * Importance of Needle Exchange Program (II)	* Title I meeting new AIDS case threshold of at least 1,000 new AIDS cases over 5 years * Possible assumption of RW into Medicaid in FY 2009

Brief Epidemiologic Overview

CLEVELAND TGA / CONSORTIUM #1 (CLEVELAND)

HIGHLIGHTS FROM 2005

- The total of new AIDS diagnoses 8% from 155 to 169 from 2004 to 2005. This figure has risen, however, by 7.6% in the five year period**.**
- While Cuyahoga county continues to experience the highest overall numbers and the highest AIDS case rate (rate per population); significant spikes have been experienced in the rest of the TGA (Lake, Lorain-2004, Ashtabula (2003).
- The Cleveland TGA represents 27.2% of new AIDS cases over the five years from 2001-2005 and 21.3% of HIV cases in 2004.
- Cuyahoga County has 22% of all PLWHA in Ohio, the highest PLWHA case rate (220.9 individuals per 100,000 population, with ¼ (25%) of all PLWHA in Title II Consortia.

HIV/AIDS Prevalence

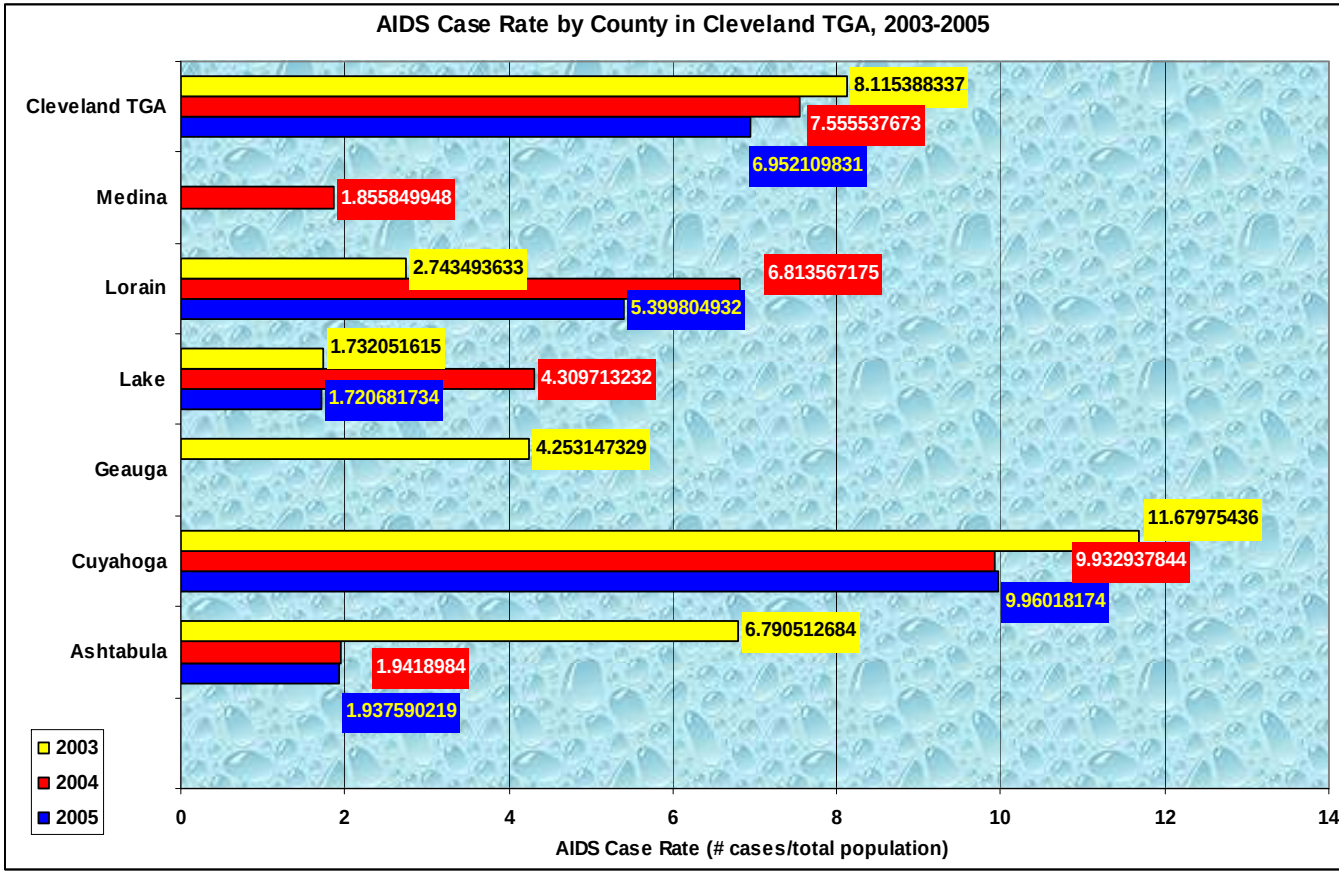
COMPARISON OF CLEVELAND TGA/CONSORTIUM #1 TO OHIO

- The Cleveland TGA and Consortium #1 had 26% of all living (prevalent) PLWHA in 2004 in Ohio.
- The Cleveland TGA and Consortium #1 have a slightly higher male fraction of PLWHA.
- The Cleveland TGA and Consortium #1 have an 11% lower Anglo population, 10% higher African American, 2% higher Hispanic and 1% higher multiracial composition or a profile dominated by people of color (60% by race, 64% by race and ethnicity) versus Ohio. (49% minority by race and 55% by race and ethnicity)
- The Cleveland TGA and Consortium #1 have an older PLWHA composition than the rest of Ohio
  (41% over 45 years of age versus 31% for Ohio)

AIDS Incidence

NEWLY DIAGNOSED AIDS CASES PER 100,000 POPULATION

AIDS Case Rate (2003-2005)
Cleveland TGA



AIDS Incidence

NEWLY DIAGNOSED AIDS CASES – IMPORTANCE

COUNTY	2001	2002	2003	2OO4	2005	TOTAL
Ashtabula	3	2	7	2	2	16
Cuyahoga	129	139	159	134	133	694
Geauga	1	1	4	0	0	6
Lake	5	5	4	10	4	28
Lorain	5	9	8	20	16	58
Medina	1			3		4
	144	**156**	**182**	**169**	**155**	**806**

Portage	2	3	3		3	11
Summit	30	20	29	30	21	130
TOTAL	**32**	**23**	**32**	**30**	**24**	**141**

947

HIV/AIDS Prevalence

RYAN WHITE TITLES EPI PROFILE (TITLE I- TGA & TITLE II-CONSORTIA)

Client Gender

Gender	Cleveland TGA	%	Consortia #1 (minus Medina)	%	Ohio	%
Male	2,917	77%	2,893	76.7%	10,878	74%
Female	885	23%	880	23.3%	3,689	25%
Transgender					48	1%
TOTAL	**3,802**	**100%**	**3,772**	**100%**	**14,615**	**100%**

Client Race

Race/Ethnicity	Cleveland TGA	%	Consortia #1 (minus Medina)	%	Ohio	%
White	1,372	40.1%	1,348	39.8%	7,158	51%
Black	1,920	55.2%	1,915	56.7%	6,257	45%
Asian	16	0.5%	16	0.5%	34	1%
Native American	6	0.2%	6	0.2%	52	1%
Multirace	101	2.9%	101	2.9%	530	4%
TOTAL	**3,415**	**100%**	**3,386**	**100%**	**14,031**	**100%**

HIV/AIDS Prevalence

RYAN WHITE TITLES EPI PROFILE (TITLE I- TGA & TITLE II-CONSORTIA #1)

