COMPREHENSIVE PLAN 2012-2015

Cuyahoga Regional HIV Services

Ryan White Part A

PRESENTED BY

COLLABORATIVE RESEARCH

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ACKNOWLEDGEMENTS

This document is the result of countless hours of participation; input and effort by members of the HIV/AIDS community committed to improving the HIV care delivery system and advancing the treatment for ALL persons affected by this epidemic. The plan also provides for the means to understand the severe need groups that constitute the epidemic, with the ability to reduce disparities in access to health care services and prevent the further transmission of HIV infection. This plan reflects the diversity of the TGA with specific details given about geographic composition, ethnic and racial backgrounds, education and income levels and the burden of HIV disease and many other co-morbidities (both sexually transmitted, medical and mental) that challenge the delivery of services for those most impacted by the disease in our area. We wish to thank all those who volunteered their time, effort, input, and knowledge of gaps and barriers in our service delivery system. We especially wish to thank all participants for their commitment to the continuous improvement of our system of care.

In particular, we wish to acknowledge:

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We would especially like to thank all the people living with HIV and AIDS for their participation.

And finally we acknowledge the support and leadership of our County Executive, Ed Fitzgerald and Mayor Frank Jackson of the City of Cleveland.

LETTER OF CONCURRENCE FROM PLANNING COUNCIL CO-CHAIRS

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TERRENCE M. ALLAN, R.S., M.P.H.
Health Commissioner

May 21, 2012

As Co-Chairs of the Cleveland Regional Ryan White Planning Council, we offer our support in the creation of the TGA's 2012-2015 Comprehensive Plan. This plan will assist the Council as it carries out its legislative mandates outlined in the 2009 Ryan White Treatment Modernization Extension Act.

We encourage stakeholders to review the plan and work collaboratively to achieve the council's goal to ensure the delivery of a comprehensive and integrated system of health and social services that guarantees 100% access to services and eliminates disparities in health outcomes for all persons living with HIV/AIDS in the Cleveland Regional TGA while we strive to meet the needs of those affected by HIV/AIDS.

Respectfully,

Cecelia Hoffman-White
PC Co-Chair

Karen Butler
PC Co-Chair

LETTER OF SUPPORT FROM COUNTY EXECUTIVE

EDWARD FITZGERALD
Cuyahoga County Executive

A Message from the Cuyahoga County Executive

May 3, 2012

I offer my support for the Cuyahoga Regional HIV Services-Ryan White Part A Planning Council in development of their 2012-2015 Comprehensive HIV Services Plan. We are extremely fortunate to have the expertise of so many fine volunteers who contributed to this plan with their ideals, enthusiasm and passion.

Daily, we are faced with unique challenges in caring for our fellow community members who are living with HIV and AIDS. This plan was formed through the input of consumers, community leaders, health care providers, the Planning Council and support staff.

I encourage other agencies and elected officials from the six counties that make up the Transitional Grant Area (Ashtabula, Cuyahoga, Geauga, Lake, Lorain and Medina counties) to review this plan. The information contained provides insight into the current HIV/AIDS epidemic within our area. This review will ensure that the Plan is a useful resource that guides the decision-making process over the next three years, as we focus on meeting the goals outlined in President Obama's National HIV/AIDS Strategy.

Sincerely,

Edward FitzGerald
Cuyahoga County Executive

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EXECUTIVE SUMMARY

GENERAL DESCRIPTION OF THE CLEVELAND TRANSITIONAL GRANT AREA (TGA)

The Cleveland TGA, which has received Part A funding since 1996, consists of six counties in three distinct regions bordering Lake Erie in the State of Ohio. The general population of this six-county area was 2,178,737 persons in 2010 or 19% of the entire population of the State of Ohio (11,536,504). The racial/ethnic profile of the Cleveland TGA varies by county. Cuyahoga and Lorain Counties are the only counties with a white population of less than 90%. Almost 30% of Cuyahoga County's residents are black and almost 5% are Hispanic. Lorain County has a black population of 8.6% and the largest Hispanic population in the TGA, at 8.4%. The state of Ohio comparatively has 83% white, 12% black and 3% Hispanic.

TABLE 1. GENERAL POPULATION IN SIX-COUNTY TGA, 2010

COUNTY	2010 POPULATION COUNT
Ashtabula	101,497
Cuyahoga	1,280,122
Geauga	93,389
Lake	230,041
Lorain	301,356
Medina	172,332
Cleveland TGA	2,178,737

(Source: U.S. Census Bureau, 2010 Census Data)

Demographics of the HIV/AIDS Population: Minority populations in the TGA are disproportionately impacted by the HIV/AIDS epidemic, since African Americans are 20% of the general population in the TGA, but comprise 54% of the affected population; Latinos are 4% of the population but 9% of PLWHA in the TGA. The combined minority comparison is 24% of the TGA population bearing 60% of the existing HIV disease burden. Increases in HIV prevalence among men who have sex with men, heterosexuals and injection drug users have been observed. AIDS prevalence rates have increased among women, African Americans, Latinos, persons ages 13-19 (youth) and those over 45 years of age.

Geography of the TGA: Cuyahoga County or the Central region comprises 58% of the six-county area, with 31% of the population of Cuyahoga County residing within the City of Cleveland. Ashtabula, Geauga and Lake Counties comprise the Eastern Region and Lorain and Medina counties, the Western Region. Distances in the TGA from Cuyahoga County, where the majority of services exist, extend over 120 miles for a round trip (Ashtabula County).

Continuum of Care: Comprehensive HIV-related medical care is provided at five prominent primary care facilities within the TGA in concert with traditional outpatient primary care. In addition, HIV/AIDS patients receiving care at these facilities have on-site access to diagnostic testing, antiretroviral and other combination drug therapies, drug therapies appropriate to the treatment and prevention of opportunistic infections, and oral health care. Nurse Care Coordinators assist patients with disease management and ensure compliance with medical regimens. Medical Case Managers ensure clients are linked to primary care and supportive services that help keep them connected to care including; mental health services, substance abuse treatment, housing, transportation, nutritional counseling and other psychosocial supports. To further encourage regular medical care visits, a physician's referral is required for many of the support services funded by Part A.

Testing sites, particularly in Cleveland and Cuyahoga County, report that their HIV+ clients are far more likely to be African American and poor (Cleveland Plain Dealer, September 16, 2008). The issue of demographics and socioeconomics is important for the TGA given migration towards the suburbs and out of Cuyahoga County.

