Ohio Statewide Coordinated Statement of Need

Prepared by the
Ryan White Part B Program
HIV Care Services
Ohio Department of Health

On behalf of
Ohio All Parts Group

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Introduction

The first Ohio Statewide Coordinated Statement of Need (SCSN) document, developed in 1997, concentrated on methods to assess the needs of people living with HIV/AIDS (PLWHA) in Ohio. For the first SCSN, staff of the Ohio Department of Health (ODH), Ryan White Part B program (formerly referred to as Title II) conducted research on nine archived needs assessments and found unreliable data and very little consistency. At that time, Ryan White Part B funded 11 regional Consortia to serve as local planning bodies and to determine the allocation of resources. As such, the developers of the 2000 SCSN concluded that Ryan White Part B Consortia were the most appropriate venues to conduct consistent annual needs assessments that would provide results specific to their areas.

In 2000, the updated SCSN focused primarily on the needs of Part B programs through an overview of the subsequent needs assessments provided by Consortia bodies across the state. Although the Consortia represent consumer interests statewide, the needs of other Ryan White Parts (formerly Titles) in Ohio were not significantly represented in the 2000 SCSN document, so the planning body concluded that the inclusion of other Ryan White Parts should be the goal for the 2003 SCSN document.

The subsequent 2003 SCSN was then expanded to examine the various issues across all Ryan White Parts in Ohio with a goal of including the needs and interests of all Ohioans living with HIV/AIDS. The 2006 SCSN was further updated, building upon the findings of the 2003 SCSN by including the needs of non-Ryan White-funded agencies serving PLWHA in Ohio. The 2009 update represented a significant shift in the process for drafting and revising the SCSN, as the Steering Committee of the All Parts Group directed the development for the first time. This led to a more comprehensive document that more fully reflected the statewide needs of Ohio with goals and priorities that were in line with the work and direction of the All Parts Group.

2012 Process for Updating Ohio's SCSN

In the time since the previous revision, there have been several significant changes to the landscape of HIV/AIDS care. At the federal level, two sentinel events have occurred since 2009: the Affordable Care Act became law in 2010, and the National HIV/AIDS Strategy (NHAS) was also published that same year. At the state level, Ohio's Part B program disbanded the Ryan White CARE Coordination Council (RWCCC) which was traditionally a source of input and data towards the SCSN. The RWCCC was replaced by the Part B Advisory Group, which is an expansion in scope of the former Part B Ohio Drug Assistance Program Advisory Board. The Part B Advisory Group is composed of representatives of all Parts from across the state, as well as medical providers, pharmacists, case managers, consumers and consumer advocates, a dentist, and AIDS service organization administrators. A structural reorganization also occurred within the Ohio Department of Health, bringing together HIV Prevention, Care, and Surveillance into one bureau in the Division of Prevention. Finally, from July 1, 2010, through September 28, 2011, Ohio instituted a waiting list for enrollment into the Ohio HIV Drug Assistance Program (OHDAP).

As with the 2009 update of the SCSN, the Ryan White All Parts Group played a primary role in the update of the SCSN for 2012. The first step in the 2012 SCSN was to present the 2009 goals and priorities to the Part B Advisory Group for comment on revisions needed. It became apparent at that time that the funding and political climates in which the Ryan White programs operate are more

uncertain than has been typical, and this creates a greater sense of uncertainty around goal identification and prioritization. As a result, in early 2012, members of the All Parts Group met to have an in-depth discussion about the emerging trends and needs of HIV care in Ohio that should be reflected in the SCSN. The meeting used the World Café[1] conversational format for facilitation. The All Parts Group is comprised of representatives from all Ryan White programs in Ohio, including Parts A, B, C (six grantees), D (two grantees), and AETC (two performance sites).[2] The Ohio AIDS Coalition (OAC), a consumer advocacy organization, also participates actively. Part B took the input from the Advisory Group and the All Parts Group and presented a draft of the 2012 SCSN for comment and revision. Part B also collaborated with Ohio AIDS Coalition to present the draft to other consumers for feedback. Epidemiologic content and data on unmet need were provided by Ohio HIV/AIDS Surveillance from the Ohio Department of Health (ODH). Finally, minor revisions were completed before the final document was sent electronically to all participants. The final version will also be available through the ODH/HIV Care Services web site.

The intent of this 2012 edition of the SCSN is to continue building upon the findings of the 2009 SCSN that reflected the needs of Ryan White programs and non-Ryan White programs serving PLWHA in Ohio.

Epidemiologic Profile of HIV/AIDS in Ohio[3]

Persons diagnosed with HIV infection are living longer. Each year the number of persons living with a diagnosis of HIV infection in Ohio continues to increase. In 2009, 16,329 persons were known to be living with a diagnosis of HIV infection in Ohio. This increased to 17,353 persons in 2010. Of the 17,353 persons living with a diagnosis of HIV infection in Ohio in 2010: 9,013 (52 percent) were living with a diagnosis of HIV (not AIDS) and 8,340 (48 percent) were living with AIDS.

Prevalence rates depict the extent to which populations are impacted by HIV infections. The overall estimated rate of persons living with a diagnosis of HIV infection in Ohio in 2010 was 150.3 cases per 100,000 population compared to 141.5 cases per 100,000 population in 2009. The rate of persons living with a diagnosis of HIV infection in Ohio in 2010 was four times greater among males than females (244.0 for males and 61.0 for females), six times higher among Blacks/African Americans than among whites (541.4 for Blacks/African Americans and 88.2 for whites), and nearly three times higher among Hispanics/Latinos than among whites (244.8 per 100,000 population for Hispanics/Latinos).

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[1] Brown, J. with Isaacs, D. (2005). *The World Café: Shaping our futures through conversations that matter.* San Francisco: Berrett-Koehler Publishers.

[2] The Ryan White grantees and their associated Parts, as of May 2012, are: Cuyahoga County Board of Health (A), Ohio Department of Health/HIV Care Services (B), ARC Ohio [Columbus] (C), Cincinnati Health Network (C), Portsmouth City Health Department (C), University Hospitals [Cleveland] (C), University of Toledo Medical Center (C/D), FACES Clinic at Nationwide Children's Hospital (D), and two Local Performance Sites of the Pennsylvania/Mid-Atlantic AETC [University of Cincinnati and The Ohio State University] (F).

[3] This Epidemiologic Profile section was prepared by HIV/AIDS Surveillance at the Ohio Department of Health. A complete profile is available at http://www.odh.ohio.gov/healthstats/disease/hivdata/pf1.aspx .
The complete citation is: Ohio Department of Health. (2012). HIV/AIDS Integrated Epidemiological Profile for Ohio: 2011 Edition.

