Ohio Integrated HIV Prevention and Care Plan 2017-2021

Version date: 9-26-2016

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Acknowledgements

The Ohio Department of Health would like to thank the following organizations for donating their time, energy and expertise in the development of the Ohio Integrated HIV Plan. The work is better for their participation.

Caracole, Inc.

Center for Community Solutions

Columbus Public Health (Ryan White Part A)

Cuyahoga County Board of Health (Ryan White Part A)

Equitas Health

Governor's Office of Health Transformation

Medicaid Managed Care Plans
- Buckeye Health Plan
- CareSource
- Paramount Advantage
- United Healthcare

Ohio Department of Aging

Ohio Department of Health
- HIV Care Services (Ryan White Part B)
- HIV Prevention
- HIV Surveillance
- STD Prevention
- Adolescent Health

Ohio Department of Medicaid

Ohio Department of Mental Health and Addiction Services

Opportunities for Ohioans with Disabilities, Bureau of Vocational Rehabilitation

Midwest AIDS Training and Education Center (MATEC)

Ohio Ryan White Programs

University of Cincinnati Emergency Medicine

Veteran's Administration, Cleveland

And countless consumers, case managers, and other interested parties . . .

*This project was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under the Ryan White HIV/AIDS grant program. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

Introduction

The plan that follows is in response to CDC/HRSA guidance yet, over the course of the last year, the Ohio Integrated HIV Prevention and Care Plan has become something much more than a written document. Ohio's approach to the development of the plan enhanced existing and aided in the development of new partnerships. The various players who participated in the development of this plan number in the hundreds. Interest in this project has ranged from participation by the Director of the Governor's Office of Health Transformation to that of individuals living with HIV, including people recently diagnosed with HIV to long term survivors.

There was agreement from the outset that the focus should be on how the state could impact HIV rather than repeating all the reasons why it was impossible to do so. Many recognized the need for a common framework that was readily understood by all. Gardener's Continuum of Care gave Ohio simple ways to focus attention on the key areas of interest: prevention of HIV transmission/infection; early diagnosis and linkage to quality care; retention in care and, ultimately, viral suppression. This focus also helped Ohio to realize that there was a shared vision for what was possible.

Enthusiasm was such that a number of "quick hits" were identified for completion in 2016 to help build momentum and lay the foundation for the larger, more complicated goals of the 5-year plan. These were each discrete items for which there were few dependencies to other tasks. In addition, earnest explorations of data-sharing have already started as Ohio understands the impacts of state efforts must be adequately measured to assess progress and make meaningful improvements. The goals and strategies identified in the plan are designed to guide activities that, over the period of the plan, will facilitate proactive interventions, identify measures of positive health outcomes, and assess the impact of specific social determinants of health for the target populations.

To be successful, Ohio knows accountability is essential. The next steps include the creation of detailed action plans for each of the plan's strategies and identifying, by name and role, the individual with responsibility for each activity. These details will be delineated with specific due dates, clarification of scope, and identification of dependencies using traditional project management tools. In addition, Ohio has committed to ongoing communication with the various partners and to the provision of regular status reports to the state prevention and care planning bodies, including reports given at 6-month intervals to the combined planning groups.

I

SECTION I: Statewide Coordinated Statement of Need/ Needs Assessment

A. EPIDEMIOLOGIC OVERVIEW

The impact of HIV on Ohio's population is described by examining epidemiologic data using two levels of morbidity: new diagnoses of HIV infection (including new AIDS diagnoses), and prevalent disease or persons living with a diagnosed HIV infection.

HIV surveillance data is collected from health care providers, medical facilities/clinics and laboratories who diagnose and report cases of HIV infection in accordance with Ohio's HIV disease reporting rule outlined in Ohio Administrative Code 3701-3-12. The valuable information collected from these public health partners provides the basis for describing the epidemiology of HIV infections in Ohio. The number of HIV diagnoses should be interpreted with caution, as data can be affected by facility-specific reporting practices and delays, and may not reflect true increases or decreases in new HIV infections.

Throughout this report the term "*diagnosis of HIV infection*" is used. This refers to persons newly diagnosed with HIV infection, regardless of the stage of disease, at initial diagnosis. Persons with concurrent HIV and AIDS diagnoses represent persons not previously reported with an HIV diagnosis who have progressed to AIDS when receiving their initial diagnosis. HIV infected persons categorized as having AIDS represent persons with a later stage HIV infection in accordance with the case definition used by the Centers for Disease Control and Prevention (CDC) for AIDS. It is important to note diagnoses of HIV infection do not necessarily represent all new infections (i.e. incident cases) in Ohio as some individuals, including those recently infected, may be unaware of their HIV diagnostic status. HIV surveillance data on diagnoses of HIV infection reflects the date of HIV diagnosis; not the date the case and/or lab results were reported to the Ohio Department of Health (ODH).

"Persons living with a diagnosis of HIV infection" (i.e., prevalent cases) is a term used to reflect all persons ever reported with an HIV infection in Ohio, regardless of stage of infection, who are not known to have died. Prevalence is used to monitor the proportion of persons in Ohio living with diagnosed HIV infection over time.

While this section of *Ohio's HIV Prevention and Care Integrated Plan* focuses primarily on the use of HIV surveillance data to describe the current epidemiology of HIV infections in Ohio; this data alone is not sufficient to describe outcomes among persons with diagnosed HIV infection and/or at risk for acquiring an HIV infection. Data collected as part of HIV testing, partner services, and treatment and care services is equally important in describing the impact of HIV on Ohio's population. Looking at any of these data sources alone and/or as the sole source of data and information required to measure and monitor outcomes along the continuum of care is contrary to the concept of "integration." For this reason, Ohio is including HIV testing, partner services, and a variety of care services data in this overview. Data from 2014 are used throughout the plan as this is the most recent year for which all collaborators had complete data.

Geographic Distribution of HIV Infections

In 2014, 950 newly diagnosed HIV infections were reported in Ohio. The overall diagnosed HIV infection rate in Ohio for 2014 was 8.2 cases per 100,000 population. However, as with all U.S. states and territories, the majority of persons newly diagnosed with an HIV infection in Ohio in any given year are among persons residing in the more densely populated, urban areas.

Table 1 reveals that while HIV infections are seen in each of Ohio's 88 counties, the majority of HIV diagnoses are among persons residing in the counties containing the eight largest urban areas of the state. These counties include Summit County (Akron), Stark County (Canton), Hamilton County (Cincinnati), Cuyahoga County (Cleveland), Franklin County (Columbus), Montgomery County (Dayton), Lucas County (Toledo) and Mahoning County (Youngstown). When combined, these counties account for 73 percent of all persons diagnosed with an HIV infection in Ohio, but represent 48 percent of Ohio's total population. Allen County (Lima), located in the northwestern area of the state, had the highest rate of HIV infection in 2014 among Ohio's geographically rural counties with 5.7 cases per 100,000 population.

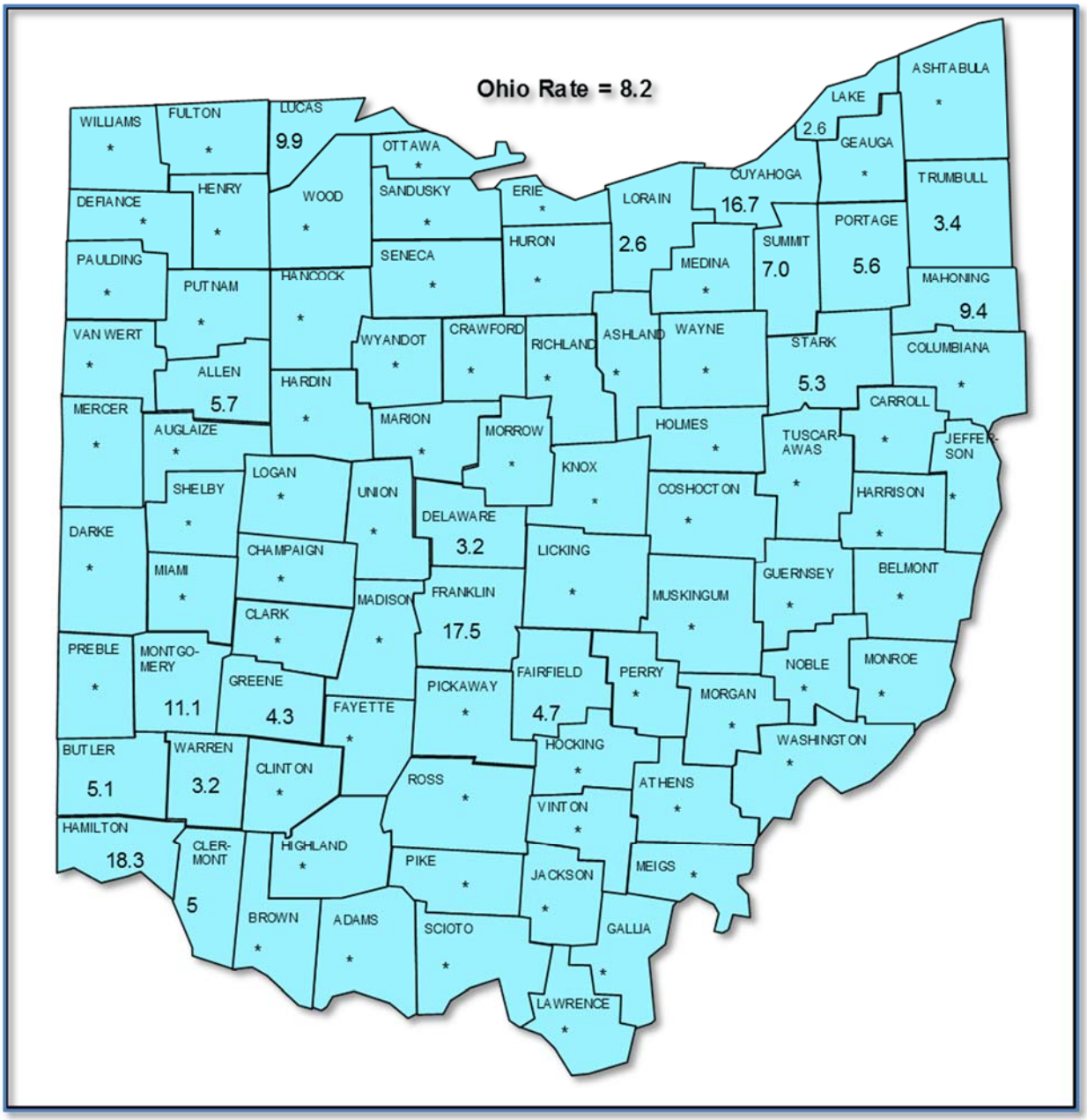


Figure 1. Diagnoses of HIV infection rates, Ohio, 2014[1]

[1] **Note**: Diagnoses of HIV infection include all reported persons with a diagnosis of HIV infection. The rate is the number of reported persons with a diagnosis of HIV infection per 100,000 population calculated using 2014 U.S. Census estimates. Asterisk (*) indicates rate not calculated for case count <5 due to unstable rates. **Source**: Ohio Department of Health HIV/AIDS Surveillance Program. Data reported through June 30, 2015.

County[b]	Diagnoses of HIV Infection[a] 2014 No.	Persons Living with a Diagnosis of HIV Infection[c] Rate[d]	Persons Living with a Diagnosis of HIV Infection[c] No.	Cumulative Reported Deaths[e] No.	County[b]	Diagnoses of HIV Infection[a] 2014 No.	Persons Living with a Diagnosis of HIV Infection[c] Rate[d]	Persons Living with a Diagnosis of HIV Infection[c] No.	Cumulative Reported Deaths[e] No.
Adams	3	92.4	26	11	Logan	-	57.1	26	19
Allen	6	152.3	160	89	Lorain	8	113.7	346	185
Ashland	1	39.6	21	11	Lucas	43	222.4	968	583
Ashtabula	3	99.8	99	39	Madison	-	102.5	45	20
Athens	2	72.6	47	30	Mahoning	22	205.8	480	271
Auglaize	-	48.0	22	14	Marion	1	105.0	69	39
Belmont	2	64.8	45	29	Medina	2	43.2	76	23
Brown	2	65.7	29	13	Meigs	-	60.0	14	6
Butler	19	91.1	341	155	Mercer	1	19.6	8	12
Carroll	-	31.9	9	8	Miami	2	70.3	73	46
Champaign	3	94.6	37	25	Monroe	-	48.4	7	4
Clark	3	93.0	127	124	Montgomery	59	244.8	1,305	776
Clermont	10	64.0	129	54	Morgan	1	121.3	18	2
Clinton	1	110.0	46	21	Morrow	1	42.7	15	16
Columbiana	4	68.1	72	48	Muskingum	2	85.1	73	41
Coshocton	2	57.5	21	9	Noble	-	69.6	10	1
Crawford	-	77.7	33	20	Ottawa	-	36.4	15	15
Cuyahoga	210	347.7	4,381	2,733	Paulding	-	63.2	12	10
Darke	3	61.3	32	21	Perry	2	81.0	29	12
Defiance	2	64.9	25	20	Pickaway	1	112.5	64	54
Delaware	6	76.7	145	38	Pike	-	67.2	19	13
Erie	4	102.9	78	60	Portage	9	59.9	97	56
Fairfield	7	97.8	147	52	Preble	3	43.3	18	12
Fayette	1	90.3	26	14	Putnam	-	14.6	5	9
Franklin	215	377.0	4,642	2,235	Richland	-	88.6	108	100
Fulton	-	54.0	23	17	Ross	1	90.7	70	49
Gallia	2	69.1	21	9	Sandusky	2	73.1	44	27
Geauga	2	36.1	34	26	Scioto	1	106.1	82	36
Greene	7	92.8	152	78	Seneca	-	37.7	21	24
Guernsey	2	58.1	23	11	Shelby	4	42.9	21	19
Hamilton	148	343.0	2,767	1,483	Stark	20	108.3	407	270
Hancock	-	53.1	40	32	Summit	38	151.3	820	504
Hardin	1	47.2	15	9	Trumbull	7	97.5	200	109
Harrison	-	38.6	6	5	Tuscarawas	1	20.5	19	17
Henry	-	39.4	11	9	Union	1	94.8	51	17
Highland	-	55.8	24	15	Van Wert	-	38.6	11	4
Hocking	1	73.1	21	11	Vinton	-	45.3	6	3
Holmes	-	-	4	5	Warren	7	64.5	143	43
Huron	-	44.3	26	14	Washington	-	67.0	41	49
Jackson	2	67.2	22	15	Wayne	2	61.5	71	30
Jefferson	1	85.7	58	57	Williams	3	61.7	23	19
Knox	-	49.0	30	17	Wood	2	50.9	66	46
Lake	6	65.4	150	89	Wyandot	-	31.3	7	5
Lawrence	-	92.5	57	29	No County	19	-	1,226	528
Licking	4	93.9	159	73	**Total**	**950**	**186.4**	**21,612**	**12,001**

[a] The number of diagnoses of HIV infection includes persons with a diagnosis of HIV (not AIDS), a diagnosis of HIV and a later AIDS diagnosis, and concurrent diagnoses of HIV and AIDS.

[b] County is based on county of residence at time of earliest HIV diagnosis. Cases whose residence is a correctional facility or whose county is unknown are included in No County.

[c] Living with a diagnosis of HIV infection represents all persons ever diagnosed and reported with HIV or AIDS who have not been reported as having died as of December 31, 2014. Persons living with a diagnosis of HIV infection represent persons living in Ohio as of December 31, 2014, regardless of whether or not the person was a resident of Ohio at time of initial HIV and/or AIDS diagnosis.

[d] The rate is the number of persons living with a diagnosis of HIV infection per 100,000 population calculated using 2014 U.S. Census estimates.

[e] Deaths of persons with a diagnosis of HIV infection may be due to any cause.

Dash (-) indicates no cases were reported for the given category.

Source: Ohio Department of Health HIV/AIDS Surveillance Program. Data reported through June 30, 2015.

Table 1. Diagnoses of HIV infection in 2014, persons living with a diagnosis of HIV infection as of December 31, 2014, and cumulative deaths reported among persons with a diagnosis of HIV infection through December, 31, 2014, Ohio, by county.

Characteristics of Persons Newly Diagnosed with an HIV Infection

Sex. Since Ohio's HIV epidemic began in the early-mid 1980's, the majority of persons diagnosed with an HIV infection each year are male. Eighty six percent (86%) of persons newly diagnosed with an HIV infection in Ohio in 2014 were male.

Age. Persons newly diagnosed with an HIV infection in Ohio are increasingly younger than in previous years. In 2014, the highest number (217 cases) and proportion (23 percent) of persons diagnosed with an HIV infection in Ohio were 20-24 years of age. This represents an increase of 12 percent within this age group since 2010. The proportion of persons 24-29 years of age diagnosed with HIV infection saw the largest proportional increase (28 percent) in new HIV diagnoses reported between 2010 (142 cases) and 2014 (181 cases). Conversely, the number and proportion of new HIV diagnoses decreased among persons 15-19 years of age, and all age groups among persons 35 years of age and older between 2010 and 2014.

Race/ethnicity. Growing disparities are observed when examining new HIV diagnoses by race/ethnicity. Racial/ethnic disparities in new HIV infections in Ohio mirror disparities observed across the nation. Black/African Americans accounted for 47 to 52 percent of new diagnoses of HIV infection reported between 2010 and 2014, but represent only 12 percent of Ohio's population in each year per U.S. Census estimates. Hispanic/Latinos accounted for 4 to 7 percent of new diagnoses of HIV infection reported between 2010 and 2014, but represent only three percent of Ohio's population in each year per U.S. Census estimates. In 2014, black/African-American males accounted for 43 percent of all diagnosed HIV infections reported in Ohio, followed by white males (33 percent), black/African-American females (9 percent), Hispanic/Latino males (6 percent), and white females (4 percent). Males and females of all other race/ethnicities combined, accounted for two percent of diagnosed HIV infections in Ohio in 2014.

Mode of transmission. Ohio's leading mode of transmission for diagnoses of HIV infection in 2014 was male-to-male sexual contact (74%) followed by heterosexual contact (17%). Among males, an estimated 87 percent of cases were attributed to male-to-male sexual contact, six percent to heterosexual contact and four percent to injection drug use (IDU). Among females, an estimated 82 percent of cases were attributed to heterosexual contact and 18 percent to injection drug use. Caution should be used in interpreting IDU as a mode of transmission as small numbers may impact the precision of the estimate.

Transmission Category	Males		Females		Total	
	No.	%	No.	%	No.	%
Male-to-male sexual contact	704	87%	N/A	0%	704	74%
Heterosexual contact	53	6%	112	82%	165	17%
Injection drug use (IDU)	29	4%	25	18%	54	6%
Male-to-male sexual contact & IDU	27	3%	N/A	0%	27	3%
Total	**813**	**100%**	**137**	**100%**	**950**	**100%**

Table 3. Leading modes of HIV transmission among persons diagnosed with an HIV infection, by sex, Ohio, 2014[2]

[2] **Note**: Numbers do not represent actual cases of HIV infection reported in each transmission category. Data reflect point estimates of cases of HIV infection statistically adjusted for reporting delays and redistribution of cases in persons initially

Statewide Trends in HIV and AIDS Diagnoses. Figure 2 illustrates the number and proportion of persons reported with an initial diagnosis of HIV infection (not AIDS) compared to persons initially diagnosed with AIDS from 2010-2014. Six percent of persons reported with an HIV infection in Ohio in 2014 were initially diagnosed with AIDS. This trend has held over the five year period examined with some progress, and suggests the overwhelming majority of persons who receive an initial diagnosis of HIV in Ohio are being diagnosed at an earlier stage of disease.

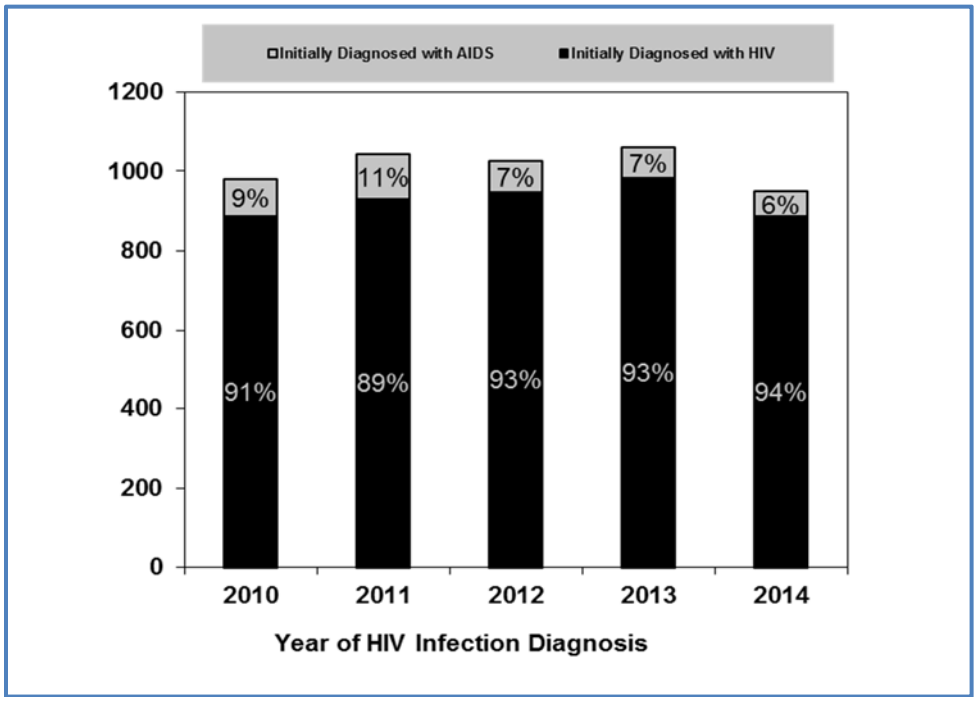


Figure 2. Diagnoses of HIV infection by initial diagnosis, Ohio, 2010-2014.

Trends identified in HIV and AIDS diagnoses include:

- The majority of persons newly diagnosed with an HIV infection in Ohio in 2014 were male (86 percent). This trend has remained unchanged since cases of HIV infection, then called AIDS, were first identified and reported in Ohio in the 1980's.

- Persons diagnosed with an HIV infection in Ohio are increasingly younger than in previous years. In 2014, the proportion of persons diagnosed with HIV infection aged 24-29 increased 28 percent and the proportion of persons diagnosed with HIV infection aged 20-24 years of age increased 12 percent since 2010.

reported without an identified transmission. The estimates have not been adjusted for incomplete reporting. Numbers of cases of HIV include persons with a diagnosis of HIV (not AIDS), a diagnosis of HIV and later AIDS diagnosis, and concurrent diagnoses of HIV and AIDS. **Source**: Ohio Department of Health HIV Surveillance Program. Data reported through June 30, 2015.

- Black/African American males were the only subpopulation group in Ohio for whom the number, percentage and rate of new infections consistently increased each year from 2010-2014. Black/African Americans accounted for between 47-52 percent of new diagnoses of HIV infections reported between 2010 and 2014, yet represented only 12 percent of Ohio's population in each of these years per U.S. Census estimates. Similarly, Hispanic/Latinos accounted for between 4-7 percent of new diagnoses of HIV infection in Ohio over the five year period, but represented only three percent of Ohio's population in each year per U.S. Census estimates.

- In 2014, black/African-American males accounted for 43 percent of the HIV infections diagnosed in Ohio. This was followed by white males (33 percent), black/African American females (9 percent), Hispanic/Latino males (6 percent) and white females (4 percent). Males and females of all other race/ethnicities combined, accounted for approximately two percent of all diagnosed HIV infections in 2014.

Diagnosis of HIV Infection by Year															
	2010			2011			2012			2013			2014		
Characteristic	Rate[a]	No.	%	Rate[a]	No.	%	Rate[a]	No.	%	Rate[a]	No.	%	Rate[a]	No.	%
Sex															
Males	14.3	809	83%	14.5	823	79%	14.8	839	82%	15.3	871	82%	14.3	813	86%
Females	2.9	170	17%	3.7	220	21%	3.2	187	18%	3.2	189	18%	2.3	137	14%
Age at diagnosis (yr)															
<13	0.3	5	1%	*	3	<1%	0.4	8	1%	0.5	9	1%	*	3	<1%
13-14	*	1	<1%	*	-	-	*	-	-	*	1	<1%	*	-	-
15-19	10.1	78	8%	8.3	64	6%	8.2	63	6%	8.3	64	6%	6.9	53	6%
20-24	24.5	194	20%	27.8	220	21%	27.1	214	21%	29.6	234	22%	27.4	217	23%
25-29	19.0	142	15%	20.7	155	15%	21.6	162	16%	23.1	173	16%	24.2	181	19%
30-34	16.8	121	12%	18.8	136	13%	20.2	146	14%	16.2	117	11%	16.8	121	13%
35-39	16.8	114	12%	16.8	114	11%	13.7	93	9%	15.0	102	10%	14.1	96	10%
40-44	14.4	105	11%	15.4	112	11%	12.5	91	9%	13.5	98	9%	11.8	86	9%
45-49	13.2	100	10%	12.2	92	9%	13.0	98	10%	12.8	97	9%	11.5	87	9%
50-54	7.4	63	6%	9.4	80	8%	9.1	77	8%	8.1	69	7%	4.7	40	4%
55-64	3.0	47	5%	3.4	54	5%	4.0	63	6%	4.8	76	7%	3.5	55	6%
65+	0.5	9	1%	0.7	13	1%	0.6	11	1%	1.1	20	2%	0.6	11	1%
Race/Ethnicity															
White, not Hispanic	4.5	415	42%	4.7	436	42%	4.5	418	41%	4.7	432	41%	3.8	355	37%
Black/African American, not Hispanic	33.1	472	48%	35.5	506	49%	34.1	486	47%	35.8	511	48%	34.6	493	52%
Hispanic/Latino	11.2	45	5%	14.9	60	6%	14.1	57	6%	15.4	62	6%	16.9	68	7%
Asian/Pacific Islander	2.6	6	1%	3.0	7	1%	2.6	6	1%	3.4	8	1%	3.4	8	1%
American Indian/Alaska Native	*	1	<1%	*	1	<1%	*	-	-	*	1	<1%	*	1	<1%
Unknown	*	40	4%	*	33	3%	*	59	6%	*	46	4%	*	25	3%
Race/Sex															
White, not Hispanic Males	8.0	363	37%	8.0	366	35%	8.1	368	36%	8.2	375	35%	6.9	314	33%
White, not Hispanic Females	1.1	52	5%	1.5	70	7%	1.1	50	5%	1.2	57	5%	0.9	41	4%
Black/African American, not Hispanic Males	54.2	369	38%	54.6	372	36%	53.7	366	36%	59.9	408	38%	60.5	412	43%
Black/African American, not Hispanic Females	13.8	103	11%	18.0	134	13%	16.1	120	12%	13.8	103	10%	10.9	81	9%
Hispanic/Latino Males	18.3	38	4%	24.1	50	5%	25.1	52	5%	22.7	47	4%	28.5	59	6%
Hispanic/Latina Females	3.6	7	1%	5.1	10	1%	2.6	5	<1%	7.7	15	1%	4.6	9	1%
Asian/Pacific Islander Males	*	4	<1%	*	4	<1%	4.5	5	<1%	5.3	6	1%	5.3	6	1%
Asian/Pacific Islander Females	*	2	<1%	*	3	<1%	*	1	<1%	*	2	<1%	*	2	<1%
American Indian/Alaska Native Males	*	1	<1%	*	1	<1%	*	-	-	*	1	<1%	*	-	-
American Indian/Alaska Native Females	*	-	-	*	-	-	*	-	-	*	-	-	*	1	<1%
Unknown	*	40	4%	*	33	3%	*	59	6%	*	46	4%	*	25	3%
Total	**8.4**	**979**		**9.0**	**1,043**		**8.8**	**1,026**		**9.1**	**1,060**		**8.2**	**950**	

Notes: Diagnoses of HIV infection include persons with a diagnosis of HIV (not AIDS), a diagnosis of HIV and a later AIDS diagnosis, and concurrent diagnoses of HIV and AIDS. Diagnoses of HIV infection by year (2010-2014) represent all reported cases diagnosed in each year.

[a] The rate is the number of persons with a reported diagnosis of HIV infection per 100,000 population calculated using 2014 U.S. Census estimates.

Dash (-) indicates no cases were reported for the given category. Asterisk (*) indicates rate not calculated for case count <5 due to unstable rates.

Source: Ohio Department of Health HIV/AIDS Surveillance Program. Data reported through June 30, 2015.

Table 2. Diagnoses of HIV infection, by year of diagnosis and cumulative diagnoses, by selected characteristics, Ohio, 2010-2014

Burden of HIV Infection, including Trends

Rates depict the extent to which populations are impacted by diagnoses of HIV infection. The rate of persons living with a diagnosis of HIV infection in Ohio in 2014 was 186.4 cases per 100,000 population. The rate of blacks/African Americans living with a diagnosis of HIV infection per 100,000 population was more than six times the rate among whites (670.1 per 100,000 black/African American compared to 107.6 per 100,000 whites). Among Ohio's Hispanic/Latino population, the rate was nearly three times higher than the rate among whites (310.0 cases per 100,000 Hispanic/Latinos). The rate of males living with a diagnosis of HIV infection in Ohio was 303.2 cases per 100,000 population compared to 74.5 cases per 100,000 population for females in Ohio.

The disproportionate distribution of HIV infections among black/African American and Hispanic/Latino Ohioans is observed among males and females. The rate of persons living with a diagnosis of HIV infection in Ohio through December 31, 2014 was 1,027.7 cases per 100,000 population for black/African American males and 450.9 cases per 100,000 population for Hispanic/Latino males, compared to 189.4 cases per 100,000 population for white males. For females, the rate was 343.3 cases per 100,000 population for black/African American females, 161.2 cases per 100,000 population for Hispanic/Latina females, and 28.9 cases per 100,000 population for white females (data not shown).

The leading mode of HIV transmission among all persons living with an HIV infection in Ohio in 2014 is male-to-male sexual contact (63 percent), followed by heterosexual contact (24 percent), and primary injection drug use (8 percent) (data not shown). Estimates indicate the number of persons living with a diagnosis of HIV infection in Ohio attributable to male-to-male sexual contact increased 27 percent from 2010 through 2014 (data not shown). Persons reporting heterosexual contact increased 18 percent, and those reporting injection drug use increased 15 percent during the same period (data not shown).

Statewide Trends among Persons Living with HIV Infection

In 2010, an estimated 17,593 persons in Ohio were living with a diagnosis of HIV infection and by 2014, this increased 23 percent to 21,612 persons (Table 4). During this same five year period, persons living with a diagnosis of HIV infection 34 years of age or younger increased by 27 percent. Whereas persons 25-29 years of age living with a diagnosis of HIV infection during this time, increased by 51 percent – from 1,120 in 2010 to 1,688 in 2014. The number of blacks/African Americans living with a diagnosis of HIV infection increased 26 percent, Hispanic/Latinos living with a diagnosis of HIV infection increased 25 percent, and whites living with a diagnosis of HIV infection increased 19 percent. Persons living with a diagnosis of HIV infection categorized as "other" or unknown race also increased, but represented no more than three percent of all cases in any given year.

Figure 3 illustrates the increase in the number of persons living with a diagnosis of HIV infection in Ohio by current disease status. From 2010 to 2014, the proportion of reported persons living with HIV (non-AIDS) increased by five percent. Of persons living with a diagnosis of HIV infection in 2014, 51 percent were living with HIV (non-AIDS) and 49 percent were living with AIDS. As people live longer with a diagnosis of HIV infection, the cumulative number of persons living with HIV in Ohio continues to increase each year. The number of persons living with a diagnosis of HIV infection reflects all persons ever reported with HIV or AIDS who are not known to have died.

	Living with a Diagnosis of HIV Infection									
	2010		2011		2012		2013		2014	
Characteristic	No.	%	No.	%	No.	%	No.	%	No.	%
Sex										
Males	13,906	79%	14,716	79%	15,553	79%	16,407	79%	17,204	80%
Females	3,687	21%	3,897	21%	4,083	21%	4,272	21%	4,408	20%
Age at end of year										
<13	61	<1%	59	<1%	66	<1%	72	<1%	65	<1%
13-14	25	<1%	21	<1%	11	<1%	8	<1%	13	<1%
15-19	176	1%	159	1%	156	1%	144	1%	136	1%
20-24	780	4%	883	5%	959	5%	1,012	5%	968	4%
25-29	1,120	6%	1,243	7%	1,364	7%	1,517	7%	1,688	8%
30-34	1,458	8%	1,521	8%	1,607	8%	1,648	8%	1,715	8%
35-39	1,962	11%	1,876	10%	1,880	10%	1,901	9%	1,959	9%
40-44	3,008	17%	2,933	16%	2,798	14%	2,671	13%	2,578	12%
45-49	3,564	20%	3,666	20%	3,648	19%	3,666	18%	3,531	16%
50-54	2,662	15%	2,938	16%	3,301	17%	3,568	17%	3,823	18%
55-64	2,319	13%	2,751	15%	3,147	16%	3,595	17%	4,070	19%
65+	458	3%	563	3%	699	4%	877	4%	1,066	5%
Race/Ethnicity										
White, not Hispanic	8,390	48%	8,818	47%	9,224	47%	9,643	47%	9,995	46%
Black/African American, not Hispanic	7,592	43%	8,083	43%	8,570	44%	9,076	44%	9,558	44%
Hispanic/Latino	1,001	6%	1,056	6%	1,122	6%	1,185	6%	1,250	6%
Asian/Pacific Islander	73	<1%	79	<1%	84	<1%	93	<1%	101	<1%
American Indian/Alaska Native	17	<1%	18	<1%	19	<1%	20	<1%	21	<1%
Unknown	520	3%	559	3%	617	3%	662	3%	687	3%
Race/Sex										
White, not Hispanic Males	7,240	41%	7,598	41%	7,951	40%	8,314	40%	8,626	40%
White, not Hispanic Females	1,150	7%	1,220	7%	1,273	6%	1,329	6%	1,369	6%
Black/African American, not Hispanic Males	5,458	31%	5,825	31%	6,196	32%	6,597	32%	6,999	32%
Black/African American, not Hispanic Females	2,134	12%	2,258	12%	2,374	12%	2,479	12%	2,559	12%
Hispanic/Latino Males	726	4%	771	4%	831	4%	879	4%	934	4%
Hispanic/Latina Females	275	2%	285	2%	291	1%	306	1%	316	1%
Asian/Pacific Islander Males	64	<1%	67	<1%	71	<1%	78	<1%	84	<1%
Asian/Pacific Islander Females	9	<1%	12	<1%	13	<1%	15	<1%	17	<1%
American Indian/Alaska Native Males	11	<1%	12	<1%	13	<1%	14	<1%	14	<1%
American Indian/Alaska Native Females	6	<1%	6	<1%	6	<1%	6	<1%	7	<1%
Unknown	520	3%	559	3%	617	3%	662	3%	687	3%
Total	**17,593**		**18,613**		**19,636**		**20,679**		**21,612**	

Notes: Living with a diagnosis of HIV infection by year (2010-2014) represents all persons ever diagnosed and reported with HIV or AIDS who have not been reported as having died as of December 31, 2014. Persons living with a diagnosis of HIV infection represent persons living in Ohio as of December 31, 2014, regardless of whether or not the person was a resident of Ohio at time of initial HIV and/or AIDS diagnosis.
Source: Ohio Department of Health HIV/AIDS Surveillance Program. Data reported through June 30, 2015.