I. WHERE ARE WE NOW?

Background: This Comprehensive Plan is concerned with the needs of and the access to services by people living with HIV/AIDS (PLWHA) in the Cleveland Transitional Grant Area (TGA). In addressing the life-long needs of residents who are HIV positive, planners must first understand the factors that impact them and the environment that surrounds them. This section describes the Cleveland TGA: the geography and population of the area served by Part A funds as well as other funding sources. This section also further describes the local and state HIV epidemics, the results of recent needs assessments, including needs, gaps and barriers to care; the level of unmet need in the TGA; includes a profile of the Ryan White funded providers and other local resources; and concludes with a description of the current continuum of care and demographics of Part A clients served.

A. DESCRIPTION OF THE LOCAL HIV/AIDS EPIDEMIC

i. HIV/AIDS EPIDEMIOLOGICAL PROFILE

Data provided by the Ohio Department of Health (ODH) for the time period ending December 31, 2010, illustrates the impact of the epidemic on severe need populations in the Cleveland TGA. This table depicts that the TGA's minority populations are disproportionately impacted by the HIV/AIDS epidemic. While 20% of the general population is African American, 54% of people living with HIV/AIDS (PLWHA) in the Cleveland TGA are African American. Four percent of the general population is Hispanic, nine percent of PLWHA in the TGA are Hispanic. Conversely, 35% of PLWHA in the TGA are white, while 88% of the general populations are white. Combined, minorities make up 24% of the general TGA population and comprises 60% of the existing HIV disease burden.

HIV/AIDS Prevalence in the TGA: The six counties comprising the Cleveland TGA account for 26% of all cases reported in Ohio. The ODH 2010 AIDS Surveillance Report shows the following estimates of persons reported living with HIV/AIDS in the TGA by county. The majority of cases in the TGA (82%) are in Cuyahoga County (central region), followed by the Western Region, with Lorain and Medina Counties accounting for 14% of cases. The Eastern Region represents 5% of cases in the TGA.

TABLE 1. CLEVELAND TGA: COUNTY LEVEL DATA, OHIO DEPARTMENT OF HEALTH

	PLWHA-AS OF DECEMBER 31, 2010	
COUNTY	NUMBER	PERCENTAGE
Ashtabula	60	1.4%
Cuyahoga	3,713	88.3%
Geauga	21	0.5%
Lake	126	2.9%
Lorain	240	5.7%
Medina	43	1%
TOTAL	**4,203**	**100%**

HIV/AIDS Cases by Demographic Characteristics and Exposure Categories: The following examines the demographics and exposure categories of the infected community within the Cleveland TGA from 2008 to 2010 with contrast drawn between newly diagnosed HIV and AIDS cases (HIV and AIDS incidence), and people living with the disease (HIV and AIDS prevalence).

Disproportionate Impact of HIV/AIDS on Certain Populations Race/Ethnicity: The percentage of PLWH and PLWA by race/ethnicity remained fairly constant over the four-year period. Exceptions in the PLWA category included the

slight drop (1%) among whites, slight increase among African-Americans (1%), and slight increase (1%) among Hispanics. In the PLWH category, there was a decrease (1%) among Hispanics and the addition of an "other" category (2%).

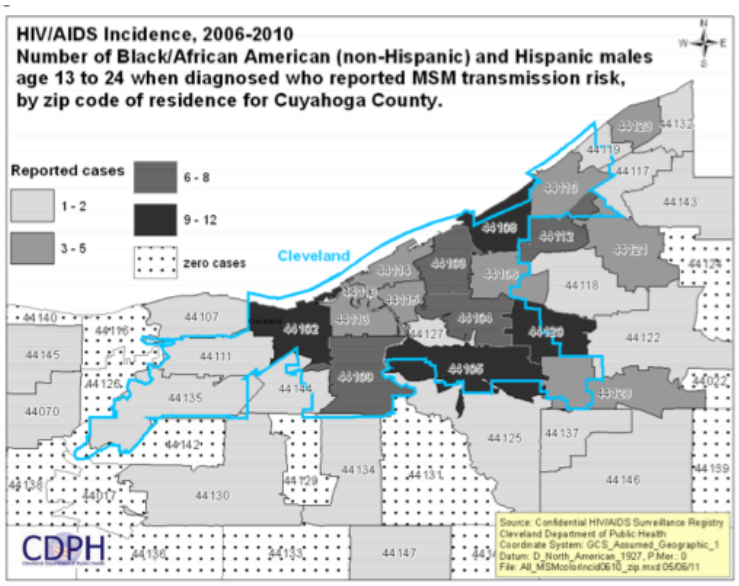
TABLE 2. PREVALENCE HIV/AIDS CASES BY RACE/ETHNICITY IN CLEVELAND TGA, 2008-2010

	2010		2009		2008	
RACE/ ETHNICITY	PLWA	PLWH	PLWA	PLWH	PLWA	PLWH
White	36%	34%	37%	34%	38%	33%
African American	53%	55%	52%	55%	52%	55%
Hispanic	9%	8%	8%	9%	9%	8%
Asian	<1%	<1%	0.3%	0.5%	0.3%	0.4%
Amer. Indian	<1%	<1%	0.1%	0.1%	0.2%	0.2%
Multiracial	1%	1%	0.9%	0.6%	0.2%	3%
Other	0	2%				
TOTAL	100%	100%	100%	100%	100%	100%

(Source: Ohio Department of Health, HIV/AIDS Surveillance, Data as of December 31, 2010)

DISPROPORTIONATE IMPACT

Specifically, within Cuyahoga County, the following geographic analysis is helpful in determining the geographic distribution of young African American and Hispanic males. This map (shown below), from the Cleveland Department of Public Health's 2010 HIV/AIDS Surveillance Summary Report, is beneficial in identifying where prevention efforts may be concentrated.



Comparison of the 2010 HIV/AIDS statistics to the general population demonstrates that disparities in HIV disease are present for African Americans for all indicators—new HIV and AIDS cases, PLWA and PLWH and Hispanics, to a lesser degree.

TABLE 3. 2010 NEW AND EXISTING HIV/AIDS CASES BY RACE/ETHNICITY AND DISPARITIES

RACE/ ETHN.	TGA (GEN. POP.)	NEWLY DIAG. HIV	NEWLY DIAG. AIDS	PLWA	PLWH	DISP. NEW HIV	DISP. NEW AIDS	DISP. EXIST. HIV	DISP. EXIST. AIDS
White	75%	30%	33%	36%	34%				
African Amer.	19%	59%	58%	53%	55%	39%	40%	36%	34%
Hispanic	5%	9%	8%	9%	8%	3%	4%	3%	4%

(Source: Ohio Department of Health, HIV/AIDS Surveillance Program. Data as of December 31, 2010)

- Age: Age group comparisons of new AIDS cases to existing AIDS and/or HIV prevalence show emerging patterns of the disease and indicate where risk behaviors are moving the epidemic. The Cleveland TGA evidences a bimodal age emergence, with young (15-24) minority MSMs being diagnosed at late stages of the disease (AIDS incidence). The group with the highest number of new AIDS diagnoses is the 20-44 age band, comprising 59% of new AIDS cases.