Client Ethnicity

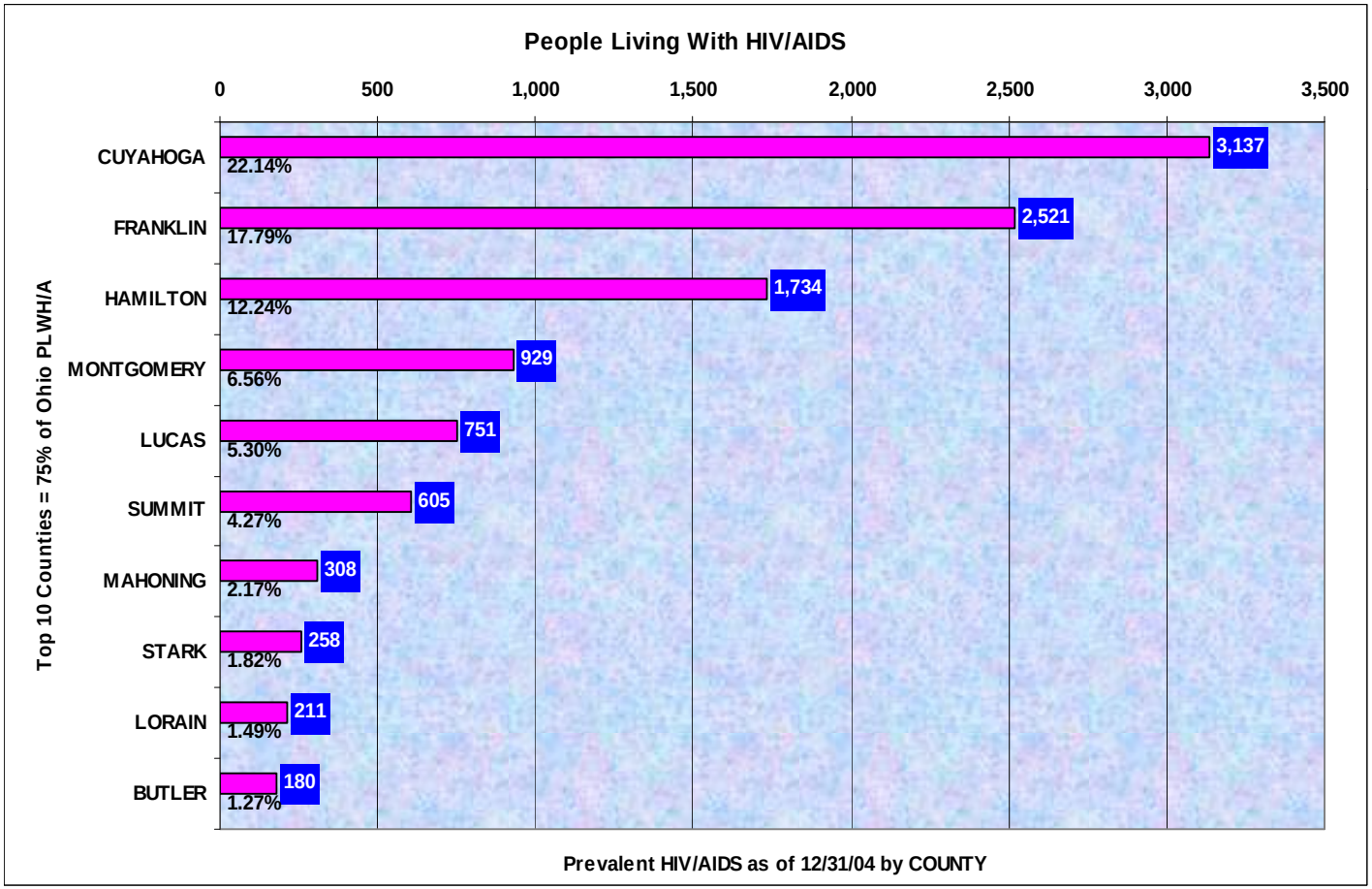
Gender	Cleveland TGA	%	Consortia #1 (minus Medina)	%	Ohio	%
Hispanic	387	10%	387	10%	1,129	8%
Non-Hispanic	3,415	90%	3,386	90%	13,329	92%
TOTAL	**3,802**	**100%**	**3,772**	**100%**	**14,458**	**100%**

Client Age

Race/Ethnicity	Cleveland TGA	%	Consortia #1 (minus Medina)	%	Ohio	%
< 13 years	30	0.8%	30	0.8%	826	5.7%
13-19	33	0.9%	33	0.9%	931	6.4%
25-44	2,192	57.7%	2,182	57.9%	8,276	56.9%
45+	1,547	40.7%	1,538	40.8%	4,505	30.9%
TOTAL	**3,802**	**100%**	**3,772**	**100%**	**14,538**	**100%**