The disparity in persons living with HIV infection among Ohio's Black/African American and Hispanic/Latino populations is more pronounced when further examining surveillance data by race/ethnicity and sex. The estimated rates of persons living with a diagnosis of HIV infection in Ohio in 2010 was 822.3 per 100,000 population among Black/African American males, 341.3 per 100,000 population among Hispanic/Latino males, and 155.7 per 100,000 population among white males. Large differences were also observed among female populations in Ohio impacted by HIV. The estimated rates of persons living with a diagnosis of HIV infection in Ohio in 2010 was 286.1 per 100,000 population among Black/African American females, 139.6 100,000 population among Hispanic/Latina females, and 23.8 per 100,000 population among white females.

For males living with a diagnosis of HIV infection in Ohio in 2010, male-to-male sexual (MSM) contact continues to be reported as the leading mode of HIV transmission. Sixty-four percent of males living with a diagnosis of HIV infection in Ohio in 2010 reported MSM as the primary mode of HIV transmission. This was followed by heterosexual contact (8 percent), injection drug use (IDU) (5 percent), and MSM and IDU (4 percent). For females living with a diagnosis of HIV infection in Ohio in 2010, heterosexual contact remains the primary mode of HIV transmission reported. Sixty percent of females living with a diagnosis of HIV infection reported this as the mode of HIV transmission. This was by followed by injection drug use (11 percent).

It is important to note that nearly 20 percent of all males and 30 percent of all females living with a diagnosis of HIV infection in Ohio currently have an unknown or unreported mode of HIV transmission; therefore, caution should be used when interpreting mode of HIV transmission data. Follow-up with health care providers is routinely performed to ascertain mode of HIV transmission in an effort to reduce the proportion of cases initially reported without this key piece of epidemiologic information.

The number of newly reported diagnoses of AIDS in Ohio remained stable between 2009 and 2010. There were 265 new diagnoses of AIDS reported in Ohio in 2009 and 256 in 2010. The highest proportions of new AIDS diagnoses reported in 2010 when observed by sex and age, were seen in males (84 percent) and persons 30-34 years of age (17 percent). Among males newly diagnosed with AIDS in 2010, male-to male sexual (MSM) contact was the primary mode of HIV transmission reported (64 percent). Among females newly diagnosed with AIDS in 2010, 43 percent identified heterosexual contact as the mode of HIV transmission, but 55 percent of all. The proportion of AIDS diagnoses reported in 2010 was evenly split between whites (47 percent) and Blacks/African Americans (46 percent). This is a change from 2009 when AIDS diagnoses among Blacks/African Americans in Ohio was 54 percent compared to 40 percent among whites. This trend is noteworthy as Blacks/African Americans make up only 12 percent of Ohio's population.

In addition to the trends in Ohio AIDS diagnoses noted above, there were 107 reports of concurrent HIV with AIDS diagnoses in 2009 and 73 in 2010. Concurrent diagnoses are those persons reported with an AIDS diagnoses at the same time of their initial HIV diagnosis and represents late diagnoses. The majority of these cases were among males (79 percent), of which 53 percent (31/58) reported MSM as the primary mode of HIV transmission. Concurrent diagnoses were reported more frequently among whites (51 percent) than Blacks/African Americans (45 percent) in Ohio 2010 – a reverse of what was observed in 2009. In 2009 and 2010, approximately 70 percent of concurrent diagnoses reported were observed among persons 35 years of age and older.

The HIV infection surveillance data noted above can be used to identify and target populations for prevention and care services, including targeted HIV testing. Our persistent efforts to increase testing will help Ohio more accurately identify the needs of PLWHA.

Findings from Needs Assessments and Other Related Documents

Needs Assessments

Part A

2009

In 2009, the Cleveland Transitional Grant Area (TGA) contracted with Collaborative Research, LLC to conduct a needs assessment survey among PLWHA who are diagnosed and not in care. The report describes the demographics and locations of those PLWHA who are out of care, as well as an assessment of service needs, gaps and barriers to care, including disparities in access and services among affected subpopulations and historically underserved communities. Approximately 35 percent of those surveyed had not seen a health care provider and had not had CD4 or viral load labs drawn in over a year. About 15 percent of respondents had not taken medication for HIV in over a year. Transportation ranked as the highest incentive (almost 63 percent) that would get respondents who had not been to a doctor in six months or longer to see a doctor. Insurance to pay for the doctor visit and meds was an incentive for over 51 percent of that group. "More information about services," "getting really sick," and "less wait time for appointments" were also high-ranking responses when asked what would get them to see a health care provider.

The needs assessment report also suggested the following strategies for reducing barriers to accessing services:[4]

Suggested Strategies for Newly Diagnosed PLWHA

Improved linkages between prevention and care

1. Locate HIV testing programs in HIV primary clinics, with aggressive offers of testing to the patients' sexual and drug-using partners and spouses
2. Use rapid testing in clinical and outreach testing settings
3. Use peer outreach testing specialists to locate and test other high-risk individuals within their own unique social networks
4. Implement same day referrals into primary HIV medical care upon testing positive
5. Use peer mentors to ease transition into care and assist with navigation of care systems

Suggested Strategies for PLWHA Receiving Some Services but NOT Primary HIV Medical Care

Improved linkages between supportive and primary care services

1. Case managers and other support staff who provide services should inquire about and encourage entry/re-entry into primary medical care
2. Case managers and therapists should ensure that the necessary supportive services are provided to stabilize the person's life situation (i.e., stable housing, food, safety) and then help ensure that these services are extended to facilitate entry into and retention in care, as indicated

[4] Collaborative Research, LLC, "Cleveland/Lorrain/Elyria TGA: 2009 Out of Care PLWHA Needs Assessment," Report of findings, June 2009 (pages 39-40).

3. Active referrals into primary HIV medical care with documented confirmations of intake appointments/re-establish appointments should be used

Suggested Strategies for PLWHA Who Have Dropped Out of Care

Improved partnerships between providers and patients and improved collaborations with peers

1. Primary care providers should make appointment reminder calls; facilitate transportation assistance; and implement/maintain "no-show" tracking and follow-up protocols
2. Examine patient lists of primary medical providers at least biannually to determine who has not returned for care; initiate telephone and/or letter contact to make appointments and encourage re-entry into care
3. Use peer advocates to get PLWHA back into care
4. Focus on reducing known barriers to care and resolving gaps in continuum of care

Suggested Strategies for PLWHA Who Have NEVER Been in Care

Improved peer-facilitated linkages between points of entry/testing/counseling and primary care

1. Active follow-up by testing/counseling agency to maintain contact and confirm entry into care
2. Peer outreach to specific populations and locations, including homeless shelters, etc.
3. Regular marketing of primary care services' availability and directions on making referrals with all points of entry staff and agencies
4. Social marketing efforts regarding benefits of care and treatment

2010-2011

Collaborative Research, LLC again conducted a needs assessment survey for the Cleveland TGA during the spring of 2010 and spring of 2011 of PLWHA newly diagnosed/new to care and those in care and out of care, respectively.[5] A highlight of findings:

In-Care Respondents (N=203)

Rank	Service NEEDS	Service USES	Service BARRIERS (Hard to Get)	Service GAPS (Can't Get)
1	Primary Medical Care	Primary Medical Care	Medical Transportation	Medical Transportation
2	Medications (HIV and non-HIV)	Medications	Medication Assistance	Medications
3	Housing Assistance	Medical Transportation	Housing Assistance	Housing Assistance (tie) Nutrition/Food Assistance (tie)
4	Nutrition/Food Assistance	Case Management	Nutrition/Food Assistance	Mental Health/Support Services (tie) Employment/Job Assistance (tie)
5	Mental Health/Support Services	Nutrition Assistance/Food Bank tied with Mental Health/Support Services	Emergency Financial Assistance	Emergency Financial Assistance & Eye Care

(p.7)

[5] Collaborative Research, LLC, "Cleveland TGA: In Care, Newly Diagnosed & Out of Care Needs Assessment," Report of findings, June 2011.

Out-of-Care Respondents (N=56)

Rank	Service NEEDS	Service USES	Service BARRIERS (Hard to Get)	Service GAPS (Can't Get)
1	Nutrition/Food Assistance	Mental Health/Support Services tied with Medication Assistance and Case Management	Medical Transportation	Medical Transportation/ Primary Med Care
2	Mental Health/Support Services		Housing Assistance	Housing Assistance tied with Health Information/Health Education
3	Primary Medical Care (tie) Housing Assistance (tie) Medical Transport (tie)		Medication Assistance tied with Primary Med Care and Health Information/Health Education	
4	Substance Abuse Treatment tied with Medication Assistance, Clothing, and Faith & Family			

(p.72)

"Out of Care" Respondents (N=56)

GAP Reasons	BARRIER Reasons
High cost	Funding
Not in Cleveland	Out of way
Rural area	Stigma
Not enough time by doctor	Location
Stigma	Red tape
Economy	Rural area
Poor pay for MD	Poor pay for MD
	Economy

(p.10)

Newly Diagnosed / New to Care Respondents (N=56)

What services would have helped you get tested earlier?		
ANSWER OPTIONS	PERCENT	COUNT
More information/health education on why I should get tested	51.2%	22
A peer to talk with about it	25.6%	11
Mental health counseling at the point of testing positive	14.0%	6
Being clean and sober	14.0%	6
An advocate to come with me to get tested	14.0%	6
Transportation assistance	4.7%	2
Other (please specify): School, private men's club and education in Africa	7.0%	3
TOTAL		43

(p.55)

Part B

2009

For the 2009 needs assessment, Part B contracted with Ohio University's Voinovich School of Leadership and Public Affairs to conduct a study of HIV care in Ohio's Full Service Jails (FSJs). This needs assessment used written surveys and interviews to examine current standards of care, HIV medication adherence and continuity of care of inmates living with HIV/AIDS. Findings indicated that jails' perceived strengths to care are:

- Inmates rarely or never miss doses of HIV-related medications
- Identifying inmates with HIV/AIDS when entering jails
- Providing access to HIV specialists.

Jails' perceived challenges to care include:

- Ensuring that inmates' medical HIV care continues after release
- Finding undiagnosed cases of HIV/AIDS among inmates
- Paying for HIV-related medication.

The study described that urban jails report more inmates living with HIV and appear to be better linked to community-based HIV care resources. By contrast, rural jails express frustration with the lack of accessible HIV care resources and appear to be less confident in their ability to obtain HIV medications and identify inmates with HIV. Survey and interview data indicate that jails perceive they lack adequate capacity for release planning for inmates with HIV/AIDS and keeping up to date with the latest medical treatment options. Jails would like local organizations to be more involved in providing care for inmates with HIV.

2010

The 2010 needs assessment was conducted in-house by the Part B program. It was designed and implemented during a fiscal crisis for the Part B program, and was therefore influenced by that crisis. During that time, HIV Care Services (HCS) had to implement cut-backs in services, tighten client eligibility standards, and institute a waiting list for enrollment into the Ohio HIV Drug Assistance Program (OHDAP). The study was designed to assess factors precipitating requests for entry into OHDAP. From September 2010 to February 2011, all new applicants placed on the waiting list were mailed a survey and a self-addressed stamped envelope along with their waiting list notification letter. This survey investigated the societal, medical and economic factors that precipitated their requests for care, and how (or if) they met those needs while waiting for Ryan White Part B assistance. A total of 126 surveys were returned, representing a 35 percent response rate. Highlights from the findings include:

- The most common factors for entry into the OHDAP program included recent discovery of Ryan White services, community re-entry from incarceration, initiation of antiretroviral therapy and new HIV diagnosis.

- Nearly one-quarter of respondents reported losing their health insurance in the previous six months and an additional 17 percent reported not having insurance or having inadequate insurance.

- Obtaining medication was an ongoing issue for OHDAP applicants, but not all applicants are equally successful in obtaining alternatives to Ryan White Part B assistance. Clients who have never been in OHDAP before reported greater participation in accessing non-OHDAP

assistance than clients previously enrolled in OHDAP. Previous OHDAP clients resorted more often to self-pay.

- Clients who were enrolled in OHDAP previously were less likely to report being in medical case management or having medical care in the past six months at the time of being placed on the waiting list than new OHDAP clients (42 percent versus 58 percent). Accessing case management may be one reason for being successful in accessing public resources.

2011

The 2011 needs assessment is also being conducted in-house by HCS and the topic is medication adherence among OHDAP clients. A literature review designed to ascertain factors influencing medication adherence showed a significant relationship between adherence and health literacy. As a result, HCS designed a confidential survey to measure clients' self-reported adherence and assess responses in conjunction with medication disbursements from OHDAP's contracted pharmacy. Surveys were sent to all OHDAP clients with nine months of continuous enrollment, of which 49 percent were completed and returned to HCS. This study is exploring the following issues:

- Demographics and distribution of surveyed clients: age, race, gender, length of OHDAP services
- Sources of health literacy education
- Supportive people and devices for medical adherence
- Health literacy of medically naïve and experienced clients
- Health literacy according to Ohio geographic region
- Reasons for non-adherence
- Emotional support by providers, case managers and other social systems

Data are currently being analyzed for the study.