TABLE 4. AGE GROUP AMONG INFECTED COMMUNITY IN CLEVELAND TGA, 2008-2010

	2010		2009		2008	
AGE AT DX	PLWA	PLWH	PLWA	PLWH	PLWA	PLWH
<13 years	<1%	<1%	0%	1%	1%	2%
13-19 years	<1%	1%	0%	1%	3%	3%
20- 44 years	35%	51%	40%	53%	40%	52%
45 + years	65%	47%	60%	46%	56%	46%
TOTAL	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

(Source: Ohio Department of Health, HIV/AIDS Surveillance Program, and Data as of December 31, 2010)

The percentage of PLWH among the 20-44-age band has stayed within two-percentage points per the past three years, decreasing slightly from 53% to 51% over the last year. The percentage of PLWH among the 45 and older age band, however, has increased slightly over the past three years, from 46% in 2008 to 47% in 2010. The percentage of PLWA in the 20-44-age band has dropped five percentage points over the same time period to 35% in 2010. For the 45 and older age band of PLWA, the trend is reversed, with 56% in 2008 and 65% in 2010. The increase in the older group is due to the aging of PLWHA.

Age group: More recently, 44 of 148 (29.7%) of all new HIV/AIDS diagnoses in Cuyahoga County in 2010 were to youth and young adults age 13 to 24. For diagnoses in Cleveland, 27 of 93 (29.0%) of all new HIV/AIDS reported in 2010 were to youth and young adults. More disturbing is that the number of Cuyahoga County teens diagnosed with HIV/AIDS in 2010 nearly doubled from 9 to 17 cases, 12 of which were Cleveland residents (Figure 2). These 17 teens with HIV/AIDS represent 11.5% of incident HIV/AIDS cases for Cuyahoga County and 12.9% for Cleveland in 2010. Most of the teens were Black/African American males, many reporting MSM/bisexual risk.

Gender: As depicted in the chart below, males have disparities among new HIV and AIDS cases, and PLWA and PLWH compared to their representation in the general population. For existing cases, women with AIDS increased 1 percentage point over last year's percentage of 20%, which had been constant for the past two years. The percentage of women with HIV also increased by 1 percentage point – a gain of one-percentage points over the past three years. This resulted in a similarly slight decrease in the percentage of men living with AIDS (79%) and living with HIV (78%).

TABLE 5. GENDER AMONG INFECTED COMMUNITY IN CLEVELAND TGA, 2008-2010

	2010		2009		2008	
GENDER	PLWA	PLWH	PLWA	PLWH	PLWA	PLWH
Male	79%	78%	80%	79%	80%	79%
Female	21%	22%	20%	21%	20%	21%

(Source: Ohio Department of Health, HIV/AIDS Surveillance Program, Data as of December 31, 2010).

Exposure/Transmission Category: MSM transmission has raised substantially among existing HIV cases from 37% in 2008 to 45% in 2010. Of the males diagnosed with HIV and HIV-with-AIDS in Cuyahoga County alone from 2009-2010, exposure, among those reporting, was 67.2% sex with men, 9.3% bisexual, 20.7% heterosexual, 2.4% IDU, 0.4% maternal. Heterosexual transmission has also increased as an overall percentage of HIV prevalence (18%) and AIDS prevalence (20%) in recent years, compared to 12% and 13% respectively in 2008. Heterosexual exposure made up 14% of new HIV cases and 22% of new AIDS cases in 2010.

TABLE 6. TRANSMISSION AMONG INFECTED COMMUNITY IN CLEVELAND TGA, 2008-2010

	2010		2009		2008	
TRANSMISSION	PLWA	PLWH	PLWA	PLWH	PLWA	PLWH
MSM	51%	45%	52%	39%	51%	37%
IDU	11%	7%	11%	8%	11%	9%
MSM: IDU	6%	3%	5%	3%	6%	3%
Heterosexual	20%	18%	14%	12%	13%	12%
Other/Unknown	13%	26%	18%	38%	19%	39%
TOTAL	100%	100%	100	100	100	100

(Source: Ohio Department of Health, HIV/AIDS Surveillance Program, Data as of December 31, 2010).

Exposure Category: The future projection of HIV/AIDS cases based on newly diagnosed AIDS cases shows that some trends continue—the highest proportion of MSMs is in the Eastern region and the highest proportion of IDUs remains in the Western region. Differing trends are evident in the proportion of heterosexuals with the Central region slightly leading the Western region, a negative trend not evident in the PLWH and PLWA trend lines.

- **By Region:** By race/ethnic group, distinct differences between the three regions are apparent—the Central Region (Cuyahoga) has the most PLWA who are African American, the Western Region (Lorain) has the highest percentage of Hispanic PLWA, and the Eastern region (Ashtabula, Geauga and Lake counties) have the highest proportion of white PLWAs.

By exposure category, the Eastern and Central regions are predominantly MSM. The Western region is the highest IDU exposure, followed by non-reported risk, then heterosexual transmission.

TABLE 7. REGIONAL COMPARISON OF NEW AND EXISTING HIV/AIDS CASES, 2009*

NEW DIAGNOSED AIDS	EASTERN	CENTRAL	WEST	TGA
White	46%	29%	33%	31%
African American	33%	56%	58%	55%
Hispanic	13%	12%	9%	11%
Other	0%	0%	0%	0%
Newly Diagnosed HIV	Eastern	Central	West	TGA
White	60%	31%	37%	33%
African American	24%	63%	49%	575%
Hispanic	8%	6%	19%	7%
Other	0%	0%	0%	0%
PLWA	**EASTERN**	**CENTRAL**	**WEST**	**TGA**
White	71%	34%	43%	37%
African American	2%	56%	43%	52%
Hispanic	9%	9%	13%	9%
Other	0%	0%	0%	0%
PLWH	**EASTERN**	**CENTRAL**	**WEST**	**TGA**
White	41%	32%	34%	34%
African American	12%	58%	49%	55%
Latino	2%	7%	16%	8%
Other	1%	2%	1%	2%

(Ohio Department of Health, HIV/AIDS Surveillance Program. Data as of Dec 31, 2009). ***Most recent information available.***

Comparison within the Cleveland TGA by Region: The TGA's Central region, consisting of Cuyahoga County, has the highest rates of the disease. Among PLWH by race/ethnicity, the highest prevalence among whites is within the Eastern region, among Hispanics, the Eastern region and among African Americans, the Western region. By gender, the only region displaying a significant difference than the average of 25% is the Western region with 34% female PLWH. By age group, only the Western region has adolescent PLWH although for PLWH it is the 'oldest' region (this is not true for PLWA). By exposure, the most common mode of transmission is IDU for the Western region, then heterosexual versus MSM for the Central and Eastern regions.

ii. UNMET NEED ESTIMATE FOR 2010

Underrepresented Populations: Persons who are aware of their HIV+ status but remain Out Of Care (OOC) in the Cleveland TGA are 1) newly diagnosed; 2) those who have been in care at some point, but have not accessed HIV care in at least the past twelve months or 3) those who have never been in care. OOC persons are likely to be significantly more fragile, with higher rates of co-morbidities, homelessness and isolation—by virtue of residing in rural areas, lacking transportation, or being undocumented citizens. The majority also reported facing mental health or substance abuse challenges.