Table 4. Persons living with a diagnosis of HIV infection, by year and by selected characteristics, Ohio, 2010-2014

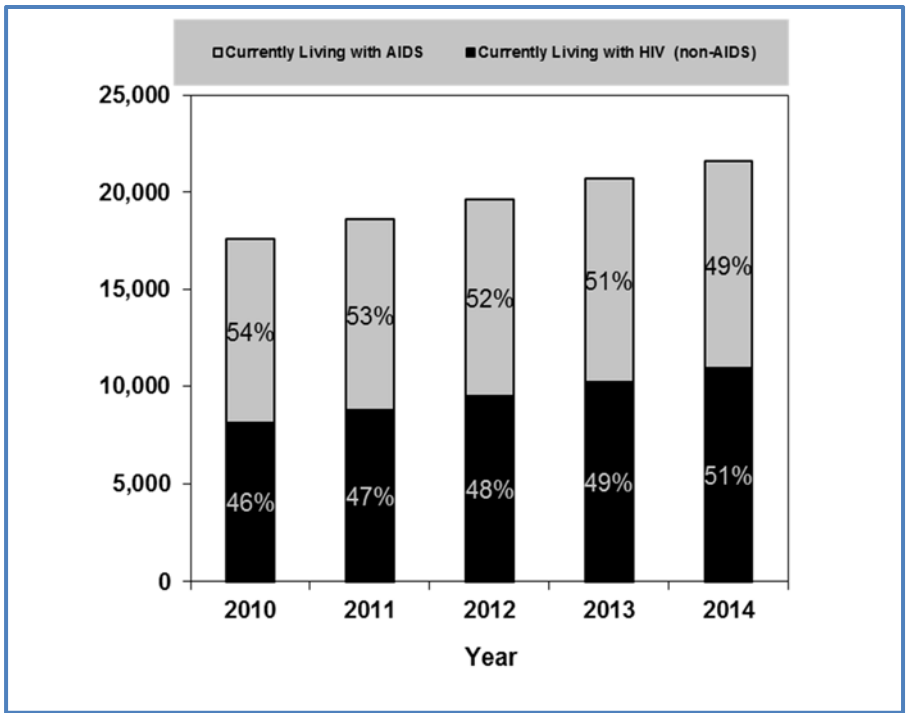


Figure 3. Persons living with a diagnosis of HIV infection by current disease status, Ohio, 2010-2014

Transitional Grant Areas (TGAs)

HIV prevalence rates within each of the Transitional Grant Areas (TGAs) in Ohio, are significantly higher than the overall state HIV prevalence rate. The state prevalence rate was 186.4 per 100,000 in 2014, yet the prevalence rates for the Cleveland and Columbus TGAs were 235.2 and 273.0, respectively (Tables 5 and 6).

Each of these TGA regions features an urban county (Cuyahoga and Franklin) surrounded by contiguous counties, often of markedly lower HIV prevalence. These two counties each have significantly higher HIV prevalence rates than the state rate: Cuyahoga at 347.7 per 100,000 and Franklin at 377 per 100,000 are the highest in the state. Although not part of an identified transitional grant area, Hamilton County (Cincinnati) and Montgomery County (Dayton) have incidence rates of 343.0 and 244.8 respectively.

COUNTY	2014		PREVALENCE RATE	TOTAL POPULATION
	INCIDENCE	PREVALENCE		
Delaware	6	145	76.7	189,048
Fairfield	7	147	97.8	150,307
Franklin	215	4,642	377.0	1,231,300
Licking	4	159	93.9	169,329
Madison	---	45	102.5	43,902
Morrow	1	15	42.7	35,129
Pickaway	1	64	112.5	56,889
Union	1	51	94.8	53,797
Columbus TGA Total	**235**	**5,268**	**273.0**	**1,929,701**
STATEWIDE TOTAL	**950**	**21,612**	**186.4**	**11,594,421**

Table 5. HIV Incidence and Prevalence for Counties comprising the Columbus TGA, 2014 (prevalence rates are per 100,000 population).

COUNTY	2014		PREVALENCE RATE	TOTAL POPULATION
	INCIDENCE	PREVALENCE		
Ashtabula	3	99	99.8	99,175
Cuyahoga	210	4,381	347.7	1,259,828
Geauga	2	34	36.1	94,295
Lake	6	150	65.4	229,230
Lorain	8	346	113.7	304,216
Medina	2	76	43.2	176,029
Cleveland TGA Total	**231**	**5,086**	**235.2**	**2,162,773**
STATEWIDE TOTAL	**950**	**21,612**	**186.4**	**11,594,421**

Table 6. HIV Incidence and Prevalence for Counties comprising the Cleveland TGA, 2014 (prevalence rates are per 100,000 population).

As shown in Table 7, for the Cleveland TGA, the largest disparities in HIV infections are seen in the incidence of new cases among black/African Americans, persons aged 20-44, and men who have sex with other men (MSM). The Ryan White Part A program focuses on closing the gaps of the disproportionately impacted within the TGA.

	New Cases of HIV	PLWH	New Cases of AIDS	PLWA
Characteristics				
Gender (%)				
Male	88	78	86	78
Female	12	22	14	22
Race/Ethnicity (%)				
White	22	33	7	35
Black	67	53	86	51
Hispanic	7	9	7	11
API	1	1	N/A	<1
Multi-Race	3	5	N/A	2
Not Reported	N/A	<1	N/A	<1
Age Groups (%)				
0-12	0.05	<1	N/A	<1
13-19	7	1	7	<1
20-44	77.5	49	50	28
45+	15	49.3	43	71.7
Exposure Category (%)				
MSM	60	51	43	53
MSM/IDU	1	2	N/A	5
Heterosexual	12	18	14	21
IDU	2	5	N/A	9
Perinatal	N/A	1	N/A	1
Not Reported	25	23	43	11

Table 7. Demographic breakout of new HIV/AIDS cases (incidence) vs PLWHA (prevalence) in the Cleveland TGA in 2014.[3] Source: Ohio Department of Health, 2014.

Deaths among Persons with HIV Infection

While deaths attributed to HIV have greatly declined with improvements in treatment, HIV remains a leading cause of death among certain population groups. According to the U.S. National Health Statistics Center, HIV was the fourteenth leading underlying cause of death for males 25 to 64 years of age in Ohio in 2014 (data not shown); however, for white and Hispanic/Latino males between 25 and 64 years of age in Ohio, HIV did not rank as a leading underlying cause of death in 2014. HIV ranked as the twelfth leading underlying cause of death for black/African American males 25 to 64 years of age in Ohio in 2014. Black males were almost six times more likely to have a death with HIV as the underlying cause compared to white males. HIV was not a leading underlying cause of death for any race/ethnicity or age group among Ohio females in 2014.

The cumulative death total included in Table 1 on a previous page demonstrates that since the beginning of Ohio's HIV epidemic, 12,001 persons with a diagnosed HIV infection have died through 2014. The death data is based upon record linkages with Ohio vital statistics and the Social Security Administration's master death index. It should be noted that cumulative deaths represents deaths among persons with a diagnosed HIV infection and not deaths from HIV infection.

Indicators of Risk for HIV Infection

Ohio's HIV Counseling, Testing, and Referral (CTR) system is one of several data sources used in this section to describe risk behaviors. These sites provide anonymous and confidential HIV testing as well as counseling, referrals and partner notification services. CTR system data reflects the number of HIV tests performed at the CTR site, not the number of individuals tested. Therefore, persons tested multiple times are counted multiple times in the CTR data system. In addition, the Ohio Disease Reporting System (ODRS) is used by local Disease Intervention Specialists (DIS) throughout Ohio to record risk factor information obtained during patient interviews of persons newly diagnosed with an HIV infection when providing partner notification services.

The following direct measures of risk behavior are collected and analyzed to provide information about how these risk behaviors are associated with an increased risk for acquiring or transmitting HIV infection:

- Number of sex partners
- Frequency of condom use
- Substance use

Men Who Have Sex with Men (MSM)

The definition of MSM used by the HIV Counseling, Testing and Referral (CTR) sites is men who acknowledge having sexual contact with another male regardless of how an individual self identifies in terms of sexual orientation, and/or regardless of any reported sexual contact with a female.

Among MSM interviewed by disease intervention specialists (DIS) for partner notification services in Ohio in 2014:

- **Number of Sex Partners.** Fifty-six percent reported having unprotected sexual contact with two to six sexual partners in the past 12 months, and 10 percent reported 10 or more sexual partners in the past 12 months.

- **Frequency of Condom Use**. *S*ix percent reported "always," 79 percent reported "sometimes," and 12 percent reported "never" using a condom or barrier method when performing anal sex during the previous 12 months. The majority of MSM (87 percent) interviewed indicated they had "never" used a condom or barrier method when performing oral sex during the previous 12 months.

- **Substance Use.** Injection drug use (IDU) and other substance use can impair a person's judgment leading to the use of contaminated/unclean equipment when injecting illicit or non-illicit drugs, unprotected sex, or exchanging sex for drugs or money. Fifty percent engaged in non-injection drug use, three percent engaged in IDU, and three percent indicated having exchanged sex for drugs/money during the previous 12 months.

Indirect Measures of Risk Behavior among MSM. Ohio's sexually transmitted disease (STD) surveillance data provides an indirect measure of risk behavior for HIV infection because other STDs serve as an indicator of unprotected sex.

Research has long demonstrated increased risk of HIV transmission in the presence of STD infections that cause genital ulcers (e.g. syphilis or herpes) as well as other STDs that are frequently asymptomatic (e.g. chlamydia and gonorrhea). Research conducted by Wasserheit (1992) found a three to five times higher risk of acquiring HIV through sexual transmission if an individual is infected with an STD compared to those not infected with an STD.[3] Further, an individual co-infected with HIV infection and another STD is three to five times more likely than an HIV-infected person with no other STDs to transmit HIV through sexual contact. Studies in Asia and in Africa have also illustrated the interrelationship between HIV and STD interventions where focus on STD prevention slowed the progress of the HIV epidemic.[4]

Trends in reported early syphilis cases (when syphilis is infectious) among MSM provides information to identify any increase in overall reported syphilis cases are used as an estimate of current transmission in the community. The number of diagnosed early syphilis infections among MSM increased more than 69 percent between 2010 and 2014. (Figure 4).

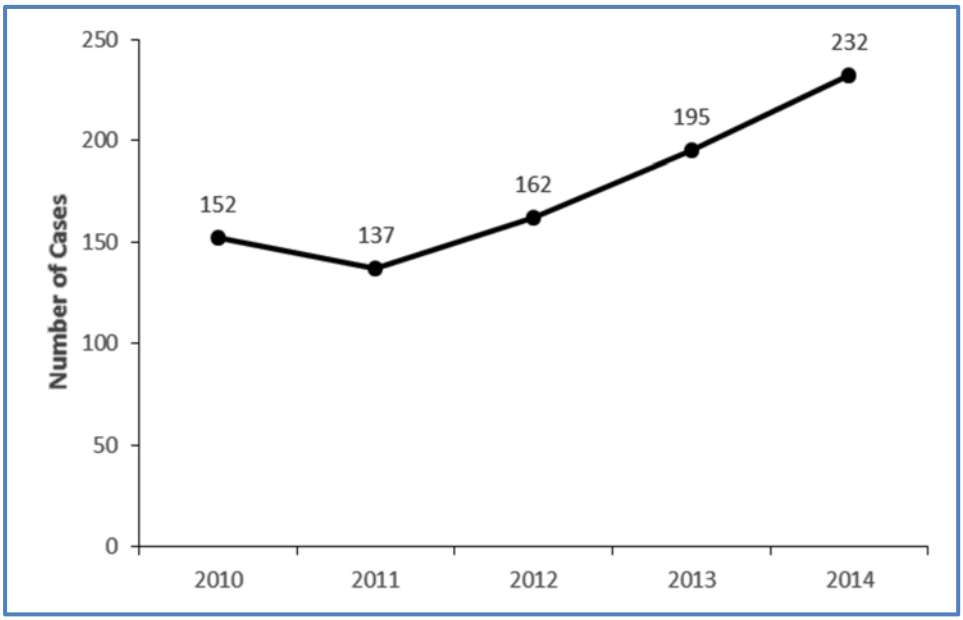


Figure 4. Trends in reported early syphilis cases among MSM, Ohio, 2010-2014. Source: Ohio Department of Health STD Surveillance. Data reported as of August 16, 2015.

[3]Wasserheit JN. 1992. "Epidemiology synergy: interrelationship between human immunodeficiency virus infection and other sexually transmitted diseases." Sexually Transmitted Diseases 9:61-77.

[4]Grosskurth H et al. 1995. "Impact of improved treatment of sexually transmitted diseases on HIV infection in rural Tanzania: randomized controlled trial." In: The Lancet, 346:530-36.

Heterosexual Contact

Similar to MSM, the following direct measures of risk behavior are collected and analyzed to provide information about behaviors associated with acquiring or transmitting HIV infection among persons engaging in heterosexual contact:

- Number of sex partners
- Frequency of condom use
- Substance use
- High risk situations (IDU, STD, anal sex, or exchange of sex for money or drugs in the last 12 months)

Questions asked of clients with a new diagnosis of HIV infection or syphilis by local disease intervention specialists (DIS) in Ohio, the Behavioral Risk Factor Surveillance System (BRFSS), and the Youth Risk Behavior Survey (YRBS) provide information on risk behaviors related to heterosexual contact.

According to the 2013 Ohio YRBS:

- **Number of Sex Partners**. Forty-three percent of high school students and 57 percent of 12th grade students reported having sexual intercourse, suggesting that the majority of students in Ohio will have sex while in high school. More than 11 percent of high school students reported having four or more sex partners. Over 12 percent of males and 10 percent of females report having had four or more sex partners, and nearly 20 percent of 12th grade students reported four or more sex partners during their lifetime.

- **Frequency of Condom Use**. Among Ohio high school students, approximately 51 percent of those surveyed who have had sexual intercourse in the previous three months reported using a condom at last sexual intercourse. More females (66 percent) than males (56 percent) who have had sexual intercourse in the past three months reported using a condom at last sexual intercourse.

- **Substance Use.** The Ohio Department of Health STD Surveillance Program also collects data that may indicate high-risk behaviors among heterosexual males and females. While heterosexual males and females with early syphilis may not be representative of all heterosexual males and females in Ohio, data on these persons does provide valuable information on HIV risk behaviors in a subpopulation of high-risk heterosexual males and females.

  Approximately 53 percent of heterosexual persons reported with early syphilis in Ohio indicated engaging in non-injection drug use in 2014. More males reported engaging in non-injection drug use (61 percent) compared to females (44 percent).

  According to the 2013 YRBS, 18 percent of Ohio high school students who had sex in the past three months used alcohol or drugs at last sexual intercourse. Alcohol and drug use at last sexual intercourse was higher among males (24 percent) than females (14 percent).

High Risk Situations. The 2010 Behavioral Risk Factor Surveillance System (BRFSS) was the last year the sexual health module was conducted that included questions regarding high-risk sexual situations. High-risk situations include IDU, contracting an STD, anal sex, or exchanging sex for money/drugs in the last 12 months. According to the 2010 Ohio BRFSS, a greater proportion of females (3.8 percent) engaged in a high-risk situation in the past 12 months compared to males (2.8 percent). In addition, approximately 11 percent of persons interviewed who were 18-24 years of age, 8.5 percent of black/African Americans, and nearly 12 percent of Hispanic/Latino persons interviewed reported engaging in a high-risk situation in the past 12 months (Table 8).

Demographic Characteristics	%
Sex	
Males	2.8%
Females	3.8%
Age as of 12/10	
18-24	10.8%
25-34	5.6%
35-44	1.4%
45-54	1.7%
55-64	0.6%
Race/Ethnicity	
White, not Hispanic	2.6%
Black/African American, not Hispanic	8.5%
Hispanic/Latino	11.6%
Total	3.3%
Source: Behavioral Risk Factor Surveillance System (BRFSS), 2010	

Table 8. Percent of high-risk situations in the past 12 months among persons who had heterosexual contact, by demographic characteristics, Ohio, 2010

Injection Drug and Other Substance Use

Among persons who report injection drugs use (IDU) or other substances (illegal and legal), the following measures of risk behavior are available in Ohio to provide information associated with acquiring or transmitting HIV infection:

- Injection drug and other substance use
- Exchanging sex for drugs or money

The Substance Abuse and Mental Health Services Administration (SAMHSA) Treatment Episode Data Set (TEDS), Youth Risk Behavior Survey (YRBS), and questions asked of clients newly diagnosed with HIV or syphilis by local Disease Investigation Specialists (DIS) in Ohio provides useful information on behaviors related to substance use.

Substance Abuse Treatment. SAMHSA TEDS provides client-level data routinely collected by states' administrative data systems to monitor their substance abuse treatment systems. The TEDS system consists of the Admissions and the Discharge Data Sets. The TEDS Admission Data Set includes client-level data on substance abuse treatment admissions from 1992 through the present. The TEDS Discharge Data Set includes information from clients discharged in 2000 and later. A Minimum Data Set of items collected by all states where individual data items are reported include demographic information, primary substances and their route of administration, frequency of use, and age at first use.

The Youth Risk Behavior Survey (YRBS) is a self-administered questionnaire distributed in public and private high schools containing grades 9-12 throughout the U.S. Schools for incarcerated youth are not included in this survey. The questionnaire contains multiple-choice questions addressing several categories of health-related behaviors including drug use, sexual behaviors, HIV infection and other STDs. The YRBS is useful in assessing HIV risk among high school students because it provides students' responses to questions about their sexual and drug use behaviors. YRBS analysis is only representative of high school students and because the survey is based upon self-reports, there is the potential for reporting bias.

The YRBS for 2013 reveals that overall, 2.2 percent of Ohio high school students reported using a needle to inject any illegal drug into their body one or more times during their life. IDU was highest among male students (3.3%) and students in twelfth grade (3.1%) (Figure 5).

Interviews conducted by local disease investigation specialists (DIS) as part of routine partner services revealed that among 870 clients newly diagnosed with HIV infection in Ohio in 2014, approximately four percent (n=33) of persons interviewed reported exchanging sex for drugs or money (data not shown).

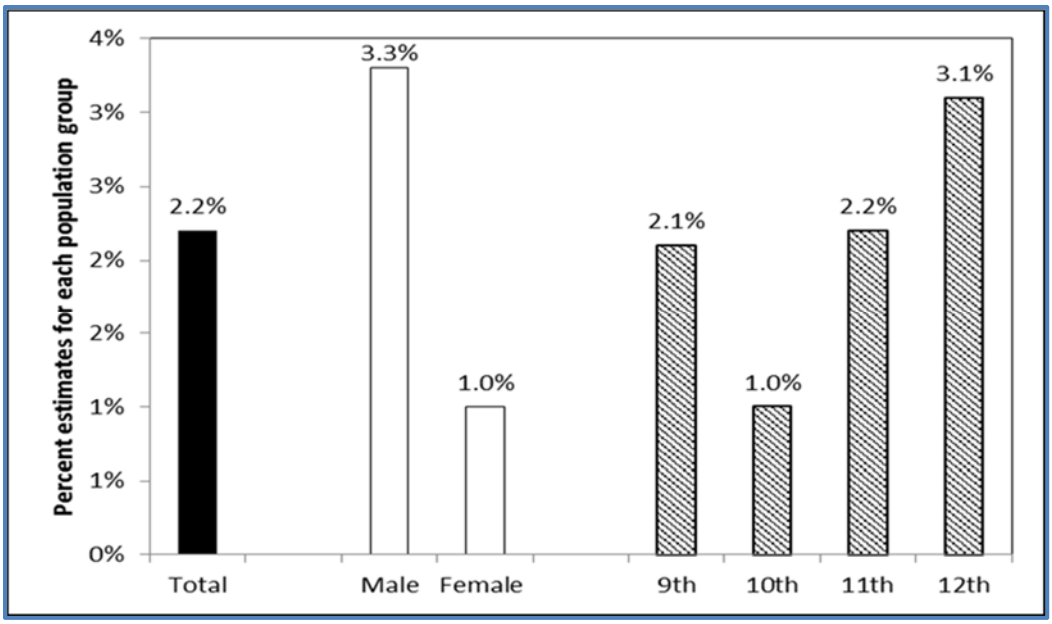


Figure 5. Injection drug use among high school students, by sex and school grade, Ohio, 2013

Indirect Measures of Substance Abuse Risk Behavior. As a national client-level database on substance abuse treatment, SAMHSA TEDS provides data on substance abuse treatment events routinely collected by states. It primarily includes information on clients admitted to programs that receive public funds. Because SAMHSA TEDS is an admission-based system, it may include duplicated individuals if an individual has multiple admissions in one calendar year.

According to SAMHSA TEDS, in 2011, there were 64,780 substance abuse admissions to Ohio licensed substance abuse treatment facilities. Wait lists for services are common so this does not represent the entire need for services. Of the 64,780 admissions, more than 14 percent were related to heroin use, almost 12 percent related to opiates other than heroin; over 6 percent related to smoking cocaine and almost 2 percent related to cocaine use through another route (Table 9). The majority of persons admitted to substance abuse treatment centers were males, between 20-29 years of age and white. However, these treatment admission demographics differ somewhat by primary substance.

Looking at sex by primary treatment admissions, the proportion of male admissions for alcohol, alcohol with secondary drug and marijuana were two or more times greater than female admissions. The majority of substance abuse treatment admissions were male except for cocaine (smoked) and opiates other than heroin, where females comprised the majority of admissions (Table 9).

The age distribution among treatment admissions differs somewhat by primary substance. Persons admitted for heroin, opiates other than heroin and marijuana use were younger compared to the other admissions categories. Almost 55 percent of heroin admissions, 53 percent of opiates other than heroin admissions and almost 75 percent of marijuana admissions were for persons between 12-30 years of age. Persons admitted for treatment due to cocaine use by a route other than smoking were younger than

persons admitted for smoking cocaine. Among cocaine smokers, over 50 percent were 35-49 years of age (Table 9).

The majority of admissions to substance abuse treatment centers by primary substance were white except for admissions due to smoking cocaine where more admissions were black (54 percent. Another notable difference is among treatment admissions for methamphetamines/ amphetamines where whites accounted for 95 percent of admissions (Table 9).

	Total Admissions*	Alcohol Only	Alcohol w/ Secondary drug	Heroin	Opiates (excluding Heroin)	Cocaine (smoked)	Cocaine (other route)	Marijuana	Metham-phetamines/ Amphetamines
Sex									
Male	61.6%	69.1%	68.6%	51.5%	46.1%	46.6%	56.3%	71.2%	50.4%
Female	38.4%	30.9%	31.4%	48.5%	53.9%	53.4%	43.7%	28.8%	49.6%
Age at Admission									
12 to 19 years	14.4%	6.0%	8.1%	4.0%	5.1%	0.8%	3.4%	36.3%	8.2%
20 to 24 years	17.5%	11.4%	14.6%	23.5%	21.0%	5.2%	10.4%	23.0%	18.1%
25 to 29 years	17.6%	12.0%	14.3%	28.6%	27.2%	8.3%	19.0%	15.5%	20.2%
30 to 34 years	14.3%	12.9%	13.7%	18.7%	19.7%	12.7%	17.1%	10.6%	23.2%
35 to 39 years	9.8%	11.9%	11.5%	9.3%	10.4%	14.3%	15.6%	5.8%	12.1%
40 to 44 years	8.6%	12.9%	11.7%	5.6%	6.1%	19.0%	12.4%	3.9%	9.1%
45 to 49 years	7.8%	13.5%	12.2%	3.7%	4.6%	18.5%	7.6%	2.5%	6.3%
50 to 54 years	6.0%	10.7%	8.9%	3.3%	3.6%	14.1%	9.0%	1.5%	2.5%
55 to 59 years	2.9%	5.8%	3.6%	2.3%	1.9%	5.4%	4.0%	0.7%	0.4%
60 years and older	1.2%	2.9%	1.3%	0.9%	0.6%	1.6%	1.5%	0.2%	0.0%
Race/Ethnicity									
White (non-Hispanic)	72.4%	81.3%	69.6%	91.6%	94.9%	43.5%	66.2%	54.0%	95.1%
Black (non-Hispanic)	25.0%	15.8%	27.9%	5.7%	3.8%	54.1%	30.3%	42.8%	3.9%
Hispanic	1.8%	2.0%	1.6%	2.2%	0.9%	1.5%	2.8%	2.2%	0.9%
American Indian/Alaska Native	0.2%	0.2%	0.3%	0.1%	0.2%	0.3%	0.0%	0.1%	0.0%
Asian/Pacific Islander	0.2%	0.4%	0.2%	0.1%	0.2%	0.1%	0.2%	0.1%	0.2%
Other	0.4%	0.3%	0.4%	0.3%	0.1%	0.5%	0.5%	0.7%	0.0%
Number of Admissions	64,780	10,186	11,691	9,263	7,562	4,137	1,207	15,887	570
Percentage of Admissions	100.0%	15.7%	18.0%	14.3%	11.7%	6.4%	1.9%	24.5%	0.9%

*In addition to substances reported in the table, total admissions also includes tranquilizers, sedatives, hallucinogens, PCP, inhalants and other/unknown substances.

Source: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS). Data received through October 15, 2012.

Table 9. Substance abuse treatment admissions by primary substance of abuse, by selected characteristics, Ohio, 2011.

Laboratory Data as Marker for Clinical Care

The Centers for Disease Control and Prevention (CDC) defines "linkage to care" using reported CD4 T-lymphocytes and viral load (VL) lab results as a proxy measure to assess whether or not a person diagnosed with an HIV infection was linked to care early in their HIV diagnosis. Ohio examined these lab results at

specific time intervals (3 months, 6 months, and 12 months) to illustrate the progression of linkage to care within the first year of diagnosis for persons diagnosed with HIV infection each year 2011-2014.

Data Source. The Ohio Department of Health (ODH) HIV case surveillance data is the source of the case and laboratory data used to estimate linkage to care. The enhanced HIV/AIDS Surveillance System (eHARS) is used to store the data used for estimating linkage to care based upon CD4 and viral load lab results reported by laboratories, hospitals, and outpatient clinics for persons newly diagnosed with an HIV infection in Ohio.

Completeness of Lab Results Reporting. Completeness of CD4 and VL lab results reporting is a key factor impacting the accuracy of linkage to care estimates which rely exclusively on these two lab tests as proxy measures of whether or not a person has received care following their initial HIV diagnosis. While Ohio's HIV disease reporting rule has required the reporting of CD4 and viral load results for persons diagnosed with an HIV infection since 2003, only those result values that met CDC's HIV surveillance case definition for AIDS were mandated as reportable to public health. A statewide effort to improve the completeness of Ohio's reported CD4 and VL data went into effect July 1, 2014. As of this date, Ohio Administrative Code 3701-3-12 was revised to require laboratories to report all CD4 and viral load values for persons with a diagnosed HIV infection in Ohio. It is essential to understand completeness of reporting not only factors in the reporting of the actual lab result values (e.g. CD4 count/percentage and/or viral load copies per mL) to public health, but also the reporting of the complete specimen collection date the lab(s) were drawn.

Calculation. To estimate on a population level the proportion of persons newly diagnosed with an HIV infection linked to care following their HIV diagnosis, two data points are required:

Numerator = All persons newly diagnosed and reported with an HIV infection in Ohio with ≥1 CD4 and/or VL performed within 3, 6 and/or 12 months following initial diagnosis.

Denominator = All persons newly diagnosed and reported with an HIV infection in Ohio in a calendar year.

Analysis. CDC provided all funded U.S. state and territorial HIV case surveillance programs with a Statistical Analysis Software (SAS) program to assist in assessing linkage to care estimates using HIV surveillance data. The analytical program provides only state-level estimates of linkage to care. Ohio's estimates were produced using the CDC created analytical program and Ohio's final HIV surveillance datasets for 2011-2014. Analyses performed compare the date of initial HIV diagnosis against the date a blood specimen was drawn to evaluate CD4 and/or viral load status as determined by the laboratory performing the testing.

Results. When using CD4 and VL lab results reported as a proxy for being linked to medical care after initial HIV diagnosis, the following estimates of the proportion of the 1,085 persons newly diagnosed and reported with an HIV infection in Ohio in 2011 were linked to care: 71 percent were linked within 3 months following diagnosis; 72 percent were linked within 6 months following diagnosis; and 80 percent were linked within 12 months following diagnosis (Figure 6). These proportions continued to increase at each time interval linkage to care was estimated in 2012 and 2013. In 2014, there was a decline in the overall number of new HIV diagnoses and the proportion of those linked to care within 3, 6 and 12 months of their HIV diagnosis.

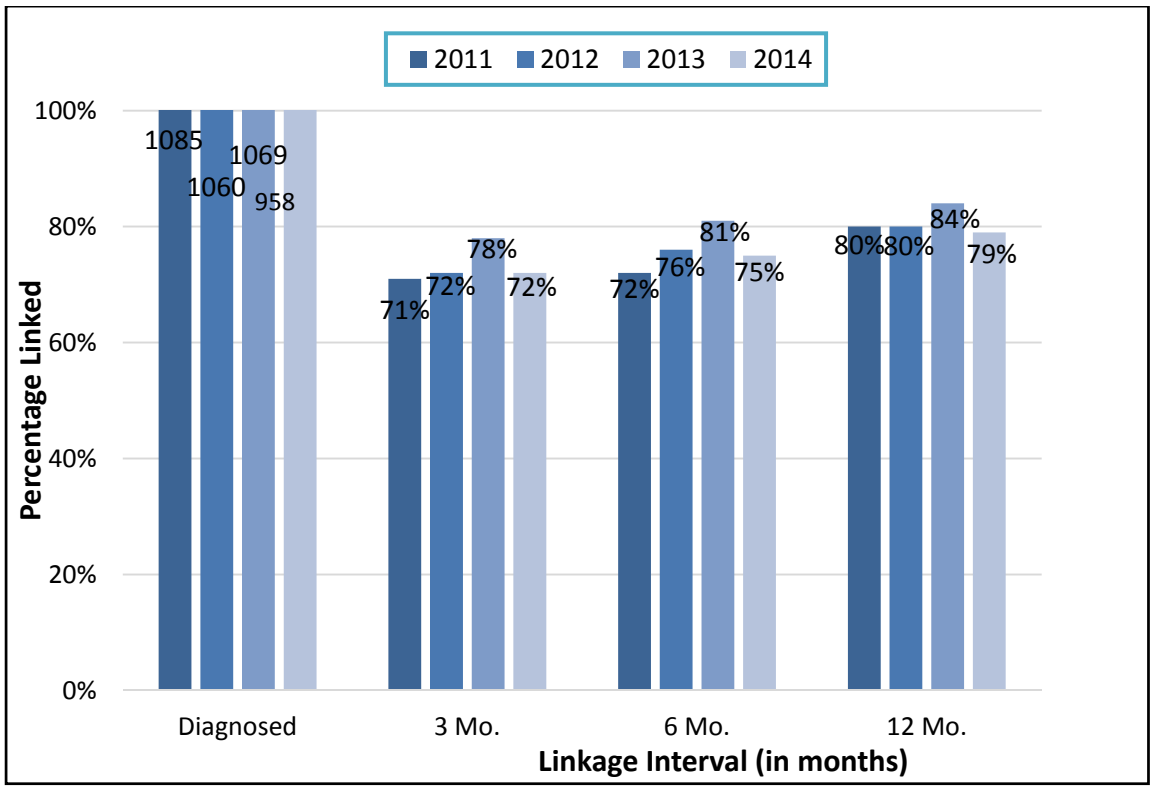


Figure 6. Ohio Linkage to Care Within One Year of Diagnosis, 2011-2014.[5]

Limitations. Results should be interpreted with great caution as the estimates of linkage to care in Ohio were based upon CD4 reporting completeness that ranged from 53%-58%, and viral load reporting completeness that ranged from 64%-71%. There are several limitations that must be factored in when using HIV surveillance data as a proxy measure of whether or not a person is linked to care. These include the following:

- Results include only persons consenting to confidential (i.e. named) testing and do not include persons newly diagnosed through anonymous testing.
- Results do not factor in persons who may be infected but have not sought testing to learn their HIV diagnostic status (i.e. persons undiagnosed).
- Results do not factor in underreporting of cases by health care providers/facilities.
- Lack of complete CD4 and/or viral load reporting impacts accuracy of linkage estimates.
- Lags in reporting CD4 and/or viral load reporting impacts accuracy of linkage estimates.