Needs of Youth and/or Transitional Youth

Camp Sunrise and Ohio AIDS Coalition (OAC) collaborated during 2008 to identify best practices in services for youth 13 to 24 years of age in Ohio. At the time the 2009 SCSN was submitted, a report was being finalized. Contracted researchers, L. Michael Gipson and Gail C. Garcia of Faithwalk Enterprises, LLC, conducted a literature review and compiled examples of best practices of organizations providing services to help youth living with HIV transition into adult care. The results were published in *Transitioning HIV Positive Youth Into Adult Care* (2009). This report is available from OAC to inform program planning for youth around the state. A highlight of a few best practices:

EFFECTIVE PROGRAMS MANAGE HIV TRANSITION PROCESSES BY:

- Maintaining an asset- or strength-based approach
- Being age and developmentally appropriate
- Being client-centered and sensitive to client readiness
- Discussing transitions early
- Creating transition plans
- Encouraging and facilitating independence among youth
- Having a health care provider supervise transitions, preferably supervising a multi-disciplinary team

- Addressing young people's knowledge of both their HIV status and sexual health issues, creating secondary prevention plans and documenting progress with plan adherence
- Progressively moving clients through transitional benchmarks related to increasing responsibilities and autonomy
- Offering, if possible, a multi-disciplinary team approach to youth care during transitional years
- Fostering youth inclusion in health care discussions and eventually in clinical decision making
- Recognizing the individual needs, abilities, experiences, beliefs, and expectations of youth
- Respecting and accommodating the cultural views and sexual diversity of clients
- Providing an open, non-judgmental environment where youth can work through their fears and anxieties and articulate expectations
- Ensuring simultaneous transition of mental health care and case management with transition of primary care
- Defining, documenting and reviewing outcome measures and success indicators throughout the process
- Offering multi-disciplinary training for adult providers in dealing with long-term survivors of perinatal HIV
- When necessary, building the capacity of adult providers through training and technical assistance follow-up to ensure collaborative partnership and uninterrupted continuum of care for the client
- Having trained staff familiar with practical application of adolescent development theory in care and service[6]

Identified Statewide Concerns and Cross-cutting Issues: Unmet Needs, Emerging Trends, Challenges and Critical Gaps

Statewide Concerns and Cross-cutting Issues

A major background influence for much of the discussion of statewide concerns during the development of the 2012 SCSN was the National HIV/AIDS Strategy (NHAS) that was released in 2010. The goals, priorities and strategic action steps of the NHAS are reflected in many of the goals and strategies proposed in this SCSN. The NHAS goals are: 1) reducing the number of people who become infected with HIV, 2) increasing access to care and optimizing health outcomes for people living with HIV, and 3) reducing HIV-related health disparities.

The following section will address the concerns and issues common to all Ryan White Parts and other HIV service providers across Ohio. These commonalities will be described in terms of unmet needs, emerging trends, challenges and critical gaps.

[6] Gipson, L. Michael; Garcia, Gail C.; Faithwalk Enterprises, LLC. (2009). *Transitioning HIV Positive Youth Into Adult Care.* Cleveland: Camp Sunrise & Ohio AIDS Coalition. Pages 41-42.

Unmet Needs

The number of persons living with a diagnosis of HIV infection in Ohio was obtained from the ODH HIV/AIDS Surveillance program. There were 17,115 HIV infection cases reported to the Enhanced HIV/AIDS Reporting System (eHARS) who were living with a diagnosis of HIV infection as of December 31, 2010, reported through October 31, 2011, comprised of 8,206 AIDS cases and 8,909 HIV (non-AIDS) cases.

Of the reported persons living with HIV in Ohio, it is estimated that 10,361 (61 percent) are receiving primary HIV care (met need), and 6,754 (39 percent) have no indication of receiving care (unmet need).[7,8]

The proportion of HIV cases in the unmet need category is higher than the proportion of AIDS cases with unmet need (51 percent vs. 27 percent). This finding is not unexpected, as it is generally assumed that persons with AIDS are more apt to seek medical care for their condition than those with only an HIV diagnosis due to the severity of illness.

Of the 6,754 PLWHA in Ohio with unmet need, 80 percent are male and 20 percent are female. The distribution by sex is similar among persons with met need: 78 percent are male and 22 percent are female. Approximately the same percentages of white, Black/African American and Hispanic/Latino persons in Ohio have unmet need (39 percent, 39 percent and 37 percent, respectively). Persons of unknown race and Asian/Pacific Islanders revealed a higher unmet need estimate (53 percent and 48 percent, respectively) when compared to all other race/ethnic groups; however, while the percentage of persons of unknown race and Asian/Pacific Islanders with unmet need in Ohio is higher when compared to other race/ethnic groups, the actual number of cases is far fewer. There were 169 persons of unknown race and 37 Asian/Pacific Islanders in Ohio with unmet need compared to 3,254 white, 2,994 Black/African American and 293 Hispanic/Latino persons with unmet need in Ohio.

Persons living with HIV/AIDS in Ohio with no self-identified risk show the highest percentage of unmet need (65 percent) among the mode of transmission categories. This is followed by injection drug users (IDU) (35 percent); men who have sex with men (MSM) (35 percent); heterosexual risk (28 percent) and MSM with IDU (MSM/IDU) (26 percent) who are not receiving care.

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[7] Ohio HIV/AIDS Surveillance prepared this unmet need estimate using the HRSA definition: a PLWHA is said to have unmet need for primary HIV medical care if there is no evidence of either a CD4 count, a viral load test, or provision of antiretroviral therapy (ART) during a specified 12-month period.

[8] Care should be used when interpreting these data, as there are two challenges that limit the precision of the unmet need estimate. (1) The data from Ryan White care programs represent one source of knowing who is in care. These data are not standardized and contain duplicates. (2) The Ryan White care data are incomplete in that only three of the Part A sites report care data for inclusion in unmet need estimates. In the future, the advantages of collecting data using the All Parts database may help to improve the accuracy of the unmet need estimate by increasing the ability to clean and de-duplicate data provided to HIV Surveillance.

Of the 11 Ryan White Part B regions (formerly referred to as consortium areas) in Ohio, the Columbus region demonstrates the highest percentage of HIV infection cases with unmet need (47 percent), while the Lima region demonstrates the lowest (29 percent).

Youth, 13-24 years of age, represented five percent of PLWHA in Ohio in 2010. Of the 776 youths living with a diagnosis of HIV infection in Ohio, 34 percent of youth living with HIV (not AIDS) and 24 percent of youth living with AIDS had unmet need for HIV primary medical care in 2010. The majority of Ohio's youth living with HIV (not AIDS) and living with AIDS received HIV primary medical care in 2010, 399 (66 percent) and 131 (76 percent), respectively.[9]

Since the 2009 SCSN, a project started by the All Parts Group that remains in progress is the creation of the All Parts Database. Initial funding to create the database was provided through a Special Projects of National Significance (SPNS) grant in 2010. A centralized repository of all Ryan White Services Report (RSR) data elements is housed at ODH. This database allows the pooling of all data regarding care provided by Ryan White program grantees. The All Parts Group will thereby have the ability to describe more accurately who is receiving care in Ohio. Data will be pulled from this database and shared with Ohio HIV/AIDS Surveillance to help refine future unmet need estimates. In addition, Part B is in the initial stages of enhancing its current web-based database to include a portal for medical providers that would enable health care providers to submit client-level data in real time directly to the database. This program would also allow access for other Ryan White Parts, as well as HIV/STD Surveillance, which will enhance the ability of HIV Care and Surveillance to share and compare data.