UNMET NEED FRAMEWORK FOR CLEVELAND-LORAIN-ELYRIA, OH TGA, 2011

COLUMN 1	COLUMN 2	COLUMN 3	COLUMN 4	COLUMN 5
POPULATION SIZES		**VALUE**	**PERCENT**	**DATA SOURCE(S)**
Row A.	Number of persons living with AIDS (PLWA), for the period of 01/01/2010-12/31/2010	2,103	50	Evaluative HIV/AIDS Reporting System (eHARS) as of June 30, 2011
Row B.	Number of persons living with HIV (PLWH)/non-AIDS/aware, for the period of 01/01/2010-12/31/2010	2,100	50	Evaluative HIV/AIDS Reporting System (eHARS) as of June 30, 2011
Row C.	Total number of HIV+/aware for the period of 01/01/2010-12/31/2010	4,203	100	
CARE PATTERNS		**VALUE**	**PERCENT**	**DATA SOURCE(S)**
Row D.	Number of PLWA who received the specified HIV primary medical care during the 12-month period 01/01/2010-12/31/2010	1,070	50.88	Viral Load/CD4 Lab Reports from eHARS, for Cleveland TGA, 2010 and Ryan White Provider Database (RW Part A, C and Private providers)
Row E.	Number of PLWH/non-AIDS/ aware who received the specified HIV primary medical care during the 12-month period 01/01/2010-12/31/2010	1,742	82.95	Viral Load/CD4 Lab Reports from eHARS, for Cleveland TGA, 2010 and Ryan White Provider Database (RW Part A, C and Private providers)
Row F.	Total number of HIV+/aware who received the specified HIV primary medical care during the 12-month period 01/01/2010-12/31/2010	2,812	66.90	
CALCULATED RESULTS		**VALUE**	**PERCENT**	**CALCULATION**
Row G.	Number of PLWA who did not receive the specified HIV primary medical care	1,033	49.12	Value: Row A-Row D
Row H.	Number of PLWH/non-AIDS/ aware who did not receive the specified HIV primary medical care	358	17.05	Value: Row B-Row E
Row I.	Total HIV+/aware not receiving the specified HIV primary medical care (quantified estimate of unmet need)	1,391	33.10	Value: Row G +Row H

Estimated Level of Service Gaps among PLWHA's: A comprehensive assessment of the service needs of PLWHA has been undertaken in the Cleveland TGA annually for the past eight years. The Needs Assessments have sought to determine service gaps and barriers for PLWHA in the Ryan White funded System of Care, as well as PLWHA outside of any system of primary HIV care (i.e., had not received any primary HIV care in at least the previous 12 months). Each survey group is sampled to reflect the TGA's epidemiological profile. The Planning Council maintains a focus on Severe Need Groups including: MSMs, African Americans, Hispanics/Latinos, minority women, IDUs and the "aged," defined as persons 45 and older. In each Needs Assessment, service gaps, defined in the survey as services which were needed but not being provided, and service barriers, defined as obstacles to receiving needed services, were identified by various subgroups.

The most recent Needs Assessment was conducted in the spring of 2010 and finalized in the spring of 2011 with a survey of individuals "in care," "new to care" and "out of care". This assessment of need included an "in care" survey questionnaire of PLWHA receiving Ryan White funded services, a "Newly Diagnosed/New to Care" survey questionnaire of PLWHA who recently entered primary medical care services within the past year and an "out of care" survey of persons living with HIV or AIDS who know their HIV status and have either been absent from PMC for one year or longer or have never entered care.

In Care: A total of 203 PLWHA participated in the "in care" needs assessment. Demographics for this group included the following:

- Almost 76% were males, 23% females and less than 2% transgender individuals (M to F).
- Almost equal proportions reported gay (41%) and straight (44%) as their sexual orientation with just over 10% reporting as bisexual.
- The majority (60%) were African American, followed by 28% White, 6% Hispanic, 4% more than one race and 1% "other."
- The respondents were largely living in poverty: 85% reported that they were unemployed and 64.6% had incomes below $10,000.
- 30% had no health insurance and over a third had Medicaid.

A substantial proportion of the in care survey respondent group reported having experienced homelessness at some time. Over 36% stated they had been recently homelessness, 16% within the past two years and 21% over two years ago. Nearly 10% were currently homeless at the time of the survey.

The risk exposure modes reported by respondents reflected similarities between the HIV transmission modes of the TGA's overall population of PLWHA, including the following: 50% MSM risk behavior, 24% heterosexual behavior; 10% MSM and IDU, 3% IDU, 4% sexual assault, 1% transfusion related, and 0.5% reported transmission from their mother with HIV/AIDS. Over 14% reported an unknown risk exposure.

The following were ranked as major service gaps that in care respondents "can't get": medical transportation, medications, housing assistance tied with nutrition/food assistance, mental health/supportive services tied with employment/job assistance and emergency financial assistance. The following were identified as "hard to get" services by in care respondents: medical transportation, medication assistance, housing assistance, nutrition/food assistance and emergency financial assistance.

Out of Care: The unmet need estimate in 2010 indicates that 28% of all PLWHA are "out of care" in the Cleveland TGA. A total of 24 PLWHA participated in the Out of Care needs assessment. Demographics for this group included the following:

- 50% were males, and 50% were females.
- 100% were over age 45.
- Two-thirds of the respondents were African American, 17% more than one race and 8.3% white and 8.3% Hispanic.
- The majority reported their sexual orientation as straight (58%), 25% reported bisexual and 17% reported gay.

Out of care respondents reported a wide span in years since their HIV diagnoses (between 1987 and 2007). Generally, the majority of respondents had not seen their PMC provider since 2010 (N=16); two since 2004, two since 2006, and four since 2009.