Summary. The proportion of persons newly diagnosed with an HIV infection in Ohio who were linked to care increased each year 2011-2013, however; linkage decreased between 2013-2014. The decline occurred in spite of the continuing increase in the total volume of CD4 and VL results reported to the ODH

[5] Assumes the use of CD4 and/or viral load lab results for persons newly diagnosed with HIV infection reported to the ODH HIV Surveillance Program as a proxy measure for receipt of clinical care. **Source**: Ohio Department of Health HIV Surveillance Program.

HIV Surveillance Program in 2014 compared to the previous three years. When linkage to care is examined on the national level for the creation of a linkage-based continuum of care, only those CD4 and/or VLs results performed (and reported) within three months of HIV diagnosis are assessed, and a person is considered linked to care only if/when one or more CD4 or viral load results were performed within three months of their initial HIV diagnosis.

Next steps. The ODH HIV Surveillance Program is committed to improving the CD4 and viral load (VL) reporting completeness levels in support of measuring outcomes along the continuum of care for persons diagnosed and living with an HIV in Ohio. The HIV Surveillance Program works with the ODH Ryan White HIV Care Services Program to perform a quarterly match against the Ryan White All Parts database to identify and import CD4 and VLs into the HIV/AIDS Surveillance System to fill in gaps in reporting of these laboratory results. HIV surveillance staff will collaborate with the ODH Electronic Laboratory Reporting (ELR) program to participate in the recruitment, onboarding and testing of laboratories to increase electronically report infectious disease lab results to ODH, including HIV lab results. It is through ELR activities where Ohio's HIV Surveillance Program will continue to improve the completeness of CD4 and VL reporting, thereby closing gaps in reporting of these results. Surveillance efforts will also focus on working with laboratories to standardize the reporting of HIV lab results using the Regenstrief Institute's recommended Logical Observation Identifiers Names and Codes (LOINC). HIV diagnostic and prognostic tests have several LOINC that are recommended for use in reporting these lab results using electronic messaging standards. Lastly, health care facilities in Ohio will be targeted for education to remind them about HIV reporting requirements in Ohio, specifically the reporting of all CD4 and VL results for persons under their treatment and care, regardless of where and when the patient was first diagnosed with HIV infection.

HIV Prevention Testing, Monitoring and Evaluation Data

The ODH HIV Prevention Program collects and analyzes HIV testing and associated outcomes data as part of Counseling, Testing and Referral (CTR) and Expanded Test Site (ETS) program monitoring and evaluation activities. The data in Tables 10 through 13 represents data reported to the ODH HIV Prevention Program by state funded testing sites and local Disease Intervention Specialists (DIS) performing Partner Services (PS). Interviewed for PS is measured as having been interviewed for PS subsequent to the positive test event. Linkage to care (LTC) is defined as documentation that the client attended their first HIV medical care appointment within 90 days of the positive test event. The significant increases in LTC and PS interview proportions observed in 2015 are likely due to increased follow up for data collection and documentation. The disparity between clients who tested at CTR sites and those testing at expanded test sites for the proportion of clients linked to care, may be due to differences in the populations testing at each type of site. Patients tested at CTR sites have actively sought testing for HIV and are likely to be healthier than patients tested at ETS sites. The highest volume of ETS testing occurs in the Emergency Departments (ED) of five large medical centers throughout Ohio. HIV testing is offered to ED patients who are seeking treatment for other health concerns. The ED patient populations include a high volume of clients with elevated barriers to healthcare access. Some of these barriers include higher rates of being uninsured, homeless, unemployed, transiency, or having substance abuse issues that make it more difficult for Disease Intervention Specialists and Linkage to Care Coordinators to locate clients and provide services. Even when a client experiencing these barriers is located and appointments are made, the person is more likely to have difficulty getting to the medical appointment and accessing care. These socio-economic

barriers may also make some clients less likely to accept partner services due to feelings of distrust for government officials and fear of stigma and repercussions within their own communities.

Over the next five years, the HIV Prevention Program will work with the Ryan White HIV Care Programs and other stakeholders across the state to create processes that increase the proportion of HIV positive individuals linked to care. This process development will define linkage, retention and re-engagement in care and outline the overlapping roles on the care continuum of prevention and care staff at the state and local levels.

Risk Category	Frequency	Percent
High-risk heterosexual contact	21972	44.51
High-risk sex with transgender or female to female contact	524	1.06
IDU	2974	6.02
Low-risk heterosexual contact	12866	26.07
Low-risk sex with transgender or female to female contact	233	0.47
MSM	6573	13.32
MSM/IDU	171	0.35
MTFSM	84	0.17
MTFSM/IDU	4	0.01
Unknown	3960	8.02
Total	**49361**	**100**

Table 10: 2014 Primary Risk Category for people utilizing the Ohio Department of Health Category A HIV test sites

The HIV Prevention Category A CTR test sites are tasked with performing targeted testing that focuses on populations at high risk for HIV infection. The goal is to achieve a 1.0% positivity rate overall as an indicator of effective targeted testing. The positivity rate at Category A sites has remained steady at approximately 0.55% between 2013 and 2015. The HIV Prevention Program will assess positivity rates by region and by sites within regions to determine whether relocation of sites and/or redirection of funds can be used to increase the positivity rates in all regions of the state.

Primary Risk Category	Primary Race	
	Black or African American	White
High-risk heterosexual contact	12296	7966
	50.08%	38.03%
High-risk sex with transgender or female to female contact	305	176
	1.24%	0.84%
IDU	203	2650
	0.83%	12.65%
Low-risk heterosexual contact	7330	4496
	29.85%	21.47%
Low-risk sex with transgender or female to female contact	159	56
	0.65%	0.27%
MSM	1898	4106
	7.73%	19.60%
MSM/IDU	19	144
	0.08%	0.69%
MTFSM	46	30
	0.19%	0.14%
MTFSM/IDU	0	4
	0%	0.02%
Unknown	2299	1317
	9.36%	6.29%
Total	24555	20945

Table 11: 2014 Primary Risk Category for people utilizing the Ohio Department of Health Category A HIV test sites by Race

Year	Number of Test Events	Newly Diagnosed Positive Test Events	Positivity Rate	Newly Diagnosed Positive Test Events with Client Linked to HIV Medical Care	Linked to HIV Medical Care Percentage	Newly Diagnosed Confirmed Positive Test Events	Newly Diagnosed Confirmed Positive Test Events with Client Interviewed for Partner Services	Percentage Interviewed for Partner Services	Newly Diagnosed Confirmed Positive Test Events with Client Referred to Prevention Services	Percentage Referred to Prevention Services
2012	50228	334	0.66%	198	59.28%	244	125	51.23%	228	93.44%
2013	49701	272	0.55%	165	60.66%	175	129	73.71%	163	93.14%
2014	43028	235	0.55%	117	49.79%	177	114	64.41%	124	70.06%
2015	45301	253	0.56%	188	74.31%	233	201	86.27%	205	87.98%
Total	**188258**	**1094**	**0.58%**	**668**	**61.06%**	**829**	**569**	**68.64%**	**720**	**86.85%**

Table 12.

Positivity, Partner Services and Linkage to Care at HIV Prevention CTR Testing Sites, 2012-2015.

Year	Number of Test Events	Newly Diagnosed Positive Test Events	Positivity Rate	Newly Diagnosed Positive Test Events with Client Linked to HIV Medical Care	Linked to HIV Medical Care Percentage	Newly Diagnosed Confirmed Positive Test Events	Newly Diagnosed Confirmed Positive Test Events with Client Interviewed for Partner Services	Percentage Interviewed for Partner Services	Newly Diagnosed Confirmed Positive Test Events with Client Referred to Prevention Services	Percentage Referred to Prevention Services
2012	10831	46	0.42%	23	50.00%	29	10	34.48%	25	86.21%
2013	12666	59	0.47%	26	44.07%	30	16	53.33%	17	56.67%
2014	11885	93	0.78%	38	40.86%	62	35	56.45%	43	69.35%
2015	14434	49	0.34%	20	40.82%	43	17	39.53%	39	90.70%
Total	**49816**	**247**	**0.50%**	**107**	**43.32%**	**164**	**78**	**47.56%**	**124**	**75.61%**

Table 13. Positivity, Partner Services and Linkage to Care at HIV Prevention Expanded Testing Sites, 2012-2015.

Ryan White Program Data

The All-Parts Clinical Quality Management Database is a central repository that houses data on care services utilized and health outcomes from all Ryan White grantees in Ohio. The data is currently hosted by the ODH HIV Care Services (HCS) Program on behalf of the Ohio All-Parts Group (a.k.a. Ohio H4C Response Team). The ODH Ryan White Program is supported by Part B funds and maintains database systems containing client-level data required for the Ryan White Services Report (RSR) and the ADAP Data Report (ADR). CAREWare is the data system used to maintain the All-Parts Clinical Quality Management Database. Ryan White partners retroactively submit data to HCS to analyze data for HIV care continuum data points, quality improvement (QI) related projects, and to assess health outcomes of clients.

An analysis of client characteristics, services utilized and health outcomes from the All-Parts Clinical Quality Management Database was performed with unduplicated client level data for 2014. The results are described below.

Characteristics of Clients Served by Ryan White Programs

Sex. Males accounted for the majority of clients served through Ohio's Ryan White Programs in 2014 (76 percent). However, the percentage of males served through Ohio's Ryan White Programs is less when compared to the percentage of males living with a diagnosis of HIV infection in Ohio in 2014 (80 percent).

Age. In 2014, clients 45-64 years of age accounted for the greatest proportion of persons being served by Ryan White Programs (48 percent). This is consistent with Ohio HIV prevalence data. The same age group accounted for 53 percent of persons living with a diagnosis of HIV infection in Ohio in 2014.

Race/ethnicity. Black/African Americans are disproportionately affected by HIV infection in Ohio. Ohio Ryan White Programs served more black/African Americans (48 percent) than any other race/ethnicity in 2014. This is similar to the proportion of black/African Americans living with a diagnosis of HIV infection in Ohio in 2014 (44 percent). White, non-Hispanic clients represented 44 percent of persons served by Ryan White in 2014, followed by Hispanics (6 percent). All other race/ethnicities accounted for slightly more than one percent of Ryan White clients served in 2014.

HIV/AIDS Status. Early diagnosis of HIV infection provides patients with timelier access to treatment which improves health outcomes and decreases potential for future transmission. Over half (51 percent) of clients served by Ohio Ryan White Programs in 2014 had HIV infection only. Thirty one percent had CDC-defined AIDS diagnosis, and 17 percent were HIV infected but with an unknown AIDS status.

Household Income. All Ryan White Services have eligibility requirements that are based upon a percentage of the federal poverty level (FPL). The majority of the clients (54 percent) served by Ohio Ryan White Programs in 2014 were below 138 percent of the FPL. Ten percent of clients served were between 139 and 200 percent of the FPL, 11 percent were between 201 and 300 percent of the FPL, and the remaining clients (4 percent) above 300 percent of the FPL. Caution should be used when interpreting Household Income due to incomplete reporting of FPL values for some of the clients (22 percent) served by Ryan White Programs in 2014.

Housing Status. Eighty one percent of clients served by Ohio Ryan White Programs in 2014 were considered to have stable housing at the end of the year, while ten percent were either not in stable housing, institutionalized, and/or in some other unstable situation. Nine percent of clients served had an unknown housing status.

Risk Factor/Exposure Category. Among clients served by Ohio Ryan White Programs in 2014, the leading risk factor/exposure category was male-to-male sexual contact (57 percent) followed by heterosexual contact (33 percent). Injection drug use was a risk factor/exposure category for three percent of clients served, and the remaining risk factors/exposure categories accounted for about six percent.

Utilization of Ryan White Program Services

Utilization of core medical services and support services by Ryan White clients was assessed for calendar year 2014. The number of clients in each service category is an unduplicated number of clients who received the service at any of the Ryan White funded providers during the 2014 reporting period. Information is also provided on medical insurance and drug assistance provided to clients enrolled in Ohio's AIDS Drug Assistance Program (ADAP) Program in 2014.

Core Services. The two most utilized core services are outpatient/ambulatory medical care (OAMC) and medical case management (MCM), which were utilized by 6,673 (71 percent) and 6,200 (66 percent) Ryan White clients, respectively. Oral health (8 percent) and mental health (10 percent) care services were also utilized by Ryan White clients, but at a much lower frequency. All other core services provided by Ohio Ryan White Parts were utilized by less than 5 percent of Ryan White clients during the 2014 reporting period.

Support Services. Support services including health education/risk education, medical transportation services, and treatment adherence counseling were the most commonly utilized support services by Ryan White clients in Ohio in 2014. During the 2014 reporting period, 2,182 (23 percent) Ryan White clients utilized health education/risk education, 1,882 (20 percent) utilized medical transportation services, and 2,419 (26 percent) utilized treatment adherence counseling.

While the above describes utilization data from all Ryan White grantees, Tables 14 (Core Medical Services) and 15 (Support Services) describe those services provided by only the Ryan White Part A and B grantees in Ohio.

CORE MEDICAL SERVICES	Part A Cleveland **Counties Served**: Lorain, Cuyahoga, Geauga, Lake, Medina, and Ashtabula	Part A Columbus **Counties Served**: Franklin, Pickaway, Fairfield, Licking, Delaware, Union, and Madison	Part B Ohio All Ohio Counties
Early Intervention Services (EIS)	3 providers	--	--
Health Insurance Premium Cost-Sharing Assistance	2 providers (300-500% FPL)	--	ADAP (statewide <300%FPL)
Home and Community-Based Health Services	1 provider	--	
Home Health Care	1 provider	--	--
Medical Case Management			
• Cleveland Clinic Foundation	1 case manager	--	--
• Mercy Regional Medical Center	1 case manager	--	--
• Metrohealth Medical Center	4 case managers	--	2 case managers
• Nueva Luz Urban Resource Center	3 case managers	--	2.25 case managers
• Signature Health	1 case manager	--	
• University Hospitals of Cleveland	3 case managers	--	
• AIDS Task Force of Greater Cleveland	--	--	7 case managers
• Equitas Health--Columbus	--	7 case managers	15 case managers
• Nationwide Children's Hospital-FACES Program	--	2 case managers	Access Point
• AIDS Healthcare Foundation	--	1.2 case managers	--
• Columbus Public Health	--	5 case managers	Access Point
• Southeast, Inc.	--	--	2 case managers
• Caracole (Cincinnati)	--	--	15 case managers
• Equitas Health--Lima	--	--	2 case managers
• Equitas Health—Toledo	--	--	5 case managers
• Equitas Health—Dayton	--	--	9 case managers
• Equitas Health--Akron	--	--	5 case managers
• Equitas Health--Canton	--	--	3 case managers
• Equitas Health—Youngstown	--	--	3 case managers
• Equitas Health--Mansfield	--	--	3 case managers
• Equitas Health—Rural Southeast	--	--	4 case managers
Local AIDS Pharmaceutical Assistance (LPAP)	3 providers	--	ADAP
Medical Nutrition Therapy	3 providers	--	--
Mental Health Services	7 providers	5.1 providers	33 providers
Outpatient Ambulatory Medical Care	5 providers	8.06 providers	119 providers
Oral Health Services	2 providers	--	53 providers
Substance Abuse—Outpatient	4 Providers	--	--

Table 14. Core Medical Service Categories funded by Ryan White Parts A and B in Ohio, by service region.

SUPPORT SERVICES	Part A Cleveland	Part A Columbus	Part B Ohio
	Counties Served: Lorain, Cuyahoga, Geauga, Lake, Medina, and Ashtabula	**Counties Served**: Franklin, Pickaway, Fairfield, Licking, Delaware, Union, and Madison	All Ohio Counties
Non-Medical Case Management	6 case managers	4 case managers	
Emergency Financial Assistance		--	
Food Bank/Home Delivered Meals	2 providers	--	
Legal Services	1 provider	--	
Medical Transportation Services	7 providers	--	
Outreach Services	4 providers	--	
Psychosocial Support Services	4 providers	--	
Substance Abuse Tx-Residential	1 provider		

Table 15. Support Service Categories funded by Ryan White Parts A and B in Ohio, by service region.

Utilization of ADAP Services

Medical Insurance Coverage. With the implementation of the Affordable Care Act (ACA) and Medicaid Expansion in Ohio, the percentage of ADAP enrollments for clients without insurance has decreased from 2014 (40 percent) to 2015 (20 percent). The percentage of enrollments in Medicaid assistance has slightly increased from 2014 (19 percent) to 2015 (23 percent). It is suspected this increase isn't higher because as clients enroll in Medicaid they often no longer need ADAP services (Tables 16).

Insurance Assistance Received and Type. Insurance assistance includes premium payments (partial or full), Medicare Part D co-insurance, deductibles, and co-pays and deductibles for medications. Of the 6,338 clients served by Ohio's ADAP in 2014, 2,795 (44 percent) received some type of insurance assistance. In 2015, the percentage of clients receiving some type of insurance assistance increased to 55 percent. As more ADAP clients are enrolled in insurance through the ACA, the data are showing an increase in full premium payment and a decrease in co-insurance or a medication co-pay/deductible. In 2014, 34.3 percent of clients received a full premium payment and 65.7 percent received co-insurance or a medication co-pay/deductible. In 2015, 39.4 percent of clients received a full premium payment and 60.6 percent received co-insurance or a medication co-pay/deductible. Please note that some Ryan White clients receive both a full premium payment and medication co-pay/deductible assistance (Table 16).

ADAP Funded Medication Dispensed. Just over 50 percent of Ohio's ADAP clients served in 2014 were dispensed medications that were paid for in full by ADAP. In 2015, only 32 percent were dispensed medications that were paid for in full by ADAP (Table 16).

Enrollment Status. Of the 6,338 clients enrolled in Ohio's ADAP in 2014, 5,001 (79 percent) received some type of ADAP service, 972 (15 percent) were enrolled but did not request services, and 365 (6 percent) were dis-enrolled. The majority of the clients dis-enrolled (74 percent) were for an unknown reason. The remaining clients were ineligible for ADAP services or deceased.

In 2015, only 3572 (70 percent) of clients received some type of ADAP service, 1091 (20 percent) were enrolled without requesting a service and 436 (9 percent) were dis-enrolled. While more clients were dis-

enrolled in 2015, the predominant reason is still unknown. Some preliminary data shows that the increase in disenrollment is actually due to Medicaid expansion. HIV Care Services is in the process of adding more disenrollment reasons in the Ryan White Part B Application Database to more accurately identify trends (Table 16).

Characteristic	No.	%
[2]Medical Insurance		
Private Health Insurance	1954	20.7
Medicaid	1825	19.3
Other Plan	55	0.6
No Insurance	3769	39.9
Medicare Part D	1839	19.5
Insurance Assistance Received		
Yes	2795	44.1
No	3543	55.9
[2]Insurance Assistance Type		
Full Premium payment	1297	34.3
Co-pay/deductible including Medicare Part D	2481	65.7
ADAP Funded Medication Dispensed		
Yes	3230	51.0
No	3108	49.0
Enrollment Status		
Enrolled, receiving services	5001	78.9
Enrolled, services not requested	972	15.3
Disenrolled	365	5.8
[3]Disenrollment Reason		
Ineligible for ADAP, no longer meets ADAP eligibility	44	12.1
Deceased	51	14.0
Other/Unknown	270	74.0
New or Exisiting Client		
Newly enrolled client	824	13.0
Exisiting Client	5514	87.0
Household Income at the end of Reporting Period (as % of FPL)		
≤ 100% of FPL	2962	46.7
101-138% of FPL	925	14.6
139-200% of FPL	1207	19.0
201-250% of FPL	660	10.4
251-400% of FPL	556	8.8
401-500% of FPL	3	0.0
More than 500% of the FPL	25	0.4
Unknown/Unreported	0	0.0
Total Clients Served by ADAP	**6338**	

Notes:

[2]Multiple Values can be indicated for any given client. The total count my exceed that of the number of clients represented.

[3]This breaks down the number of disenrolled from the Enrollment Status characteristic.

Source: Ohio Department of Health HIV Care Services Program. Data reported through December 31, 2014.

Table 16. Clients enrolled in Ohio's ADAP Program as of December 31, 2014 by selected characteristics

Health Outcomes among Clients Receiving Ryan White Services

The health outcomes adopted from the Ryan White Services Report (RSR) and the performance measures suggested by HRSA's HIV/AIDS Bureau (HAB) help Ryan White Programs assess whether they are meeting the standards of care for HIV. All outcome measures described below are for Ryan White clients with at least one outpatient ambulatory medical care (OAMC) visit in 2014, unless otherwise specified. The outcome measures reported here were calculated using data reported from all the Ryan White Parts in Ohio. The data was further analyzed and described to present the outcome measures for all of the Ryan White clients. Caution should be used when comparing the data to outcome measures reported by individual Ryan White grantees because of possible differences in data definitions.

OAMC Visits. There were 6,673 Ryan White Clients who received an OAMC visit during the 2014 reporting period. Of these, one third (33 percent) had only one OAMC visit. The majority of clients (67 percent) had more than one OAMC visit.

ART. Among the Ryan White Clients with at least one OAMC visit, 4,593 (75 percent) were prescribed anti-retroviral therapy (ART) at some point during the 2014 reporting period. This result is lower than the expected based upon other data sources. Due to implementation of ACA and Medicaid expansion in Ohio, fewer Ryan White clients are getting their medication directly through Ohio's ADAP but more are receiving assistance with insurance copayments. The data from these non-ADAP providers are not always reported back to various Ryan White Parts in Ohio and could affect the outcome measure of clients on ART.

Screenings. In general, screening rates are lower than expected, and effort is being made to improve reporting of this data to determine if the current rates are representative of the Ryan White Program. Mental health and substance abuse screening were the two exceptions. There were 5,084 (83 percent) Ryan White clients in Ohio who received a mental health screening, and 5,146 (84 percent) who received a substance abuse screening during the 2014 reporting period.

Hepatitis B Vaccination. Completion of the Hepatitis B vaccine series is another performance measure for which complete data is lacking and the reported rate does not likely reflect program performance for this measure. Only 105 (2 percent) Ryan White clients completed the Hepatitis B vaccine series at the end of the 2014 reporting period.

Most Recent VL. There were 4,666 (76.3 percent) Ryan White clients whose viral load was less than 200 copies/ml on their most recent viral load test. Only 284 (4.5 percent) Ryan White clients had a viral load value that was not reported or unknown during the 2014 reporting period. The proportion of missing viral load data for the reporting period was much lower than it has been in previous years, and is one of the major benefits of having a centralized repository for all the Ryan White grantee data.

Most Recent CD4. The analysis of the most recent CD4 count shows that 622 (10.2 percent) of Ryan White clients had a CD4 count of <200 cells/mm3 on their most recent test, and 5,643 (84.6 percent) had a CD4 count value ≥200 cells/mm3 on their most recent test during the 2014 reporting period. Only 315 (5.2 percent) Ryan White clients had a CD4 count that was unreported or unknown during the reporting period. This proportion is slightly higher than the number of clients with a missing viral load value.

PCP Prophylaxis. In 2014, Ohio Ryan White clients where PCP prophylaxis was indicated, 545 (28.4 percent) received PCP prophylaxis. The provision of PCP prophylaxis in the remaining 1,376 (71.6 percent) was not documented.

Early Identification of Individuals with HIV/AIDS (EIIHA)

The Early Identification of Individuals with HIV/AIDS (EIIHA) is a Health Resource Service Administration (HRSA) HIV/AIDS Bureau (HAB) Ryan White Care Services initiative. The goals of EIIHA for Ryan White Part B programs are to: 1) increase the number of individuals who are aware of their HIV status, 2) increase the number of HIV positive individuals who are in medical care, and 3) increase the number of HIV negative individuals referred to services that contribute to keeping them HIV negative. Based on available data and suggested methods, Ohio currently estimates that 4,840 persons in the state have an undiagnosed HIV infection.

The data shown in Table 17 below represents newly diagnosed positive HIV test events performed by testing sites throughout Ohio who received funding for testing services through the Ohio Department of Health (ODH) HIV Prevention Program from the period of January 1, 2014 to December 31, 2014. Three at risk populations were selected for targeting in Ohio: 1) white men who have sex men (MSM), 2) black men who have sex with men (MSM), and 3) other black men who are not identified as MSM.

	Newly Diagnosed Positive HIV Test Events January 1, 2014 – December 31, 2014	**MSM White**	**MSM Black**	**Black Male**	**Total Tests**
a)	Number of testing events	5052	2181	15787	63965
b)	Number of newly diagnosed positive test events	73	152	67	380
c)	Number of newly diagnosed positive test events with client linked to HIV medical care	48	99	32	227
d)	Number of newly diagnosed confirmed positive test events	58	121	48	293
e)	Number of newly diagnosed confirmed positive test events with client interviewed for partner services	44	91	33	213
f)	Number of newly diagnosed confirmed positive test events with client referred to prevention services	46	102	36	233
g)	Total number of newly diagnosed confirmed positive test events who received CD4 cell count and viral load	UNKNOWN			

Table 17. Newly Diagnosed Positive HIV Test Events

Cleveland RWHAP Part A EIIHA. The Cleveland TGA has identified the following as their target populations for the EIIHA initiative: Black, Non-Hispanic MSM, MSM Aged 45+, Black Non-Hispanic and Hispanic/Latino(a) youth aged 13-24. All of the targeted populations in the Cleveland TGA are historically underserved and are the populations that continue to be newly diagnosed in disproportionate

percentages. Currently, one of the innovative approaches that the Cleveland TGA is using to address barriers to assessing testing and treatment is the Ryan White Part A program staff working closely with HIV prevention to increase joint meetings between agencies funded by HIV Prevention dollars in the area, as well as their sub-grantees that are receiving EIIHA funding. In 2013, the Cleveland TGA started having annual joint meetings with HIV prevention in order to work together and identify and address gaps in various areas of the continuum. During FY2015, one joint meeting was convened, so far in 2016 one meeting has taken place, and another is scheduled for the fall. Another one of the Cleveland TGA EIIHA funded agencies works closely with the county jail system re-release program, working to link those individuals leaving jail with medical care, to ensure continuity of care. Additionally, two of the Cleveland TGA funded EIIHA agencies have recently received a CDC prevention grant to conduct targeted testing with young, MSM of color. This collaboration will overlap with one of the EIIHA target populations, and identify individuals in that group that are unaware of their status, and bring them into care, and ultimately to viral suppression.

Non-Ryan White Funded HIV Medical Services

The ability to describe the health status of the non-Ryan White community is critical as they account for over 50% of Ohioans living with HIV/AIDS. Ryan White-funded providers work with other payer systems to ensure they are the payer of last resort. These payers include Medicare, Medicaid (including Medicaid Expansion and Medicaid Managed Care) and Affordable Care Act (ACA) marketplace plans. The essential health benefits are required of all marketplace plans, including Infectious Disease medical visits, primary care services, hospital level services and medication. Utilization data from these payers is limited for CY 2014 due to the magnitude of migration between payers. As a result of the HIV Integrated Planning process, a data subcommittee has been meeting to address the need for data sharing across all payers. This will allow a more complete and accurate picture of PLWHA who are HIV-positive but undiagnosed, diagnosed but not in medical care and are virally unsuppressed, regardless of payer.

B. HIV CARE CONTINUUM

Description of HIV Care Continua

Ohio HIV Care Continuum

The Ohio Department of Health HIV Surveillance Program follows the guidance set forth by the Centers for Disease Control and Prevention (CDC) HIV Incidence and Case Surveillance Branch on using HIV surveillance data to create a state level HIV continuum of care graph. The first step of this process relies on the state/jurisdiction having a reporting rule that includes the reporting of all CD4 levels of T-lymphocyte and viral load results for persons with a diagnosed HIV infection. Effective July 1, 2014, Ohio's HIV reporting rule was revised to include the reporting of all levels of CD4 and viral load results for persons diagnosed with an HIV infection in Ohio. As this change was more recent, complete CD4 and viral load data is not available in Ohio at this time. Ohio anticipates having sufficient CD4 and viral load results to produce a diagnosed-based HIV care continuum in 2017-2018. However, antiretroviral therapy (ART) will not be included as a "bar" in this graphic visual, as ART is not collected as part of case surveillance. Several states have produced continua of care excluding ART in their graph for this very reason. The national HIV

continuum of care created by CDC uses data on ART from a sample of states funded to collect this information. In addition, the national continuum of care uses CD4 and VL data from a subset of states and U.S. territories who currently have complete reporting of these lab data.

All Ryan White Parts Care Continuum

Although a statewide HIV Care Continuum is not available, the Ryan White HIV/AIDS Program (RWHAP) All Parts Group has created an HIV Care Continuum for 2014 using just the data on clients from those Ryan White Programs. The All Parts Group is comprised of representatives from all Ryan White Parts that are funded in Ohio: Part A (two TGAs – Cleveland and Columbus), Part B (statewide), Part C (seven grantees from across the state), Part D (two grantees – Cleveland and Toledo), and Part F (AETC – Columbus and Cincinnati). The group meets to discuss shared data and quality issues. Figure 8 uses surveillance data to identify people living with a diagnosis of HIV infection in Ohio at the end of calendar year 2014. The remaining bars use de-duplicated data collected by HIV Care Services through Ryan White Parts in Ohio and only represent Ryan White Clients. Numerator and denominator definitions are identified in Table 19.

The number of people living in Ohio with diagnosis of HIV infection as of December 31, 2014 was 21,612. The Ryan White Programs in Ohio collectively served 9,346 (43 percent) people living with the diagnosis of HIV/AIDS at some point of time during calendar year 2014. The number of clients who received at least one Outpatient Ambulatory Medical Care (OAMC) visit through Ryan White Programs was 6,673, which accounts for 71 percent of people served by Ryan White Programs in Ohio in 2014. The remaining categories only use data on people who received at least one OAMC visit through Ryan White Programs in 2014.

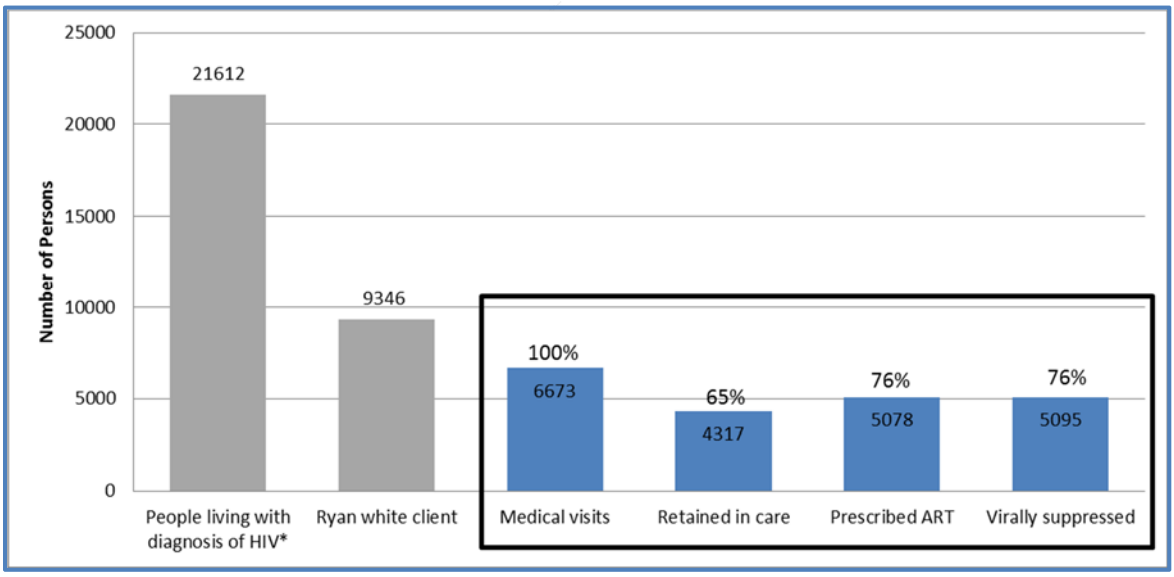


Figure 7: Ryan White All Parts HIV Care Continuum, Ohio[6]

[6] ***Notes:** Living with a diagnosis of HIV infection by year (2010-2014) represents all persons ever diagnosed and reported with HIV or AIDS who have not been reported as having died as of December 31, 2014. Persons living with a diagnosis of HIV infection represent persons living in Ohio as of December 31, 2014, regardless of whether or not the person was a resident of Ohio at time of initial HIV and/or AIDS diagnosis. **Source**: Ohio Department of Health: HIV/AIDS Surveillance Program and HIV Care Services Program. Data reported through December 31, 2014.

HIV Care Continuum Stage	Numerator	Denominator
People Living with diagnosis of HIV infection	People Living with a diagnosis of HIV infection represents all persons ever diagnosed and reported with HIV or AIDS who have not been reported as having died	
Ryan White Clients	Clients who received any Ryan White Funded service during the reporting period (RW Clients)	
Received Medical care (Medical Visits)	Clients who had at least one Outpatient/ambulatory medical care visit during the reporting period	Clients who had at least one Outpatient/ambulatory medical care visit during the reporting period
Retained in Care	Clients who had 2 or more OAMC visits, viral load (VL) measures or CD4 counts at least 3 months apart during the reporting period	
Prescribed ART (ARV Therapy)	Clients who were prescribed ART at any time during the reporting period	
Virally Suppressed	Clients whose viral load value was <200 copies/ml on their most recent viral load test during the reporting period	

Table 18: Numerator and Denominator Definitions, Ryan White All Parts HIV Care Continuum, Ohio.