The creation of the All Parts Database has been a major accomplishment since the 2009 SCSN. At that time, several SCSN goals were developed regarding the collection and analysis of data across Parts; specifically, to describe the medical care utilization patterns of those in care. At this time, six of ten grantees representing 11 Ryan White programs have uploaded data for calendar year 2010 into the All Parts Database. For calendar year 2011 data, three of ten grantees have completed uploads. By the end of September 2012, the goal is for all ten grantees to have uploaded data for calendar year 2011 into the database. The completion of the first data upload to the database will allow the All Parts Group to perform analyses related to care utilization among individuals who are served by one or more of the Ryan White Parts in Ohio.

Priorities related to Unmet Need:

- Develop strategies to increase retention in care among PLWHA currently in care[10]
- Develop strategies to identify the youth and/or transitional youth who have been diagnosed with HIV and who are not receiving primary HIV medical care and link them to care[11]
- Develop strategies to identify all other PLWHA who are not receiving primary HIV medical care and link them to care

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[9] Ohio Department of Health. (2012). HIV/AIDS Integrated Epidemiological Profile for Ohio: 2011 Edition. Page 173.

[10] Strategies will include collaborating with HIV Prevention programs and communicating the National Quality Center's in+care Campaign measures and results from the participating agencies in Ohio.

[11] Youth refers to persons aged 13 to 24 years; transitional youth refers to the subgroup of persons generally aged 18 to 24 who are young adults living independently or semi-independently.

Emerging Trends

Ohio's unique geographic and cultural landscapes contribute toward the variety of sub-populations across the state. There continues to be an increase in new HIV diagnoses among minority populations based on race, ethnicity, gender, age, and sexual orientation, as was described previously in the Epidemiologic Profile section beginning on page 3. When compared to the general population of Ohio, where 15.8 percent[12] of the population has an income at or below the Federal Poverty Level (FPL), the population of PLWHA served by Ryan White programs in Ohio has disproportionately lower incomes. Even as compared to the elevated levels of poverty seen across the state, the Ryan White client population faces higher levels of poverty, often with over half of clients served living at or below the FPL.

Ohio HIV/AIDS Surveillance program, using data reported through June 30, 2011, has noted a recent trend regarding diagnoses of HIV infection by age. Young adults 20-24 years of age were the only age group where there was a consistent increase in the number of new diagnoses of HIV infection reported in Ohio each year between 2006 and 2010 (138, 151, 177, 190, and 200 cases, respectively). Even though persons 20-24 years of age accounted for only 3 percent of persons living with a diagnosis of HIV infection in Ohio in 2009, from 2005-2009, the number of persons within this age group increased by over 500 percent, significantly more than any other age group. They also accounted for the largest proportion (19 percent) of new diagnoses of HIV infection compared to all other age groups.

Given the increase in youth diagnosed with HIV infection compared to the highest prevalence rate of PLWHA being among persons 45-49 years of age, the members of the All Parts Group identified an emerging trend related to the dichotomy of populations of PLWHA based on age and their respective needs. As PLWHA are living longer and reaching their fifties and beyond, they are facing the additional medical changes of aging complicated and often accelerated by the impact of HIV and other co-morbid conditions. Conversely, youth, transitional youth and young adults face different challenges as they anticipate maturing while living with a complex chronic disease. Even within the population of youth, there are differing medical and emotional needs among those with perinatal and behaviorally acquired infections. Both the younger and the older PLWHA have a variety of developmental needs that programs will need to address over the next planning period and beyond.

One such need that will differ greatly across the spectrum regardless of age is health literacy. Health literacy is now becoming more recognized as an important determinant of health outcomes. The All Parts Group would like to focus both on assessing and improving health literacy levels among consumers. Related to health literacy, system literacy has been identified as an important trend; an assessment should be made of how well clients are able to navigate the system of care, particularly around entry to care. Key to both system and individual health literacy is an assessment of how well health care providers understand clients' health literacy and are able to apply strategies for improving health literacy. Taken as a whole, a goal of improving system and health literacy will support the second and third goals of the National HIV/AIDS Strategy (NHAS): increasing access to care and optimizing health outcomes for people living with HIV, and reducing HIV-related health disparities.

[12] The most recent data available by county from the US Census Bureau are from 2010, "Small Area Income & Poverty Estimates for Ohio Counties." A table estimating all ages in poverty for Ohio in 2010 is available in the state and county interactive tables at http://www.census.gov/did/www/saipe/county.html

Another trend that the All Parts Group is concerned with is an increased focus on the Early Identification of Individuals with HIV/AIDS, also known as the EIIHA initiative. EIIHA focuses on individuals who are unaware of their HIV status and how best to bring HIV positive individuals into care. The EIIHA initiative also supports all three of the NHAS goals: 1) reducing the number of people who become infected with HIV, 2) increasing access to care and optimizing health outcomes for people living with HIV, and 3) reducing HIV-related health disparities.

Recent needs assessments have been in line with the focus of EIIHA and getting PLWHA into care. The 2009 Part A needs assessment specifically surveyed those persons who were diagnosed HIV positive but had dropped out of care. The 2010 Part A needs assessment examined the needs of individuals who are newly diagnosed and new to care. The 2011 Part A needs assessment included a special focus on again assessing the needs of clients who are "out of care." Looking forward, the 2012 Part B needs assessment will examine, among other elements, the relationships between the barriers to testing and access or barriers to care. The needs assessment will also examine the factors associated with access to HIV care as well as reasons people living with HIV/AIDS experience gaps in care or stop receiving care. The All Parts Group is also concerned with addressing stigma and its impact on testing, access to care, and outcomes of care.

The Cleveland Part A TGA has already started working locally with HIV Prevention and Early Intervention Services (EIS) to develop strategies to identify individuals at risk for HIV, get them tested and enrolled in care services. The goals and activities developed for the Part A 2012-2015 Comprehensive Plan include collaborative activities between the TGA and EIS that are aimed at meeting the goals of EIIHA initiative and the NHAS. The goals 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
3. Increase the number of HIV negative individuals referred to services that contribute to keeping them HIV negative

The major activities that Part A will use to address these goals are universal HIV testing; Early Intervention Services/Outreach with extant providers; health literacy/health education with peer involvement; partner notification; and linkage to care. Part A meets quarterly with Prevention, EIS and Outreach to address several of the collaborative activities, such as strengthening referrals to care and determining best practices in integrating secondary HIV prevention, care and services. Quarterly meetings also provide opportunities for Disease Intervention Specialists (DIS) to promote partner notification. DIS reinforce with medical providers the benefits of encouraging their newly diagnosed patients to cooperate with DIS by sharing partner contact information so they may engage in Partner Counseling and Referral Services (PCRS).