When asked about reasons for HIV testing, responses included: 29% tested as part of a routine physical exam; 25% were tested when in the hospital or ER for a health issue; 17% were tested at the request of their partner/friend, and an equal proportion (8%) reported getting tested by the courts, as part of an outreach testing event and through a voluntary request to be tested. Four percent were tested as part of routine prenatal care.

All 100% reported initial entry into care after receiving an HIV diagnosis, however, half delayed their entry by one year or more. The primary reasons included: not liking the way they were treated, depression, not feeling it was necessary, mistrust of doctors, and incarceration.

The following were selected the most often by out of care respondents as interventions that may be helpful in assisting them to re-enter care, including:

- If I get really sick (43%)
- Someone to go with me (32%)
- Peer support/someone to help me understand (42%)
- More information about services (47%)
- Better quality of services (42%)

(*Respondents selected more than one intervention)

The following were ranked as major service needs for the out of care population: nutrition/food assistance, mental health/sportive services, and outpatient/ambulatory medical care tied with housing assistance and medical transportation. The following reasons were cited for being out of care: high cost, do not live in Cleveland, rural area, not enough time given by doctor, stigma and economy.

Newly Diagnosed: According to the Ohio Department of Health, HIV/AIDS Surveillance data, there were 217 newly diagnosed individuals throughout the Cleveland TGA in 2009. The respondents to the newly diagnosed survey comprised approximately 26% of the newly diagnosed within the past year. An important reason for undertaking the Newly Diagnosed needs assessment study was to determine effective strategies for reaching the unaware in the service area. Demographics for this group included the following:

- 86% were males, and 14% were females.
- 23% of respondents were white, 64% African-American, 5% Hispanic, 2% Asian, and 6% multi-race.
- Age groups reflected the full population-based data with the exception of a significantly higher portion of 20-29 year olds than in the epidemiologic reports (9% vs. 2%).
- The majority reported their sexual orientation as straight (58%), 25% reported bisexual and 17% reported gay.

Exposure categories sited included 55% MSM, 16% Heterosexual, 16% unknown, 4% IDU and 4% sexual assault. While almost half of the respondents reported learning their HIV status upon a voluntary request for testing, almost 27% received their diagnosis when in the hospital or ER for treatment of another condition. Almost 9% of the initial diagnoses were rendered as part of a street/community outreach testing event; less than 2% occurred during a regular physical exam; over 7% of women learned they were HIV positive as part of their prenatal care; and almost 4% of respondents tested positive in jail or prison.

Other major findings in this study included the following:

- Over 40% of the newly diagnosed respondents were not sure of how long they had been living with the disease prior to their initial diagnosis.
- The vast majority of respondents (86%) reported having heard HIV prevention messages prior to becoming tested and learning their HIV status. Of those who had heard messages, fifty percent found them helpful and fifty percent found them NOT helpful. The top four locations included TV/radio (67%), books/magazines/newspapers (46%), outreach workers (40%) and Internet websites (40%). Those who felt they were not helpful reported a lack of impact because they didn't think they were at risk for HIV and that the messages did not pertain to them.
- The Newly Diagnosed respondents reported a number of strategies that would prompt earlier testing, with over half reporting more information/education about risk and the benefits of testing and care. Over a quarter reported that having a peer to talk with them would have prompted earlier testing.

IMPACT ON COST AND CARE COMPLEXITY FOR PLWHA WHO WERE FORMERLY FEDERAL, STATE OR LOCAL PRISONERS DURING THE PRECEDING THREE YEARS:

The impact of formerly incarcerated PLWHA is significant in the TGA, particularly in Cuyahoga County. Ohio has a total of 32 correctional institutions (29 male facilities; 3 female facilities) and a population of nearly 26,000 inmates at a given time. Cuyahoga County is among the top seven counties with the highest number of committed inmates in Ohio. According to

the most recent Census of the Ohio Department of Rehabilitation and Correction (ODRC) Institutional Population report, Cuyahoga County has a total of 8,536 committed inmates, or 18% of the total committed population in the State, consisting of 7,947 males and 589 females. It is estimated that approximately 12-19% of those incarcerated at the Cuyahoga County jail are HIV-positive, though these inmates may opt not to disclose their status or are unaware that they are infected.
In the most recent Cleveland TGA Needs Assessment, a total of 5% of the In Care respondents reported a recent jail stay and over 2% reported a recent incarceration in prison. Fewer than half reported HIV medical care upon release from jail/prison while more than half reported they were not offered a referral to medical care. Four percent of In Care respondents learned their HIV diagnosis in jail or prison.

Inmates with HIV face significant barriers in accessing appropriate medical care both within the jail system and following release. Highly active antiretroviral therapy (HAART) may not be readily available within the correctional settings. Even if the appropriate medical treatment is available, inmates may fear to disclose their status and may opt to forego treatment while incarcerated to maintain their confidentiality within the system. When transitioning from the correctional setting into the community medical care may not be immediately coordinated by those working on the release of the inmate due to their unawareness of the inmate's HIV-positive status. This results in a lost opportunity for early intervention resulting in more complex chronic conditions and increased the cost of care once they seek medical care.

iii. EARLY IDENTIFICATION OF INDIVIDUALS WITH HIV/AIDS (EIIHA)/UNAWARE ESTIMATE FOR CY 2009:

To address the needs of the Unaware population, the Cleveland TGA conducted a Newly Diagnosed Needs Assessment during summer of 2010. Results from this study were used in setting the FY 2011 priorities and service category allocations. Additionally, the Newly Diagnosed survey results are being used by the Planning Council to enhance the TGA's EIIHA strategies. The following chart illustrates the fact that many Unaware PLWHA thought they were HIV+ but failed to have a confirmatory test.

TABLE 8. QUESTION FROM NEWLY DIAGNOSED SURVEY, 2010

HOW LONG DO YOU THINK YOU MAY HAVE BEEN LIVING WITH HIV BEFORE YOU RECEIVED YOUR FIRST POSITIVE TEST?	
ANSWER OPTIONS	**RESPONSE PERCENT**
1-3 months	12.5%
3-6 months	10.7%
6-12 months	19.6%
More than 1 year	10.7%
More than 2-3 years	5.4%
I do not know	41.1%

The TGA's EIIHA initiative will address the following reasons for delays in HIV testing by sub-group with specific strategies outlined later in this section.