This is the first attempt to create a continuum of care for Ryan White Clients in Ohio and there are several limitations. The amount of data missing for key elements of the traditional continuum of care model (both prevalence and diagnosed based) was high. There was not enough information to analyze and describe the linkage to care for Ryan White clients. It is expected that the linkage to care measure will be included on future continuum of care reports. The number of Ryan White clients on ART was lower than the number of Ryan White clients who are virally suppressed. This was an unusual finding and is most likely due to incomplete data on this field. Due to implementation of ACA and Medicaid expansion in Ohio, fewer Ryan White Clients are getting their medication directly through the Ohio HIV Drug Assistance Program (OHDAP) and are receiving assistance with their insurance copayments for formulary medication instead. The data from these non-OHDAP providers are not always reported back to various Ryan White Parts and could affect the outcome measure of clients on ART. Also, viral load information was more complete than ever before. A higher proportion of missing data on ART combined with lower proportion of missing data on viral load could have led to the above finding. Combined with these issues is the fact that data in 2014 were still being reported under a Ryan White funded scope; the switch to eligible scope reporting in 2015 should mitigate some of these factors impacting the measures along the continuum going forward, specifically the Retained in Care measure.

In addition to the RWHAP All Parts continuum, the Cleveland and Columbus RWHAP Part A Programs have each created HIV Care Continuums for their jurisdictions, which are presented below.

Medicaid HIV Care Continuum

Medicaid serves a large proportion of HIV positive persons in Ohio. In 2014, 53 percent of Ohioans living with HIV were enrolled in Medicaid. Combining Medicaid claims data with ODH HIV Surveillance, Prevention and Care data is essential in creating a statewide HIV continuum of care that depicts a more complete representation of people living with HIV in Ohio. There are not currently adequate data sharing policies in place, but ODH HIV Care and Prevention staff were able to collaborate with Medicaid to develop an HIV continuum of care representative of the HIV population Medicaid serves based on claims data. Once adequate data sharing agreements are in place, the overall goal is to implement continual sharing of data between Medicaid and ODH to better assess the care status of people living with HIV in Ohio.

Below is a chart that compares the Ryan White All Parts continuum of care to the Medicaid continuum of care along with the definitions for the Medicaid measures. Please refer to Table 18 in the previous section for the Ryan White definitions.

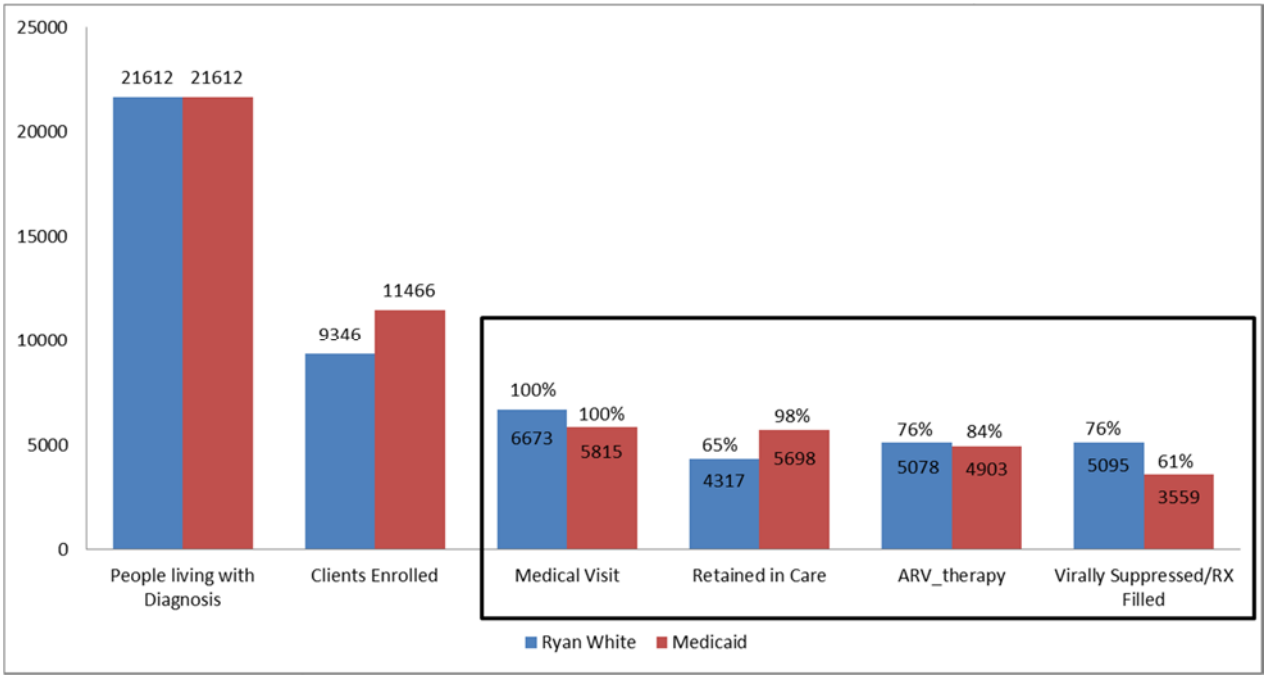


Figure 8: Medicaid and Ryan White HIV Care Continuum, Ohio

HIV Care Continuum Stage	Numerator	Denominator
People Living with diagnosis of HIV infection	People Living with a diagnosis of HIV infection represents all persons ever diagnosed and reported with HIV or AIDS who have not been reported as having died	
Medicaid Clients	Clients enrolled in Medicaid at any time during the reporting period who are HIV positive	
Received Medical care (Medical Visits)	Clients who were prescribed ART or had at least one HIV Care related medical care visit or ART during the reporting period	Clients who were prescribed ART or had at least one HIV Care related medical care visit or ART during the reporting period
Retained in Care	Clients who had a combination of 2 or more HIV Care related medical visits, viral load (VL) measures, CD4 counts, or ART prescription filled at least 3 months apart during the reporting period	
Prescribed ART (ARV Therapy)	Clients who were prescribed ART at any time during the reporting period	
Continually Filling ART Rx	Clients who filled ART prescriptions greater than 75% of the time based on number of months the client was enrolled	

Table 19: Numerator and Denominator Definitions, Medicaid HIV Care Continuum, Ohio.

Limitations:
There were people living with HIV in Ohio in 2014 who were enrolled in Ryan White Services and Medicaid. Because of this, there is some overlap between the Medicaid and Ryan White patient populations.

For the Medicaid Continuum of care, the received medical care column and the retained in care column contains ART prescription data that is not used in the Ryan White definition for these measures. If Ryan White ART prescription data were included, then these measure would likely increase for the Ryan White continuum of care. Moving forward, ODH HIV Programs and Medicaid will work to create standardized definitions that work for all programs.

The Ryan White Program has access to viral load result data and therefore reflects actual viral load suppression. Medicaid claims data does not include viral load results data and therefore the best proxy for this measure is based on ART prescriptions filled.

Cleveland RWHAP Part A HIV Care Continuum

The HIV Care Continuum depicted in Figure 9 uses data collected through the Ryan White Part A, Cleveland TGA CAREWare database for calendar year 2014. The definitions used to calculate each stage of the continuum are presented in Table 20. Surveillance data were used to identify the 5,086 people living with a diagnosis of HIV infection in the Cleveland TGA at the end of calendar year 2014. The remaining bars only reflect individuals represented in the Ryan White HIV/AIDS Program (RWHAP) Part A system of care that

had a Ryan White Part A funded medical visit in the measurement year. The definitions used to calculate each stage of the Cleveland TGA continuum are as follows:

HIV Care Continuum Stage	Numerator	Denominator
People Living with diagnosis of HIV infection	People Living with a diagnosis of HIV infection represents all persons ever diagnosed and reported with HIV or AIDS who have not been reported as having died who reside in the Cleveland TGA	
Ryan White clients	Clients who received any Ryan White Part A funded service in the measurement year.	
Medical Visits	Clients who had at least one Ryan White Part A funded medical visit in the measurement year.	Clients who had at least one Ryan White Part A funded medical visit in the measurement year.
Retained in Care	Clients who had a minimum of two Ryan White Part A funded medical visits at least 90 days apart during the measurement year.	
Prescribed Antiretroviral Therapy (ART)	Clients who were prescribed ART at any time during the measurement year.	
Virally Suppressed	Clients whose HIV viral load was less than 200 copies/mL at last test during the measurement year.	

Table 20: Numerator and Denominator Definitions, Ryan White HIV Care Continuum, Cleveland TGA.

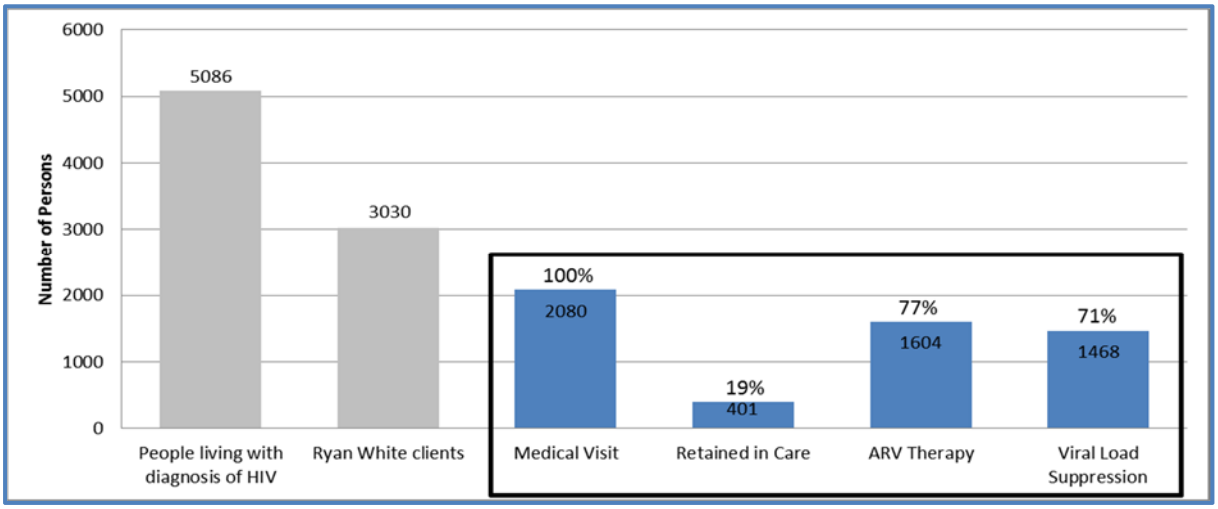


Figure 9: RWHAP Part A HIV Care Continuum, Cleveland TGA[7]

[7] ***Notes:** Living with a diagnosis of HIV infection by year (2010-2014) represents all persons ever diagnosed and reported with HIV or AIDS who have not been reported as having died as of December 31, 2014. Persons living with a diagnosis of HIV infection represent persons living in Ohio as of December 31, 2014, regardless of whether or not the person was a resident of Ohio at time of initial HIV and/or AIDS diagnosis. **Source**: Ryan White Part A, Cleveland TGA CAREWare database; Calendar year 2014.

Columbus RWHAP Part A HIV Care Continuum

The HIV Care Continuum depicted in Figure 10 uses data collected through the Ryan White Part A, Columbus TGA CAREWare database for calendar year 2014. The definitions used to calculate each stage of the continuum are presented in Table 21. Surveillance data were used to identify the 5,268 people living with a diagnosis of HIV infection in the Columbus TGA at the end of calendar year 2014. The remaining bars only reflect individuals represented in the Ryan White HIV/AIDS Program (RWHAP) Part A system of care that had a Ryan White Part A funded medical visit in the measurement year. It is important to note Columbus is a newer TGA with a growing infrastructure and data management system. Complete and accurate data reporting remains a primary focus for the Columbus TGA. The definitions used to calculate each stage of the Columbus TGA continuum are as follows:

HIV Care Continuum Stage	Numerator	Denominator
People Living with diagnosis of HIV infection	People Living with a diagnosis of HIV infection represents all persons ever diagnosed and reported with HIV or AIDS who have not been reported as having died who reside in the Columbus TGA	
Ryan White clients	Clients who received any Ryan White Part A funded service in the measurement year.	
Medical Visits	Clients who had at least one Ryan White Part A funded medical visit in the measurement year.	Clients who had at least one Ryan White Part A funded medical visit in the measurement year.
Retained in Care	Clients who had a minimum of two Ryan White Part A funded medical visits at least 90 days apart during the measurement year.	
Prescribed Antiretroviral Therapy (ART)	Clients who were prescribed ART at any time during the measurement year.	
Virally Suppressed	Clients whose HIV viral load was less than 200 copies/mL at last test during the measurement year.	

Table 21: Numerator and Denominator Definitions, Ryan White HIV Care Continuum, Columbus TGA.

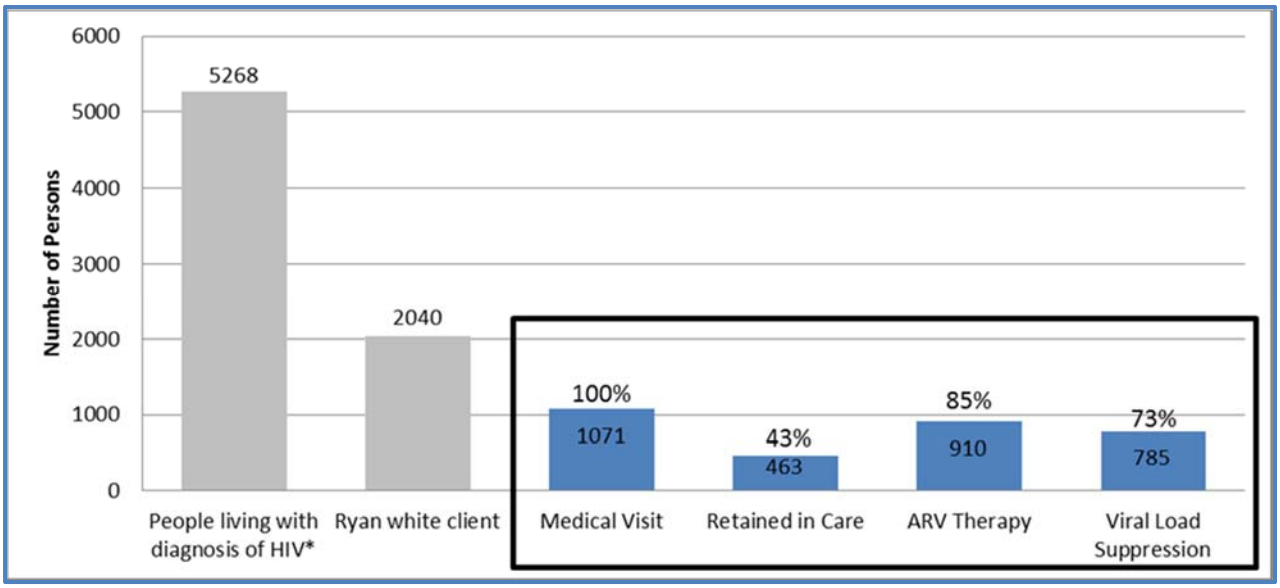


Figure 10: RWHAP Part A HIV Care Continuum, Columbus TGA[8]

Disparities in Key Population Engagement

All Ryan White Parts Care Continuum Key Population Disparities. The data used from surveillance and from Ryan White Parts show that there are health disparities among several populations along the Ryan White HIV Care Continuum. Ryan White clients receiving at least one OAMC visit in 2014 who are black/African American or young (ages 13-24) are less likely to be virally suppressed and have worse outcomes along the continuum compared to other groups. While men who have sex with men (MSM) are shown to have health disparities along the HIV Care Continuum nationwide, the Ryan White specific HIV care continuum for Ohio shows that MSM who received at least one OAMC visit are not different when compared to other groups receiving at least one OAMC visit.

[8] ***Notes**: Living with a diagnosis of HIV infection by year (2010-2014) represents all persons ever diagnosed and reported with HIV or AIDS who have not been reported as having died as of December 31, 2014. Persons living with a diagnosis of HIV infection represent persons living in Ohio as of December 31, 2014, regardless of whether or not the person was a resident of Ohio at time of initial HIV and/or AIDS diagnosis. **Source**: Columbus Public Health. (2014). Columbus TGA Ryan White Part A CAREWare data, Calendar year 2014. The Columbus TGA is a new Ryan White Part A grant recipient as of 2013. Therefore, 2014 data may be incomplete.

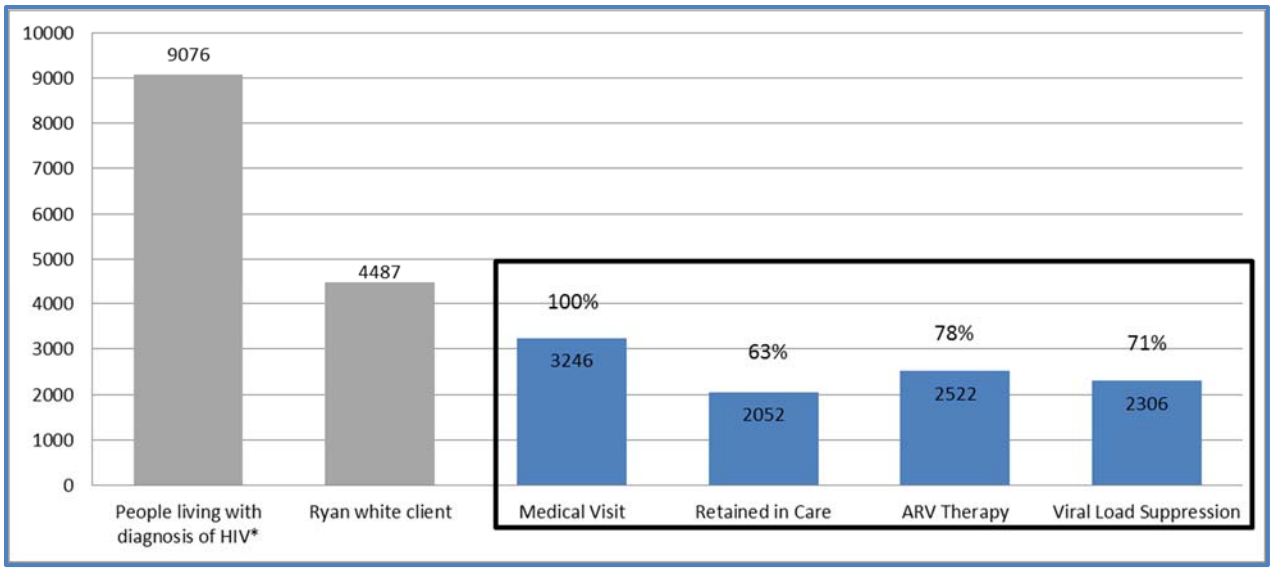


Figure 11: Ryan White Black/African American Care Continuum, Ohio, 2014.[9]

Black/African Americans who received a Ryan White funded OAMC visit in 2014 follow a similar care continuum as the entire Ryan White population except for viral load suppression.

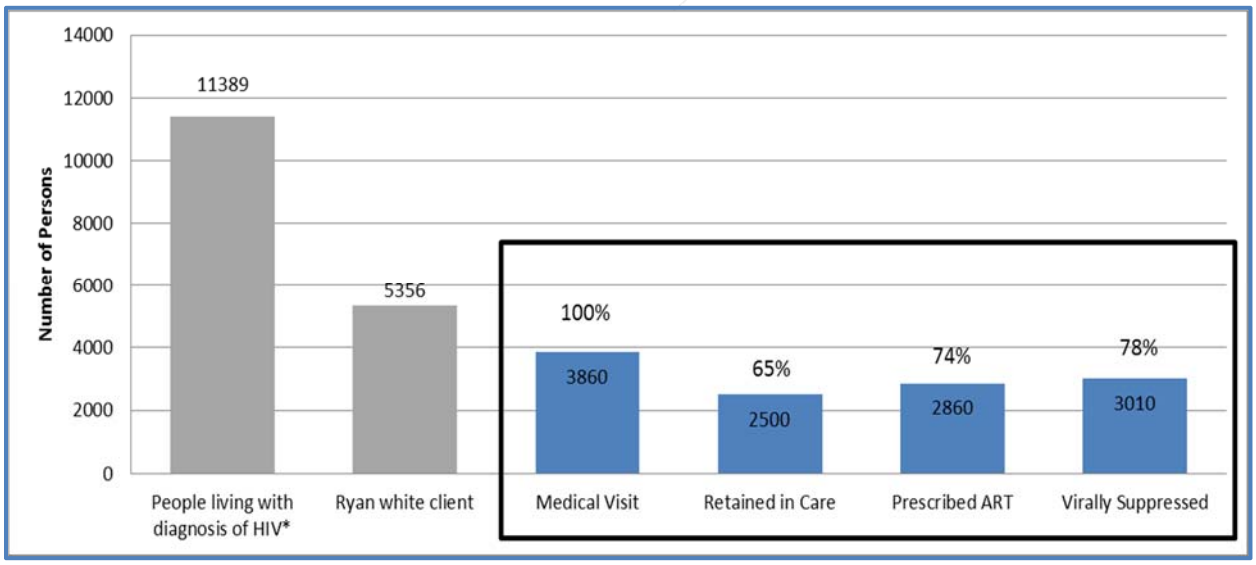


Figure 12: Ryan White Care Continuum for MSM exposure category, Ohio, 2014.[10]

The transmission category male-to-male sexual contact (MSM) accounted for 63 percent of all people living with an HIV infection in Ohio in 2014. Ryan White Programs across Ohio reach approximately 47

[9,10] ***Notes**: Living with a diagnosis of HIV infection by year (2010-2014) represents all persons ever diagnosed and reported with HIV or AIDS who have not been reported as having died as of December 31, 2014. Persons living with a diagnosis of HIV infection represent persons living in Ohio as of December 31, 2014, regardless of whether or not the person was a resident of Ohio at time of initial HIV and/or AIDS diagnosis. **Source**: Ohio Department of Health: HIV/AIDS Surveillance Program and HIV Care Services Program. Data reported through December 31, 2014.

percent of this population. While this population is disproportionately affected by HIV infection, once they are linked to Ryan White Services, their care continuum is very similar to Ryan White clients as a whole.

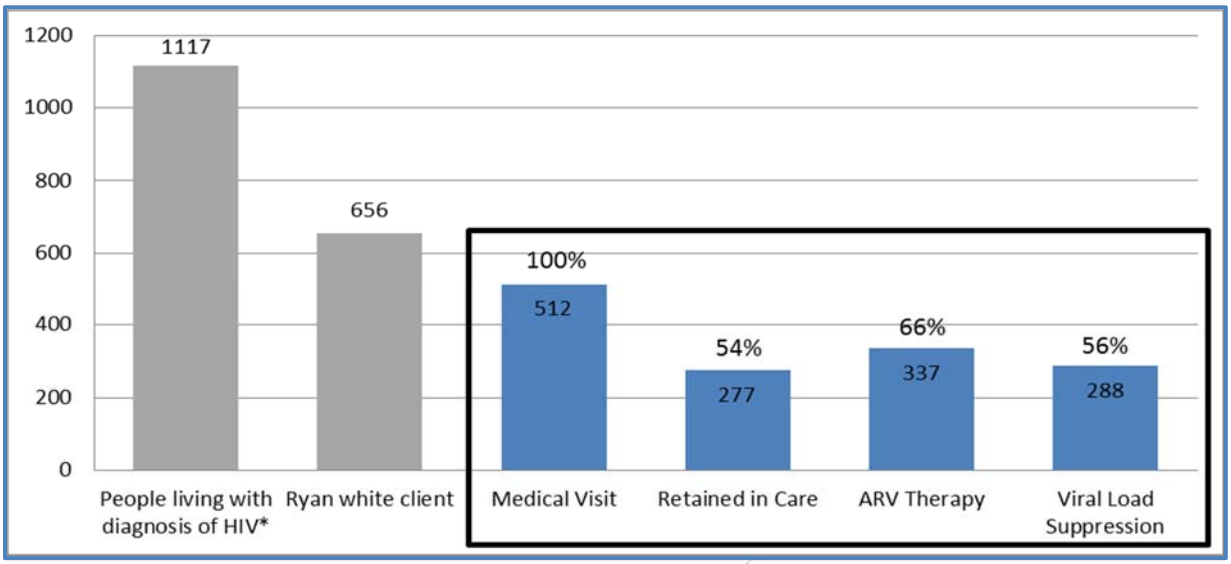


Figure 13: Ryan White Care Continuum for 13-24 Year Olds, Ohio, 2014[11]

In 2014, Ryan White Programs across Ohio served nearly 59 percent of 13-24 year olds living with an HIV diagnosis. While Ryan White programs reached a large proportion of this age group and 78 percent received at least one OAMC visit, the last three categories of the care continuum are much lower when compared to all Ryan White clients who received at least one OAMC visit in 2014.

Cleveland RWHAP Part A HIV Care Continuum Key Population Disparities. On a quarterly basis, the Grantee presents Planning Council with a Cleveland TGA care continuum broken out by client demographics. This data is used to monitor change and determine targeted populations that consistently fall below the TGAs continuum averages. Grantee staff also analyze the profiles of individuals who are not virally suppressed on a bi-monthly basis. Of the individuals who are not virally suppressed, there are three demographics that consistently fall below the TGA's average: Black Non-Hispanics, Hispanic/Latino(a), and Youth (13-24). The Grantee works with providers to make sure that outreach activities and efforts focus on those three demographics and are provided in a culturally competent fashion.

Columbus RWHAP Part A HIV Care Continuum Key Population Disparities. As a newer Ryan White Part A grant recipient, the Columbus TGA is just beginning to examine health disparities related to race/ethnicity, gender, and age among populations comprising the RWHAP Part A HIV Care Continuum. The Columbus TGA has explored disparities in viral load suppression, the prescription of antiretroviral therapy, and gap in medical visits. Significant disparities in viral load suppression exist among Black/African

[11] ***Notes:** Living with a diagnosis of HIV infection by year (2010-2014) represents all persons ever diagnosed and reported with HIV or AIDS who have not been reported as having died as of December 31, 2014. Persons living with a diagnosis of HIV infection represent persons living in Ohio as of December 31, 2014, regardless of whether or not the person was a resident of Ohio at time of initial HIV and/or AIDS diagnosis. **Source**: Ohio Department of Health: HIV/AIDS Surveillance Program and HIV Care Services Program. Data reported through December 31, 2014.

Americans, transgender persons, and youth between the ages of thirteen (13) and twenty-four (24). Other disparities will be further explored in FY 2016 by the Planning Council and the Part A Quality Committee.

Utilization of the Continuum in Planning

Utilization of the Statewide HIV Care Continuum in Ohio. The statewide HIV Care Continuum is used in several ways for planning. The first way is to identify areas of need for future data collection. Currently linkage-to-care data as defined in the Integrated Plan guidance are not available for Ryan White clients. Additionally data for retention in care and prescribed anti-retroviral therapy (ART) measures are limited. Due to implementation of the Affordable Care Act and Medicaid Expansion in Ohio, fewer Ryan White clients are getting their medical care and medications covered in full by Ryan White and OHDAP programs. The data from non-Ryan White providers are not always reported back to various Ryan White Parts and affect both the ART and retention measures. Several strategies are being implemented that will improve these numbers in the future (e.g., a new Part B clinical data collection form, continued coordination with All-Parts, Prevention, and Surveillance, etc.).

The HIV Care Continuum is also being used by the Ohio Department of Health (ODH) for planning purposes. HIV Care Services has worked closely with ODH staff to include the Part B ART measure in the new Ohio State Health Improvement Plan (SHIP). As part of the SHIP, HCS will report quarterly the percentage clients on ART for Part B-funded providers and, for providers whose percentages fall below the state average, the number of providers who receive technical assistance.

The HIV Care Continuum will also be a critical tool for other payers such as Medicaid, Medicare and ACA plans to plan services and measure client outcomes.

Cleveland RWHAP Part A Utilization of the Local Continuum. The Cleveland TGA began presenting the local continuum throughout the region in fiscal year 2013. Because of the lack of de-duplicated statewide data, the Grantee proceeded with creating a Ryan White Part A specific care continuum. Throughout the 2013 grant year, the Grantee worked with the Planning Council's Quality Improvement committee to re-align the continuum to local definitions that would meet regional needs and mirror the data that was accessible at the time. In FY2013 Ohio was also chosen as one of five states to participate in a HRSA Sponsored, NQC project titled HIV Cross-Part Care Continuum Collaborative, or H4C. Through this project, all Ohio Ryan White Grantees and quality experts from throughout the state began working on creating a statewide care continuum and attempting to collect de-duplicated Ryan White Data on a state and regional level. The Cleveland TGA continues to work with the H4C group and has used quality improvement models learned from the group at a local level.

In FY2015, the Grantee began to analyze the past years continuum trend data collected for the TGA and drill down information by targeted population. The Grantee began presenting the continuum data to the Planning Council's Quality Improvement Committee broken out by client demographic and by funded service category. On a quarterly basis now the QI Committee reviews the status of the Cleveland TGA Care Continuum, discusses any changes in the continuum data, and looks for trends in data broken down by demographic characteristics. The table below is a sample of the data that is presented on a quarterly basis using the continuum definitions listed above.

	Diagnosed	Linked		Retained		Prescribed ART		Virally Suppressed	
Black (non-Hispanic)	1,700	949	56%	166	17%	805	85%	627	66%
Hispanic/Latino(a)	300	166	55%	45	27%	136	82%	113	68%
White (non-Hispanic)	952	578	61%	149	26%	508	88%	458	79%
More than one race	33	18	55%	9	50%	16	89%	13	72%

Table 22. Care Continuum by demographic, FY2015[12]

Columbus RWHAP Part A Utilization of the Local Continuum. There are several limitations with using the current Columbus TGA HIV Care Continuum in the planning, prioritizing, targeting and monitoring of available resources in the Columbus TGA. Because Ohio only recently changed the laboratory reporting requirements for HIV viral load results and because access to data from other payer sources is extremely limited, it is very difficult for the Columbus TGA to produce an accurate HIV Care Continuum in which the needs of all PLWHA in the jurisdiction are considered. The current Columbus TGA HIV Care Continuum should be considered alongside other relevant program and local HIV service information in order to make well informed decisions related to improving engagement at each stage of the continuum. As a newer Ryan White Part A grant recipient, the Columbus TGA is continuing to develop ways to integrate the HIV Care Continuum into planning and prioritizing processes.

Within the Ryan White Part A system of care in the Columbus TGA, less than half (47%) of individuals with a diagnosis of HIV who had at least one medical visit in the last year had two or more documented medical visits, viral load tests, or CD4 tests performed at least three months apart—which would indicate that they had been retained in care. Consequently, discussions regarding retention in care and medical case management have occurred in the context of prioritizing and allocating Ryan White Part A funds in the Columbus TGA.

In addition, the Columbus Part A Planning Council has been trained on the current HIV Care Continuum and will continue to assess and reassess the data related to gaps in HIV service delivery within the Columbus TGA and to determine where additional resources are needed. The Planning Council prioritizes and continues to fund service categories that engage individuals in each step of the continuum based upon available local data.

Improving Engagement and Outcomes

Improving Engagement and Outcomes in Ohio. Statewide, all RWHAP Parts have participated in the aforementioned Ohio HIV Cross-Part Care Continuum Collaborative (H4C) over the past two years. This group has held a critical role in evaluating Ohio's data in each of the continuum areas. A primary goal of the H4C Response Team is to follow a cohort of non-virally suppressed individuals and ultimately have 20% become virally suppressed. Now that the official Collaborative has concluded, efforts are underway to

[12] **Source**: Cleveland TGA CAREWare database - June, 2015

secure a contractor who will continue to work with the Ohio All-Parts Group to identify additional strategies to engage clients at each stage of the continuum.

Ryan White Part B is also funding Quality Innovation grants to test strategies for that exact purpose. The goal of these demonstration projects is to identify specific strategies that can be expanded to the rest of the state. Part B is also committed to the sustainability of the H4C initiative and will be securing the contractor to support their efforts to bring together groups of clients and stakeholders to discuss strategies for increasing viral load suppression. The outcomes of both efforts will in turn guide the planning, prioritization, and targeting of services over the next few years.

Cleveland RWHAP Part A Improving Engagement and Outcomes. Although the Cleveland TGA HIV Care Continuum shows consistently higher averages across the majority of the stages of the continuum than national models, the TGA decided to work under the H4C model outlined above and focus quality improvement efforts on the final stage of viral load suppression. Beginning in FY2014, a TGA-wide viral load suppression quality improvement project was implemented. At the beginning of the project, the Grantee extracted a client list for each of the Outpatient Ambulatory Medical Care (OAMC) providers from the Cleveland TGA CAREWare database to include clients that were identified as having a viral load count of 200 copies/mL or higher. The Grantee presented and reviewed this list with each of the providers and then began working with them to develop agency specific quality improvement projects to attempt to bring 20% of those clients who were not virally suppressed as of June, 2014, back into care and virally suppressed by June, 2016. Throughout the remainder of the 2014 grant year and into the 2015 grant year the Grantee staff continued to pull client lists on a quarterly basis and monitor the viral load data per provider and provide any quality improvement technical assistance necessary. While this TGA-wide quality improvement project focuses only on viral load suppression, the Grantee expects to also see an impact on the continuum components of individuals retained in care and individuals prescribed ART by the end of FY2016. Additionally, linkage to care efforts continue, and EIS projects are funded. Prevention and care providers meet on an annual basis to trouble shoot linkage systems to ensure an efficient process and experience for patients.

Columbus RWHAP Part A Improving Engagement and Outcomes. The Columbus TGA will address gaps along the HIV Care Continuum by continuing to provide targeted HIV testing services for persons at high risk for acquiring HIV in an effort to identify individuals living within the Columbus TGA who are unaware of their infection. In addition, the Columbus TGA will continue to fund the Early Intervention Services (EIS) program that will be responsible for following up on program referrals for newly diagnosed and out of care clients and successfully linking them to a medical provider for necessary HIV medical care—using the Anti-Retroviral Treatment and Access to Services (ARTAS) intervention, which ensures persons newly diagnosed with HIV attend their first HIV medical appointment.