A current activity to support EIIHA that has been in the Part A Comprehensive Plan since 2009 is implementing universal HIV testing in hospitals and emergency departments in the TGA. One of the largest hospitals in the TGA and also the major public county-run hospital system, MetroHealth Medical Center, is currently implementing universal HIV testing. The Part A strategy to increase the number of individuals who are aware of their HIV status also includes community-based HIV testing efforts. Part A staff, providers, and consumer subcommittee members will target testing at health fairs and community events in neighborhoods where surveillance and needs assessment data indicate highest risk. The Part A Planning Council has funded and prioritized EIS and Outreach services in support of innovative strategies to engage clients in primary HIV medical care. One of these strategies is a peer navigator program. At least two local providers, MetroHealth Medical Center and Lake County General Health District, have peer counselor or navigator systems to guide newly diagnosed PLWHA to care and

services. The Part A Consumer AIDS Advocacy Panel (CAAP) is working to engage more providers in this strategy.

By funding EIS and Outreach services with existing providers, Part A is able to reach a developed network serving the homeless, underinsured, isolated public housing residents and individuals incarcerated in the local jails to provide HIV testing. Currently Part A funds an EIS provider that works with inmates within 90 days of discharge from the county jail. This provider is able to provide testing, health literacy and health education, referrals to services for HIV positive and at-risk individuals, and linkage to outpatient medical care and HIV medication access. Additionally, all but two of the EIS/Outreach providers in the TGA are also Ambulatory/Outpatient Medical Care providers through Part A. In additional efforts to promote health literacy and provide health education, EIS providers conduct community-level Health Education campaigns to raise awareness about HIV. These campaigns also involve peer counselors in outreach, educating individuals about HIV and living with HIV, as well as navigating the system of care, and coaching support.

Finally, Part A providers also work closely with all prevention, counseling, testing outreach and EIS providers to provide a smooth transition from informing individuals of their HIV status and referring them into care. EIS counselors will have strong working relationships with partner contact and referral services and medical case managers to ensure individuals are supported in navigating the system of care. The goals, objectives and activities outlined in the Part A Comprehensive Plan all support the NHAS goals of reducing the number of people who become infected with HIV, increasing access to care and optimizing health outcomes for people living with HIV, and reducing HIV-related health disparities.

Regarding the entire state, HIV Prevention and HIV Care Services at ODH currently have five strategies for identifying individuals unaware of their HIV status: the comprehensive HIV prevention program, the expanded HIV testing initiative, HIV Care Messengers trainings to increase basic HIV knowledge among persons making referrals for testing and care, a health literacy handbook for African Americans, and testing all inmates for HIV upon entry into state prison facilities (in conjunction with Ohio Department of Rehabilitation and Correction). The comprehensive HIV prevention program funds eight local health districts across the state to implement HIV testing, prevention with PLWHA, condom distribution, and interventions for high-risk negatives. Within this program 78 agencies with over 300 testing locations conduct 60,000 HIV tests a year. Additionally, expanded HIV testing is helping to identify individuals who are unaware of their HIV status by increasing the available locations able to offer HIV testing. Since 2007, with the addition of the Centers for Disease Control and Prevention (CDC) expanded HIV testing grant, ODH Prevention has enrolled 44 unique site locations, 20 of which are federally qualified health centers (FQHCs), to conduct expanded HIV testing. Of the 44 locations, five are emergency departments (EDs), two of which are children's hospital EDs. ODH is also currently working with another FQHC system based in Cuyahoga County, which has six locations, each of which provides primary medical care, STD screening and treatment, dental and prenatal care. Expanded testing initiatives relate directly to the first goal of the NHAS (early identification of those with HIV/AIDS) and provide Ohio the opportunity to address the second goal of the NHAS (increase access to care while optimizing health outcomes for people living with HIV).

Similar to how the expanded testing initiative creates more locations for testing opportunities, the HIV Care Messenger trainings will increase the number of referral points to connect the at-risk population to testing and care opportunities. Needs assessment research with audiences found that non-HIV allied professionals were often lacking the information about basic HIV facts, local trends, new treatment developments, existence of or eligibility guidelines for HIV care services, or relationships with HIV professionals. Research showed that education and outreach initiatives with non-HIV case managers or

allied health professionals who are already working with at-risk persons in other social service settings needed to be a priority. By using allied professionals as "gatekeepers" in the same communities where the at-risk population lives, during the course of their regular activities the HIV-unaware will encounter professionals trained to alert, inform, and advise their clients regarding HIV risks, and to link them to appropriate agencies. ODH will be working with a contracted provider to offer 11 such trainings in FY2012 and reaching a minimum of 200 allied (non-HIV) professionals across all regions of the state. The ultimate goal of the trainings is to connect Ohioans who are at risk, who have recently been diagnosed with HIV/AIDS, or who currently do not get consistent care with information about transmission, testing, linkages, referrals, and care. The HIV Care Messenger strategy has the potential to meet all three goals of the NHAS: reducing the number of people who become infected with HIV, increasing access to care and optimizing health outcomes for people living with HIV, and reducing HIV-related health disparities.

There are numerous cultural impacts and health beliefs that inadvertently sustain disparities. While it might be helpful to produce health literacy materials that focus solely on HIV/AIDS, the materials will do little good if individuals are uncomfortable taking them or being seen in possession of them. Fears about implied behaviors from just having such reading material can be the determinant for an individual choosing not to pick up and read the content. Further, erroneous beliefs about who gets infected by HIV can further prevent individuals from recognizing their personal risk and choosing to learn more. Part B will produce an African American Health Literacy Handbook written at a third grade reading level and addressing each major health disparity (including HIV) to be disseminated through and with further education from both health care providers and leaders in the African-American community who serve the target population. The successfully piloted and well-received health literacy handbook contains information about health issues common in the African-American community. By combining HIV information with heart disease, diabetes, and other health issues requiring testing, the reader will be presented with the need to be tested for HIV, as well. The intent is to create awareness of and encourage self-testing for HIV/AIDS by presenting culturally sensitive information as part of a general health booklet, as opposed to a pamphlet identified as solely HIV-related. This idea has been embraced by the ODH Health Disparities Administrator throughout the project. This effort is designed to address all three goals of the NHAS: reducing the number of people who become infected with HIV, increasing access to care and optimizing health outcomes for people living with HIV, and reducing HIV-related health disparities.