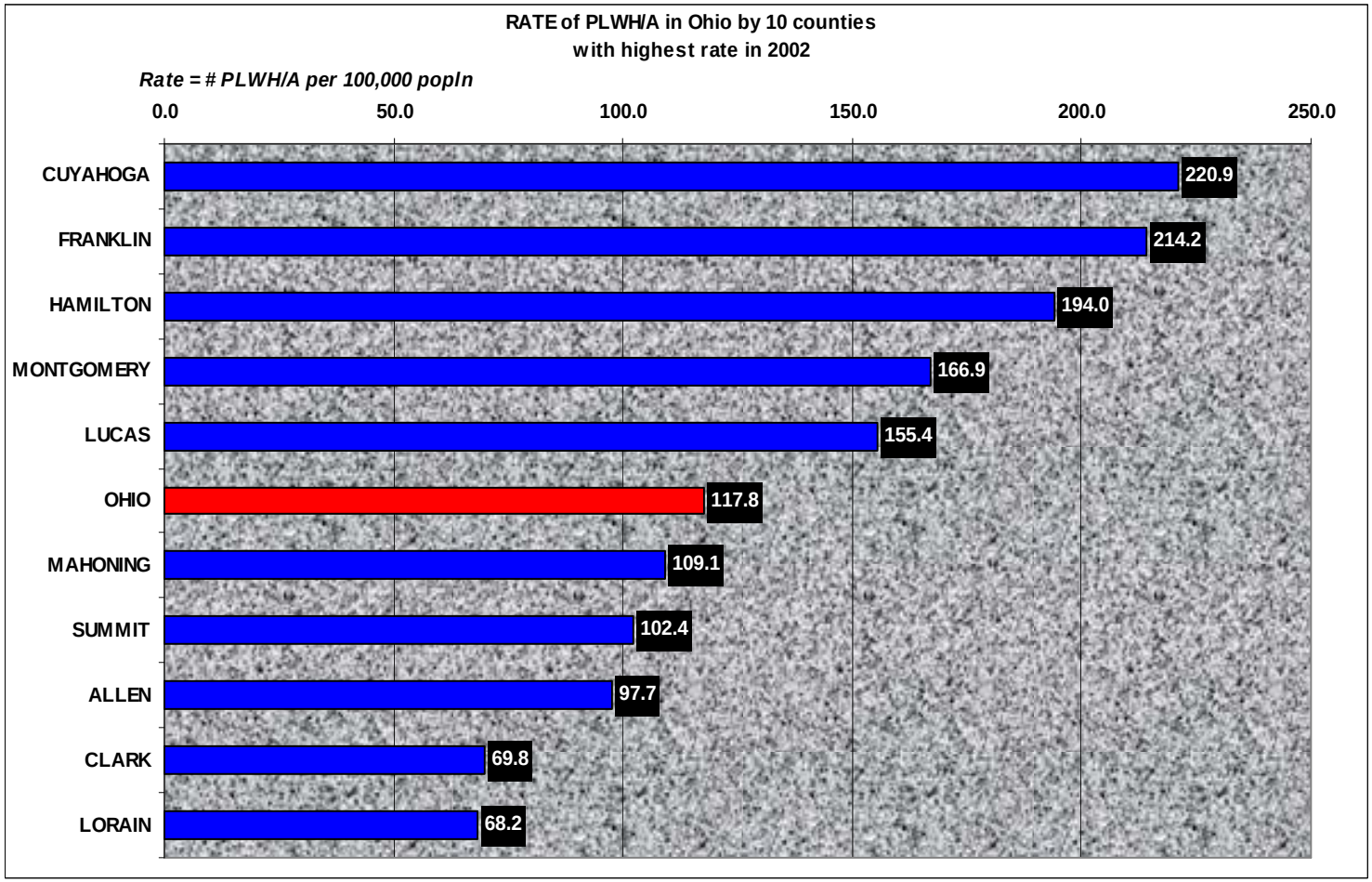
HIV/AIDS Prevalence Comparison

TOP OHIO COUNTIES - 2004



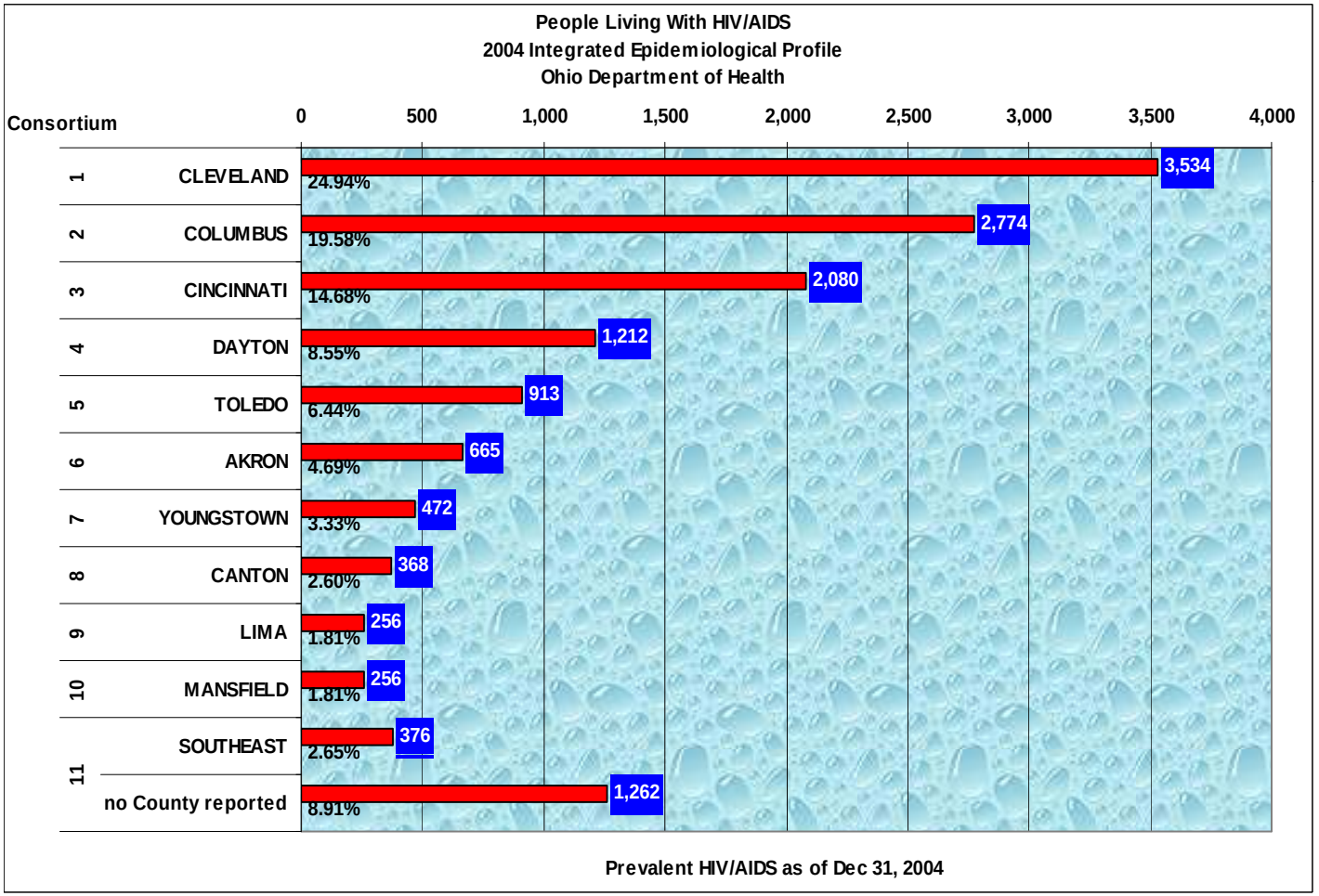
HIV/AIDS Prevalence Comparison

TOP OHIO COUNTIES BY RATE (PLWHA/TOTAL POPULATION) - 2004



HIV/AIDS Prevalence Comparison

BY CONSORTIA IN OHIO - 2004



Current Disparities by County

CURRENT HEALTH SYSTEM DISPARITIES

RACE/ETHNIC GROUP	ASHTABULA	CUYAHOGA	GEAUGA	LAKE	LORAIN	MEDINA	EMA	OH	Newly Dxed AIDS	PLWA	PLWH			
White	94.1	67.4	97.4	95.4	85.5	97.3	89.5	85	35%	38%	34%			
Black	3.2	27.4	1.2	2	8.5	0.9	7.2	11.5	55%	50%	51%	7.638889	6.944444	7.083333
Hispanic	2.2	3.4	0.6	1.7	6.9	0.9	2.6	1.9	9%	11%	9%	3.461538	4.230769	3.461538
Asian	0.3	1.8	0.4	0.9	0.3	0.6	0.8	1.2	0.32%	0.40%	0.50%			
Native American	0.2	0.2	0.1	0	0	0.6	0.2	0.2						
Multiracial	1.4	1.7	0.7	0.9	2.2	0.8	1.3	1.4	0.70%	0.60%	5.50%			
	101.4	**101.9**	**100.4**	**100.9**	**103.4**	**101.1**	**101.6**		**100.0%**	**100.0%**	**100.0%**			

GENDER	ASHTABULA	CUYAHOGA	GEAUGA	LAKE	LORAIN	MEDINA	EMA	OH	Newly Dxed AIDS	PLWA	PLWH			
Male	48.7	47.2	49.2	48.6	49.1	49.3	48.7	48.6	74%	79.8%	77%	1.519507	1.638604	1.581109
Female	51.3	52.8	50.8	51.4	50.9	50.7	51.3	51.4	26%	20.2%	23%			
TOTAL	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**			

AGE GROUP	ASHTABULA	CUYAHOGA	GEAUGA	LAKE	LORAIN	MEDINA	EMA	OH	Newly Dxed AIDS	PLWA	PLWH			
0-12	17.2	17.1	15.1	14.3	16.9	16.2	16.1	16	1%	0.66%	0.92%			
13-19	16.1	15.7	19.8	16.8	16	18.3	17.1	14.7	1%	0.45%	1.30%			
20-44	28.5	29.5	26.5	29.9	29.4	30.6	29.1	29.4	73%	55.05%	64.07%	2.508591	1.891753	2.201718
45+	38.2	37.7	38.6	39	37.7	34.9	37.7	39.9	26%	43.85%	33.71%		1.16313	
TOTAL	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**			

Epidemiology

CONCLUSIONS & RECOMMENDATIONS

1) Seriously consider consolidating Consortium #6 (Medina, Portage & Summit counties) into Consortium #1 (Cleveland-Ashtabula, Cuyahoga, Geauga, Lake & Lorain counties)

RESULT: maintenance of TGA status through meeting 1,000 newly diagnosed AIDS cases over prior 5-year period (without: 806)

2) Focus on emerging group of IVIDU among young males throughout the Cleveland TGA (historic home has been Lorain county/Western region among Latinos, recent witness of spread to Anglos and heterosexual transmission; now witnessing emergence in larger numbers among Anglo and African American MSM and males in Cuyahoga County (Central region).

Re-address need for needle exchange program.

RESULT: reduce secondary transmission to heterosexual population.

3) Jointly (all Ryan White Titles) address potential impact of conversion to full HIV-based formula funding vs. AIDS-based funding.

RESULT: A 2004 General Accounting Office (GAO) study estimates the impact to the Cleveland TGA of converting to a HIV-based formula as positive, in the range of $610,000-940,000 in incremental funds or a 33% increase.

Ohio (Ryan White Title II) would have a similar increase, with an increment from $640,000 - $940,000 or a 15% increase.

Funding

FUNDING SOURCES FOR HIV/AIDS CARE

NATIONAL FUNDING FOR HIV/AIDS CARE:

- 29 percent Medicaid only
- 12-13 percent dually eligible for Medicaid and Medicare (Medicare Part D)
- 6 percent Medicare only
- 31 percent private insurance
- 20 percent uninsured

Source: Kaiser Family Foundation

OHIO FUNDING FOR HIV/AIDS CARE:

- 32 percent Medicaid only
- 11 percent dually eligible for Medicaid and Medicare (Medicare Part D)
- 7 percent Medicare only
- 19 percent private insurance
- 31 percent uninsured

Source: Kaiser Family Foundation

Funding: Comparison of Federal Source for HIV/AIDS

FEDERAL FUNDING SOURCE/RANK & RYAN WHITE TITLE SPECIFIC COMPARISON

AREA	CDC HIV/AIDS Funding	HOPWA Funding	SAMHSA HIV/AIDS Funding	OMH HIV/AIDS Funding	Ryan White CARE Act Funding	Total
Ohio	$ 5,814,704	$2,947,000	$2,659,506	$349,983	$25,134,624	$36,905,817
RANK	#22	#17	#13	#9	#18	#18
U.S. (2005)	$507,482,021	$288,431,177	$116,862,616	$8,765,224	$1,983,796,235	$2,905,337,273
	AIDS Case Rate	**New AIDS Cases**	**PLWA, All Ages**	**TOTAL ADAP Clients**	**Annual Reported HIV Infections***	**Cumulative Reported HIV infections***
Ohio	#31	#14	#16	#15	#9	#9