The Columbus TGA will also continue to directly fund a Part A medical case management program and collaborate with the Ohio Ryan White Part B medical case management program to ensure enrollment for all clients needing the necessary medical, housing, financial, transportation and psychosocial support services needed to maintain care. There is also a current medical case management network quality improvement project that is focusing on standardizing and improving the efficiency of medical case management services being received by consumers, and is aimed at ultimately improving retention in care

for PLWHA. This project involves the development of an acuity scale to prioritize client need and the standardization of medical case management documentation across all agencies and Ryan White Parts.

The Columbus TGA will continue to promote collaboration among HIV service providers, such as AIDS Healthcare Foundation, Equitas Health, and the Ryan White Part B Ohio AIDS Drug Assistance Program (OHDAP), who can assure that antiretroviral therapy is available to all eligible PLWHA in the Columbus TGA. In conjunction, the Columbus TGA will work with HIV service providers to identify patients that are not virally suppressed and design strategies and interventions to improve viral load suppression among all PLWHA.

C. FINANCIAL AND HUMAN RESOURCES INVENTORY

The Midwest AIDS Training + Education Center (MATEC) is a federally-funded training center, providing AIDS and HIV clinical training and support to health care professionals in Illinois, Iowa, Indiana, Kansas, Michigan, Minnesota, Missouri, Nebraska, Ohio and Wisconsin. MATEC is part of the AIDS Education and Training Centers (AETC) Program (funded under Part F) of the Ryan White HIV/AIDS Program. The AETC Program increases the number of health care providers who are educated and motivated to counsel, diagnose, treat, and medically manage people living with HIV and to help prevent behaviors that lead to HIV transmission.

In accordance with HRSA's Guidance, the AETC's findings regarding the clinical workforce needs and gaps, were provided for inclusion in Ohio's Integrated Plan. MATEC hosted their 2016 Policy Training Advisory Council (PTAC) meeting and included representatives from all Part A and B programs in the MATEC region and, at that meeting, the group agreed to a definition of "HIV Clinical Workforce" to include physicians, physician assistants, nurse practitioners, registered nurses, dental providers and clinical pharmacists. In addition, other HIV professionals (e.g., social workers, case managers, public health providers, etc.) were also taken into consideration.

HIV Resources Inventory

Needs of the HIV Clinical Workforce

Based on AETC data, there are high-volume clinicians who provide HIV care (most frequently, clinicians in urban and/or Ryan White settings) and who have the highest level of knowledge and low-volume clinicians (frequently rural and private practice clinicians) who have the lowest level of knowledge. Ohio has several large medical schools with specialized HIV care providers and 3 NIH sponsored AIDS Clinical Trials Units: Northwest Ohio –University of Toledo, RW part B, C, and D; Northeast Ohio-Case Western Reserve and University Hospitals, RW part A, B, C, D and AIDS Clinical Trials Unit; Central Ohio–Ohio State University, RW part A, B, C and AIDS Clinical Trials Unit; and Southwest Ohio–University of Cincinnati, RW part B and C and AIDS Clinical Trials Unit.

As low-volume providers are more likely to refer HIV-positive patients for HIV care, there is an opportunity for MATEC to increase providers' knowledge and skill levels, enabling them to provide a broader range of

HIV care services and retain HIV-positive patients in their practices. The data suggest that trainings of low volume providers need to focus on initiating anti-retroviral treatment (ART), monitoring adherence, and evaluating for drug resistance. As studies show that providers treating more than 20 HIV patients achieve a higher level of care, attention should be given to developing and implementing effective referral and consultation systems for low-volume providers. The provider-identified priority topics for training and technical assistance are shown on Table 23.

Training and Technical Assistance	Priority Topics
Clinical Management	(1) Opportunistic Infections
	(2) Acute HIV Infection
	(3) Adherence
Prevention and Behavior Change	(1) Prevention strategies
	(2) Harm reduction
	(3) Substance use /addictions treatment

Table 23. PRIORITY TRAINING/TA TOPICS IN OHIO, BETWEEN 8/18/2014 AND 12/16/2014.[13]

Across MATEC's region, PrEP and Treatment as Prevention was mentioned as the highest priority topic, following by Clinical Management of HIV and Testing/Routine Screening. Additional topics that were mentioned but did not make the top of the list are: Cultural Competence with special populations (transgender clients, LGB, MSM, women), STD's, Adherence, and Primary Care/Co-Morbidities.

Accordingly with new HRSA guidelines for funding allocations for the AETC grantees, a significant proportion of funds must be allocated to new projects (i.e., HIV Practice Transformation and HIV Inter-professional Education). Hence, the funding level for AETCs to fulfill other training and technical assistance needs has significantly decreased for Fiscal Years 2016 through 2019.

HIV Workforce Capacity

The HIV workforce in Ohio scores 6-7 percentage points better across all question categories compared to the United States, making it the top scoring state in the entire country for three of the four question categories (all, basic, and biomedical interventions), while being the second highest scoring state in the treatment category. Despite these glowing numbers, there are still opportunities for training to increase the workforce's knowledge, especially in the treatment and biomedical intervention categories (Table 23). And while the 45% of Ohio's workforce respondents who indicated they are familiar with PrEP is higher than the national average, this number means that there is a need to increase PrEP knowledge among most of Ohio's workforce.

Based on data from the report, black/African American and Latino HIV workers were significantly less likely than white respondents or those of other racial/ethnic backgrounds to show robust HIV science and treatment knowledge, with black/African Americans scoring on average 6 points lower than white

[13] Source: Pennsylvania/MidAtlantic AIDS Education and Training Center. February 2015

respondents, and Latinos scoring on average 8 points lower. Other findings of the survey were that respondents working in small organizations (< 10 employees) had lower overall knowledge scores than those working for larger organizations. Participants affiliated with Community-Based Organizations (CBO) exhibited lower knowledge scores than workers associated with AIDS Service Organizations (ASO) and health departments. Predictors of strong HIV science and treatment knowledge included the participant's level of education, length of time in the HIV workforce, geographic location in the US, and role within the organization.

		All Questions	Basic Knowledge and Terminology	Treatment	Biomedical Interventions
USA	All Respondents	61%	73%	54%	45%
	Black/African American (n=68)	57%	69%	51%	41%
	White (n=69)	67%	80%	59%	49%

Table 24. Knowledge Scores by Question Category, Whites and African Americans, 2012-13 HIV Workforce Survey.[14]

A number of studies have examined issues of racial concordance in clinical care and training programs. A multicenter study that examined the role of cultural distance between HIV-infected patients and providers in perceived quality of care found that patients who rated lower perceived cultural similarity with their providers rated significantly lower quality of care and lower trust in their providers. Cultural concordance was assessed in terms of speech and language, reasoning, communication style, and values which, based on the findings of the study, indicated the importance of positive patient-provider interactions and cultural competency in provision of HIV care (Saha et al., 2011). Given these realities, the need for culturally competent clinicians, particularly from the communities most affected by HIV, is crucial.

The Institute of Medicine, in examining workforce needs for *HIV Screening and Access to Care* (2011), acknowledged that the HIV/AIDS workforce is aging. They estimated nationally that 33 percent of physicians, 24 percent of pharmacists and 45 percent of nurses will likely reach retirement age by 2020. Meanwhile, the HIV-infected population is increasing in number and advancing in age, with both factors placing greater demands on health professionals. A 2010 survey of HIV Medical Association (HIVMA) members, a physician group specializing in HIV care, found that at least 45% of its members were 51 years and older, with 17% over the age of 61. That same year, the Association of Nurses in AIDS Care (ANAC), reported that 60% of nurse members were between the ages of 40 and 50, and only 7% were between the ages of 20-29, suggesting that young nurses were not choosing HIV/AIDS as their specialty. The National Alliance for HIV Education and Workforce Development made recommendations regarding this issue: "The early cohort of experienced HIV-care clinicians, who brought passion and commitment to patients early in the epidemic, entered the field 20 or more years ago and are nearing retirement. As they leave, a service gap will be created, and these providers will need to be replaced with well-educated, skilled clinicians who are able to provide comprehensive HIV care." (NAHEWD, 2014, p. 8)

[14] *Source: The Black AIDS Institute HIV Work Survey: When We Know Better, We Do Better: The State of HIV/AIDS Science and Treatment Literacy in the HIV/AIDS Workforce in the United States. Blank AIDS Institute, 2015*

Further investigation into retirement and its affects upon the Ohio workforce needs to be carried out. Few published articles reveal what clinical climate would encourage part-time and retired or aging clinicians to remain active and what can be instituted to encourage new clinicians to provide primary and HIV care. This is an avenue worth exploring.

MATEC efforts such as the HIV Interprofessional Education Project (HIPEP) and the Clinician Scholars Program are programmatic activities which specifically aim to prepare the next generation of skilled and dedicated HIV practitioners. HIPEP is a regional collaborative that includes six University-based Interprofessional Education programs to develop, implement and evaluate inter-professional team-based training programs for health professions students to prepare a workforce which is ready and able to optimize care and outcomes for persons living with HIV/AIDS. The MATEC Clinician Scholars Program is a 12-month training program specifically designed for minority or predominately minority serving, front line clinical care providers (Physicians, Physician Assistants, Nurse Practitioners, and Pharmacists) who are interested in the diagnosis, treatment, medical management, and prevention of HIV/AIDS.

Other Issues for Consideration

The recent HIV outbreak in Scott County, Indiana, prompted MATEC to explore the literature about rural counties in the region which may be vulnerable to similar outbreaks. In doing so, an article was found (recently accepted for publication in the *Journal of Acquired Immune Deficiency Syndrome* cited above) in which the authors identified "U.S. counties potentially vulnerable to rapid spread of HIV, if introduced, and new or continuing high rates of hepatitis C virus (HCV) infections among persons who inject drugs". In Ohio, the following 11 counties were identified: Adams, Athens, Brown, Clinton, Gallia, Highland, Jackson, Meigs, Pike, Scioto, and Vinton. Although, this does not mean an outbreak is imminent in these counties, it does identify the importance of further exploring the vulnerability of and target interventions to prevent transmission of HIV and HCV among persons who inject drugs in these counties. In Table 25, each of the eleven counties is identified along with the number of community health centers (CHC) and other HIV providers in each county.

County	Prevalence	CHC providing HIV Care	Nearest County with CHC providing HIV Care	Ryan White Site	HIV Prescriber
Adams	26	None	Pike, Scioto	None	None
Athens	47	None	Fairfield	None	None
Brown	29	None	Clermont, Pike	None	None
Clinton	46	None	Butler, Ross, Clermont	None	None
Gallia	21	None	Lawrence	None	None
Highland	24	None	Pike, Ross	None	None
Jackson	22	None	Ross	None	**Yes**
Meigs	14	None	Lawrence	None	None
Pike	19	**Yes**	n/a	None	**Yes**
Scioto	82	**Yes**	**n/a**	**Yes**	**Yes**
Vinton	6	None	Ross	None	None

Table 25. Ohio Counties vulnerable for Rapid Dissemination of HIV or HCV among persons who inject drugs.[15]

Funding Sources and Continuation of HIV Prevention, Care, and Treatment (Jurisdictional HIV Resources Inventory)

Funding Sources	YR16 Funding Amount ($) (Items with asterisks [*] are YR15 amounts)	Funded Service Provider Agencies	Services Delivered	HIV Care Continuum Steps Impacted
CDC	350,000	Equitas Health (formerly AIDS Resource Center Ohio—Columbus)	HIV Testing Linkage to Care Referral to Prevention and Essential Support Services Community PROMISE for HIV +/- MSM Condom Distribution	Prevention (HIV Negatives) HIV Diagnosed Linkage to Care
PRIVATE	40,000	Equitas Health (formerly AIDS Resource Center Ohio—Columbus)	Outreach Services Prevention Syringe Access HIV Testing	Prevention HIV Diagnosed
PRIVATE	15,000	Equitas Health (formerly AIDS Resource Center Ohio—Columbus)	Client Assistance	Retained in Care

[15] Source: County-level Vulnerability Assessment for Rapid Dissemination of HIV or HCV Infections among Persons who Inject Drugs, United States. *JAIDS Journal or Acquired Immune Deficiency Syndromes* Publish. *(June 2016, Ahead of Print.)*
http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=ovft&AN=00126334-900000000-97209&PDF=y

Funding Sources	YR16 Funding Amount ($) (Items with asterisks [*] are YR15 amounts)	Funded Service Provider Agencies	Services Delivered	HIV Care Continuum Steps Impacted
CDC (thru ODH thru Columbus Public Health)	230,000	Equitas Health (formerly AIDS Resource Center Ohio—Columbus)	Outreach Services HIV Testing	Prevention HIV Diagnosed
HRSA RW Part A: Behavioral Health (thru City of Columbus/ Columbus Public Health)	334,461	Equitas Health (formerly AIDS Resource Center Ohio—Columbus)	Mental Health Services Substance Abuse Tx (Outpatient)	HIV Diagnosed
HRSA RW Part A: Medical (thru City of Columbus/ Columbus Public Health)	910,035	Equitas Health (formerly AIDS Resource Center Ohio—Columbus)	Outpatient Ambulatory Medical Care (OAMC)	Retained in Care Viral Suppression
HUD HOPWA (thru City of Columbus/ Columbus Public Health)	658,050	Equitas Health (formerly AIDS Resource Center Ohio—Columbus)	Housing Services	Retained in Care
PRIVATE	100,000	Equitas Health (formerly AIDS Resource Center Ohio—Columbus)	Oral Health Services	Retained in Care
HUD SHELTER PLUS CARE (thru Community Shelter Board)	22,772	Equitas Health (formerly AIDS Resource Center Ohio—Columbus)	Administrative Costs	
	616,036	Columbus Metropolitan Housing Authority (CMHA)	Housing Services	Retained in Care
PRIVATE	30,000	Equitas Health (formerly AIDS Resource Center Ohio—Dayton)	Oral Health Services	Retained in Care
PRIVATE	60,000	Equitas Health (formerly AIDS Resource Center Ohio—Dayton)	Oral Health Services	Retained in Care
PRIVATE	45,000	Equitas Health (formerly AIDS Resource Center Ohio—Ohio AIDS Coalition)	Public Policy Advocacy	
PRIVATE	2,000	Equitas Health (formerly AIDS Resource Center Ohio—Ohio AIDS Coalition)	Public Policy Advocacy	

Funding Sources	YR16 Funding Amount ($) (Items with asterisks [*] are YR15 amounts)	Funded Service Provider Agencies	Services Delivered	HIV Care Continuum Steps Impacted
PRIVATE	100,000	Equitas Health (formerly AIDS Resource Center Ohio)	PrEP Community Engagement	Prevention HIV Diagnosed
PRIVATE	10,000	Equitas Health (formerly AIDS Resource Center Ohio) Camp Sunrise	Summer Camp for HIV affected and Infected Kids	Retained in Care Viral Suppression
PRIVATE	5,000	Equitas Health (formerly AIDS Resource Center Ohio)	Outreach HIV Testing Biomedical Prevention	Prevention HIV Diagnosed
PRIVATE	50,000	Equitas Health (formerly AIDS Resource Center Ohio—Dayton) MPowerment Center	Prevention Testing	Prevention HIV Diagnosed
PRIVATE	237,595	Equitas Health (formerly AIDS Resource Center Ohio) Campaign for Hope	Outpatient Ambulatory Medical Care (OAMC)	Retained in Care ART Use Viral Suppression
PRIVATE	3,000	Equitas Health (formerly AIDS Resource Center Ohio) Opening Doors for the Homeless	Housing Services	Linked to Care Retained in Care ART Use Viral Suppression
PRIVATE	30,000	Equitas Health (formerly AIDS Resource Center Ohio) Protecting Our Youth	Prevention Testing	Prevention HIV Diagnosed
CDC	306,259 152,130	Equitas Health (formerly AIDS Resource Center Ohio)	Outreach Services Prevention HIV Testing Linkage to Care	Prevention HIV Diagnosed Linkage to Care
HRSA Ryan White Part C—Capacity Building	100,000	Equitas Health (formerly AIDS Resource Center Ohio)	Evidence-based Prevention (Motivational Interviewing)	Prevention HIV Diagnosed Linkage to Care ART Use Viral Suppression
HRSA Ryan White Part C—Early Intervention	252,003	Equitas Health (formerly AIDS Resource Center Ohio)	Outpatient Ambulatory Medical Care (OAMC)	Prevention ART Use Viral Suppression
United Way of Greater Dayton	13,950	Equitas Health (formerly AIDS Resource Center Ohio) Protecting Our Youth	Prevention HIV Testing	Prevention HIV Diagnosed

Funding Sources	YR16 Funding Amount ($) (Items with asterisks [*] are YR15 amounts)	Funded Service Provider Agencies	Services Delivered	HIV Care Continuum Steps Impacted
United Way of Greater Dayton	18,472	Equitas Health (formerly AIDS Resource Center Ohio--Dayton)	Housing Services	Retained in Care ART Use Viral Suppression
United Way of Greater Toledo (FEMA)	3,000	Equitas Health (formerly AIDS Resource Center Ohio—Toledo)	Emergency Food/Shelter	Retained in Care
United Way of Greater Toledo	40,000	Equitas Health (formerly AIDS Resource Center Ohio—Toledo) MPowerment	Prevention HIV Testing	Prevention HIV Diagnosed
United Way of Central Ohio	151,000	Equitas Health (formerly AIDS Resource Center Ohio--Columbus)	Medical Case Management	Retained in Care ART Use Viral Suppression
CDC (thru ODH thru Lucas County Health Department)	36,255	Equitas Health (formerly AIDS Resource Center Ohio—Toledo)	HIV Testing	Prevention HIV Diagnosed
CDC (thru Public Health Dayton & Montgomery County	99,924	Equitas Health (formerly AIDS Resource Center Ohio—Dayton)	Prevention HIV Testing	Prevention HIV Diagnosed
HOPWA (thru Ohio Development Services Agency)	947,366	Equitas Health (formerly AIDS Resource Center Ohio)	Housing Services	Retained in Care
Recovery Resources-Cleveland	757,793	Recovery Resources-Cleveland	HIV Testing Personalized Cognitive Counseling Linkage to Care Referral to Prevention and Essential Support Services d-UP for +/- AA MSM Condom Distribution	Prevention (HIV Negatives) HIV Diagnosed Linkage to Care

Funding Sources	YR16 Funding Amount ($) (Items with asterisks [*] are YR15 amounts)	Funded Service Provider Agencies	Services Delivered	HIV Care Continuum Steps Impacted
CDC Category A- Regionally Funded Sites (thru ODH Prevention Programs)	3,780,557	Cleveland City Health Department Columbus City Health Department Hamilton County Public Health Lucas County Regional Health District Public Health-Dayton & Montgomery County Health Department Portsmouth City Health Department Canton City Health Department Summit County General Health District	HIV Testing Comprehensive Prevention with Positives Condom Distribution Linkage to Care Partner Services Evidenced Based Interventions Distribution of HIV-STD educational material	Prevention HIV Diagnosed Linkage to Care
CDC Category A - Statewide Initiative (thru ODH Prevention Programs)	83,203.00	Statewide Initiative: Equitas Health (formerly AIDS Resource Center Ohio)	HIV Hotline, website with a chat option and HIV Risk Meter App. Includes referral resources for HIV testing sites.	Prevention HIV Diagnosed
CDC Category B-- Emergency Departments (thru ODH Prevention Programs)	250,0000	Cleveland Clinic Foundation Nationwide Children's Hospital Cincinnati Children's Hospital Medical University of Cincinnati Summa Foundation	HIV Testing in Healthcare Settings Linkage to Care	Prevention HIV Diagnosed Linkage to Care
Ohio General Revenue Funds Category A (thru ODH Prevention Programs)	780,000	Cleveland City Health Department Columbus City Health Department Hamilton County Public Health Lucas County Regional Health District Public Health-Dayton & Montgomery County Health Department Portsmouth City Health Department Canton City Health Department	HIV Testing Comprehensive Prevention with Positives Condom Distribution Linkage to Care Partner Services Evidenced Based Interventions Distribution of HIV-STD educational material Statewide Initiative: HIV Hotline, website with a chat option and HIV Risk Meter App. Includes referral resources for HIV testing sites.	Prevention HIV Diagnosed Linkage to Care

Funding Sources	YR16 Funding Amount ($) (Items with asterisks [*] are YR15 amounts)	Funded Service Provider Agencies	Services Delivered	HIV Care Continuum Steps Impacted
		Summit County General Health District Statewide Initiative: Equitas Health (formerly Aids Resource Center Ohio) Statewide Initiative: Equitas Health (formerly Aids Resource Center Ohio)		
CDC Category B-- Community Based Organizations (thru ODH Prevention Programs)	150,000	Planned Parenthood of Southwest Ohio AIDS Healthcare Foundation	HIV Rapid Testing in non-clinical Community Settings Linkage to Care	Prevention HIV Diagnosed Linkage to Care
HRSA Ryan White Part A Cleveland TGA	4,539,408	Cuyahoga County Board of Health	Early Intervention Services Home and Community-Based Health Services Home Health Care Outpatient Ambulatory Medical Care (OAMC) Medical Case Management Non-Medical Case Mgmt. Medical Nutrition Therapy Mental Health Services Oral Health Services Substance Abuse Tx—Outpatient Emergency Financial Assistance Food Bank/Home Delivered Meals Legal Services Medical Transportation Services Outreach Services Psychosocial Support Services Substance Abuse Tx-Residential Health Insurance Premium Cost-Sharing Assistance LPAP	HIV-Diagnosed Linkage to Care Retained in Care Antiretroviral Use Viral Suppression
HRSA Ryan White Part C Cleveland	*$504,830 *$231,563	University Hospitals of Cleveland, CARE Alliance Health Center	Outpatient Ambulatory Medical Care (OAMC) AIDS Pharmaceutical Assistance Oral Health Care Mental Health Services Medical Nutrition Therapy Non-Medical Case Management Medical Transportation Services	HIV-Diagnosed Retained in Care Antiretroviral Use Viral Suppression

Funding Sources	YR16 Funding Amount ($) (Items with asterisks [*] are YR15 amounts)	Funded Service Provider Agencies	Services Delivered	HIV Care Continuum Steps Impacted
HRSA Ryan White Part D: Cleveland	*$331,902	University Hospitals of Cleveland	Outpatient Ambulatory Medical Care (OAMC) AIDS Pharmaceutical Assistance Mental Health Services Medical Nutrition Therapy Medical Case Management Medical Transportation Services Psychosocial Support Services	HIV-Diagnosed Retained in Care Antiretroviral Use Viral Suppression
HRSA Ryan White Part F: Cleveland	*$600,000	MetroHealth System	Mental Health Services Health Education/Risk Reduction Outreach Services Referral for Healthcare/Supportive Services Treatment Adherence Counseling	HIV-Diagnosed Linkage to Care Retained in Care Antiretroviral Use Viral Suppression
SAMHSA	*$180,000	Northern Ohio Recovery Association, Inc	Substance Abuse Services/Outpatient Health Education/Risk Reduction Treatment Adherence Counseling	Prevention Retained in Care Antiretroviral Use Viral Suppression
HOPWA	*$1,368,628	City of Cleveland	Emergency Financial Assistance Food Bank/Home Delivered Meals Housing Services Medical Transportation Services Referral for Healthcare/Supportive Services	Linkage to Care Retained in Care
Cleveland Foundation ADAMHS Board of CC Cuyahoga County City of Cleveland George Gund Foundation United Way of Greater Cleveland Mt. Sinai Healthcare Foundation	530,000	AIDS Funding Collaborative (AFC) fiscally sponsored by the Center for Community Solutions	Training Grant-making Convening Advocacy	Prevention Retained in Care
HRSA Ryan White Part A: Columbus TGA	4,346,027	Columbus Public Health	Medical Case Management Non-Medical Case Management Mental Health Services Outpatient Ambulatory Medical Care (OAMC)	
HRSA Ryan White Part C: Columbus	542,005	Equitas Health (formerly AIDS Resource Center Ohio)	Outpatient Ambulatory Medical Care (OAMC) Early Intervention Mental Health Services	Linkage to Care Retained in Care Antiretroviral Use Viral Suppression

Funding Sources	YR16 Funding Amount ($) (Items with asterisks [*] are YR15 amounts)	Funded Service Provider Agencies	Services Delivered	HIV Care Continuum Steps Impacted
			Medical Nutrition Therapy Non-Medical Case Management Linguistic Services Medical Transportation Services Outreach Services	
HRSA Ryan White Part C: Columbus	475,000	Nationwide Children's Hospital	Outpatient Ambulatory Medical Care (OAMC) AIDS Drug Assistance Program AIDS Pharmaceutical Assistance Early Intervention Services Mental Health Services Medical Case Management Non-Medical Case Management Child Care Services Health Education/Risk Reduction Linguistic Services Medical Transportation Services Outreach Services Psychosocial Support Services Referral for Health Care/Supportive Services Rehabilitation Services Substance Abuse Service s-Residential Treatment Adherence	HIV-Diagnosed Linkage to Care Retained in Care Antiretroviral Use Viral Suppression
HUD HOPWA (Columbus)	817,516	Awarded to City of Columbus Administered by Columbus Public Health	Non-medical case management Housing Services	Retained in Care
HRSA Ryan White Part B	23,357,652	Ohio Department of Health	Medical Case Management Non-Medical Case Mgmt Outpatient Ambulatory Medical Care (OAMC) Mental Health Services Oral Health Services Medical Transportation Services ADAP/HIPP	Linkage-to-Care Retained in Care Antiretroviral Use Viral Suppression
Ohio General Revenue Fund	3,944,909	Ohio Department of Health	Medical Case Management Outpatient Ambulatory Medical Care (OAMC) Mental Health Services Oral Health Services Medical Transportation Services HIPP	Linkage-to-Care Retained in Care Antiretroviral Use Viral Suppression
Ryan White Part C	316,469	Ursuline Center	Early Intervention Services	Linkage-to-Care

Funding Sources	YR16 Funding Amount ($) (Items with asterisks [*] are YR15 amounts)	Funded Service Provider Agencies	Services Delivered	HIV Care Continuum Steps Impacted
HRSA Ryan White Part C	$542,005	Equitas Health	Early Intervention Services	Linkage-to-Care
	Unreported	Nationwide Children's	Early Intervention Services	Linkage-to-Care
	249,219	Portsmouth Health Dept.	Early Intervention Services	Linkage-to-Care
	100,000	Equitas Health	Capacity Development	Linkage-to-Care
	Unreported	Nationwide Children's	Capacity Development	Linkage-to-Care
	582,753	University of Cincinnati Infectious Diseases Center	Outpatient Ambulatory Medical Care (OAMC) Referral for Specialty Care Outreach Services Mental Health Services Substance Abuse Counseling Health Education/Risk Reduction	Early Intervention
	38,510	Northern Kentucky Health Department	Medical Case Management Referral for Healthcare/Supportive Services	Treatment Adherence HIV Diagnosed Linkage-to-Care
	149,579	Cincinnati Health Network	Grant/program administration Quality Management Technical assistance Medical Case Management Mental Health Services Substance Abuse Counseling Referral for Healthcare/Supportive Services	Linkage-to-Care Retained in Care Treatment Adherence
	68,911	University of Cincinnati Department of Emergency Medicine	HIV Testing Linkage-to-Care	Prevention HIV Diagnosed Linkage-to-Care
	460,326	University of Toledo Medical Center	Early Intervention Services Outpatient Ambulatory Medical Care (OAMC) Medical Case Management Non-Medical Case Mgmt. Medical Nutrition Therapy Mental Health Services Substance Abuse Tx—Outpatient Emergency Financial Assistance Medical Transportation Services Outreach Services Psychosocial Support Services AIDS Pharmaceutical Assistance Oral Health Care Treatment Adherence Counseling Health Education/Risk Reduction	Linkage to Care Retention in Care Antiretroviral Use Viral Suppression

Funding Sources	YR16 Funding Amount ($) (Items with asterisks [*] are YR15 amounts)	Funded Service Provider Agencies	Services Delivered	HIV Care Continuum Steps Impacted
HRSA Ryan White Part D Programs	440,760	University of Toledo Medical Center	HIV Services provided to Women, Infants, Children, Youth <24 years	Linkage to Care Retention in Care Antiretroviral Use Viral Suppression
Healthy Relationships—ODH via Toledo-Lucas County Health Dept.	32,860	University of Toledo Medical Center	HIV Testing Linkage to Care Referral to Prevention and Essential Support Services Comprehensive Prevention with Positives Condom Distribution Distribution of HIV-STD educational material Evidenced Based Interventions	Prevention (HIV Negatives) HIV Diagnosed Linkage to Care
HRSA Ryan White Part F Programs	153,007	Ohio State University	Base Programming MAI Healthcare Practice Transformation Project (HPTP)	Prevention Linkage to Care Retention in Care Antiretroviral Use Viral Suppression
	184,741	University of Cincinnati	Base Programming MAI Healthcare Practice Transformation Project (HPTP) HIV Interprofessional Educator Project (HIEP)	Prevention Linkage to Care Retention in Care Antiretroviral Use Viral Suppression
	*$11,217	Ohio State University	Support for ODH and Expanded HIV Testing Grant	Prevention
Ohio General Revenue Fund	11,146,573	Ohio Department of Rehabilitation and Corrections	Outpatient Ambulatory Medical Care (OAMC) Mental Health Oral Health Provision of Medication	Linkage-to-Care Retained in Care Antiretroviral Use Viral Suppression
Medicaid	19,630,277	Ohio Department of Medicaid	Outpatient Ambulatory Medical Care (OAMC) Medical Case Management Medical Nutrition Therapy Mental Health Services Oral Health Services Substance Abuse Tx—Outpatient Medical Transportation Services Substance Abuse Tx-Residential Provision of Medication	Retained in Care Antiretroviral Use Viral Suppression

Funding Sources	YR16 Funding Amount ($) (Items with asterisks [*] are YR15 amounts)	Funded Service Provider Agencies	Services Delivered	HIV Care Continuum Steps Impacted
Veterans Administration	17,401	VA--Chillicothe, OH	Outpatient Ambulatory Medical Care (OAMC) Mental Health Services Psychosocial Support Services Substance Abuse Treatment (In and Out Patient) Treatment Adherence Counseling	Retained in Care
	141,614		Provision of Medication	Antiretroviral Use Viral Suppression
	255,549	VA—Cincinnati, OH	Expanded HIV Testing and Case Management	HIV Diagnosed Linkage to Care Retained in Care
	27,583		Outpatient Ambulatory Medical Care (OAMC) Mental Health Services Psychosocial Support Services Substance Abuse Treatment Substance Abuse Treatment (In and Out Patient) Treatment Adherence Counseling	Retained in Care
	2,473,291		Provision of Medication	Antiretroviral Use Viral Suppression
	139,379	VA—Cleveland, OH	Outpatient Ambulatory Medical Care (OAMC) Mental Health Services Psychosocial Support Services Substance Abuse Treatment Substance Abuse Treatment (In and Out Patient) Treatment Adherence Counseling	Retained in Care
	3,934,119		Provision of Medication	Antiretroviral Use Viral Suppression
	51,892		Mental Health Services	Retained in Care
Veterans Administration	67,097	VA—Dayton, OH	Outpatient Ambulatory Medical Care (OAMC) Mental Health Services Psychosocial Support Services Substance Abuse Treatment Substance Abuse Treatment (In and Out Patient) Treatment Adherence Counseling	Retained in Care
	2,181,081		Provision of Medication	Antiretroviral Use Viral Suppression

Table 26. Ohio Jurisdiction HIV Resources Inventory

Needed resources /services not provided and steps taken to secure them

The following are needed workforce resources and the steps being taken to secure them.

Aging Workforce. Much of the HIV care in Ohio is provided by Infectious Diseases specialists. According to The Robert Graham Center, Ohio has an average ratio of Primary Care Providers to patients at 1482:1 (national average 1463:1) and will need to have an increase of 681 by 2030 to maintain the status quo. Although measures are in place to address this shortfall, it is unrealistic to plan for all primary care clinicians to provide quality HIV care. The evidence continues to show that the quality of care is lower when a practice prescribes ART for <20 patients (IDSA 2015). HRSA added new projects to The AIDS Education and Training Centers narrowing the focus of the AETC in order to provide stronger outcomes. The AETC's are required to provide a Practice Transformation Project to increase capacity to deliver state of the art HIV care. In Ohio the AETC is working with 2 FQHCs on this new project and results are not available at the time of this writing. Additionally the Minority Scholars Program is an intensive 12-month training program specifically designed for minority or predominately minority serving, front line clinical care providers (Physicians, Nurse Practitioners, Advanced Practice Nurses, Physician Assistants, Registered Nurses, Oral Health Providers, and Pharmacists), who are interested in the diagnosis, treatment, medical management, and prevention of HIV/AIDS. It is a standardized, yet participant-centered program. To address the physician shortage, there are an increasing number of Nurse Practitioner and Physician Assistant educational programs in the state.

Hepatitis C Awareness. The increase of heroin and other injectable drug use throughout Ohio has created a need for heightened awareness of the risk and potential transmission of Hepatitis C as well as a rise in HIV cases.

PrEP Knowledge. Many of the clinicians providing HIV care also provide PrEP. Student health and some primary care clinicians are also offering PrEP. One challenge is that the co-insurance expense has been a barrier for some patients, as unlike for HIV care where Ryan White can fill in this gap, there is no assistance for PrEP. While pharmaceutical company copay cards can help with obtaining medication, PrEP requires quarterly visits for testing as well which can be costly. Steps are continuing to ensure educational opportunities for clinicians and for potential patients related to PrEP resources.

HIV Testing. Ohio eliminated the need for a separate written consent in 2010, but left a number of special conditions attached to testing. This has created a barrier to routine testing in some hospital settings as risk management views this as a liability. Also new testing technologies have caused confusion regarding the algorithm for a positive result and have resulted in people testing false positive, but given a positive diagnosis.

Sexual Assault Survivors. Assault survivors are offered prevention for syphilis but not routinely offered rapid testing for HIV and access to nPEP.