TABLE 9. QUESTION FROM NEWLY DIAGNOSED SURVEY, 2010

IF YOU DELAYED GETTING TESTED FOR HIV, WHAT WERE YOUR REASONS FOR NOT GETTING TESTED?	
ANSWER OPTIONS	**RESPONSE PERCENT**
Not ready to know	17.8%
Not ready to deal with it	13.3%
Felt well	33.3%
Fear of others finding out I was HIV positive	8.9%
Worry about how to tell partner/family if I came up positive	8.9%
General stigma surrounding HIV disease/Fears about discrimination	4.4%
Concerns about confidentiality/privacy	11.1%
No insurance	15.6%
Other (please specify)	20.0%
didn't think I was at risk	did not specify
had no reason to assume	wasn't sexually active outside my partner
didn't feel I was at risk	Never thought I'd have it

The TGA will incorporate information from Newly Diagnosed Survey respondents about services that would have facilitated earlier testing into the EIIHA initiative.

TABLE 10. QUESTION FROM NEWLY DIAGNOSED SURVEY, 2010

WHAT SERVICES WOULD HAVE HELPED YOU GET TESTED EARLIER? (PLEASE CHECK ALL THAT APPLY.)	
ANSWER OPTIONS	**RESPONSE PERCENT**
More information/health education on why I should get tested	51.2%
Mental health counseling at the point of testing positive	14.0%
Being clean and sober	14.0%
A peer to talk with about it	25.6%
An advocate to come with me to get tested	14.0%
Transportation assistance	4.7%

Target Groups for the Cleveland TGA are outlined in the EIHHA Matrix below:

EIIHA Matrix

P1. **ALL Individuals in Cleveland/Lorain/Elyria TGA who are Unaware of their HIV Status** *(HIV Positive & Negative – Tested & Untested – Publically & Privately Tested)*										
P2. **Tested in the Past 12 Months**			P3. **Not Tested in the Past 12 Months**							
P4. **Individuals Not Post-Test Counseled** *(HIV positive & HIV negative)*		P5. **Received Preliminary HIV Positive Result Only – No Confirmatory Test**	P9. **High Risk Individuals**						P9. **Moderate & Low Risk Individuals**	
P1. **Tested Confidentially**	P2. **Tested Anonymously**		P6. **MSM**		P7 **Black**		P8 **Hispanic**		P4. **Not Tested in Past 24 Month**	P5. **Not Tested in Past 48 Month**
				P6. MSM/Hispanic Substance Abusers (IDU, Alcohol)		P7 MSM and Black Youth Ages 13-19		P8 MSM and Black Adults Ages 45+	P9 Women of Color	P10. Heterosexual Men/Women of Color

The Strategies for the Early Identification of Individuals with HIV/AIDS (EIIHA) in the Cleveland TGA responds to an estimate of approximately 1,157 individuals that are unaware but HIV-positive. This figure was determined by using the estimated back-calculation from the Center for Disease Control & Prevention (CDC) and applying the national estimate for 'Unaware and HIV positive' to the Total Number of People Living With HIV from December 31, 2009. Using the proportion of PLWHA and applying them to that total figure determined further projections of Parent and Target Groups. This results in the estimate of Unaware and HIV positive.

Parent Groups most likely to be HIV positive and Unaware in the Cleveland TGA are African Americans, Hispanics, and MSM. Target groups includes: 45+; IDU; Youth (13-19 years); 45+; high-risk heterosexual women of color; and high risk heterosexual Hispanic men.

Through the needs assessment survey conducted in the FY2010, the Cleveland TGA collected the following data to assist in the development to the target groups.

Sixty percent (60%) of all newly diagnosed AIDS cases occur in the Central region. This trend does not appear to be diminishing based on the three-year analysis. It's notable that among MSMs in the Cleveland TGA, transmission rates are highest among African Americans. Likewise, rates of infection among the 45 and older population occur most frequently among African Americans.

Latinos are the next most disproportionately affected, representing 9% of all newly diagnosed AIDS cases in the Cleveland TGA. The Western region accounts for 10% of these cases, closely followed by the Central region with 9%.

75% of newly diagnosed AIDS cases are male and 25% female. This figure is rising for newly diagnosed HIV cases, but not for AIDS cases. This may represent an earlier stage diagnosis for females, or a worsening trend for MSM in the Cleveland TGA. The region with the most newly diagnosed AIDS cases for females is the Central region. The region with the greatest number of female PLWH is the Western region. Minority women are most heavily impacted, with heterosexual contact with IDUs and bisexual MSMs being the most prevalent transmission category.

Unlike the HIV and AIDS prevalence figures, the Western region does not display any adolescent cases for newly diagnosed AIDS. The Western region is also the 'oldest' region to present with 43% of newly diagnosed AIDS cases that are 45 years+. This

is a newer development; as it contrasts with the HIV and AIDS prevalence figures that show the Eastern region to be the most with individuals 45 and older. This development is interpreted to be due to two factors—the stability of the MSM population in the Eastern region (not presenting with escalating new cases of AIDS) and the deterioration of the IDU subgroup in the Western region. The Central region follows the Western region with 24% of 45 and older newly diagnosed AIDS cases, then the Eastern region with 14%. However, the alarming rise in sexually transmitted infections, especially syphilis, among young MSM (13-19 years of age) in the Central region merits inclusion of this group.

The future projection of HIV/AIDS cases based on newly diagnosed AIDS cases shows that some trends continue—the highest proportion of MSMs is in the Eastern region and the highest proportion of IDUs remains in the Western region. Differing trends are evident in the proportion of heterosexuals with the Central region slightly leading the Western region (12% versus 10%), a negative trend not evident in the PLWH and PLWA trend lines.

TABLE 11. COMPARISON OF SUB-GROUPS BY CARE STATUS, 2010

	A	B	C
TARGET GROUPS	**EXISTING HIV/AIDS**	**NEW HIV/AIDS**	**UNAWARE OF HIV+**
45 years+	57% (2,540)	31% (210)	54.5% (630)
IDU	13% (587)	7% (51)	13% (156)
High Risk Heterosexual Women of Color	3% (122)	3% (20)	13%(153)
High Risk Heterosexual Hispanic Males	1% (60)	1% (8)	1% (14)
13-19 years	1% (37)	5% (35)	1% (12)

(Sources: A. Epidemiologic Profile for 6-county Cleveland TGA from ODH; 2010 B. Epidemiologic Profile for Cleveland TGA, 2009 & 2010; C-2009 Out of Care study using estimated Unmet Need derived in 2009; D-CDC back calculation using 2009 Existing HIV cases.)

B. DESCRIPTION OF CURRENT CONTINUUM OF CARE

The TGA's Established Continuum of HIV/AIDS Care and Access to Care: In coordination with other funders and stakeholders in the local health care and HIV/AIDS communities, the Cleveland TGA's Planning Council developed a comprehensive continuum of care that provides access to quality medical, dental and support services. Services are delivered regardless of age, gender, race, ethnicity, income, or insurance status.