The fifth strategy to address EIIHA takes place in Ohio's state prison system. The Ohio Department of Rehabilitation and Corrections (ODRC) tests all inmates for HIV upon entry into the prison system, upon request during their sentence, and when deemed medically necessary. In 2003, Part B formed an ongoing partnership with ODRC to familiarize inmates with the Ryan White program, to provide short term or transitional case management and to make medical referrals and linkages for HIV-positive inmates that are within 120 days of release. All HIV-positive inmates seen by a Community Linkage Coordinator (CLC) will have received post-test counseling and basic information about the HIV diagnosis. While incarcerated, they will have received treatment for their disease as recommended by the treating physician. This EIIHA initiative not only seeks to identify individuals with HIV/AIDS and make them aware of their serostatus, but also works to help meet goals 2 and 3 of the NHAS: increasing access to care and optimizing health outcomes for people living with HIV, and reducing HIV-related health disparities.

The two Part F Ohio AETC sites have partnered with various entities throughout the state on numerous projects and initiatives to improve access to care, promote EIIHA, and address the three NHAS goals. The University of Cincinnati and The Ohio State University Local Performance Sites of the Pennsylvania/Mid-Atlantic AETC have been funded since 2003 and have partnered with the Ryan White

Parts and HIV Prevention over the years in a variety of ways: membership on the Part B Advisory Group and former OHDAP Advisory Board; providing HIV expert faculty for the Ohio prison system HIV clients by telemedicine; partnering in various initiatives such as "Ask, Screen, Intervene" (ASI), routine testing, the expanded HIV testing initiative, and Program Collaboration and Service Integration (PCSI) projects. The Part F sites have worked with Ryan White quality management teams, consortia, regional advisory groups, and have supported and co-presented case manager trainings and World AIDS Day programs. The AETCs routinely provide technical assistance and training to health care providers throughout the state, provide webinars, decision support tools, and more. A few of the tools that have been developed in collaboration with ODH are the routine HIV testing toolkit and the "Patient Assistance and Co-Pay Program for HIV Medications" brochure. A tool that was developed as a result of an identified need was the "Oral Signs of HIV Infection" brochure.

Another trend the All Parts Group continues to focus on is the use of technology in health care for record keeping and data sharing. As mentioned previously, the All Parts Database is nearing the completion of the first data upload by all grantees. This will have an impact on the ability to document quality of care and make quality improvements. The All Parts Group also recognizes that the development of health information exchanges and more providers adopting electronic health records will have an impact on care. While offering improved efficiencies in care and increases in quality of care, there are other impacts to consider with technological improvements. Data compatibility issues, the need for IT resources, and ensuring security and confidentiality are examples of concerns the All Parts Group has expressed.

Because the disproportionate growth in HIV diagnoses among underserved populations continues, Ohio's Ryan White Parts continue to develop their quality management programs and even work to synchronize their efforts with a statewide Quality Management Plan. Incorporating a proactive response to the needs of underserved populations who are quickly becoming the majority of cases will ensure that as many HIV-positive Ohioans as possible who need assistance will have access to quality medical services with available resources.

Priorities related to Emerging Trends in Underserved Populations

- Recruit and train providers in collaboration with AETCs in Ohio related to the needs of and services available to PLWHA in Ohio, with a focus on cultural competence, confidential care and decreasing stigma associated with HIV disease
- Identify and retain in care the harder to reach populations of PLWHA across the state, including transgendered persons, prisoners, immigrants, youth and/or transitional youth, and older adults

Priorities related to EIIHA:

- Increase awareness of the statewide listing of federally and state funded testing sites
- Create a statewide listing of care sites
- Promote routine testing as a state
- Collaborate with HIV Prevention programs to improve access to and retention in care

Challenges and Critical Gaps

Access to Services

When the All Parts Group met in January 2012 to discuss the variables that impact care at all levels – client, system, community, region, state, and federal – there was an atmosphere to the conversations that differed from the discussions for developing the 2009 SCSN. This difference can be described as a shift in emphasis. The focus in 2009 was on the demographics of PLWHA, whereas the conversation in 2012 is mainly on the system of care delivery. The factors influencing this shift are many: the development of health information exchanges; the impact of the National HIV/AIDS Strategy; the mandates of the Affordable Care Act and the uncertainty of its enactment as passed; the potential changes as a result of reauthorization of the Ryan White HIV/AIDS Treatment Modernization Act; and the outcome of the next presidential election, among others. This change in emphasis is reflected in the difference between the 2009 goals and the 2012 goals that are listed after this section. Many of the goals and strategies that the All Parts Group discussed reflect this need to respond to these system-level influences and translate that to care delivery. One major goal identified was for the All Parts Group to commission a Task Force that will engage in scenario-based planning to anticipate changes on the horizon for RW programs. Other strategies focus on increasing sustainability, integrating systems and services (such as with Patient-Centered Medical Homes), and improving system literacy.

Ensuring access to services for all PLWHA continues to be a challenge that Ohio HIV service providers face. Today's funding climate in the state increases the difficulty for organizations to continue providing services at the current level in the future. Reductions in funding levels for public and private social service programs create bigger gaps for Ryan White grantees to fill as benefits and services are scaled back. Additionally, there is a great degree of uncertainty given the current political landscape. Current legislation and funding may disappear or be modified depending on the outcomes of state and federal elections. It is, therefore, difficult to predict exactly what impact those elements may have on service delivery. Coordination among the Parts and CDC-funded HIV Prevention programs is crucial to ensure that not only are services not being duplicated, but that other appropriate resources are also used first.

Additional challenges were also identified through the needs assessments referenced earlier. These issues include housing assistance, transportation, and food assistance. Many areas of the state continue to struggle with a lack of adequate and affordable housing. Transportation continues to be a problem for many consumers, especially in rural areas of the state where there is a lack of access to adequate public transportation. With the recent economic difficulties across many communities in Ohio, food insecurity has been a common problem facing many individuals and families; access to adequate nutrition remains a concern for PLWHA. Mental health issues and access to services, especially accessing affordable mental health and substance abuse treatment in a reasonable amount of time, continues to create barriers to service for many PLWHA across Ohio. Support services such as transportation, nutrition and housing are no longer available through Part B. Exploring the impact of this cost containment strategy (elimination of support services) will be included in the Part B needs assessment for 2012.

Dental care has been consistently identified as an unmet need and a cross-cutting issue across the state since 2003. In July 2010, Part B implemented cost containment strategies which included eliminating all support services and greatly reducing dental care. Recently some dental care has been reinstated with a cap of $2500 per client per year.

Another area of need for PLWHA in Ohio is core medical services for people over 300 percent of the Federal Poverty Level (FPL). The Ohio HIV Drug Assistance Program (OHDAP) reduced its eligibility from 500 percent FPL to 300 percent FPL in FY2010, affecting 257 clients. The Ohio Part A TGA and patient assistance programs through pharmaceutical companies are available to assist those making more than 300 percent FPL, but it is suspected this is still an area of need for clients.

The All Parts Group continues to meet quarterly to discuss progress on shared challenges. Major challenges are sharing data within the context of HIPAA and overcoming technical obstacles in the development of the All Parts Database (which is soon to be loaded with a full year's worth of data). As mentioned previously, Part B is in the preliminary stages of expanding its web-based database to increase the coordination of data among all Parts, Surveillance, medical service providers, and medical case management. It is expected that a portal that can accommodate all of these key organizations will further streamline data analysis, reporting, and ultimately improve the quality of client care.