Cultural competency. Cultural competency of providers surrounding LGBTQ populations has also been noted at several statewide meetings.

D. ASSESSING NEEDS, GAPS, AND BARRIERS

Description of Process Used to Identify Needs, Gaps, and Barriers

Description of Needs Assessment Process Used in Ohio: A number of state-level needs assessment methods for gathering needs, gaps and barriers exist in Ohio. They include assessments from the Integrated Planning process, HIV Prevention, HIV Care and other HIV-related organizations.

For the Integrated Planning process, the Ohio Department of Health (ODH) recruited a Steering Committee. The steering committee included ODH staff from HIV surveillance, prevention, and care services; Ryan White Parts; state level prevention community planning group (OCPG); local performance sites for the Midwest AIDS Education and Training Center (MAETC); other state agencies (i.e. Office of Health Transformation, Aging, Medicaid, Mental Health and Substance Abuse); community organizations including the Ohio AIDS Coalition and the Center for Community Solutions; and Ohioans living with HIV/AIDS. The Integrated Plan Steering Committee has been meeting monthly since November 2015 and also hosted a statewide meeting on March 9, 2016 for consumers, advocates, and diverse professionals working in HIV, including the state level planning groups for HIV prevention and care. The purpose of the statewide meeting was to collect additional information to flesh out identified gaps in services across the care continuum for Ohio. The same group also met July 27, 2016 to review and provide feedback on the final Integrated Plan goals and objectives. Additionally regional meetings were hosted around the state to ensure that program planners were aware of any region-specific needs, gaps, and barriers across the care continuum, from prevention and testing through viral suppression (Table 27). In each regional area, one meeting was held for the general population having interest in HIV and a separate meeting was conducted in each region for interested consumers who did not wish to attend the general meeting.

Date	Regional Meeting
May 17, 2016	Columbus Region - Consumer
May 24, 2016	Columbus Region - General
May 24, 2016	Toledo Region – General
May 25, 2016	Cleveland Region – General
May 25, 2016	Cleveland Region – Consumer
May 26, 2016	Dayton Region – General
June 3, 2016	Cincinnati Region – General
June 6, 2016	Youngstown Region – General and Consumer
June 6, 2016	Dayton Region – Consumer
June 9, 2016	Cincinnati Region – Consumer
June 9, 2016	Summit Region – General
June 15, 2016	Akron Region – Consumer
June 15, 2016	Canton Region – General
June 21, 2016	Toledo Region – Consumer
July 22, 2016	Rural Region (North and South) – General

Table 27. Integrated Plan Regional Meetings, 2016

The ODH HIV Prevention Program does not currently have a formal needs assessment. In the previous five year grant cycle for CDC Cooperative Agreement PS12-1201, only HIV surveillance data was used as the sole data source for the creation of a needs assessment. The previous assessment was based upon subgroups identified from data collected and analyzed by HIV surveillance, and was used during a target setting process at the Ohio HIV Community Planning Group (OCPG). Since that time, data specifically being collected by the HIV Prevention Program, including HIV counseling, testing and referral, and partner services data, has been recognized as a key component of the information gathering process for a formal HIV prevention needs assessment. A formal needs assessment process for the HIV Prevention Program will be developed during 2017-2018.

The Ohio Department of Health (ODH), HIV Care Services section, is conducting a three-year HIV/AIDS Out-of-Care Needs Assessment study for the Ryan White Part B Program. The goal of this project is to gather data and information necessary to understand the needs of out-of-care people living with HIV/AIDS (PLWHA) and possible solutions and strategies that will help bring this population into care. The results of this study will help develop a plan to reduce the number of out-of-care PLWHA and the impact of co-morbidities on PLWHA. The first year of this three-year study was conducted in 2015. The focus of the first year was to examine the demographic and other attributes of PLWHA who are consistently in care, intermittently in care, or never in care. A goal was to identify the characteristics and circumstances that have predictive value for people not being in, or not remaining in care. Building on the results from the year one study, the second year study was conducted between the Fall of 2015 and Spring of 2016. Two research focus areas were explored in year two. The first goal was to deepen the knowledge of the predictive factors that prevent PLWHA from entering and remaining in HIV care by gathering qualitative data through focus groups. The second goal was to explore the impact comorbidities have on PLWHA. Specifically, this study explored the prevalence of comorbidities, whether comorbidities hinder or help PLWHA in seeking care, and whether comorbidities are related to quality of life factors for PLWHA, such as provider relationships, client needs being meet, and perceptions of stigma or social supports.

Additionally, a number of white papers/reports have been prepared by different special interest groups describing what each group identified as opportunities. The white papers include observations about both prevention and care activities, the needs, gaps and barriers identified in these documents are included below.

Cleveland RWHAP Part A Needs Assessment Process. The Cleveland Transitional Grant Area (TGA) consists of Ashtabula, Cuyahoga, Geauga, Lake, Lorain, and Medina Counties in the northeast region of the state. The comprehensive needs assessment conducted in 2014, included a survey of individuals living with HIV/AIDS, as well as individuals unaware of their status. Professionals surveyed included key providers in the HIV care network and numerical data were collected from a number of sources.

In 2015, a targeted assessment of the TGA focused on capacity and capabilities of service providers which included specific issues identified by the grantee as areas of special interest. These topics include outpatient ambulatory specialty care services, the referral network, wait lists for services, desired areas for technical assistance, capacity to geographically expand service offerings, the capacity of mental health and substance use services, and staffing turnover issues.

The 2016 targeted assessment examined the impact of two years of expanded access to private and public insurance on the availability of Core Services in the TGA. Methods employed to identify progress and remaining gaps included a comparison of Part A core services with the services covered by the Medicaid alternative benefit plan and the Ohio benchmark plan, as well as, interviews with Part A providers and other key stakeholders. An expanded provider inventory to include Medicaid was conducted to assess the scope of service availability post-expansion.

Columbus RWHAP Part A Needs Assessment Process. The Columbus Transitional Grant Area (TGA) consists of Delaware, Fairfield, Franklin, Pickaway, Licking Madison, Morrow, and Union Counties in the central region of the Ohio. Because Columbus was a new Part A region, the 2014 needs assessment helped to establish baselines of needs, gaps, and barriers for the region. The 2014 Needs Assessment was conducted by Measurement Resources and consisted of a 51-item paper-and-pencil consumer survey. The topics and questions included on the survey were developed by a Needs Assessment Advisory Committee based on a review of needs assessment activities from other communities (including those used in Massachusetts and Memphis). The questions were pilot tested with a smaller group to check ease of understanding and length of completion time. The surveys were administered in a variety of settings, including offices of HIV/AIDS medical providers, HIV/AIDS program providers and specific community locations and organizations serving special populations. Efforts were made to recruit out-of-care consumers by offering six open survey dates at Stonewall Community Center (a local LGBT center). These dates were advertised at community festivals, on Facebook, on flyers, and by word-of-mouth.

Description of Service Needs of those at risk for HIV and PLWHA

Service Needs in Ohio. Prevention and care service needs were noted in the state-level needs assessment processes include:

- Awareness and education and outreach for providers, educators and the general public
- Access to PrEP and nPEP
- Need for increased access to targeted HIV testing (e.g. Emergency Departments, Federally Qualified Health Centers; etc.)
- Increased access to syringe-exchange programs
- Need for broad communication and messaging about the current state of HIV
- Ready-access to culturally-competent providers co-located with medical and social support services at one site
- Peer support and navigation
- Lack of readily available tools for identifying patient readiness for treatment;
- Tools for treating patients who also face co-morbidities, particularly substance use/abuse and mental health diagnoses
- Housing (e.g. relocation, security deposits, and housing stability concerns);
- Integrate comprehensive Linkage to Care, retention, and re-engagement services;
- Tools for reaching and engaging high-risk target populations
- Further data analysis of differences in linkage to care among subpopulations and diagnosing facility is needed
- Re-engagement in care resources for positive individuals who are not currently in or have fallen out of care
- More seamless coordination between linkage to care activities and partner services
- Lack of health insurance and needed financial assistance

- Access to food pantries (southwest and southeast Ohio regions)
- Need for financial assistance, like food stamps (northwest, northeast and central Ohio regions)
- Reduction of stigma

Cleveland RWHAP Part A Service Needs. Participants in Cleveland region's 2014 Needs Assessment identified the top five service needs (in order) as follows:

1. Outpatient/ambulatory medical care
2. Prescription Medications
3. Dental Care/Oral Health Services
4. Medical Case Management
5. Psychosocial Support Services

In general, the HIV-positive survey participants reported being well-connected to the services available to them and prioritized getting medical care for their HIV/AIDS as important. Regardless of whether or not they received a referral, 83 percent saw an HIV/AIDS doctor within three months of their diagnosis. Of those who did not see a doctor immediately, almost 40 percent (11 people) reported that they were not ready to think about their HIV status.

Columbus RWHAP Part A Service Needs. In the 2014 needs assessment conducted for the Part A Columbus region, the top five service need areas identified (in order) were:

1. HIV Medical Care
2. Primary Medical Care
3. Dental x-rays and cleaning
4. Connection to medical care services and supports
5. Case management for medical services

Participants in the 2014 Columbus Region HIV/AIDS Needs Assessment were asked to indicate which of a variety of medical services they had needed in the prior 12 months. Over 75 percent of those who needed medical services were able to access them, with the exception of certain dental services (e.g., dentures, fillings, extractions, tooth repair), nutrition education or counseling, drug/alcohol/tobacco counseling, specialized services such as occupational or physical therapy, and support groups for PLWHA children/family.

The only service that a majority of participants reported needing was financial assistance for utilities and rent. Approximately, 40 percent of participants reported needing food pantry or food services and assistance in obtaining other social services. Those needing social services appear to have a greater difficulty accessing them compared to accessing medical services. Less than 75 percent of the participants who needed services reported receiving financial assistance for utilities or rent, legal guardian assistance, childcare, housing for people with HIV/AIDS, vouchers to buy food, home delivered meals or groceries, housing for families, and housing for people recovering from or with current substance abuse problems.

Description of Service Gaps

Service Gaps in Ohio. Prevention and care gaps noted in the state-level needs assessment processes include:

- Uneven access to PrEP and nPEP across the state
- Education for targeted populations and the awareness of risk and/or services is seen to be a gap
- Integration of HIV prevention and testing services in health care settings (e.g., emergency departments and federally qualified health centers)
- Provider knowledge and workforce availability; access to fourth generation HIV testing; and HIV prevention and testing integration in health care
- Transportation
- Gaps between prevention and care along the continuum
- Variability of program financial eligibility from location to location
- Inconsistent availability of housing resources
- Inconsistent availability of mental health providers
- Inconsistent availability of treatment options for addiction services
- Integrated approach to linkage, retention, and re-engagement in care that includes both HIV prevention and care

Cleveland RWHAP Part A Service Gaps. Participants in Cleveland region's 2014 Needs Assessment identified the top five service area gaps (in order) as follows:

1. Dental Care/Oral Health Services
2. Housing Services
3. Non-Medical Case Management
4. Emergency Financial Assistance
5. Nutritional Therapy (tie)
6. Transportation Assistance (tie)

Columbus RWHAP Part A Service Gaps. In the Columbus region needs assessment for 2014, services were divided by both priority and access. Of the identified high priority needs for this region, access was also reported as good for these services (HIV medical care, primary medical care, dental x-rays and cleanings, connection to medical care services and supports). The only high priority area identified as having "poor" access was financial assistance for utilities or rent.

Description of Service Barriers

Service Barriers in Ohio. Prevention and care gaps noted in the statewide integrated planning process include:

- Stigma
- Cultural competency and an understanding of HIV and those at risk
- Providers, especially those in primary care, are perceived to be uncomfortable with discussing HIV prevention and testing
- Need for updated generationally appropriate messaging (e.g., social media, online resources) and consistent messages across the regions of Ohio

- Unreliable transportation, also transportation during partner services or linkage to care activities
- Inflexibility in the workplace to attend to medical needs
- Lack of knowledge about and understanding of HIV/AIDS among HIV-positive, people at risk for acquiring HIV and among the public
- Drug addiction and challenges with meeting daily survival needs
- Fear of others knowing status (especially among PLWHA in rural, African American or Spanish-speaking communities)
- HIV ignorance of family, friends, peers and strangers
- The need to meet survival needs before medical care
- The HIV criminalization statutes in Ohio were addressed as a barrier to testing
- Lack of state law regarding teaching about HIV may have contributed to the lack of urgency and general knowledge about the disease in the state
- Lack of clarity around funding and restrictions on funding were an area where better communication is needed
- Cohort of staff members with significant HIV experience who will all likely retire about the same time
- Absence of a statewide HIV Care Continuum
- Timely access to shared data to enhance partner services, linkage to care, and re-engagement in care
- Decreased program services and the availability of funding
- Awareness of importance of role HIV tester and front line staff members play in a person's initial response to a positive HIV diagnosis
- Need for better medical service system coordination (including testing) and more holistic treatment options (central Ohio and northeast regions)
- More access points to services (northeast and southeast regions)
- More personal and compassionate care (northwest region)
- More help navigating available services (southwest region)
- Need for more friend and family support
- Lack of support from the community
- Need for streamlined service delivery (DIS, LTC, CARE, etc.)
- Need for more medication adherence counseling
- Disparities across state/lack of equity
- Real time access to Medicaid service and medication utilization claims information for Ryan White case managers
- Increased options for medication access (pharmacy pick up vs. mail order)
- Lack of health insurance and financial assistance
- Flexibility in provider schedules for transient clients/new clients
- Outreach to and education for non HIV-specific service providers
- Lack of mental health providers who are culturally competent/diverse
- Shortage of providers with experience treating those with HIV over the age of 50

Cleveland RWHAP Part A Service Barriers. Barriers identified in the Cleveland TGA include:
- Mental illness
- Substance addiction
- Homelessness

- Hunger
- Stigma
- Pre-ACA/Medicaid Expansion- Lack of insurance, underinsurance or lack of ability to pay for services
- Post-ACA/Medicaid Expansion: Clients continue to experience systems-level challenges related to obtaining/maintaining insurance coverage; program needs to continue realigning services in response to expanded insurance coverage
- Need for more data-driven targeted outreach to PLWHA and other high-risk populations, more evidenced-based prevention and other services and increased marketing to increase the community visibility of programs
- Need to increase coordination among Planning Council, the grantee and providers
- System of care- need to expand provider network and provider capacity to serve additional clients, and, for shared clients, need increased collaboration, data sharing and care coordination
- Need to increase consumer participation and membership diversity on Planning Council

Columbus RWHAP Part A Service Barriers. Barriers identified in the Columbus TGA area included:

- Not knowing where to get services
- Ability to pay for services
- Depression diagnosis
- Medication adherence
- Mental health diagnoses including depression
- Poverty
- Homelessness
- Finding affordable housing
- Access to food assistance
- Stigma

E. DATA ACCESS, SOURCES, AND SYSTEMS

Primary Data Sources

HIV surveillance data was used to calculate numbers and rates of persons newly diagnosed and persons living with a diagnosed HIV infection in Ohio. HIV infection surveillance data represents confidential reports of HIV infection and AIDS diagnoses; it does not represent all persons with an HIV infection. The distinction is that HIV diagnosis data represent the earliest date of diagnosis reported to the ODH HIV Surveillance Program. The earliest date reported may not be the earliest date an individual became aware of their HIV infection. Individuals may have previously tested anonymously or were diagnosed out-of-state prior to being confidentially tested and reported to Ohio. HIV infection surveillance data may underestimate the level of recently infected persons because some infected persons do not know they are infected as they have not sought testing or did seek testing but did not respond to learn their test results. Reporting of mode of HIV transmission may not be complete as some persons diagnosed with an HIV infection may be reluctant to disclose their sexual and/or drug use history. 2014 is the most current HIV surveillance data as surveillance activities require annual projects related to retrospective death matching and interstate de-duplication before data is final. Limited CD4 and viral load prognostic lab results were used to estimate persons linked to care within the first year of HIV diagnosis. Sources of data used by the

HIV Surveillance Program for these analyses were health care providers and facilities who report HIV/AIDS diagnoses, and laboratories that perform and report HIV diagnostic testing, and CD4 and viral load testing for health care providers. Ohio's version of CDC's enhanced HIV/AIDS Reporting System (eHARS) is the system used to store surveillance data used in these analyses. Supplemental data incorporated to look at direct and indirect measures of risk included syphilis incidence and partner services data stored in the Ohio Disease Reporting System (ODRS) and analyzed by the ODH STD Surveillance Program. Other sources of data were the Behavioral Risk Factor Surveillance System, Youth Risk Behavior Survey, and National Substance Abuse and Mental Health Administration Treatment Episodes.

Data systems used for HIV Prevention include Evaluation Web, ODRS and eHARS. Evaluation Web is a test based system used to report all HIV testing funded by the ODH HIV Prevention Program Counseling, Testing and Referral (CTR) and Expanded Test Site (ETS) programs. Data collected in this system includes information regarding demographics, risk behaviors, test results, partner services and linkage to care. Partner services data for all HIV positive cases in Ohio are extracted from ODRS and submitted to the CDC HIV Prevention Program through Evaluation Web. Data from eHARS is used by HIV Prevention Program staff to assist with linkage to and re-engagement in care.

Data used to create the statewide Ryan White HIV Care Continuum was collected from all Ohio Ryan White Grantees (i.e., 2014 RSR data) and is stored in a CAREWare database by Part B. The Cleveland TGA utilizes the CAREWare system for data collection and reporting operations. One-hundred percent of the Cleveland TGA sub-grantees entered CY2014 client level data. Similarly, the Columbus TGA also utilizes CAREWare for data collection and reporting purposes. All Columbus Ryan White Part A sub-recipients are reporting data through CAREWare. Both the Cleveland and Columbus Part A HIV Care Continua were developed using data collected through CAREWare.

The Role of Data Policies

Ohio recently updated Ohio administrative code 3701-3-12 to require all laboratories in Ohio to report all HIV viral load results and all HIV CD4 counts to the Ohio Department of Health. This represents a significant shift in HIV prognostic lab reporting, as previously labs were only required to report detectable viral load results, and HIV CD4 counts under 200 cells per cubic millimeter of blood that were specifically used in the diagnosis of an AIDS. Access to data beyond the scope of the Ryan White Programs (e.g., data related to individuals who are out of care, data related to individuals who are accessing care through private insurance, etc.) is a barrier to producing an accurate HIV Care Continuum for all Ryan White Parts as well as the two Part A regions. Policies or agreements that would facilitate the sharing of HIV medical data between payer sources have yet to be implemented. All RWHAP Parts will continue to work together to create a Ryan White-specific state-wide database to enable data sharing across the Ryan White parts until state-wide data, including all lab values from public and private sectors, is made available.

Unavailable Data

Access to other health service utilization and clinical outcomes data (i.e., data for clients who may be covered by private insurance, Medicaid, Medicare, etc.) for medical care would greatly enhance the ability

of the state to produce an accurate HIV Care Continuum in which the needs of all PLWHA in the jurisdiction are considered. As a result of this integrated planning process, a data-sharing committee was created in an effort to address unavailable data.

II

SECTION II: Integrated HIV Prevention and Care Plan

A. Integrated HIV Prevention and Care Plan

Using the information in this plan through the integrated planning process, the following key prevention and care goals for Ohio have been identified for 2017-2021. Efforts will be made to coordinate with other Ohio initiatives and programs, the Ohio State Health Assessment (SHA) and the State Health Improvement Plan (SHIP) when carrying out the goals and strategies laid out in this plan.

Goal 1: Develop and Implement Data to Care. *Data to Care* is a new public health prevention strategy that aims to use HIV surveillance data as the primary data source to identify HIV-diagnosed individuals not in care. It is primarily accomplished through the sharing of data and information to identify HIV infected persons for initial linkage to care, and also to potentially identify persons who may have fallen out of care to approach for re-engagement. To implement linkage and re-engagement in care interventions, the national Data to Care strategy suggests health departments should use all of the data sources that they have available (e.g. ADAP, CareWare, Prevention Program Monitoring and Evaluation). To support Ohio's Data to Care strategy, a dedicated staff person will be hired to coordinate and oversee the use of HIV related data collected by the various ODH programs to be used for local linkage and re-engagement in care activities in the short term, and other ODH partner agency data (e.g. Medicaid managed care data on persons with HIV) as part of the long term strategy related to this goal.

- Goal 1A: Create an Ohio Care Continuum. It has not been possible yet to create an accurate state level continuum of care graph. The national continuum of care graph developed and disseminated by CDC includes CD4 T-lymphocyte and viral load (VL) laboratory results based upon data submitted by a subset of states and U.S. territories with 95 percent completeness of reporting of these prognostic lab results, and data from selected states funded for a supplemental project that looks at treatment and care received on a sample of persons diagnosed with HIV infection. To help Ohio achieve the 95 percent completeness level so that an accurate state level continuum of care graph can be developed, Ohio's HIV reporting rules surrounding CD4 and viral reporting were revised in July 2014. The Ohio Care Continuum goal will explore the use of data from multiple data sources so that Ohio's response to HIV may be viewed in a meaningful context.

- Goal 1B: Improve Data Sharing between Programs. The importance of collecting high quality data to assess and measure multiple outcomes along the continuum of care is essential to the planning of both prevention and care objectives. Data sharing is an area for improvement not only between ODH programs, but also between local public health agency staff working in HIV prevention and care services programs who perform the essential services of HIV testing, partner services, and linkage to care. To support improve data sharing, ODH will create a data system that uses data from current ODH prevention, care, and surveillance databases to serve as the primary linkage to care system in Ohio. Data quality and management will also require those who enter and report data to improve the quality of data they submit. Ohio's data sharing strategy will also extend to the larger policy and legislative

process in Ohio that currently places limitations on the sharing of protected health information reported to the director of health.[16]

Goal 2: Improve the Implementation of Linkage to Care. Ohio has a need for an improved linkage to care protocol. The strategies are intended to improve how to assess current linkage to care practices, identify areas of improvement, and develop a new protocol that will also address strategies for re-engagement in care.

Goal 3: Increase the Availability of Targeted HIV Testing. The need for more targeted testing was identified in several care-oriented needs assessments as well as the statewide and regional integrated plan meetings to assess needs, gaps and barriers. The strategies are intended to improve how to assess where testing needs to be occurring to increase the overall positivity rates for the activity and, ultimately, to bring positive individuals to care as early as possible in the course of their disease.

Goal 4: Ensure the Statewide Availability of Pre-exposure Prophylaxis (PrEP). There is uneven knowledge of and access to PrEP programs across Ohio. The availability of PrEP is often limited to the major metropolitan areas. ODH will work towards developing a directory of PrEP providers and supporting PrEP implementation across the state to minimize geographical disparities.

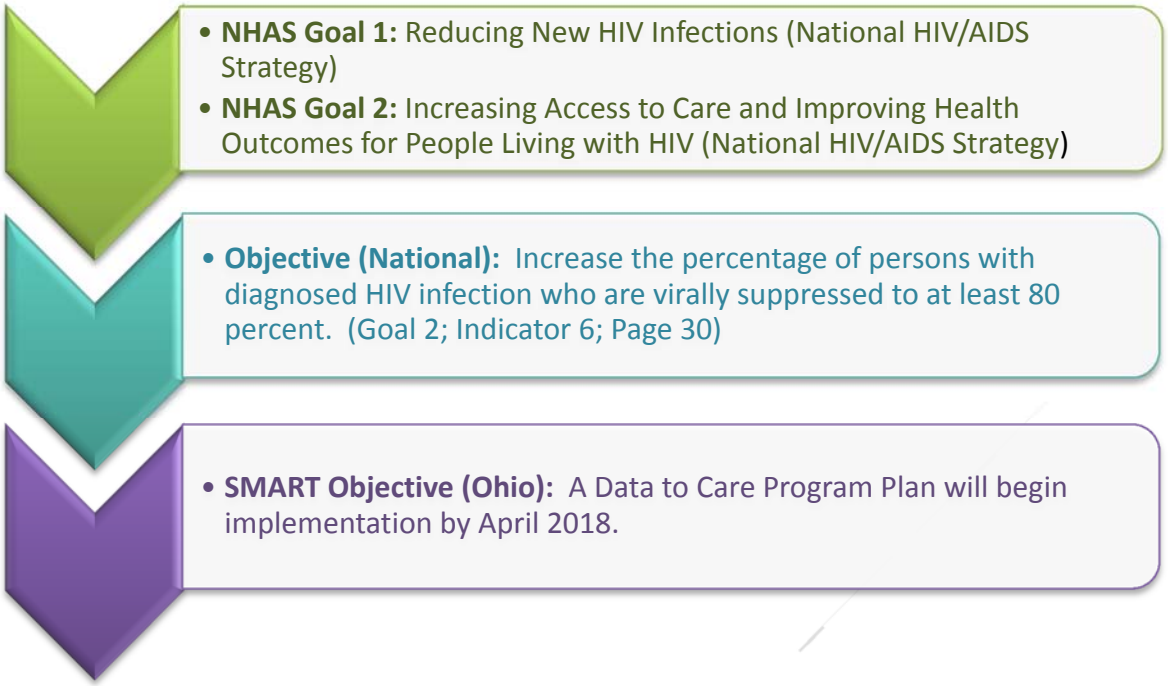
Goal 5: Address Housing Needs for PLWHA in Ohio. Concerns about housing include providing assistance with paying for housing as well as the availability of safe housing. Housing is an activity that other entities provide without HIV-specificity and it is important to take the lessons they have learned to revisit potential opportunities for collaboration with them in concert with them to ensure housing in all regions of the state where there is a need.

Goal 6: Continue and expand the Ryan White All-Parts Statewide Quality Management Program. Ryan White Parts in Ohio have a long-standing record of working collaboratively with each other and with the National Quality Center to identify and follow-through on statewide quality management objectives. The Integrated Planning process gave a key opportunity to formalize the continuation and expansion of these activities to ensure that prior collaborative efforts may be built upon in assessing Ohio's response to HIV.

Goals 7 and 8: Target Health Inequities. A review of Ohio's testing, treatment, care and surveillance data demonstrates the disproportionate impact of HIV on communities of color and young men who have sex with other men. An expansion of testing and linkage to care efforts to engage persons of color and other high risk groups disproportionately diagnosed and at increased risk for acquiring HIV infection is necessary to reduce overall new infections in Ohio.

[16] https://effectiveinterventions.cdc.gov/en/highimpactprevention/publichealthstrategies/DatatoCare.aspx

GOAL 1:
DEVELOP AND IMPLEMENT A DATA TO CARE INITIATIVE



Strategy 1: By December 30, 2016 review current data available and how it is being used.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By September 30, 2016	ODH HIV Prevention, Surveillance and Care Programs	Review current HIV prevention, surveillance, and care data available	All records with HIV-related data	Positivity rates; target populations and populations served; linkage to care rates; partner services rates
By December 30, 2016	Data Committee	Facilitate discussions with Ohio Medicaid to determine what data is available and how it may be used to supplement ODH data	All records with HIV-related data	List of data indicators available through Medicaid

Strategy 2: By December 30, 2016, allocate resources for and identify a Data to Care workgroup that is representative of care, surveillance and prevention.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By December 30, 2016	Representatives from ODH HIV Prevention, Care and Surveillance, and local prevention and care professionals responsible for performing linkage to care	Hold first meeting to identify roles and responsibilities and what the data to care landscape in Ohio will look like	Entities who provide services along the HIV Care Continuum	Workgroup roster, meeting minutes
By November 30, 2016	ODH Prevention and Care Administrators ODH Leadership	Identify funding source for dedicated Data to care activities	Ohioans with HIV	Minutes from meeting between HIV prevention and care leadership, Office of Financial Affairs, and Office of Human Resources
By December 29, 2016	ODH Leadership	Assess workload capacity to determine responsibility for coordination of the Data-to-Care program	Ohioans with HIV	Responsible party identified

Strategy 3: By March 31, 2017, develop and present a detailed plan/proposal for a Data to Care Program.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By March 31, 2017	HIV Data to Care workgroup	Develop action plan for development of a Data to Care Program	Workgroup members	Action plan developed with clear timeframes, action steps and responsible parties
By June 30, 2017	HIV Data to Care workgroup	Present Data to Care Program Plan to leadership and gain approval for implementation	Workgroup members	Final Data to Care Program Plan and approval for resources needed to implement plan
By October 2, 2017	Data to Care workgroup	Present approved Data to Care plan to HIV Steering Committee	Workgroup members	Presentation of plan at Steering Committee meeting

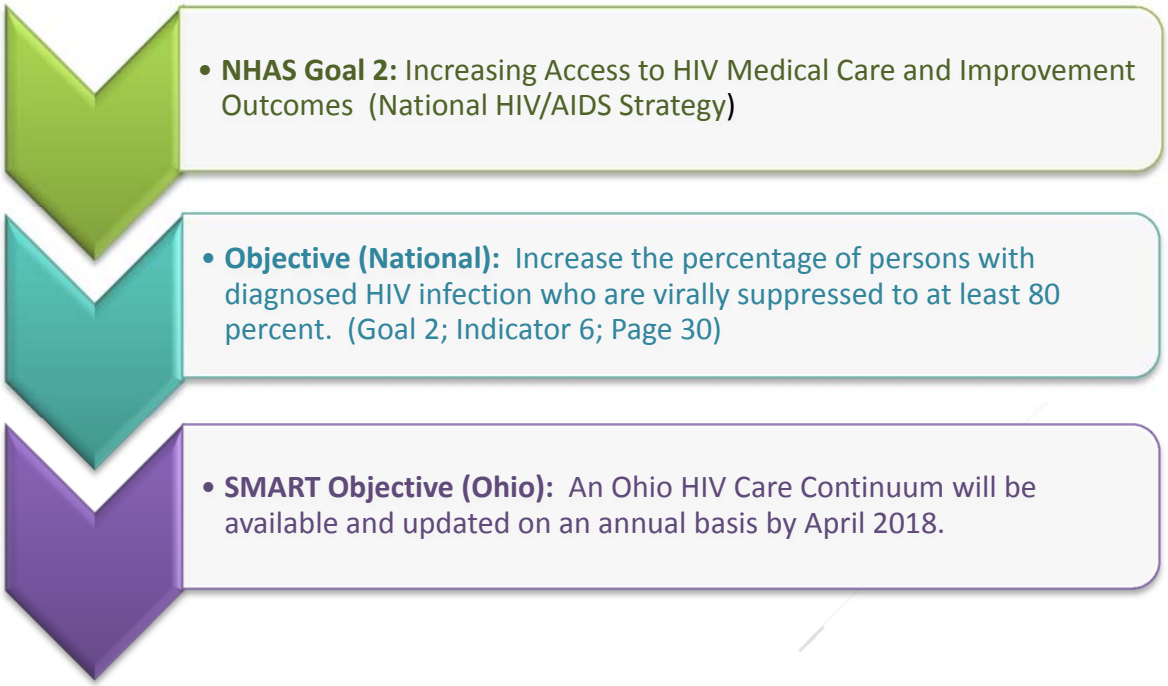
Resources for Implementation. Representatives from ODH HIV Prevention, Surveillance, and Ryan White Part B Care Program, local Ryan White Part A Programs, Disease Intervention Specialists (DIS), Ryan White case managers, Medicaid managed care plans, HIV Prevention test sites, and infectious disease providers.

Relation to the Continuum of Care. Creation of a Data to Care program will establish a process for identifying HIV positive Ohioans who are not in care through HIV surveillance data, data sharing arrangements and collaboration with external stakeholders. The program will also outline strategies to link or re-engage these individuals to HIV care through DIS and linkage to care coordinators.

Monitoring Progress. Progress will be measured by quarterly review of the action plan development.

Anticipated Challenges/Barriers. Appropriate resources (time and money) will need to be allocated and dedicated to developing a sustainable Data to Care Program. In addition, there are currently legal hurdles related to sharing HIV data needed to accurately identify HIV diagnosed individuals who are out of care.