The available continuum of care includes medical, pharmaceutical, case management, dental, substance abuse and mental health services funded by Medicaid, Medicare, the Veterans Administration, Part A, Part B, Part C, public behavioral health dollars, private insurance and private philanthropy. There are over 100 public and nonprofit social service organizations in the six-county TGA providing supportive services designed to help PLWHA stay in care; these include provision of core services as well as home health care, nutritional counseling, home delivered meals, housing assistance, support groups, transportation, child care and hospice. Services are available from providers throughout the TGA but are concentrated in the Central Region, in which 82% of PLWHA reside.

Data collected from Part A service records indicates that over the past three years, of the total number of PLWHA in the local system of care, only 18% have private insurance, approximately 33% have some form of public insurance (Medicare, Medicaid, Veterans Administration, etc.) and over 49% have no insurance coverage at all. Additionally, where women or disabled persons do have Medicaid coverage, many supportive services necessary to get, and keep, PLWHA in care, are not covered. Part A funding fills this coverage gap, primarily experienced by minorities, thereby ensuring that access to services is increased and HIV health disparities are decreased.

Particular attention is given to tailoring services to populations newly affected or disproportionately impacted by the epidemic. A packet for the newly diagnosed (which includes a comprehensive overview of the illness, treatment information and local

service providers) is given to individuals who test positive at all testing sites in the TGA. Culturally specific case management and supportive programs address the needs of African Americans, Latinos, women, and formerly incarcerated persons who have recently been released from prison. It should be noted that there is universal access to any or all funded services regardless of entry point into the system.

I. RYAN WHITE FUNDED – HIV CARE AND SERVICE INVENTORY (BY SERVICE CATEGORY, ORGANIZED BY CORE AND SUPPORT SERVICES):

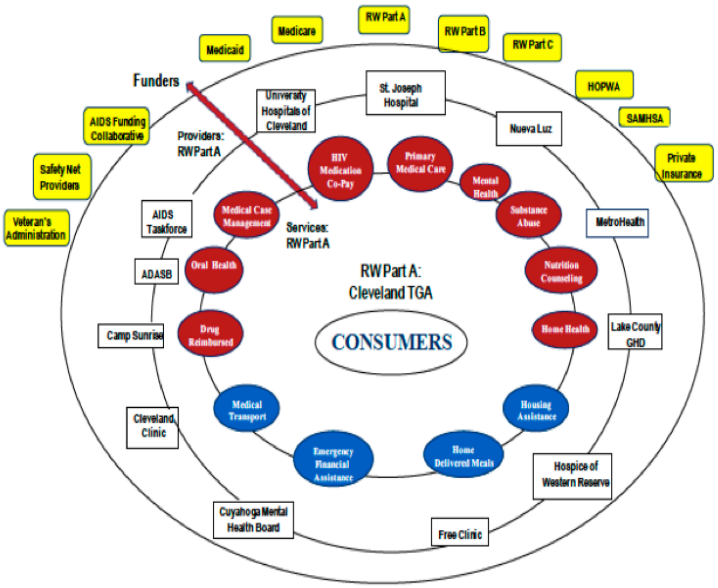
The chart below depicts the contracted Part A agencies by services.

	CLEVELAND CLINIC	UNIVERSITY HOSPITAL	METROHEALTH	FREE CLINIC	LAKE COUNTY	MERCY HOSPITAL	ADAMHS BOARD	RECOVERY RESOURCES	AIDS TASKFORCE	HOSPICE OF THE WESTERN RESERVE	CARE ALLIANCE	NUEVA LUZ	CAMP SUNRISE	OHIO DEPT OF HEALTH	CCDSAS
SERVICE CATEGORIES	CORE SERVICES														
Ambulatory Outpatient Medical Care	•	•	•	•	•										
Laboratory Services	•	•	•	•	•										
AIDS Pharmaceutical Assistance														•	
AIDS Pharmaceutical Assistance (Local)	•	•	•	•		•					•				
Medical Case Management	•	•	•	•	•	•						•			
Oral Health Care		•	•	•											
Early Intervention Services				•	•			•			•				
Home Health Care Services															•
Home/Community Based Health Care															•
Hospice Services										•					
Medical Nutritional Therapy		•			•										
Mental Health Services		•	•				•								
Substance Abuse-Outpatient							•								

	CLEVELAND CLINIC	UNIVERSITY HOSPITAL	METROHEALTH	FREE CLINIC	LAKE COUNTY	MERCY HOSPITAL	ADAMHS BOARD	RECOVERY RESOURCES	AIDS TASKFORCE	HOSPICE OF THE WESTERN RESERVE	CARE ALLIANCE	NUEVA LUZ	CAMP SUNRISE	OHIO DEPT OF HEALTH	CCDSAS
SUPPORTIVE SERVICES															
Psychosocial Support													•		
Substance Abuse-Inpatient							•								
Home Delivered Meals									•						
Health Education/Risk Reduction															
Outreach Services	•		•		•	•					•				
Medical Transportation					•	•			•						
Housing Services									•						

In addition to Part A funded-services, other federal, state and local monies for HIV/AIDS services flow into the area. The state of Ohio's Department of Health is a recipient of Part B funding and uses the medical case management services and the AIDS Drug Assistance Program (OHDAP) in the Cleveland TGA. Two providers receive Part C funds to provide primary medical care and to conduct outreach and Early Intervention Services in the TGA.

The graphic below demonstrates the model of care for clients in the Cleveland TGA. It illustrates the relationship between funded categories, the wide spectrum of service providers and other funding resources throughout the TGA:



ii. NON-RYAN WHITE FUNDED - HIV CARE AND SERVICE INVENTORY (ORGANIZATIONS & SERVICES)

The City of Cleveland Department of Public Health receives funding for HIV prevention programs from the Centers for Disease Control. The Alcohol and Drug Addiction and Mental Health Services Board of Cuyahoga County receives support in the form of block grant funding from the Center for Substance Abuse Treatment for addiction prevention and treatment services for PLWHA, as well as funding from the Ohio Department of Alcohol and Drug Addiction Services for local outreach. The Grantee also works closely with the City of Cleveland, as the local HOPWA grantee, to research housing options for PLWHA in the community. HOPWA funds are used for utility payments, housing payments and housing deposits. There is a waiting list in this area for subsidized housing units, even among special needs populations.

iii. HOW RW FUNDED CARE/SERVICES INTERACT WITH NON-RW FUNDED SERVICES TO ENSURE CONTINUITY OF CARE

The continuum of care begins with the client's awareness of HIV and the availability of services. RW materials are distributed at public events and in health and social service agencies throughout the community housing testing sites and services for PLWHA.