RYAN WHITE TITLE I & II FUND RANKING BY SUB-CATEGORY (FY 2006):

	FY 2006 TOTAL $	FORMULA	SUPPLEMENTAL	MAI	
Cleveland TGA (RWT1)	**#38/51**	**#39/51**	**#40/51**	**#33/51**	
	FY 2006	**BASE**	**ADAP**	**MAI**	**EC**
Ohio (RWT2)	#18/59 (59 rec'd funds)	#16/59 (59 rec'd funds)	#20/59 (54 rec'd funds)	#16/59 (51 rec'd funds)	#7/59 (18 rec'd funds

Funding: CARE Act funds to 'Urban Areas'

CLEVELAND TGA (TITLE I) FUNDING TREND (1996-2006)

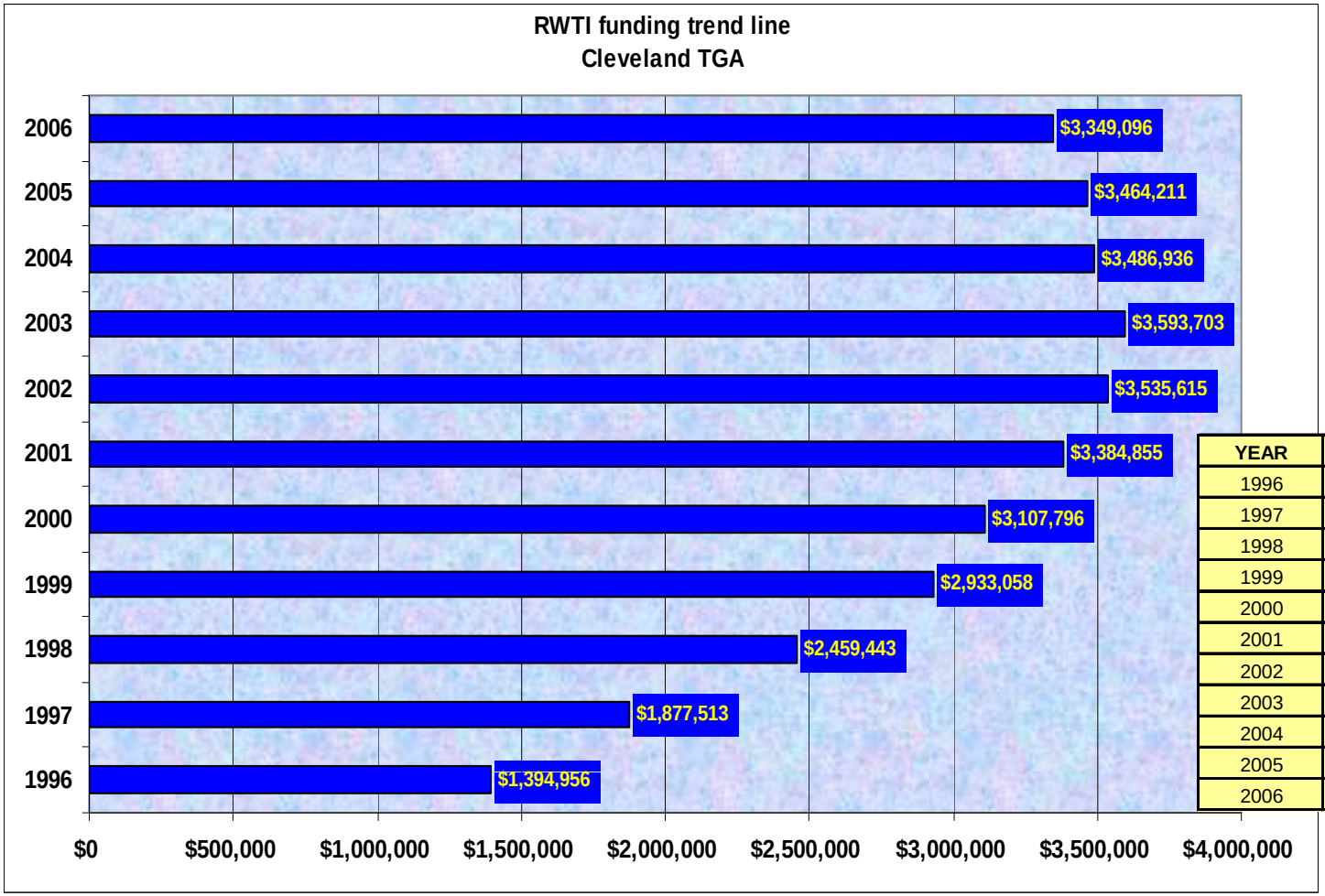
Ryan White Title I

Program Review

Program Year	Nationwide	Nationwide	Cleveland EMA	Contracted	Cleveland EMA % of National
1991	$86,083,000	16			
1992	$119,426,000	18			
1993	$182,326,998	25			
1994	$319,989,000	34			
1995	$349,370,000	42			
(first local grant) 1996	$372,141,000	49	$1,394,956	11	**0.38%**
1997	$429,377,900	49	$1,877,513	12	**0.44%**
1998	$445,176,000	49	$2,459,443	17	**0.55%**
1999	$485,816,900	51	$2,933,058	18	**0.60%**
2000	$526,811,000	51	$3,107,796	23	**0.59%**
2001	$582,727,700	51	$3,384,855	24	**0.58%**
2002	$597,256,000	51	$3, 535,615	19	**0.58%**
2003	$599,513,000	51	$3,593,703	18	**0.60%**
2004	$595,342,001	51	$3,486,936	18	**0.59%**
2005	$587,425,500	51	$3,464,211	18	**0.59%**
2006	$579,686,392	51	$3,349,096	18	**0.57%**
Total over 11 years of RWTI:	**$5,801,273,393**		**$29,051,567**		**0.50%**

Cleveland TGA (Title I) Trend

CLEVELAND TGA (TITLE I) TREND – 1996-2006



YEAR	$	% change
1996	$1,394,956	0%
1997	$1,877,513	26%
1998	$2,459,443	31%
1999	$2,933,058	19%
2000	$3,107,796	6%
2001	$3,384,855	9%
2002	$3,535,615	5%
2003	$3,593,703	2%
2004	$3,486,936	-3%
2005	$3,464,211	-1%
2006	$3,349,096	-3%

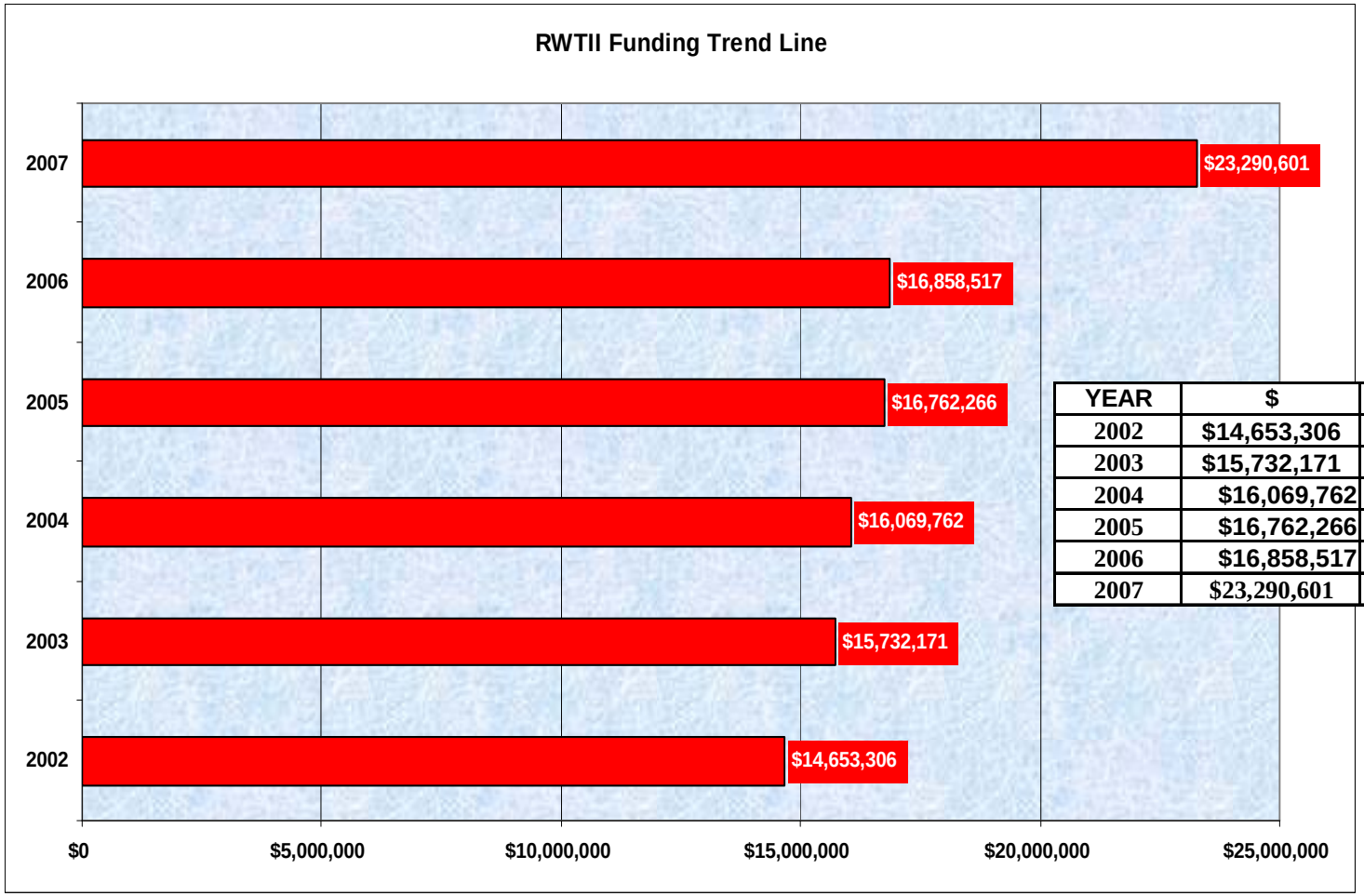
Funding: CARE Act funds to 'States'