GOAL 1A:
CREATE AN OHIO CONTINUUM OF CARE



Strategy 1: By December 31, 2016, identify an HIV Care Continuum workgroup that is representative of entities who provide services along the continuum.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By December 30, 2016	Ohio Department of Health	Identify workgroup members and hold first meeting	Entities who provide services along the HIV Care Continuum	Workgroup roster, meeting minutes

Strategy 2: Develop an action plan for the development of an Ohio HIV Care Continuum.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By March 31, 2017	HIV Care Continuum workgroup Data to Care workgroup	Coordinate with Data to Care workgroup and develop action plan for development of an Ohio HIV Care Continuum	Workgroup members	Action plan developed with clear timeframes, action steps and responsible parties

Strategy 3: Create a baseline Ohio HIV care continuum graph.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By September 29, 2017	Data to Care workgroup	Examine continuum of care data "bars" and data sources that may be used to measure	Workgroup members	Action plan developed with clear timeframes, action steps and responsible parties
By December 29, 2017	Data to Care workgroup	Create baseline diagnosis-based Ohio HIV care continuum graph and disseminate	Workgroup members	Graph displaying various points along continuum of care

Strategy 4: Updates on the action plan will be provided quarterly to the HIV Integrated Plan Steering Committee.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
Ongoing	HIV Care Continuum Data to Care workgroup	Updates provided to the HIV Integrated Plan Steering Committee	HIV Integrated Plan Steering Committee	Documentation of updates on progress towards continuum

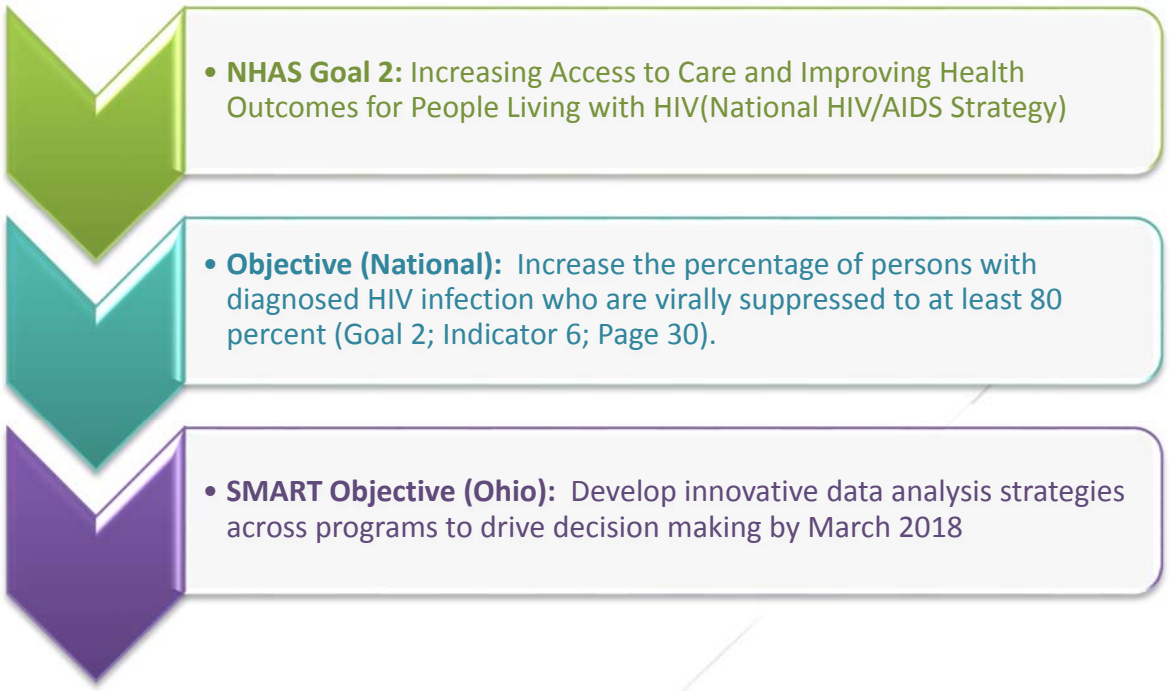
Resources for Implementation. Participation in the workgroup will be required of representatives from ODH HIV Surveillance, Prevention and Ryan White Part B Care Programs, local Ryan White Part A Programs, Disease Intervention Specialists (DIS), Ryan White case managers, Medicaid managed care plans, HIV Prevention test sites, and infectious disease providers.

Relation to the Continuum of Care. Creation of a continuum of care will provide the foundation for program evaluation that identifies opportunities to increase the proportion of persons in Ohio who know their HIV status and to maximize the proportion of HIV positive persons who are linked to and retained in HIV care, and are virally suppressed.

Monitoring Progress. Progress will be measured by quarterly review of the action plan development.

Anticipated Challenges/Barriers. The accurate measurement of linkage and retention in care is currently limited by the incomplete reporting of CD4 and viral load test results to the ODH HIV Surveillance Program. The Ryan White Part B Program serves approximately half of those living with HIV each year.

GOAL 1B:
IMPROVED DATA SHARING AND DATA USAGE



Strategy 1: Develop data sharing protocols and processes across ODH programs and other state agencies providing service to persons in Ohio with HIV infection.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By September 29, 2017	HIV Prevention, Surveillance and Care Program Managers	Create data sharing processes and protocols between HIV Prevention, Surveillance and Care Programs	HIV Prevention, Surveillance and Care Program Staff	CD4 cell count and viral load; Ryan White pharmacy data
By September 29, 2017	Data committee	Facilitate the development of data sharing agreements with Medicaid	HIV Prevention, Surveillance and Care Program Staff	CD4 cell count and viral load; Medicaid pharmacy data

Strategy 2: Incorporate local data sharing expectations into RFPs to ODH sub-grantees.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By October 2, 2017	ODH HIV Prevention and Care Programs	Incorporate language regarding data sharing practices and expectations in ODH HIV prevention and care RFPs to sub-grantees		

Strategy 3: Identify innovative data analysis strategies and share findings.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By January 31, 2017	HIV Prevention, Surveillance and Care Programs	Identify data analysis needs for each program	HIV Prevention, Surveillance and Care Services	Data indicators to be determined by discussion
By July 5, 2017	HIV Prevention, Surveillance and Care Programs	Develop new data analyses that leverage HIV Surveillance, Prevention and Care data	HIV Prevention, Surveillance and Care Services	Positivity rates; target populations and populations served; linkage to care rates; partner services rates; other indicators as determined by discussion
By December 29, 2017	HIV and STD Prevention Program Managers	Share and analyze matching data between HIV and STD Prevention Programs	STD Prevention and Surveillance Program Managers	HIV and STD Comorbidity Reports

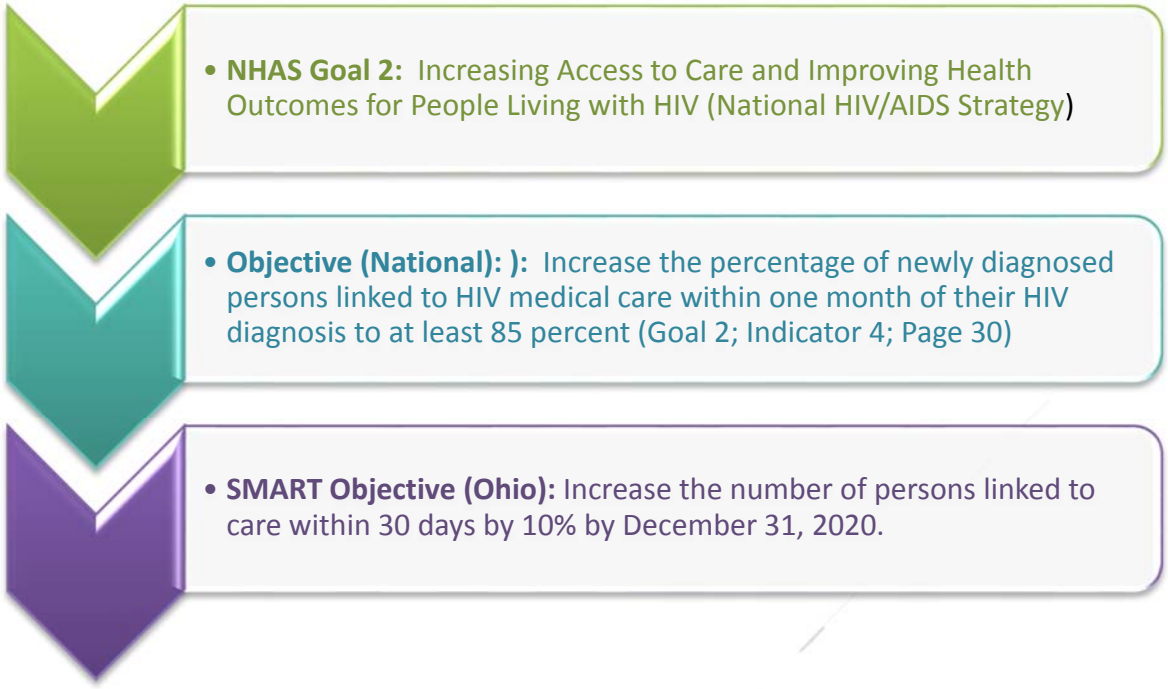
Resources for Implementation. Collaboration and data sharing among HIV Surveillance, Prevention, Ryan White Part B Care and Medicaid Programs will be required.

Relation to the Continuum of Care. Enhanced data sharing and analysis to assess outcomes for those testing positive for HIV will inform data driven decisions for improving partner services, linkage to care, retention in care, and re-engagement in care outcomes.

Monitoring Progress. The timeline will be used to ensure that data analysis, discussion and decision making are on track to meet this goal.

Anticipated Challenges/Barriers. Matching and analyzing data from four different data systems that may use varying definitions for the same outcomes may prove challenging. Technical difficulties such as lack of documentation for a data system (e.g. lack of a data dictionary) will create barriers to timely analysis of the data. There are legal and logistic concerns that will need to be addressed and resolved in order for data sharing between agencies to occur. Limitations in data sharing between and across industry partners due to the various laws, licensing, credentialing, auditing and review boards' restrictions on receiving and/or releasing data.

GOAL 2:
IMPROVE THE NETWORK OF LINKAGE TO CARE



Strategy 1: Establish baseline for Linkage to Care (LTC).

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By June 30, 2017	ODH HIV Prevention	Evaluate the current state of LTC services and the success rate of the services; identify the populations served	Newly diagnosed individuals	Number of persons linked to care, percentage of persons linked to care in 30, 60, and 90 days
By September 29, 2017	ODH HIV Prevention ODH HIV Care RW Part A	Create a LTC committee consisting of representatives from HIV Prevention and Care to review linkage, retention, and re-engagement services, policies, processes	Newly diagnosed individuals, persons in care, persons who have fallen out of care	Committee roster

Strategy 2: Evaluate data in current data systems to identify differences in linkage to care for various subpopulations.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By September 29, 2017	ODH HIV Prevention & Surveillance ODH STD Prevention & Surveillance	Analyze HIV prevention, surveillance, and partner services data to identify trends in LTC data including disparities among subpopulations	Newly diagnosed individuals	Completed analysis for HIV prevention, surveillance, and partner services data LTC rates within 30, 60, 90 days for each subpopulation
By September 29, 2017	Data Sharing Committee LTC Committee ODH Legal	Prepare written data security and confidentiality guidelines for the LTC and Data to Care initiatives	Ohioans with HIV	Guidelines will be prepared Prepare written Confidentiality Agreement to be signed by all parties engaged in LTC and Data to Care initiatives
By September 29, 2017	Data Sharing Committee LTC Committee	Review the three different Data to Care programs promoted by the CDC to determine the most appropriate model for Ohio	Not-in-Care (NIC) individuals	A Data to Care Program Model from CDC will be selected for Ohio
By September 29, 2017	Data Sharing Committee LTC Committee	Generate output lists from HIV Surveillance Database with key inclusion data for the not-in-care (NIC) list	Not-in-Care (NIC) individuals	An initial NIC list will be created
By September 29, 2017	Data Sharing Committee LTC Committee HIV Care, Prevention and Surveillance Teams	Determine and document the Ohio strategy to "work" the NIC list	Not-in-Care (NIC) individuals	A written protocol for "working" the NIC list will be created
By December 29, 2017	Data Sharing Committee LTC Committee HIV Care, Prevention and Surveillance Teams	Determine the precise measures to assess the number of HIV+ individuals who are in care and NIC and assess the number of HIV+ individuals who have an undetectable viral load	Ohioans with HIV	Written measures will be available

By December 29, 2017	ODH Leadership	Assess workload capacity to determine responsibility for coordination of the implementation of linkage, retention, and re-engagement strategies	Ohioans with HIV	Responsible party identified

Strategy 3: Develop an integrated LTC plan and determine resource needs.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By September 29, 2017	LTC Committee Data Sharing Committee	Create an action plan to develop and implement a new LTC protocol in conjunction with the Data to Care elements that includes re-engagement services in conjunction with the Data to Care program elements	Newly diagnosed individuals, those who have fallen out of care	Completed action plan Completed LTC protocol that includes data to care program components
By December 29, 2017	LTC Committee Data Sharing Committee	Facilitate a statewide LTC meeting with funded regions to review the completed LTC protocol and assess the need for additional resources, e.g. additional staffing	Newly diagnosed individuals, those who have fallen out of care	Meeting minutes; list of resources identified
By June 29, 2018	ODH HIV Prevention and ODH HIV Care	Incorporate updated LTC protocol (developed by LTC committee), performance measures, and additional resources in a combined HIV and STD Prevention solicitation	Local health departments (LHDs) that serve high risk populations	Solicitation posted to the ODH website
By June 29, 2018	LTC Committee Data Sharing Committee	Perform program monitoring and evaluation of the efficacy of the activities	Ohioans with HIV	Monthly Progress Reports will be available

Strategy 4: Implement integrated linkage-to-care plan.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By January 30, 2019	Agencies funded for LTC HIV Prevention	Implement updated LTC protocol as described within the solicitation	Newly diagnosed individuals, those who have fallen out of care	LTC performance measures
By April 30, 2019; July 31, 2019; October 31, 2019; and January 31, 2020	Agencies funded for LTC	Conduct quarterly analysis of LTC performance measures and identify areas of improvement and create performance improvement plans as needed	Newly diagnosed individuals, those who have fallen out of care	Completed analysis of LTC performance measure Written plans provided to ODH

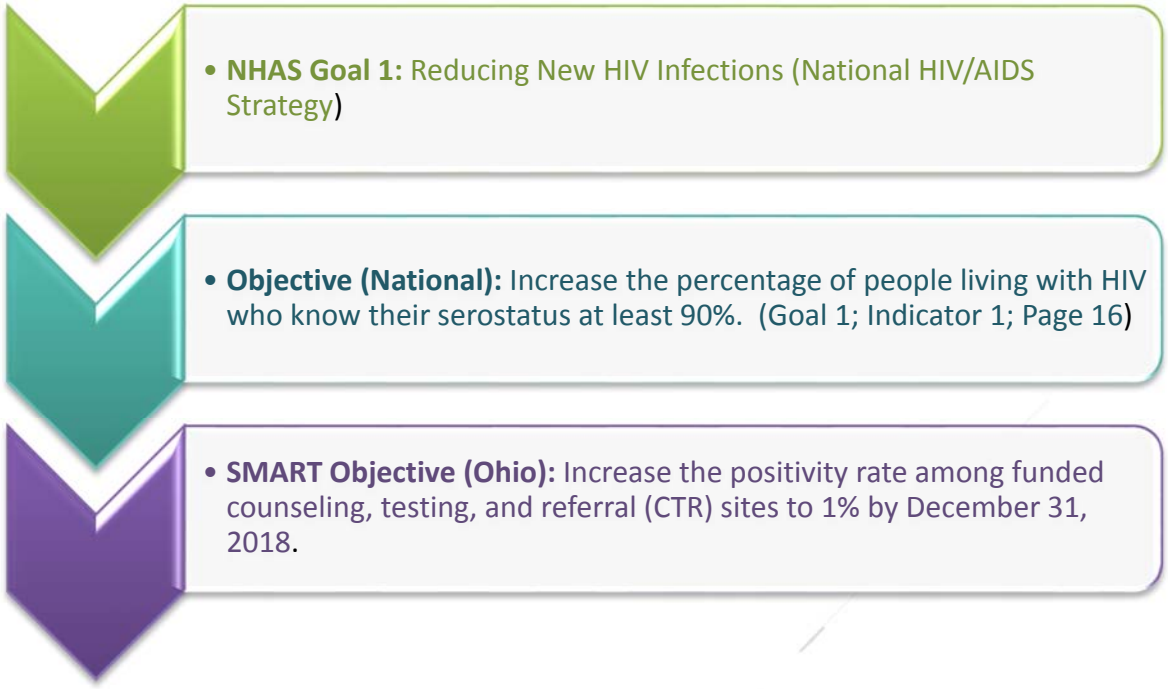
Resources for Implementation. Collaboration and data sharing among HIV Surveillance, Prevention and Ryan White Part B Care Programs will be required.

Relation to the Continuum of Care. Linkage to and retention in care is essential to lowering individual and community viral load, thereby reducing transmission and new diagnoses of HIV.

Monitoring Progress. HIV Surveillance, HIV Prevention and Ryan White HIV Care program data (from all Parts) will be used to assess the baseline linkage to care outcomes and to monitor and evaluate those outcomes after the implementation of the new linkage to care protocol.

Anticipated Challenges/Barriers. Currently, the linkage to care goal is to have the HIV positive person attend their first medical care appointment within 90 days after diagnosis. Setting the linkage goal to within 30 days will likely prove challenging. Additional resources (e.g. additional DIS positions) will be needed to accommodate the increased follow up and linkage activities for newly diagnosed clients and previously diagnosed clients who have fallen out of care. Further, defining the roles of HIV Prevention and HIV Care staff in the process of linkage, retention and re-engagement to care, so that the process is as seamless as possible for the client will require a high level of coordination and flexibility among a large number of HIV Prevention and HIV Care program staff.

GOAL 3:
INCREASE THE EFFECTIVENESS OF TARGETED HIV TESTING



Strategy 1: Evaluate test volume and positivity rate among funded HIV testing sites for the last three years.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By August 31, 2016	HIV Prevention Monitoring and Evaluation Manager	Determine test volume and positivity rate of each funded HIV testing site	ODH HIV Prevention	Test volume, positivity rate for each site
By August 31, 2016	HIV Prevention Monitoring and Evaluation Manager	Identify sites that do not meet minimum criteria for targeted testing	ODH HIV Prevention	List of sites

Strategy 2: Reorganize CTR testing facilities across funded regions.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By September 30, 2016	HIV Prevention Program Manager	Process map site close out for the sites identified in Strategy 1	ODH HIV Prevention	Completed process map
By December 30, 2016	ODH HIV Prevention	Implement site close out process to close or defund identified sites not meeting minimum criteria	Funded CTR sites	Number of CTR sites closed
By July 31, 2017	HIV Prevention Monitoring and Evaluation Manager	Evaluate January-June 2017 data to compare target populations to the populations being reached through remaining CTR sites	ODH HIV Prevention, Regional HIV Prevention Coordinators	Test volume, positivity rate

Strategy 3: Identify remaining gaps in targeted testing and establish new testing sites to reach targeted populations.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By August 31, 2017	HIV Prevention Monitoring and Evaluation Manager	Using information from Strategy 2, identify regions that are not reaching targeted populations at CTR sites	ODH HIV Prevention, Regional HIV Prevention Coordinators	Regions identifies as not reaching target populations
By December 29, 2017	HIV Prevention Monitoring and Evaluation Manager, HIV Surveillance	Create a map overlaying the locations of CTR testing sites, HIV surveillance incidence and prevalence by zip code, and HIV testing data by zip code	ODH HIV Prevention Program, Regional HIV Prevention Coordinators	A completed map
By January 31, 2018	ODH HIV Prevention	Identify gaps in targeted testing by region utilizing the map created in Activity 2	ODH HIV Prevention, Regional HIV Prevention Coordinators	Areas of need identified

By March 30, 2018	HIV Program Manager	Facilitate a targeted testing workgroup to review the evaluation data, the completed map, and identified gaps, and create an action plan to improve targeted testing in the regions	ODH HIV Prevention, Regional HIV Prevention Coordinators	Workgroup roster, completed action plan
By June 29, 2018	ODH HIV Prevention	Provide resources and assist funded regions in implementing the action plan	ODH HIV Prevention, Regional HIV Prevention Coordinators	New testing sites established, number of individuals tested in targeted populations
By January 30, 2019	HIV Prevention Monitoring and Evaluation Manager	Evaluate July-December 2018 data to compare target populations to the populations being reached through new and existing CTR sites	ODH HIV Prevention, Regional HIV Prevention Coordinators	Test volume, positivity rate
By March 29, 2019	HIV Prevention Monitoring and Evaluation Manager	Evaluate January-December 2018 testing data to compare target populations being reached in each of the regions and determine if goal has been met	ODH HIV Prevention, Regional HIV Prevention Coordinators	Test volume, positivity rate

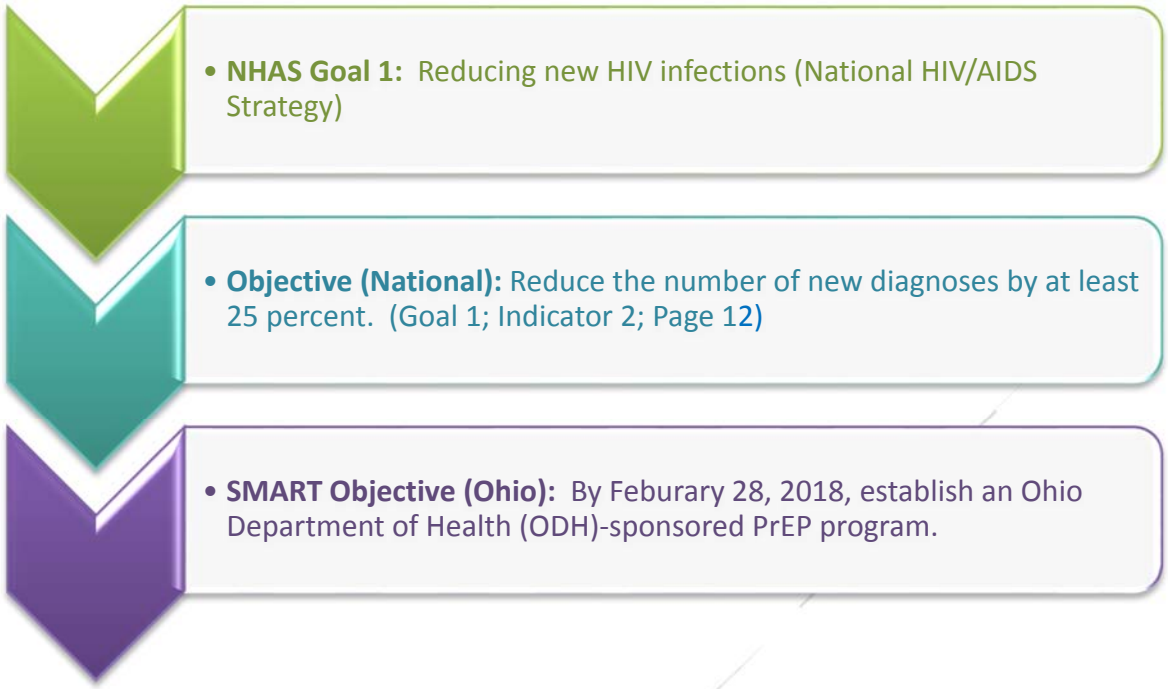
Resources for Implementation. The HIV Prevention Program managers and staff will need to use the HIV testing data to define an algorithm or process for determining whether a site is reaching high priority populations for HIV testing. The HIV Prevention Program data will be used to make data driven decisions. Coordination with goals 6 and 7 to increase peoples' awareness of their risk for acquiring HIV.

Relation to the Continuum of Care. Targeted testing is a key factor in identifying previously undiagnosed HIV positive individuals in the community. Increased identification of persons infected with HIV provides enhanced opportunities to engage clients in Partner Services, Prevention activities and Linkage to Care. Targeted testing also provides an avenue for HIV positive persons who have fallen out of care to be re-engaged in HIV care services in order to achieve viral suppression.

Monitoring Progress. HIV Prevention Program testing data will be used to establish baseline levels of testing within target populations. This data will be used to make decisions about re-aligning resources to maximize testing in high priority populations. The evaluation of testing data will continue at least bi-annually to assess for increases in testing among those persons at highest risk of infection with HIV.

Anticipated Challenges/Barriers. Discontinuation of testing at sites that are not reaching positivity rates indicative of testing in targeted populations will likely cause some concern among HIV Prevention test sites regarding their ability to continue to provide HIV testing to their consumers. HIV Prevention Coordinators and other local partners will need additional education regarding the rationale for the changes and clear guidance on the implementation of the transition.

GOAL 4:
ENSURE STATEWIDE AVAILABILITY OF PrEP
(Pre-Exposure Prophylaxis)



Strategy 1: Assess baseline data on PrEP access in Ohio.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By June 30, 2017	ODH HIV Prevention	Identify all PrEP programs operating within the state.	Existing Ohio programs offering PrEP to high-risk Ohioans	Comprehensive list of all PrEP programs doing business as of 7-1-2017
By August 31, 2017	ODH HIV Prevention	Contact existing PrEP programs to assess number of program participants statewide	Existing Ohio programs offering PrEP to high-risk Ohioans	Number of programs reached
By October 31, 2017	ODH HIV Prevention	Map existing programs and their associated catchment areas	Existing Ohio programs offering PrEP to high-risk Ohioans	Completion of map

By October 31, 2017	ODH HIV Prevention ODH HIV Care	Send letter to all Ryan White Part B providers to determine who is or may be interested in providing a PrEP program in their area.	Ryan White Part B Providers	Responses from a survey of Ryan White Providers sent by mail to them.
By December 29, 2017	ODH HIV Prevention	Identify gap areas around the state where PrEP programming should be implemented	Gap areas identified when comparing surveillance data to existing PrEP program locations	Surveillance data and identified gap areas

Strategy 2: Develop a state-sponsored PrEP programming model.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By June 30, 2017	ODH HIV Prevention ODH Care	Review other state-sponsored PrEP programs extant in the nation.	Existing Ohio programs offering PrEP to high-risk Ohioans	Written interpretation and review
By September 29, 2017	ODH HIV Prevention ODH Care	Create a protocol for delivery of PrEP services in gap areas of Ohio	Existing Ohio programs offering PrEP to high-risk Ohioans	Written protocol
By December 29, 2017	ODH HIV Prevention	Determine the number of additional PrEP sites needed to address gap areas.	Existing Ohio programs offering PrEP to high-risk Ohioans	Findings from assessment of statewide gap areas

Strategy 3: Implementing state-sponsored PrEP programming.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By June 30, 2017	ODH HIV Prevention	Develop roles and responsibilities for implementation	Management and staff	Roles and responsibilities document
By September 29, 2017	ODH HIV Prevention	Written work plan will be developed	Existing Ohio programs offering PrEP to high-risk Ohioans	Work plan
By December 29, 2017	ODH HIV Prevention	Implement PrEP	Existing Ohio programs offering PrEP to high-risk Ohioans	Implementation plan

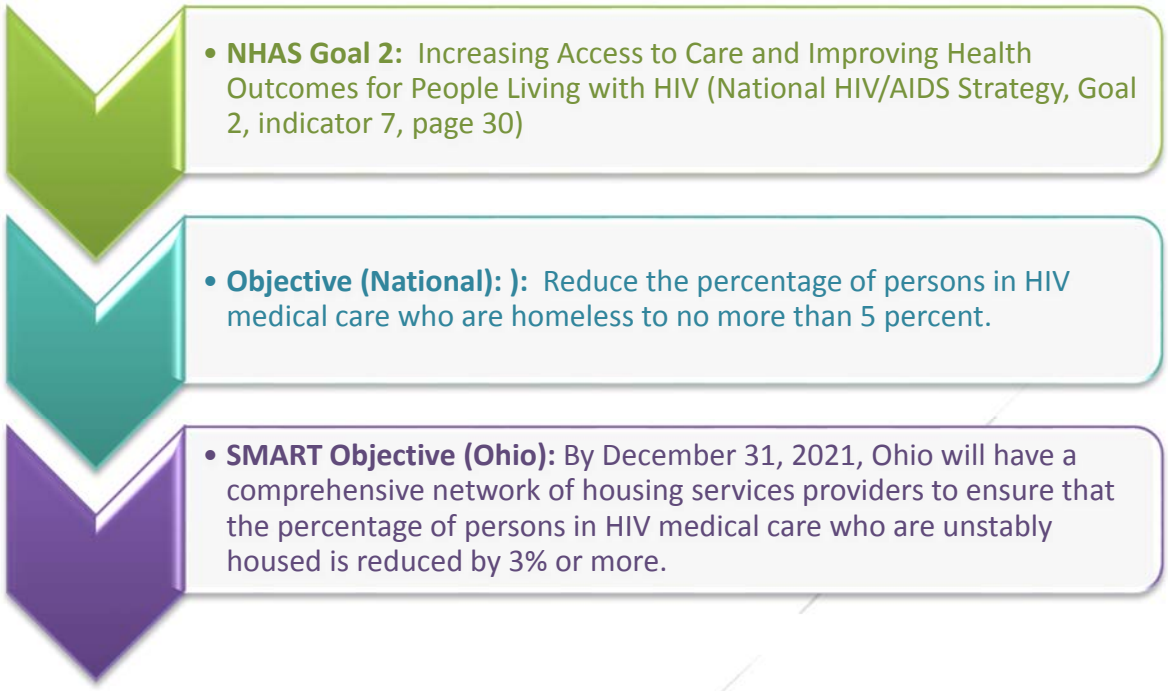
Resources for Implementation. Collaboration and data sharing among HIV Prevention and Ryan White Part B Care Programs will be required to assess the best strategies for reaching high risk populations that would benefit the most from increased access to PrEP.

Relation to the Continuum of Care. Increasing access to PrEP will prevent new HIV infections within high risk populations. The protocol for monitoring a person taking PrEP involves regular testing for HIV infection and thereby ensures the detection of new infections due to treatment failure among high risk populations taking PrEP.

Monitoring Progress. The timeline will be used to ensure that data analysis, discussion, decision making and the relevant documentation are on track to meet this goal.

Anticipated Challenges/Barriers. PrEP is expensive and this presents a barrier for the uninsured as well for the insured who may have prohibitively high co-pays or whose insurance will not cover the cost at all. Additionally, there is a PrEP knowledge gap among providers, including requirements for monitoring and clinical evaluation, contributing to reluctance to prescribing PrEP, which may cause some reluctance to prescribe Truvada due to the lack of provider self-efficacy regarding patient monitoring and evaluation. Other challenges and barriers to this goal will depend on whether state funded PrEP programs are centralized at the state level or whether local sites are funded to implement state sponsored PrEP programs.

GOAL 5:
ADDRESS THE HOUSING NEEDS OF OHIOANS WITH HIV



Strategy 1: Establish an inventory of available HIV housing service providers in Ohio.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By June 30, 2017	ODH HIV Care Part As HOPWA HUD	Identify HIV-specific housing providers in Ohio.	Housing Services Providers (e.g. HOPWA)	A comprehensive list of HIV housing providers will be created with associated contact information
By August 15, 2017	Ryan White Parts A and B	Conduct a survey of housing providers to assess 1) catchment area; 2) available funding resources; 3) specific services offered	Housing Services Providers	Survey results compiled after conducting survey activity
By August 31, 2017	Ryan White Parts A and B	Invite participants to an event to identify needs, gaps, and barriers in the current housing provider network/system.	Housing Services Providers	Invitations and RSVP list

Strategy 2: Establish a baseline of Ohioans with HIV who need housing services.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By April 28, 2017	All Ryan White Parts	Maintain a list of Ryan White clients in HIV medical care who report 1) stable housing and 2) unstable housing	Consumers of Ryan White Services in Ohio	List of clients, by program, and associated housing status.
By June 30, 2017	Epidemiologists in ODH HIV Care	Map clients on map of Ohio showing where individuals are stably or unstably housed along with mapping of available housing services.	Consumers of Ryan White Services in Ohio	Map of Ohio Ryan White clients showing housing stability.
By August 31, 2017	Epidemiologists in ODH HIV Care	Identify the geographic locations in Ohio with clear need for housing services.	Housing Services Providers	Develop baseline measures
By August 31, 2017	All Ryan White Parts	Share map with the HIV Housing Providers who will be participating in the event.	Housing Services Providers	List of those who received the information.

Strategy 3: Conduct a process improvement event to address HIV housing in Ohio.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By October 31, 2017	Ryan White Parts A and B	Determine a location and a contractor to conduct the Ohio HIV Housing event	Housing Services Providers	Location and Contractor information available
By December 29, 2017	ODH HIV Care	Host the event for all existing HIV housing service providers to document available services	Housing Services Providers	Sign-in sheets from housing event Resultant action steps from housing event

By December 29, 2017	ODH HIV Care	Use the results from the event to determine regional strategies to address services gaps for Ohioans living with HIV.	Housing Services Providers	Documentation of resources, needs, gaps, and barriers. Development of progress measures

Strategy 4: Provide coordinated housing services in regions with housing gaps.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By March 30, 2018	All Ryan White Parts Other interested Housing Services Providers	Take the results from the epi-review of housing and the event to determine the priority regions to target for provision of housing services.	Ohioans with HIV who lack housing	Priority regions in Ohio identified. Action plan created.
By June 29, 2018	All Ryan White Parts Other interested Housing Services Providers	Determine the housing services provider best positioned to address the gaps in each area.	Ohioans with HIV who lack housing	
By September 28, 2018	All Ryan White Parts ODH HIV Prevention	Send information about available housing initiatives to interested parties to help reach potential housing clients.	Ryan White funded Case Managers and Medical Providers Linkage-to-Care Personnel	List of Individuals
By September 28, 2018	Ryan White Part B	Implement action plan to develop a Part B housing program to address any remaining gaps, if needed.	Ryan White Part B clients	

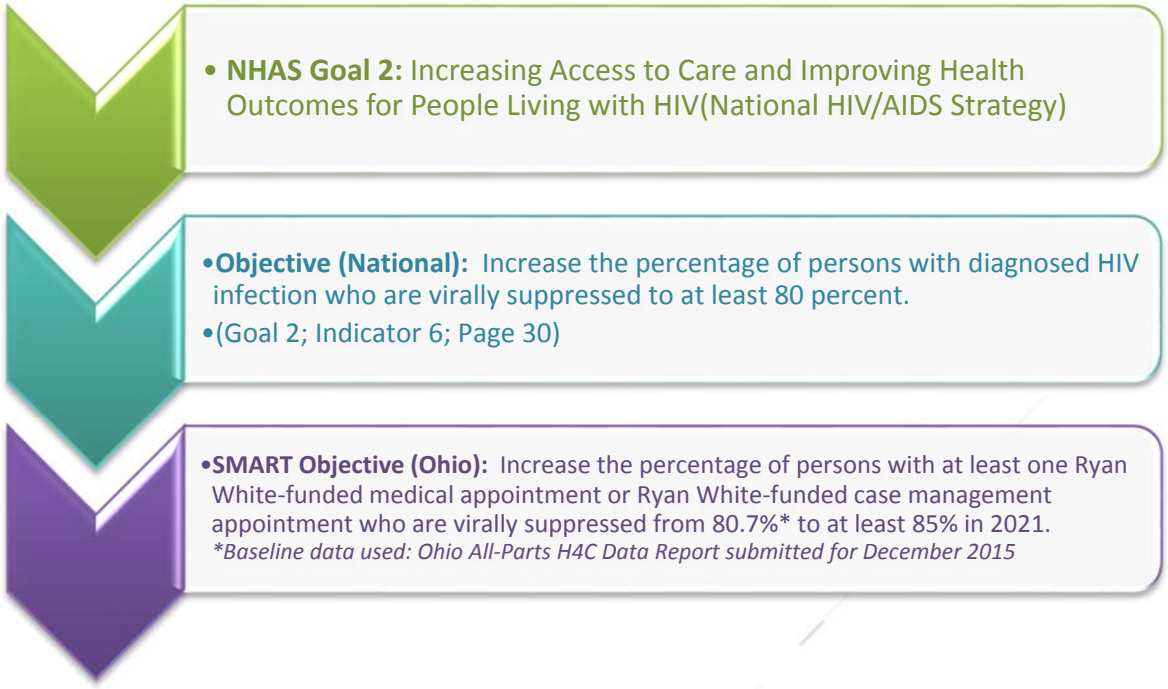
Resources for Implementation. This activity will require the cooperation of all HIV housing services providers in Ohio. Ryan White Part B will budget resources to conduct the housing event and personnel to coordinate the activities.