Priorities related to access to core services

- Ensure access to all core services by integrating systems and services into a cohesive model that seeks to enroll and keep clients in care
- Develop strategies to increase the number of HIV-related service providers who will accept new patients living with HIV/AIDS, especially those providing dental care and substance abuse treatment
- Develop strategies to ensure that available providers are fully utilized
- Increase transportation options for consumers to access services, especially in rural areas of the state
- Address the need for resources to meet increasing needs related to housing, transportation, nutrition and dental care
- Engage medical providers to assist in retaining PLWHA in care

Goals

Planning and Program Sustainability

Goal 1: The All Parts Group will convene a time-limited Task Force to address changes on the horizon for Ryan White programs through scenario-based planning

Goal 2: Increase sustainability of services while maintaining and improving client care

- Strategy 1: Anticipate and plan for the possible implications of the Affordable Care Act
- Strategy 2: Explore working with Community Health Centers and Federally Qualified Health Centers as part of the system to expand options for care
- Strategy 3: Maximize the offsetting of costs with public assistance (Medicare Part D, back-billing Medicaid, etc.)
- Strategy 4: Explore how all case management agencies becoming Medicaid certified will impact sustainability
- Strategy 5: Collaborate among Parts to maximize revenue received from rebates
- Strategy 6: Decrease client dependency on Ryan White programs as the sole system of care

Access to Care

Goal 3: Improve system literacy
- Strategy 1: Assess client health literacy
- Strategy 2: Improve health care provider, staff, and DIS knowledge of client health literacy
- Strategy 3: Assess clients' ability to navigate the system of care, particularly around entry into care, and to manage the renewal cycles that prevent gaps in coverage

Goal 4: Address and evaluate through delivery of care the concerns across the spectrum for youth/transitional youth and older PLWHA
- Strategy 1: Increase health literacy informed by understanding specialized needs of PLWHA of different age groups
- Strategy 2: Consider developmental differences influenced by:
  - Age
  - Risk (e.g., perinatal vs. behaviorally infected youth)

Goal 5: Continue to address stigma and its impact on testing, access to care, and care outcomes

Collaboration and Service Coordination

Goal 6: Link consumer advisory group to Part B Advisory Group and formalize communication with consumers through this linkage

Goal 7: Ensure improved access to and retention in all core services by integrating systems and services into a holistic model that seeks to enroll and keep clients in care. Consistently measure access and retention efficacy performance in this process
- Strategy 1: Develop and test co-location strategies that alter current ways of working with Community Health Centers, FQHCs, mental health and substance abuse treatment providers, and others that specifically demonstrate service delivery facilitation and care that is more holistic
- Strategy 2: Examine or pilot PCSI[13] and Patient-Centered Medical Home models of service delivery as they apply to HIV-related chronic care to determine if they lead to improved service integration and care that is holistic

Data and Quality Management

Goal 8: Analyze and publish findings from the shared All Parts Database

Goal 9: Focus on the quality of HIV care by using HRSA/HAB clinical quality measures and data reports selected by the All-Parts Group to demonstrate performance

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[13] PCSI - Program Collaboration and Service Integration - "is a mechanism for organizing and blending interrelated health issues, activities, and prevention strategies to facilitate comprehensive delivery of services." Pasted from <http://www.cdc.gov/nchhstp/programintegration/About.htm>

Goal 10: Examine and evaluate technology as an overarching influence on service delivery, including HIV chronic and specialty care service delivery integration
- Strategy 1: Collaboration among providers using technology to improve service delivery and coordination, particularly between primary care, chronic care, and specialty care
- Strategy 2: Address clients' fears about technology threatening confidentiality of protected health information (PHI)
- Strategy 3: Coordinate access to electronic medical records (EMR) for quality improvement

Unmet Needs and EIIHA

Goal 11: Use emerging epidemiologic trends as a starting point for identifying PLWHA not in care

Goal 12: Align efforts of statewide HIV prevention and statewide HIV care to more effectively get at-risk persons tested, connected to care, and to help them to stay in care
- Strategy 1: Continue Counseling, Testing and Referral (CTR) program and expanded testing initiative, including training for partner services and health care providers
- Strategy 2: Examine the impact of and contribute to the exploration of new testing initiatives
- Strategy 3: Conduct HIV Care Messengers trainings
- Strategy 4: Develop and promote peer counselor systems to guide newly diagnosed persons to care

Summary and Conclusions

Ohio Ryan White grantees and local service providers will continue their work to coordinate services and more effectively use statewide data. Each Part will use the priorities and goals outlined in the SCSN to develop program plans to be discussed in their respective planning documents, such as the Comprehensive Services Plan (CSP) and work plans connected with federal and state HIV funding. In addition to the direct services that Parts A through D provide and fund, both Part F AETC Local Performance Sites in Ohio will continue to use the SCSN to develop program plans and reduce gaps in care and prevention through education and consultation to health care providers and staff. HIV Prevention programs can also reference the SCSN while planning prevention efforts, as Prevention programs share several areas of overlap with care goals and priorities.

Needs assessment activities and data collection mechanisms will be revised to solicit more informative and accurate data. One objective of this process will be to achieve statewide implementation of HRSA clinical quality measures. Data sharing through the All Parts Group will enhance quality improvement measures related to these data. Focusing on the quality of HIV care using the clinical quality measures, including adaptations to changed HIV care guidance from the U.S. Public Health Service (PHS), is a statewide priority for the coming years.

The All Parts Group will examine the demographics of new clients infected with HIV as well as the demographics of the clients identified as having unmet need for testing, access to care, and retention in

care. This will in turn inform the development of specific strategies to meet the goals identified in the SCSN. Strategies to increase data sharing will also be explored.

The All Parts Group will also focus on statewide and cross-Part collaborations to plan and respond to changes in funding and legislation that affect service delivery. The Task Force that has been proposed is one such tactic for exploring program planning and sustainability. Finding ways to engage other service providers such as FQHCs and Community Health Centers in order to integrate systems is also an important priority that ultimately seeks to retain consumers in care and ensure sustainability.

In conclusion, the development of this document builds upon the existing momentum to increase coordination among all Ryan White Parts in Ohio. The All Parts Group expressed a desire to compile a Statewide Coordinated Statement of Need that will be functional, be reflective of the work happening around the state, and be responsive to the needs of the Parts. In 2009, significant changes were made to the format and scope of the SCSN, and as expected, this revision builds upon those modifications. With direction from the All Parts Group and Task Force, the SCSN should continue to reflect the progress of the service coordination of that group, as well as progress on the goals of the National HIV/AIDS Strategy and EIIHA initiative.