OHIO TITLE II FUNDING TREND (2004 TO 2007)

Program Year	Total Dollars	Total National $	Ohio as % of Nation
2004	**$16,069,762**	**$1,032,405,270**	**1.6%**
ADAP	$10,909,930	$742,535,408	1.5%
Emerging Communities	$294,660	$9,012,155	3.3%
Base	$4,865,172	$280,857,707	1.7%
2005	**$16,762,266**	**$1,050,886,747**	**1.6%**
ADAP	$10,909,930	$ 748,862,744	1.5%
Emerging Communities	$ 336,063	$ 10,000,000	3.4%
Base	$ 5,516,273	$ 292,024,002	1.9%
2006	**$16,858,517**	**$1,068,939,364**	**1.6%**
ADAP	$11,455,538	$ 779,750,980	1.5%
Emerging Communities	$456,668	$10,000,000	4.6%
MAI	$82,000	$6,858,000	1.2%
Base	$4,864,310	$272,330,384	1.8%
2007	**$23,290,601**	**$1,104,710,500**	**2.1%**
ADAP	$14,529,892	$775,320,700	1.9%
Emerging Communities	$673,243	$5,000,000	13.5%
Base	$8,087,466	$324,389,300	2.5%

Ohio (Title II) Funding Trend Line

OHIO TREND (TITLE II) – 2002 TO 2006



YEAR	$	% Change
2002	$14,653,306	
2003	$15,732,171	7%
2004	$16,069,762	2%
2005	$16,762,266	4%
2006	$16,858,517	1%
2007	$23,290,601	38%

Funding

OTHER FEDERAL FUNDING SOURCES

- HIV Prevention: Community Development Block Grant (CDBG) funded by the Centers for Disease Control, administered by the City of Cleveland Department of Public Health.
- HOPWA: (Housing Opportunities for Persons With AIDS) funded by the Department of Housing & Urban Development (HUD), administered by the City of Cleveland Department of Public Health through a grants program in which providers can apply to provide various housing programs.
- Medicare
  - Medicare Part D (dual eligibles)
  - SSI (Supplemental Security Income)
  - SSDI (Supplemental Security Disabled Income)
- Medicaid: (TANF or Temporary Aid to Needy Families), joint Federal: State matching program (60%: 40% in Ohio) administered through regional branches of the Ohio Department of Jobs & Family Services (ODJFS). Majority of Medicaid is through the categorical entitlement under ABD (Aged, Blind & Disabled).
  - Medicaid Spend-Down
  - Medicaid Re-determination

Funding

ISSUES WITH FUNDING SOURCES FOR HIV/AIDS CARE (NATIONAL/OHIO)

- Medicaid
  - In a recently released study, Ohio ranked **35th out of 50 states for eligibility** and earn only 41.4 percent of the maximum point value, as a result of its exclusion of individuals whose higher-than-standard income is offset by extreme medical expenses and its failure to cover those receiving state supplemental payments.

	OH score	Total Points
Coverage of the aged, disabled and blind	**30.6**	**91.9**
Coverage offered	15.3	30.6
State supplemental payments based on financial status	0	30.6
Supplemental security income based on financial status	15.3	30.6

  - With respect to **reimbursement, Ohio ranks 36th.** Although it pays its Medicaid providers close to the national mean, its fees are lower than those paid to Medicare physicians, the overall ratio between the two being .68.

Source: Unsettling Scores: A Ranking of State Medicaid Programs, 2007 http://www.citizen.org

- Medicare Part D was intended to improve treatment access for Medicare recipients, but it may be doing the opposite for HIV-infected patients, according to preliminary results from an informal survey of U.S. HIV health care providers conducted by the American Academy of HIV Medicine and the HIV Medicine Association. Bureaucratic hurdles, high co-pays and plans that won't cover necessary medications prevent many HIV-infected patients from getting their antiretrovirals and other drugs, the survey found. Of the 561 HIV health care providers who answered the survey, 83% said their HIV-infected patients had trouble getting their prescriptions filled since joining a Medicare drug plan. Seventy-nine percent also said they were spending more time now than before making sure Medicare patients obtained their medications.

Source: “HIV Medical Provider Medicare Part D Survey," www.aahivm.org.

Funding

ISSUES WITH FUNDING SOURCES FOR HIV/AIDS CARE (CLEVELAND TGA/CONSORTIUM #1)

CONSUMER

- 21/72 or 29.2% of Focus Group respondents had interrupted Medicaid coverage due to an issue with re-determination
- 15/72 or 21% of Focus Group respondents dealt with Medicaid spend-down and 4 were eligible (but had not been informed—private practice)
- Outside Ryan White system of care, only resources that PLWHA are aware of/access are 'core' services of Primary Medical Care, Labs and Meds.
- Of 9 private practice, 5 qualified for assistance with copay, only 2 were aware of this qualification. (2/5 = 40% aware, 3/5 = 60% unaware)

FUNDER/PROVIDER

- Pot 15 is serious issue for Cleveland TGA: In GY 2006, ODH interpreted mandates to HRSA to put dollars into core services by centralizing all services (vs. allocation by Consortia) except for Transportation, Housing & Nutrition
- Allocations to Consortia are now 20% vs. historical 50%, remainder 'paid' to Consortia through contract with the Board of Cuyahoga County Commissioners AFTER up-front expenditure (reconciliation)
- Monies should be directly fund Consortia, with allocations made through priority setting process.
- Key issues:
  (1) EFA as resource determinant
  (2) Case managers functioning as gatekeepers
  (3) Assumption that agencies will up-front funds followed by reconciliation

Funding

CONCLUSIONS & RECOMMENDATIONS

Funds Flow:

1) Ohio experienced a dramatic increase in Title II funds from 2006 to 2007 (38%), and should:

- **a) Eliminate the 'Pot 15' hold of funds to the Cleveland TGA**
- **b) Both Title II and I should reconsider division of funds by Service Category given new definitions of core services**
- **c) Re-consider (Title II) GY 2006 decision to centralize all services (vs. Consortia allocation of funds to services) limiting Consortia control to three services: Nutrition, Transport and Housing.**

2) Ohio's relatively low AIDS Case Rate (#31). Shows that despite high ranking in new AIDS cases (#14), PLWA (#16), Total ADAP (#15), Annual Reported HIV Infections (#9) and Cumulative Reported HIV Infections (#9); the population size reduces funds based on an AIDS-based definition—study the impact of conversion to HIV-based formula.