Relation to the Continuum of Care. The provision of housing is specifically identified in the National HIV/AIDS Strategy stating that "[A]ccess to housing is an important precursor to getting many people into a stable treatment regimen. Individuals living with HIV who lack stable housing are more likely to delay HIV care, have poorer access to regular care." As a result, it is anticipated that reducing the number of unstably housed PLWHA will have impacts across the continuum.

Monitoring Progress. Developing both baseline and progress measures will be an outcome of the housing event.

Anticipated Challenges/Barriers. There are concerns about the availability of housing rental stock in certain parts of Ohio including Appalachia. Further, discerning alternative strategies to secure safe housing will be a key element. For example, anecdotal reports indicate that eradicating vermin might be a more practical and cost-effective option to having clients move to new housing.

GOAL 6:
CONTINUE AND EXPAND RYAN WHITE STATEWIDE HIV QUALITY MANAGEMENT ACTIVITIES



Strategy 1: Conduct a minimum of two meetings per year of the Ohio RW All-Parts Group to plan and coordinate quality improvement activities for RW-funded services statewide.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
Semi-annually	Ohio Ryan White All-Parts Group including the Midwest AIDS Education and Training Center	Hold semi-annual meeting	RW All-Parts Sub-grantees	Number of meetings held

Strategy 2: Conduct at least 3 quality improvement trainings for RW medical providers to build QM capacity aimed at viral suppression.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By December 31, 2018	Ohio Ryan White All-Parts Group	Plan and conduct trainings	RW-funded medical providers	Number of trainings held; possibly viral suppression rates pre/post training

Strategy 3: Conduct at least one statewide RW All-Parts quality improvement project aimed at viral suppression.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By December 31, 2019	Ohio Ryan White All-Parts Group	Plan and conduct a statewide RW QI project	RW All-Parts sub-grantees; RW-funded medical providers	Percentage of RW clients who are virally suppressed (pre/post QI project)

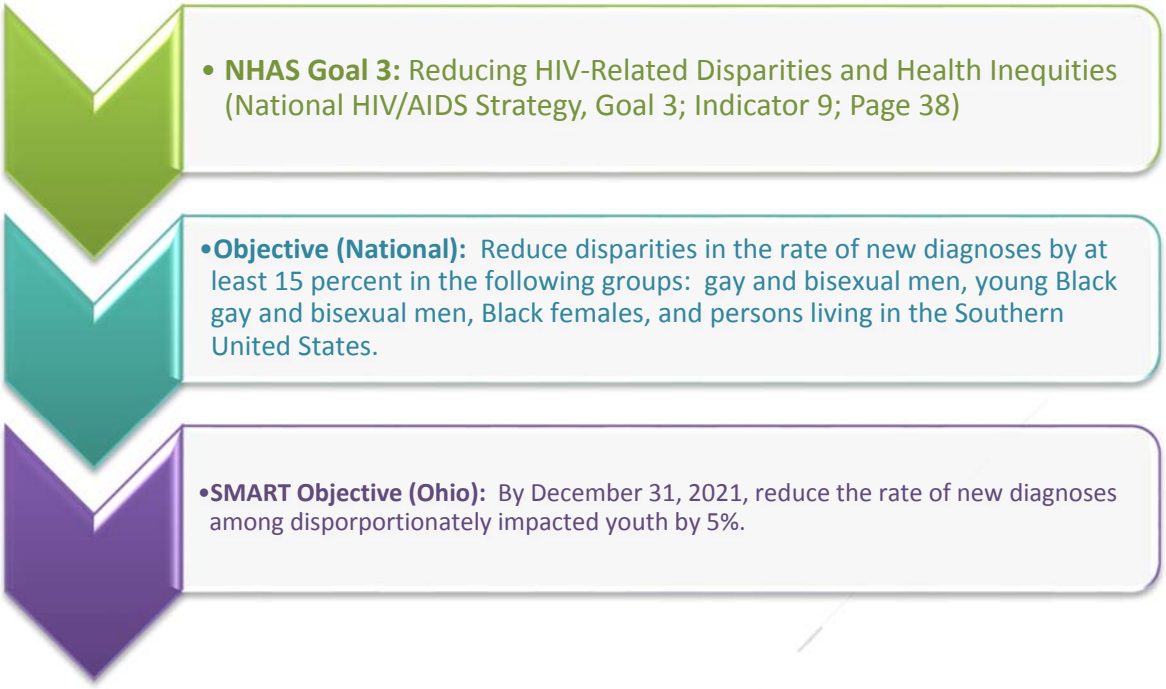
Resources for Implementation. It will be necessary to contract for services to manage and implement the described activities. Ryan White Part B has the necessary funding for such a contract. It will be necessary for All Ohio Ryan White Parts to continue the levels of engagement witnessed to date. Further, it will be important to ensure that participants from all the Ryan White Parts have quality improvement knowledge and training experience to generate meaningful performance measure data.

Relation to the Continuum of Care. Providing the described statewide quality management program is directly related to client viral suppression and is indirectly related to the retention and provision of antiretroviral (ART) therapy measures.

Monitoring Progress. Quarterly progress reports will be prepared and semi-annual outcomes data will be collected, reviewed, monitored and distributed among the parts.

Anticipated Challenges/Barriers. Due to the limited time available on the part of staff involved in the statewide QM efforts, it will be necessary to secure an external contractor to ensure the completion of activities.

GOAL 7:
TARGET HEALTH INEQUITIES--YOUTH



Strategy 1: Identify social determinants of health that play a role in disproportionate HIV diagnosis rates for targeted populations in Ohio.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By June 30, 2017	ODH Health Equity Office All Ryan White Parts ODH HIV Prevention	Convene committees of statewide subject matter experts to identify the various social determinants of health playing a role in disproportionate HIV diagnosis rates	African American Trans Women (under 30 years of age)	3-5 social determinants of health will be identified for each target population
			MSM (under 30 years of age)	
			MSM of color (under 30 years of age)	2-3 entry points for intervention for each target population will be identified

By August 31, 2017	ODH Health Equity Office All Ryan White Parts ODH HIV Prevention	Using available data sets, assess the extent to which the identified social determinants (for each population identified) play a role in each region of the state.	As above	Regional disparities between social determinants of health will be identified.
By December 29, 2017	ODH Epidemiologists in HIV Prevention and Care ODH Health Equity Office	Identify the larger picture of community characteristics that endanger the health of the targeted populations (not limited to HIV). When possible, map the geospatial relationships between identified HIV cases from the target population and corresponding economic, employment, environmental, housing, medical, public health, and other key dimensions to identify specific social determinants for each population	As above	Identified characteristics list Available map

Strategy 2: Conduct focus groups to craft and test messaging for targeted populations based on the identified social determinants of health.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By October 16, 2017	Ryan White Parts A and B ODH HIV Prevention Contractor ODH Health Equity Office	Determine a location and a contractor to conduct the focus groups (by region and by population)	African American Trans Women (under 30 years of age) MSM (under 30) MSM of color (under 30)	Locations and Contractor information available

By April 30, 2018	As above	Conduct focus group round 1 activities	As above	Sign-in sheets from focus group activities Data from focus groups to craft messages
By July 31, 2018	As above	Craft messages for testing in focus group round 2 based on information from focus group round 1	As above	Discrete messages crafted for each group regarding both HIV prevention and care seeking
By September 28, 2018	As above	Test messages with focus group round 2 Inquire in round 2 focus groups about media mechanisms to reach each targeted group by region	As above	Responses to each of the messages and final choice(s) made for messaging. List of media mechanisms to promote campaign

Note: For Strategy 2, the intention is to craft effective messages to 1) increase awareness of importance of early testing, 2) increase awareness of available resources across the continuum of care, 2) to increase participation in care, 3) to retain the target populations in care OR determine why individuals in the target populations did not remain in care and 4) identify and implement activities that effectively address the measured impact of co-morbid/co-existing conditions on retention and viral load suppression rates among African Americans, youth and the aged.

Strategy 3: Determine Population-Specific Media for Message Distribution.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By December 31, 2018	Ryan White Parts A and B ODH HIV Prevention Contractor ODH Health Equity Office	Identify appropriate media mechanisms to reach each of the identified target populations	African American Trans Women (under 30 years of age) MSM (Under 30) MSM of color (Under 30)	List of message distribution resources and timeline for message distribution
By December 31, 2018	As above	Assess feasibility of each of the identified media mechanisms identified.	As above	

Strategy 4: Disseminate Tested Messages.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By March 29, 2019	Ryan White Parts A and B ODH HIV Prevention ODH Health Equity Office	Measure the efficacy of the messages to: 1) Increase testing 2) Increase entry into care 3) Increase retention in care	African American Trans Women (under 30 years of age) MSM (Under 30) MSM of color (Under 30)	Continued assessment of increased representation of the target population in care.

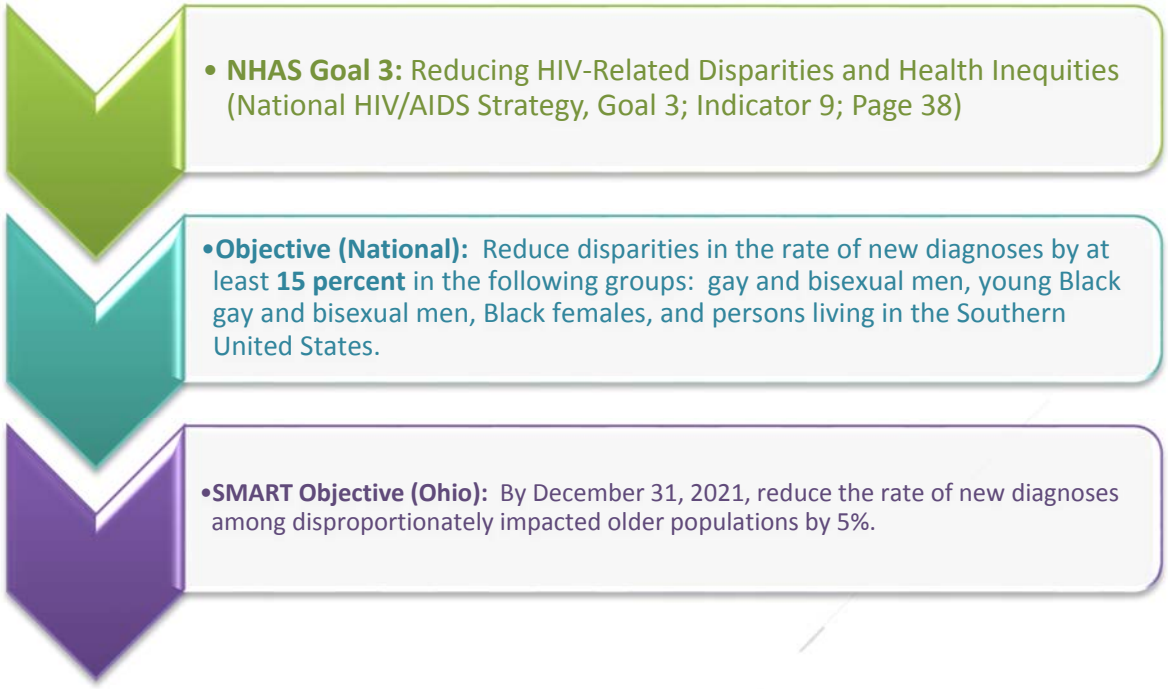
Resources for Implementation. It is likely that it will be necessary to contract for services to hold focus groups with appropriate reach into the targeted communities. It will also be necessary to have a number of the elements of the data-sharing goal in place in order to effectively measure the activities of this goal. Additionally, solicit and utilize the facilitators shared by HIV+ AA, youth and aging communities who have successfully achieved and maintained VLS.

Relation to the Continuum of Care. This goal is designed to assess how well sub-populations are able to navigate the continuum of care with effective supports in place.

Monitoring Progress. A timeline will be used to ensure that activities are on track to meet this goal.

Anticipated Challenges/Barriers. Adequate resources, need for data-sharing to measure effectiveness.

GOAL 8:
TARGET HEALTH INEQUITIES--AGING



Strategy 1: Identify social determinants of health that play a role in disproportionate HIV diagnosis rates for targeted populations in Ohio.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By June 30, 2017	ODH Health Equity Office All Ryan White Parts ODH HIV Prevention	Convene committees of statewide subject matter experts to identify the various social determinants of health playing a role in disproportionate HIV diagnosis rates	African American Trans Women over 45 years of age	3-5 social determinants of health will be identified for each target population
			MSM over 45 years of age	
			MSM of color over 45 years of age	2-3 entry points for intervention for each target population will be identified

By August 31, 2017	All Ryan White Parts ODH HIV Prevention ODH Health Equity Office	Using available data sets, assess the extent to which the identified social determinants (for each population identified) play a role in each region of the state.	As above	Regional disparities between social determinants of health will be identified.
By December 29, 2017	ODH Epidemiologists in HIV Prevention and Care ODH Health Equity Office	Identify the larger picture of community characteristics that endanger the health of the targeted populations (not limited to HIV). When possible, map the geospatial relationships between identified HIV cases from the target population and corresponding economic, employment, environmental, housing, medical, public health, and other key dimensions to identify specific social determinants for each population	As above	Identified characteristics list Available map

Strategy 2: Conduct focus groups to craft and test messaging for targeted populations for identified social determinants of health.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By October 16, 2017	Ryan White Parts A and B ODH HIV Prevention Contractor ODH Health Equity Office	Determine a location and a contractor to conduct the focus groups (by region and by population)	African American Trans Women over 45 years of age MSM over age 45 MSM of color over age 45	Locations and Contractor information available

By April 30, 2018	As above	Conduct focus group round 1 activities	As above	Sign-in sheets from focus group activities Data from focus groups to craft messages
By July 31, 2018	As above	Craft messages for testing in focus group round 2 based on information from focus group round 1	As above	Discrete messages crafted for each group regarding both HIV prevention and care seeking
By September 28, 2018	As above	Test messages with focus group round 2 Inquire in round 2 focus groups about media mechanisms to reach each targeted group by region	As above	Responses to each of the messages and final choice(s) made for messaging. List of media mechanisms to promote campaign

Note: For Strategy 2, the intention is to craft effective messages to 1) increase awareness of importance of early testing, 2) increase awareness of available resources across the continuum of care, 2) to increase participation in care, and 3) to retain the target populations in care OR determine why individuals in the target populations did not remain in care. There is particular interest from consumers in determining the social supports necessary to retain older, treatment experienced populations in care. At this time, the information is anecdotal and it will be important to assess the extent to which this is a measurable concern.

Strategy 3: Determine population-specific media for message distribution.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By December 31, 2018	Ryan White Parts A and B ODH HIV Prevention Contractor ODH Health Equity Office	Identify appropriate media mechanisms to reach each of the identified target populations	African American Trans Women over 45 years of age MSM over age 45 MSM of color over 45	List of message distribution resources and timeline for message distribution
By December 31, 2018	As above	Assess feasibility of each of the identified media mechanisms identified.	As above	

Strategy 4: Disseminate tested messages.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By March 29, 2019	Ryan White Parts A and B ODH HIV Prevention ODH Health Equity Office	Measure the efficacy of the messages to: 4) Increase testing 5) Increase entry into care 6) Increase retention in care	African American Trans Women over 45 years of age MSM over 45 MSM of color over 45	Continued assessment of increased representation of the target population in care.

Resources for Implementation. It is likely that it will be necessary to contract for services to hold focus groups with appropriate reach into the targeted communities. It will also be necessary to have a number of the elements of the data-sharing goal in place in order to effectively measure the activities of this goal.

Relation to the Continuum of Care. This goal is designed to assess how well sub-populations are able to navigate the continuum of care with effective supports in place.

Monitoring Progress. A timeline will be used to ensure that activities are on track to meet this goal.

Anticipated Challenges/Barriers. Adequate resources, need for data-sharing to measure effectiveness.

B. COLLABORATION, PARTNERSHIPS, AND STAKEHOLDER INVOLVEMENT

Ohio's Governor Kasich created the Governor's Office of Health Transformation (OHT) to achieve a number of health-related goals in Ohio. One of the guiding principles of OHT posits that "with forward thinking, solutions-oriented strategies we can transform Ohio into a model of health and economic vitality—and bring the system back in line with our heartland values." OHT's vision is very specific about principles related to chronic disease (such as HIV) and states to "prevent chronic disease whenever possible and, when it occurs, coordinate care to improve quality of life and help reduce chronic care costs."

In Ohio, the 130th General Assembly created the Joint Medicaid Oversight Committee (JMOC) under Senate Bill 206. The committee consists of five state senators and five state representatives. The primary function of JMOC is to provide continuing oversight of all facets of the state's Medicaid program. The committee oversees Medicaid compliance with the legislative intent, evaluates legislation for long-term impact on Medicaid, and assists in limiting the rate of spending growth, while improving quality of care and health outcomes for individuals enrolled in the state's Medicaid program. One of the charges for the JMOC group was to prepare a report on the impact of the Affordable Care Act (ACA) on select Ohio Department of Health programs (including Ryan White Part B) and to make a series of recommendations.

Great care has been taken to include as many stakeholders and key partners in the integrated planning process as possible in a state as diverse as Ohio. An executive committee including representatives from the Ohio Department of Health (ODH) HIV Prevention, Surveillance, and Care met and invited an initial group of potential "Steering Committee" members to a meeting. At the outset, the Steering Committee included the ODH Prevention, Surveillance, and Care personnel as well as consumers, representatives from the two Ohio Part A regions, the AETC at the Ohio State University (OSU), and one of the co-chairs of the statewide HIV Prevention Group. To avoid the creation of a number of plans at potential cross-purposes one with another, representatives from JMOC and OHT were invited to participate in the steering committee for the HIV Care and Prevention Integrated Plan in Ohio. This helped ensure a single vision for a statewide plan to address HIV into the next decade in Ohio. Additionally representatives from each of Ohio's Medicaid Managed Care Plans actively participates on the committee.

As noted in the Needs, Gaps and Barriers section, statewide meetings were convened on March 9, 2016 and July 27, 2016. The nearly 100 participants at each meeting included consumers, medical case managers, case management supervisors, disease intervention specialists, HIV service provider staff, state agency staff, policy makers, and more. In the morning session, representatives from HIV Surveillance, Prevention and Care each presented general information about the programs to ensure all participants had a strong working knowledge of the different roles. In the afternoon session, the participants were broken into the following workgroups: 1) HIV Prevention; 2) HIV Testing and Diagnosis; 3) Linked to Medical Care; 4) On Anti-Retroviral Therapy (ART) and 5) Virally Suppressed. Each group was asked to brainstorm the needs, gaps and barriers of individuals living with HIV in Ohio specific to their assigned column. Each group had a facilitator and a recorder and was comprised based on random group assignment to ensure that each group included representatives who were very familiar with the assigned column as well as those for whom the subject matter was not necessarily an area of expertise. This enabled an engaged dialogue with cross-cutting questions. At the end of the day, the groups came back together and shared the identified needs, gaps and barriers for each respective column.

In an effort to ensure that the needs, gaps, and barriers identified were consistent throughout the state, a series of regional meetings were scheduled. Fifteen meetings each were held in nine regions. Most regions included a private meeting for interested PLWHA (whether service consumers or not) and a public meeting. At each regional meeting, participants were shown the information identified from the March 9 statewide meeting and given opportunity to provide feedback as to whether the needs, gaps, and barriers identified were accurate for the respective region of the state.

Notes were recorded for meetings of the executive committee, steering committee, break-out sessions, regional meetings, conference calls and shared widely. This included through a Glass Cubes account to enable any interested party access to the various drafts of documents and reference/discussion documents. In addition, information was available on the ODH webpage and any interested party could request being added to the email list for all of the documents as well as information regarding any of the public meetings.

C. PEOPLE LIVING WITH HIV/AIDS (PLWHA) AND COMMUNITY ENGAGEMENT

Ohioans livings with HIV/AIDS were involved in all phases of plan development. PLWHA actively participated in the following ways:

- HIV Integrated Plan Steering Committee members
- Participation in statewide meetings on March 9 and July 27
- Participation in each of the regional meetings between May and July

Efforts were made to ensure the regional meetings were reflective of the local epidemic and included diverse populations. Data was not collected from participants but meeting organizers reached out to populations reflected in the epidemic.

The Planning Council for the Cleveland TGA has formed an ad-hoc committee, specifically to assist with the development of this Integrated Plan. The ad-hoc committee consists of local providers for both care and prevention services, a community funder, as well as consumers. The ad-hoc committee plays an active role in the development of the Integrated Plan for the TGA in that it has laid the foundation for the regional meetings to take place by organizing the logistics of the meeting, as well as designing an outline that works for the local community. Additionally, the ad-hoc committee is responsible for reviewing and approving all information submitted for the Integrated Plan by the Ryan White Part A Cleveland TGA grantee. All Planning Councils have the federal requirement of being reflective of the local HIV epidemic.

The Cleveland TGA also invited Recovery Resources to be a part of their Regional Planning meetings. Recovery Resources has received a targeted testing grant from the CDC focusing on young men who have sex with men (MSM) of color. This agency plans to invite their current participants in the program to participate in the Integrated Plan regional feedback process as well. The local prevention partners are involved in the local integrated planning process. City of Cleveland HIV Prevention personnel participate in the Part A Planning Council as well as in the integrated planning group.

During the development of the plan, Ohio AIDS Coalition (OAC) hosted three programs in which needs, gaps and barriers were learned from clients. The programs include The Intersection of Mental Health and HIV (Columbus and Dayton), The Graying of HIV (Columbus and Dayton) and Reducing Barriers to

Treatment at the Intersection of HIV and Identity among Trans Women (Columbus). During these meetings OAC was able to capture the needs of PLWHA within the state of Ohio. OAC also partnered with the Ohio Department of Health and Measurement Resources to engage Ohioans living with HIV/AIDS to ensure HIV prevention and care activities are responsive to their needs.

SECTION III: Monitoring and Improvement

Updating Stakeholders on Implementation Plan Progress

Written action plans with detailed timelines and responsible parties, identified by role and name, will be developed for each goal and strategy in the plan. Below is a table outlining the schedule for regularly updating planning bodies and stakeholders, soliciting feedback and making plan improvements.

Monitoring and Improvement Activity	Description	Timeline/ Frequency	Responsible Parties
Gather updates on the status of plan strategies, objectives and goals	An assigned person from the HIV Integrated Plan Steering Committee will collect updates on each Integrated Plan goal, objective and strategies; updates will be documented in a uniform way	Semi-annual, at a minimum	HIV Integrated Plan Steering Committee
Update planning bodies and stakeholders on progress of plan	Updates on goal, objective and strategy progress will be shared with planning bodies and stakeholders. At a minimum this will include the state and, as applicable, regional HIV Prevention and Care bodies	Semi-annual, at a minimum	HIV Integrated Plan Steering Committee
Solicit feedback on progress of plan	Every year information will be collected from HIV Prevention and Care stakeholders on the progress of the plan	Annual	HIV Integrated Plan Steering Committee
Used feedback from stakeholders for plan improvements	Using feedback collected, amendments will be made to the plan as needed to continue improving outcomes	Annual (by Sept. 30th each year)	HIV Integrated Plan Steering Committee

Table 28. Integrated Plan Monitoring Schedule

Plan to Monitor Goals and Objectives

The HIV Integrated Plan Steering Committee will continue to meet on a regular basis and will serve as the core group responsible for the monitoring and evaluating of the plan. At a minimum the SMART objectives and goals will be updated on a semi-annual basis. The updated objectives and goals will be reviewed at steering committee meetings and adjustments made to strategies as needed.

Using Data to Improve Outcomes

A data subcommittee has been created as a component of the HIV Integrated Plan Steering Committee. This subcommittee is exploring ways to document health outcomes data for all Ohioans living with HIV/AIDS. This strategy will continue as more comprehensive data will allow for more enhanced long-range planning.

Another strategy will be the regular reporting of health outcomes data related to the plan outcomes on a semi-annual basis. Sharing data results and data assessment tools will allow all stakeholders within the

HIV service delivery system to evaluate and improve health outcomes within their respective program(s) and the state. Additionally, as state data become more standardized and complete, quality improvement projects focused on specific health outcomes can be initiated to identify effective health improvement strategies for those with or at-risk for HIV, and likely other, populations of interest.

Letters of Concurrence

THE CITY OF COLUMBUS
ANDREW J. GINTHER, MAYOR

COLUMBUS PUBLIC HEALTH

September 20, 2016

Steven R. Young, MSPH
Director, Division of Metropolitan HIV/AIDS Programs
Attn.: Funding Program
HIV/AIDS Bureau, HRSA Parklawn Building, Room 9W 12
5600 Fishers Lane
Rockville, MD 20857

Dear Mr. Young,

The Central Ohio Ryan White Part A Planning Council and Central Ohio HIV Planning Alliance (COHPA) integrated on July 26th, 2016 and is now called COHPA concurs with the following submission by the City of Columbus Public Health in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan.

The planning body, COHPA has reviewed the Integrated HIV Prevention and Care Plan submission to the CDC and HRSA to verify that it describes how programmatic activities and resources are being allocated to the most disproportionately affected populations and geographical areas that bear the greatest burden of HIV disease. The planning body concurs that the Integrated HIV Prevention and Care Plan submission fulfills the requirements put forth by the Funding Opportunity Announcement PS12-1201 and the Ryan White HIV/AIDS Program legislation and program guidance.

COHPA utilized a World Café (small group discussion) to provide input to the steering committee on the jurisdiction's plan. COHPA will continue to participate in the implementation of the jurisdictional plan and consider the plan's objectives when allocating future resources.

The signature(s) below confirms the concurrence of the planning body with the Integrated HIV Prevention and Care Plan.

Signature: Date:

Eddie Hamilton — 9/20/2016

Francesca Schumann — 9/20/2016

Central Ohio HIV Planning Alliance Chair(s)

240 Parsons Avenue | Columbus, OH 43215 | **T** (614) 645.7417 | **F** (614) 645.7633 | health@columbus.gov | www.publichealth.columbus.gov

CUYAHOGA COUNTY
BOARD OF HEALTH

YOUR TRUSTED SOURCE FOR PUBLIC HEALTH INFORMATION

September 21, 2016

Monique Worrell
Lieutenant Commander, U.S. Public Health Service
Division of Metropolitan HIV/AIDS Programs, HIV/AIDS Bureau
Health Resources and Services Administration
Department of Health and Human Services
5600 Fishers Lane
Rockville, Maryland 20857

Dear Ms. Worrell:

The Cuyahoga Regional HIV Health Services Planning Council and the Cuyahoga County Board of Health concur with the following submission by the Ohio Department of Health for the Integrated HIV Prevention and Care Plan in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan.

The planning body and the grantee have reviewed the Integrated HIV Prevention and Care Plan submission to the CDC and HRSA to verify that it describes how programmatic activities and resources are being allocated to the most disproportionately affected populations and geographical areas that bear the greatest burden of HIV disease. The planning body and grantee concur that the Ohio Integrated HIV Prevention and Care Plan submission fulfills the requirements put forth by the Funding Opportunity Announcement PS12-1201 and the Ryan White HIV/AIDS Program legislation and program guidance.

The Cuyahoga Regional HIV Health Services Planning Council established an Ad-Hoc committee which coordinated local planning and review efforts that contributed to the development of the State of Ohio's Integrated Prevention and Care Plan. The Ad-Hoc committee coordinated two local planning meetings to obtain input from consumers and community partners. This information was used in the development of the plan. In addition, the grantee's office participated with the state's steering committee which included state government agency's as well as prevention and care partners. The information obtained from the steering committee was communicated back to the ad-hoc committee of the planning council.

The State of Ohio plans on continuing planning efforts to ensure progress is made on the integrated plan.

5550 Venture Drive ♦ Parma, Ohio 44130
Direct: 216-201-2000 ♦ Fax: 216-676-1311 ♦ TTY: 216-676-1313 ♦ www.ccbh.net
Terrence M. Allan, R.S., M.P.H. Health Commissioner

The signatures below confirm the concurrence of the planning body and the grantee with the Integrated HIV Prevention and Care Plan.

Sincerely,

Kimberlin Dennis- Co-Chair Planning Council Date:

Claire Boettler, RN, MPH Project Director Date:

5550 Venture Drive ♦ Parma, Ohio 44130
Direct: 216-201-2000 ♦ Fax: 216-676-1311 ♦ TTY: 216-676-1313 ♦ www.ccbh.net
Terrence M. Allan, R.S., M.P.H. Health Commissioner

September 13, 2016

Sam Van Leeuwen
Centers for Disease Control and Prevention
Division of HIV/AIDS
Prevention Program Branch
1600 Clifton Road, NE
Atlanta, GA 30033

Dear Mr. Van Leeuwen:

The Ohio HIV Prevention Community Planning Group concurs with the following submission by the Ohio Department of Health in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan.

The Ohio HIV Prevention Community Planning Group has reviewed the Integrated HIV Prevention and Care Plan submission to the CDC and HRSA to verify that it describes how programmatic activities and resources are being allocated to the most disproportionately affected populations and geographical areas that bear the greatest burden of HIV disease. The planning body concurs that the Integrated HIV Prevention and Care Plan submission fulfills the requirements put forth by the Funding Opportunity Announcement PS12-1201 and the Ryan White HIV/AIDS Program legislation and program guidance.

The OCPG Chair acted as the Co-Chair of the Integrated Planning Steering Committee, helping to develop meeting agendas, facilitate integrated planning group meetings, and coordinate regional integrated planning meetings. The members of OCPG participated in two statewide combined meeting with members of the Ryan White Part B Advisory Group as well as eight regional meetings to identify needs, gaps, and barriers related to HIV prevention and care in the state of Ohio. Members of the planning committee were also given draft copies of the Ohio Integrated HIV Prevention and Care Plan to provide feedback on. OCPG will continue to be involved in the Integrated Planning process by participating in bi-annual combined meetings with the Ryan White Part B Advisory Group, participating in workgroups as necessary, assisting with goal implementation at the local level, and providing feedback through the planning process.

The signature(s) below confirms the concurrence of the planning body with the Integrated HIV Prevention and Care Plan.

Signature: Andrew H Rutherford Date: 9/13/2016
OCPG Co-Chair

Signature: Michael Burkhardt, MD, DHSc, MS, BSN Date: 9/13/16
OCPG Co-Chair Elect

OHIO DEPARTMENT OF HEALTH

246 North High Street
Columbus, Ohio 43215

614/466-3543
www.odh.ohio.gov

John R. Kasich/Governor

Richard Hodges/Director of Health

September 28, 2016

Amy Richter Griffin, MSW
Project Officer, Northeastern/Central Services Branch
Division of State HIV/AIDS Programs, HIV/AIDS Bureau
Health Resources and Services Administration
5600 Fishers Lane
Mail Stop 09W27A
Rockville, MD 20857

Dear Ms. Griffin:

The Ryan White Part B Advisory Group concurs with the following submission by the Ohio Department of Health (Part B and HIV Prevention), Columbus Public Health (Part A), Cuyahoga County Department of Health (Part A), in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan.

Members of the Part B Advisory Group participated in the development of the Integrated HIV Prevention and Care Plan, have discussed the Plan at meetings of the group, and have had opportunity to review the plan submission to the CDC and HRSA to verify that it describes how programmatic activities and resources are being allocated to the most disproportionately-affected populations and geographical areas that bear the greatest burden of HIV disease. The advisory group concurs that the Integrated HIV Prevention and Care Plan submission fulfills the requirements put forth by the Funding Opportunity Announcement PS12-1201 and the Ryan White HIV/AIDS Program legislation and program guidance.

An Integrated Plan Steering Committee, open to any interested stakeholders, was created and included participation of consumers, providers, representations from Ryan White Parts, prevention program personnel, and multiple state agencies (Departments of Aging, Medicaid, Mental Health and Addiction Services, and Health along with the Governor's Office of Health Transformation). This Steering Committee met on a monthly basis and hosted two statewide meetings and numerous regional meetings to gain input on needs, gaps and barriers as well as to create opportunities to brainstorm meaningful solutions for incorporation into the project goals and strategies.

In the past, care and prevention have had separate planning activities and the Integrated Planning process has pointed to the need for combined planning and assessment of progress. Toward that end, the care and prevention planning bodies have agreed to two combined statewide meetings each year--in March and September—to replace each group's regular meeting in those respective

months. In addition, the Integrated Plan Steering Committee will meet quarterly beginning in 2017 to ensure forward progress on the Plan goals and strategies. Each of these groups is open to the public and the dates for each are widely shared in advance.

The Ohio Integrated Plan has resulted in eight discrete goals, each with strategies designed to help our state reach our HIV goals. We expect work groups will be developed to address the goals and would expect diverse participation of Part B Advisory Group members in these ongoing efforts.

The signature below confirms the concurrence of the Ryan White Part B Advisory Group with the Integrated HIV Prevention and Care Plan.

Katherine E. Shumate, MPH

Katherine E. Shumate, MPH
Ohio Ryan White Part B Administrator and
Ohio Ryan White Part B Advisory Group Chair

September 28, 2016

Date