3) Include Ryan White Title III funded entities in all discussions

4) Continue to expand/explore other funding sources (Healthcare for the Homeless, SAMHSA, CDC & NIH)

Policy-Related to Funding:

1) Medicaid Waiver: Most people with HIV who qualify for Medicaid meet the program's income and disability standards once their illness has progressed. Many low income people with HIV have their eligibility postponed until they become disabled, even though there are therapies available that may prevent disability and national treatment guidelines recommend access to early treatment. 1115 Waivers and TWWIIA demonstrations are two ways in which states have sought to address this limitation.

a) **1115 waiver** - Section 1115 of the Social Security Act authorizes the executive branch of the Federal government to waive the statutory and regulatory provisions of the Medicaid program. States have used "1115 waivers" to make changes in eligibility, benefits, and other areas of their Medicaid programs. The Centers for Medicare and Medicaid Services and several states have been analyzing the implications of expanding Medicaid eligibility to people with HIV prior to disability through the use of Section 1115 waivers of the Social Security Act. To use 1115 waivers, states face several challenges, particularly the need to demonstrate "budget neutrality" to the Medicaid program - that the costs of an expansion over a designated period of time (usually 5 years) would not exceed the costs to Medicaid in the absence of the expansion.

b) **TWIIA waiver** -Ticket to Work/Work Incentives Improvement Act of 1999: TWWIIA expand State options under Medicaid by creating new Medicaid buy-in options for working individuals with disabilities and extended Medicare coverage for working individuals with disabilities. The Act also authorizes state demonstration programs to provide Medicaid to workers with potentially severe disabilities, including HIV/AIDS, who are not yet disabled but whose health conditions could be expected to cause disability.

2) Enhance Medicaid provider reimbursement to equivalent level of Medicare fee schedule

Planning

CURRENT PLANNING BODIES (3) BY FUNDING SOURCE – DIRECT HIV Care

Funding Source	Planning Body	Representation	Stated Purpose	Meeting Schedule
Ryan White Title I: HRSA through the HIV/AIDS Bureau	Cuyahoga Regional HIV Services Planning Council	The Council is a **40 person** planning body which must maintain at least 33% membership of persons living with HIV/AIDS whose members are appointed by the Cuyahoga County Commissioners.	A federally mandated planning body responsible for determining service categories, and service allocations for persons living with HIV/AIDS in the Cleveland area	3rd Wednesday of month at 5:30-7:30 p.m.
Ryan White Title II: HRSA through the HIV/AIDS Bureau	*CARE Coordination Council:* *Consortium #1*	*State:* CARE Coordination Council Two (2) consumers by region; **35 representatives** and 13 working subcommittees. *Consortium #1:* Mirror epidemic in Consortium (54% AA, 37% White, 9% Latino(a): 77% Male and 23% Female—at least 25% of membership is PLWHA; member from each county (5) in Consortium; member all programs; representative prevention planning group (CPG or RAG) – **14 voting members (avg 6 guests)**	*Council:* "To coordinate HIV/AIDS care services and service delivery in Ohio, and to enhance the quality of these services through collaboration of providers, funders, consumers and communities affected by the virus. Consortia: To monitor & assure the coordination of services between HOPWA (City of Cleveland),	3rd Thursday of every month except Feb, July, Sept & Dec @ 2-4 p.m.

Planning

CURRENT PLANNING BODIES (2) – Prevention & Indirect Funding/Practice

Funding Source	Planning Body	Representation	Stated Purpose	Meeting Schedule
HIV Prevention: City of Cleveland Department of Public Health is one of nine (9) regional areas with funds provided by the Ohio Dept. of Health (29%) and from the Center for Disease Control & Prevention (CDC) (71%)	Regional Advisory Group for HIV Prevention (RAG) Group:	**35 people**	Provides leadership that builds capacities in agencies that are dedicated to developing and mobilizing community resources to prevent the transmission of HIV. The Health Dept. distributes dollars to community-based organizations for HIV prevention and education programming	2nd Thursday of the month but not in January, February, June & July.
AIDS Funding Collaborative: Private Foundation funds	AIDS Funding Collaborative	Board: Funding partners, Community At Large & designated community organizations (21, 19 voting members)	Capacity Building	
PRACTICE NOT POLICY GROUP				
HIV Case Managers	*Network or Care Coordinator meeting*	**25-30 participants**		2nd Wednesday of every month at 2pm at the Free Clinic

Recommendations

Correlation to Comprehensive Strategic Plan

GOALS FOR 2003-2005 & 2006-2008

2003 - 2005

I. GOAL: Increased coordination of all Titles, Private Foundations, City of Cleveland, County and State funding sources for People Living With HIV/AIDS (PLWH/A)
II. GOAL: Develop a system of improved client access to the local Continuum of Care through education and awareness of the Title I Program
III. GOAL: Assess quality of care for PLWH/A in the Cleveland EMA
IV. GOAL: Develop enhanced Needs Assessment and Priority Setting process for Cleveland EMA that determines the Health Care and Social Service needs of PLWH/A in the community
V. GOAL: The 40-member Planning body is reflective of the Epidemiologic Profile and knowledgeable about the Ryan White CARE Act.

2006 - 2008

I. GOAL: Strategies for identifying individuals who know their HIV status but are Not in Care ("Aware and Not In Care")
II. GOAL: Response to Managed Care Environment Particularly Medicare Part D
***III.* GOAL: Disparities in Care Based on higher disease incidence/prevalence vs. general population**
IV. GOAL: Secondary Prevention

Unmet Need Estimate

UNMET NEED ESTIMATE – FY 2005

Row	Population Size	Value	%	Data Source
Row A.	# of Persons Living With AIDS (PLWA) as of December 31, 2003	1,686		HIV/AIDS Surveillance Data: Ohio Department of Health Reporting System – 12/31/2003
Row B.	# of Persons Living With HIV (PLWH) as of December 31, 2003	1,979		HIV/AIDS Surveillance Data:Ohio Department of Health Reporting System – 12/31/2003
	Care Patterns			
Row C.	# of PLWA who received the specified HIV primary medical care service during the 12-month period Jan 1, 2003 – Dec 31, 2003	1,157		Title I and other primary medical care providers actual client service data for calendar year 2003.
Row D.	# of PLWH/non-AIDS who received specified HIV primary medical care services from Jan 1 – Dec 1, 2003	1,736		Title I and other primary medical care providers actual client service data for calendar year 2003.
	Calculated Results			
Row E.	# of PLWA who did not receive primary medical care	529	31%	# of PLWA – # of PLWA who received care (Value A – Value C) = # of PLWA who did not receive PMC % = Value E./Value A
Row F.	# of PLWH who did not receive primary medical care	243	12%	# of PLWH-# PLWH who received PMC (Value B-Value D). % = Value F/Value B
Row G.	Total HIV/Aware not receiving primary medical care	**772**	**21%**	# of PLWH/A not receiving PMC = Value E+F/Value A + B. % - Value G/Value A + B

ODH estimates that the Unmet Need for the 5-county area comprising Consortium #1 (Cleveland) – excluding Medina county -- is 68% of PLWH (977), 43% of PLWA (799) for an overall Unmet Need Estimate of 54% (1,776 PLWHA) or 2.3 times that of the Cleveland TGA estimate. The TGA is slightly differently defined than Consortium #1, comprised of 6-counties versus 5. (Medina is in the TGA but not in Consortium #1).

Policy Issues for TGA and State to Explore

1) Needle Exchange Program for IVIDU
    a) *Local governments have interpreted state law* to allow needle exchange programs, but no programs currently exist. This is the most egregious and frustrating area, in that multiple efforts by area providers and administrators have been invested to change this practice. No support is evident at the state level for actual enactment of needle exchange programs despite the rising incidence of IVIDU. (compare: 32 states have needle exchange programs and the American Medical Association has endorsed syringe exchange to reduce HIV infection/prevent secondary transmission)
2) Medicaid Program Expansion for HIV/AIDS
    a) Ohio has not investigated either 1115 or Ticket to Work Initiative waivers, probably due to the rapid escalation in percent of Medicaid in the State budget and the high (40%) cost share
3) More Aggressive HIV Testing for ¼ that are HIV+ and Unaware
    a) Voluntary Opt/Out
    b) Expansion to Portals of Entry
    c) Non-facility based HIV Counseling & Testing
4) Minors Right to Consent
    a) Ohio, with all 50 states, allows minors to consent to STD testing.
    b) In addition, compared to 30 states, Ohio explicitly allows consent to HIV testing
5) Criminal Statutes on HIV Transmission
    a) Ohio criminalizes HIV transmission as a fourth degree felony (compare: 28 states)
6) Sex/HIV Education
    a) Ohio does NOT mandate sex education, and if taught voluntarily, there are no state guidelines (compare: 20 states + D.C. mandate)
    b) Ohio DOES mandate STD/HIV education, requiring emphasis on abstinence (compare: 36 states + D.C. mandate)

Planning

CONCLUSIONS & RECOMMENDATIONS

Consumer:

1) Consider annual forum to include all PLWHA regardless of funding qualification or addition of private pay consumer to Planning Council.
2) See Recommendation #1 regarding combination of Planning entities— echoed by Consumer members of Title I Planning Council and Consortium
3) Characterization of PC vs. Consortium:
   PC: more structured decision process, more representative, more clout
   Consortium: looser discussion, sometimes explore issues with less constraints but much less clout and diminishing.

Policy Issues related to Planning:

1) Needle Exchange Program for IVIDU
2) Medicaid Program Expansion for HIV/AIDS
3) More Aggressive HIV Testing for ¼ that are HIV+ and Unaware
   a) Voluntary Opt/Out
   b) Expansion to Portals of Entry
   c) Non-facility based HIV Counseling & Testing
4) Minors Right to Consent
5) Criminal Statutes on HIV Transmission
6) Sex/HIV Education

Planning Process:

1) *Recommendation:*

Combine multiple (at least 3) planning groups with ability to have individual group session per funding source then aggregate group meeting at same session

Rationale: Coordination of efforts, Reduction in provider/consumer time and funding body expense, ability to jointly address issues with accountability from larger party(ies).

2) *Recommendation:* Conduct unified needs assessment, ideally by single consultant, but at minimum using single process/set of tools. Jointly decide, using forum above, a set of hypotheses/topical areas to resolve or investigate with the ability to customize these by funder, geographic area, special population group. Share results with disaggregation by funder, geographic area, service category and/or special population. FOCUS on quantifiable data vs.

Qualitative information, wherever possible (translates best to funding increases). This would hopefully eliminate contradictory and frustrating information that hurts Ohio funding, policy direction and service delivery (i.e. contradictory Unmet Need Estimate, very divergent service unit definitions (HIV Case Management), lack of coordination of policies regarding funding (i.e. Pot 15)

Rationale: Coordinated and comparable dataset that can be used for multiple (recommend: three year) timeframe with exponential resources that allows for in-depth study and creation of database.

Service Delivery: Cleveland TGA Continuum of Care

CURRENT CONTINUUM OF CARE

SERVICE CATEGORY	2003 RANK	2004 RANK	2005 RANK	2006 RANK
Primary Medical Care	1a	1a	1a	1a
Lab Testing	1b	1b	1b	1b
Short-term Medication Program	2a	2a	2a	2a
Ohio AIDS Drug Assistance Program	2b	2b	2b	2b
Local Medication Program	2c	2c	2c	2c
Emergency Assistance Medication	3	3	3	3
Dental/Oral Health	4	4	4	4
Nutritional Counseling	5a	5a	9a	9a
Home Delivered Meals	5b	5b	9b	9b
Housing Assistance	6	6	8	8
Early Intervention Services	7	7	11	NA
Outreach	8			
Case Management	9	8	5	5
Transportation Assistance	10	9	10	10
Mental Health Counseling	11	10	6	6
Psychosocial Support Groups	11	11	12	11
Substance Abuse Treatment	12	12	7	7
Home Health Care	13	13	13	12
Hospice	14	14	14	13
Child Care	15	15	15	NA

Comparison of HIV Case Management

SERVICE	CLEVELAND TGA (PER PROVIDER RFP -)		ODH – RYAN WHITE TITLE II (PER PROVIDER RFP – 12/8/2006)
HIV Case Management Service Definition	HIV case management is comprehensive management of HIV care free of charge to an individual. This includes a comprehensive psychosocial assessment to assist the client in identifying service needs and directly linking clients to services.		A method of providing services whereby a professional social worker assesses the needs of the client, and the client's family when appropriate, and arranges, coordinates, monitors, evaluates and advocates for a package of multiple services to meet the specific client's complex needs.
Focus	1. Increased number of HIV positive clients who access primary medical care 2. Increased number of HIV positive clients who maintain their primary medical regimen 3. Increased number of HIV positive clients who adhere to their prescribed HIV medication regimen.		On-site HIV case management provision to PLWHA. (1) Central processing point for Title II Emergency Assistance funds (2) Attend all community-based HIV Case Management development trainings (2-3 per year) (3) Attend all consortia meetings (4) Follow program personnel guidelines
Reimbursement	1 direct service contact between case manager & client (face to face or telephone)		1. 60% Direct processing of Title II EFA
	(for TGA on annual basis allocated to cover 1,200 PLWHA or 6,000 units of care)		2. 10% Preparation and presentation of Title II Emergency Assistance reports for Consortia
			3. 10% Supervision/Administrative/Staff development

Comparison of HIV Case Management (2)

	CLEVELAND TGA		ODH – RYAN WHITE TITLE II
Requirements/ Standards of Care	1. Verify LISW and supervision of 2 hours per month (Licensed Independent Social Worker) 2. Conduct annual comprehensive psychosocial assessment 3. Conduct annual Individualized Service Plan (ISP) 4. Document interventions to achieve ISP goals 5. Document progress notes regarding interventions 6. Verify primary medical, laboratory and dental visits (annual primary care visit and dental screening)		1. Baccalaureate or graduate degree from a social work program accredited by the Council on Social Work Education. 2. The social work case manager shall use his or her professional skills and competence to serve the client. 3. The social work case manager shall ensure that clients are involved in all phases of case management practice 4. The social work case manager shall ensure the client's right to privacy and confidentiality when information about the client is released to others. 5. The social work case manager shall intervene at the client level to provide and/or coordinate the delivery of direct services to clients and their families. 6. The social work case manager shall intervene at the service systems level to support existing case management services and expand the supply of needed services 7. The social work case manager shall be knowledgeable about resource availability, service costs, and budgetary parameters and be fiscally responsible. 8. The social work case manager shall participate in evaluative and quality assurance activities designed to monitor appropriateness and effectiveness of both the service delivery system and the case manager's own services. 9. The social work case manager shall carry a reasonable caseload that allows the case manager to effectively plan, provide, and evaluate case management tasks. 10. The social work case manager shall treat colleagues with courtesy and respect.

Provider: Accessibility

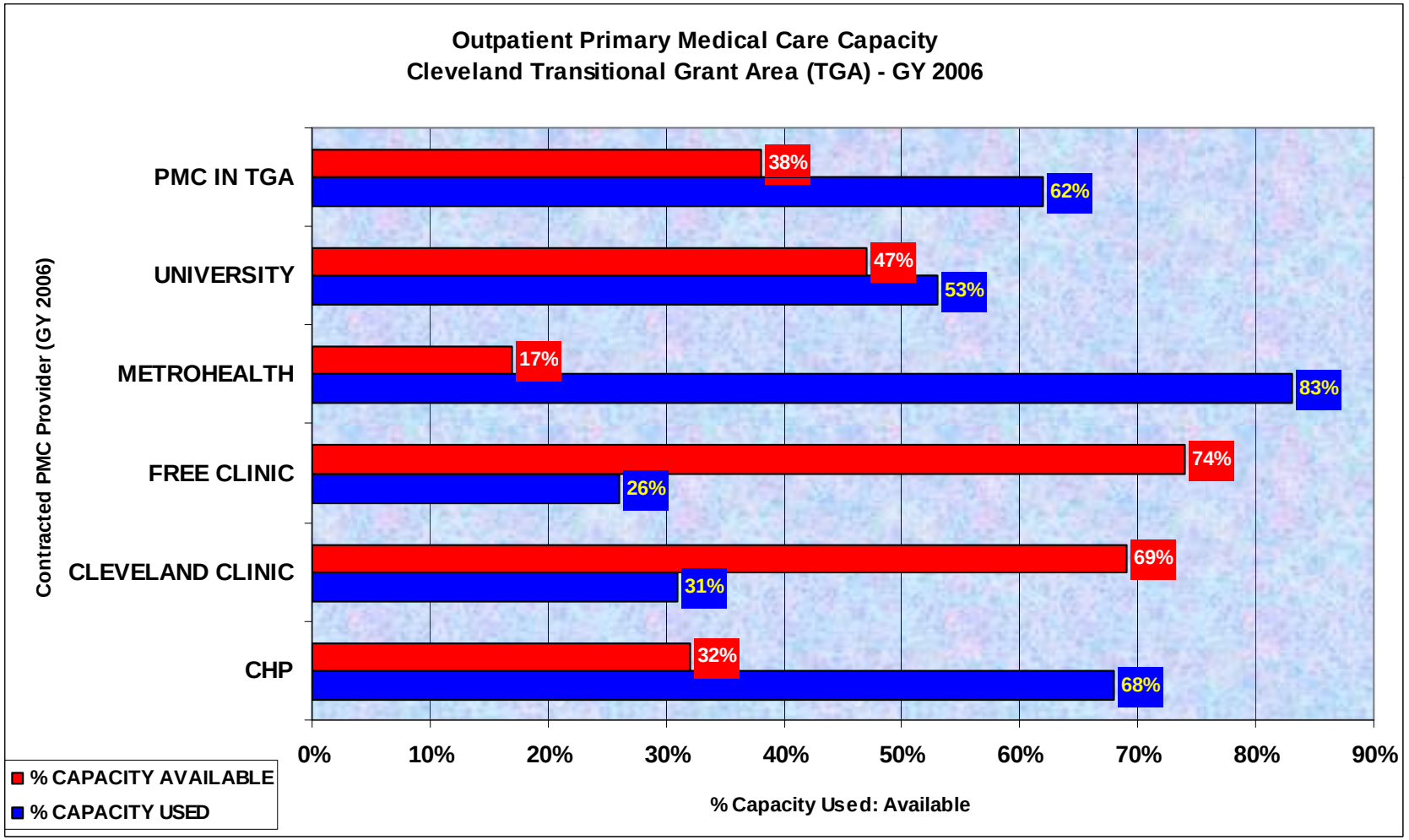
Comments from Focus Groups involving 66 PLWHA (both In Care, Ryan White System and In Care, Other Systems)

CONSUMER

%	Rank	Access Issue	Regional Percentages
32%	#1	Financial Eligibility	Central - 21%, Priv-75%. Eastern 29%, W- 60%, 80% Priv Prac
23%	#2	Geographic Locn	Central - 18%, Eastern - 100%, Western - not
18%	#3	Provider Capacity	Central - 27%
11%	#4	Appt Scheduling	Central - 14%, Eastern - in Central (8%), Western - 20%
6%	#5	Time seen @ appt	Central - 7%, Eastern - in Central (4%), Western 20%
6%	#6	Hours of Operation	Central - 7%, Eastern - in Central (5%), Western 20%

Regarding Issue #3, see following chart of Estimated Provider Capacity for Primary Medical Care

Provider: Capacity



Provider: Acceptability

Comments from Focus Groups involving 66 PLWHA (both In Care, Ryan White System and In Care, Other Systems)

%	Rank	Acceptability Issue	Regional Percentages
27%	#1	Sexual Orientation	Central - 32%, Eastern 43%, Western - 20%
21%	#2	Gender	Central - 21%, Eastern - 57%, Western - 20%
12%	#3	Language	Central - 14%, Eastern - 14%, Western - 20%
12%	#4	Culture	Central - 7%, Eastern - 0, Western - 20%
5%	#5	Disabled	Central - 2%, Eastern - 7%, Western - 3%

Service Delivery

CONCLUSIONS & RECOMMENDATIONS

CONSUMER

- 72% of respondents cited barriers 'ever' to access Primary Medical Care. 'Severe' barriers resulting in failure to access care were reported by 28% of respondents.
- Transportation was the #1 issue, particularly for residents of the Eastern region.
  - ***Cited by 33% of respondents*** (Eastern: 100%, Central: 32% and Western: 20%)
- Copays for medications was frequently mentioned as a barrier to care access, the #1 issue for private pay patients
  - ***Cited by 14% of all respondents*** (Eastern: 14%, Central 5% (Private: 75%), Western 5% (Private: 50%)
- Dental care and Housing tied for the third most frequently cited barriers
  - ***Cited by 11% (each) of all respondents***
  - Dental: Eastern: 5%, Central 9%, Western 60%
  - Housing: Eastern 5%, Central 11%, Western 40%
- Food, particularly Home Delivered Meals mentioned by 5% of only Central region

PROVIDER

- Providers cited issues with the recent decision to restrict Consortia funds as a barrier to service provision of core services.
- Medications were mentioned as the #1 issue by primary care providers, with the ability to efficiently provide HIV meds curbed by:
  a) Medicare Part D
  b) Issues with qualifying for OHDAP
  c) Issues with Medicaid Spend-down
- Following HIV medications, the growing problems with need for 'Other medications' for co-morbid conditions was cited.
- Transportation and Housing were mentioned as ongoing issues with maintaining PLWHA in care
- HIV Case Management frequently mentioned as confounding issue by providers, with difference b/w RWTI & 2 and more frequently, b/w CBO and Hospital

Conclusions: Revisit Hypotheses

CONCLUSIONS BASED ON FINDINGS

AREAS OF CONSENSUS	CONCLUSIONS	RECOMMENDATIONS
* PLWHA involvement throughout the process * Need to preserve funding for Ohio PLWHA * Use of Priority Setting process to allocate Resources * Need to place voice of consumer in process through annual Needs Assessment	* Perceived as more in-depth clout in Planning Council (RWTI) vs. Consortium (RWTII) * Concern regarding GY 2006 'switch' of allocation to only 3 services (Housing, Transportation, Nutrition) as removing clout from local area * Desire to consolidate Needs Assessment processes among funders	1) Consolidated Planning body for all funders with separate meetings by funder to deal with specific issues and joint sessions to coordinate resources, determine directions 2) Need to 'undo' centralization of RWTII service allocation especially given HRSA mandate for all funders of core services 3) Consolidate Needs Assessment (ideal: one consultant, practical: unified set of tools, methodology)

Conclusions: Revisit Hypotheses

CONCLUSIONS BASED ON FINDINGS

AREAS OF DISAGREEMENT	CONCLUSIONS	RECOMMENDATIONS
* Gatekeeper model * Emergency/episodic care vs. continuous care model * Emergency Financial Assistance to allocate resources for services * Use of 'up-front' EFA by providers (Pot 15) * Audit/QM process * Unmet Need estimate	* Gatekeeper model is problematic especially given 'dependence model' it fosters using Emergency Financial Assistance as level (EFA potentially in peril as service at HRSA) * Pot 15 and use of 'up-front' monies is serious and equivalent fracture in care system—both invalidates Consortium and furthers issues with EFA misuse * Combined or equivalent Audit system necessary for uniform quality management * Unmet Need estimate requires substantial review/annual re-exploration	1) Eliminate current gatekeeper model of HIV Case Management using EFA 2) Move to HIV Medical Case Management (do NOT allow Case Manager to gatekeep to Primary Medical Care—critical mistake contributing to ODH high Unmet Need estimate) 3) Combine/coordinate essential processes: a) Unmet Need Estimate b) Quantifiable, Core Service related, Integrated Program: Financial Quality Management

Conclusions: Revisit Hypotheses

CONCLUSIONS BASED ON FINDINGS

AREAS THAT ONE OR BOTH DON'T CARE ABOUT (BUT SHOULD)	CONCLUSIONS	RECOMMENDATIONS
* Service unit definition of 'core' services (II) * Epidemiologic Profile as Foundation of Formula funding * Quantifiable QM (I) * Rules based ADAP qualification (II) * Severity of Need Index/ Severe Need Groups/ Stage of Disease. Complexity & Cost of Care * Importance of Needle Exchange Program (II)	•Clearer service unit definitions need to be stated that are NOT tied to single other service (i.e. EFA) • Epidemiology Profiles by ODH Surveillance appear sound, sophisticated—need to serve as linchpin for a) Unmet Need Estimate b) Funding qualifications c) Project into Future to support a) and b) * ADAP needs to be more rules-based with more transparency (especially during initial application) with less exceptions to the rule * More attention by both funders to Severity of Need index/ Disease Staging/Complexity & Cost of Care * Implement Needle Exchange program	1) Define service definitions that if not identical, are clear in their understanding of differences and why these may 'suit' the remainder of the State (without Title I) and 2) Determine where RWTII can 'cede' or declare 'deemed status' to RWTI or vice versa to end ongoing squabbles 3) Jointly use EPI Profile (adding predictive models) as foundation of planning & funding efforts 4) Similar to service definitions, convert ADAP to strict rules-based model with transparency of processing applications to consumer 5) Invest considerable time into Disease Staging, Complexity & Cost of Care 6) Fight hard, using a unified front, for a Needle Exchange program

Conclusions: Revisit Hypotheses

CONCLUSIONS BASED ON FINDINGS

NEW AREAS OF CONCERN	CONCLUSIONS	RECOMMENDATIONS
* Title I meeting new AIDS case threshold of at least 1,000 new AIDS cases over 5 years * Possible assumption of RW into Medicaid in FY 2009	•Critical issue for Cleveland TGA to maintain Ryan White Title I status * Predictive scenario planning to observe, proactively remain involved in political arena for post-2009	1) Stated in Epidemiologic Profile: conscript Consortium #6 (Medina, Portage & Summit counties) to ensure meeting the 1,000 AIDS cases threshold