Persons in the Cleveland TGA are generally diagnosed in one of several settings: a primary care site, an infectious disease clinic, a dental office, during a physical exam for life insurance, an HIV counseling and testing site, prison, the military, a substance abuse treatment facility, the emergency room or a blood/plasma donation center. The "newly diagnosed" packet and a Consumer's Guide to HIV Services are provided to direct newly diagnosed PLWHA to primary care and other resources within the TGA. Each type of testing site has been provided with these materials, and encouraged to refer clients to a primary care site. Comprehensive Needs Assessment data indicate that a significant number of persons who are outside of the system of care, traditionally underserved and hard to reach, were diagnosed at a plasma donation center, but were never referred for primary HIV care. The grantee works collaboratively with prevention and testing through other local funders, hospitals, community health centers and other community based organizations to ensure the continuity of care in all areas, specifically addressing the needs of special and/or underserved populations. Ryan White Part A EIS providers work closely with prevention and disease control programs. Most notably, the City of Cleveland Health Department's Disease Intervention Specialists (DIS) unit has a strong connection with all Ryan White Part A providers as it relates to partner notification and linkage to care. DIS is part of the Regional Advisory Group as well as the RAG/EIS quarterly meetings. Given current expertise and infrastructure to conduct HIV testing, providers augment efforts in areas that are isolated yet are known to have probability of yielding higher seropositivity results than traditional venues. Outreach specific to those arenas (homeless shelters, public housing complexes or 'estates') enhances traditional results. Informing these individuals of their status follows all regulatory protocols while honoring the culture, environment and circumstances of these individuals. HIV testers are required to complete the ODH Client-Centered Counseling training, which is offered to professionals seeking to provide HIV testing in collaboration with ODH. This course not only provides them with the necessary skills to test, but it allows them to access the network of established testing providers for additional support.

iv. HOW THE SERVICE SYSTEM/CONTINUUM OF CARE HAS BEEN AFFECTED BY STATE AND LOCAL BUDGET CUTS, AS WELL AS HOW THE RYAN WHITE PROGRAM HAS ADAPTED

Ohio's Medicaid program has undergone significant changes due to state budget cuts. Overall, state Medicaid cuts for the current biennial budget are an estimated $1.4 billion. The Cleveland TGA encompasses the largest county in the state (Cuyahoga) along with largest regional population (Northeast Ohio), therefore the majority of the funding cut burden. Locally, the Cleveland Department of Public Health (CDPH) received an $84,000 reduction from the Community Development Block Grants (CDBG) and $214,000 funding reduction from ODH both impacting the HIV prevention program.

Specific concern for PLWHA related to the Ohio HIV Drug Assistance Program (OHDAP) occurred in June of 2010 that initially resulted in loss of eligibility for over 320 PLWHA, creating a waiting list and cuts to a program that served about 5,000 people in Ohio with HIV. In the summer of 2011, OHDAP restructured the program, therefore eliminating the waiting list. This happened through changing the income eligibility criteria from 500% FPL to 300%, reducing other Part B supportive services, and realizing revenue from pharmaceutical rebate programs. While the program has improved this past year, its future service levels are uncertain and more changes may be necessary beyond 2012.

The Cleveland TGA was responsive to this funding crisis by establishing a temporary medication assistance guideline to provide RW Part A funds for TGA consumers cut off of OHDAP as well as provided short-term medication assistance for consumers with pending applications for PAPs, and medication assistance for consumers with income levels between 300% and 500% of FPL and a Nadir CD4 of 350 or less that are not eligible for PAPs. Yet the fear of some PLWHA of having to pay out of pocket for medications resulted in them becoming out of care.

C. DESCRIPTION OF NEEDS

i. CARE NEEDS

A Need, Use, Barrier and Gap ranking was developed through the Cleveland TGA to be utilized in the Needs Assessment care surveys. The Needs Assessment provides a "snapshot" of community service uses, needs, barriers, and gaps as expressed by consumers in the service area. These rankings of the Needs Assessment are displayed for all respondents. These are defined as:

USE	Number of client survey respondents who indicated service use in the past year
NEED	Number of client survey respondents who stated "I currently need this service."
BARRIER	Number of client survey respondents who indicated that a service is 'Hard to Get'.
GAP	Sum of client survey respondents who answered 'Yes' to Need and 'No' to availability of that service

ii. IMPACT OF CO-MORBIDITIES AND CO-FACTORS ON SERVICE COSTS AND COMPLEXITY OF CARE

The TGA's overburdened local health care safety net system continues to struggle to meet the increasing health care needs of the poor and uninsured in the face of simultaneously diminishing resources.

Sexually Transmitted Infections: Sexually Transmitted Disease (STD) infections have become endemic in some segments of teens ages 15 to 19 and youth ages 20 to 24 throughout the Cleveland TGA. Three quarters (74.6%) of Chlamydia and gonorrhea reports for Cleveland were among these age groups, consistent with data from previous years. STD rates (all ages) increased 34.7% from 2008 to 2009 and 9.1% from 2009 to 2010, where 6,008 and 6,032 STD cases were reported. The former reflects an increase in infections reported, while the latter reflects the 8.0% change in census population from 2009 to 2010.

Overall, prevalence of Chlamydia and gonorrhea for the Cleveland TGA is 1.5% (1,520.1 per 100,000). Chlamydia incidence rates among teens (8,368.97 per 100,000) increased by 22.1% from 2008 (from 6,856.3 per 100,000 teens); rates for youth age 20 to 24 (6,593.88 per 100,000) decreased by 1.8%. Of those age 15 to 24 reporting race, over two-thirds (68.4%) of reported Chlamydia cases in Cleveland were Black/African American, with rates as high as 13,944.3 per 100,000 (13.9%) among Black/African American teen females. In Cuyahoga County, 60.8% of all cases were Cleveland residents, a decrease from 2008 (63.0%). In 2010, overall, Chlamydia incidence for the county (9,875 cases, 771.4 per 100,000) reached its highest level since 1995.

Homelessness: The National Coalition for the Homeless estimates the general prevalence of homelessness in the country to be 0.8% of the general population, or over 22,000 persons each year in the TGA. The Coalition released a report in 2009 that estimated that 3.4% of the homeless population is estimated to be HIV positive compared to 0.4% of the general population. The interrelated nature of homelessness and HIV status are due to many factors, including: PLWHA are at increased risk for becoming homeless due to job loss as a result of discrimination or health-related absences; the costs of medications; and high-risk for contracting the virus through IDU or MSM in shelter settings.

Uninsured: Across the state of Ohio, over 1.25 million adults continue to be uninsured and over 200,000 children for a total of 15% of the population.[1] For low-income individuals below 200% FPL, 37% are uninsured and 23% are covered by Medicaid. For those below 100% of the FPL, this is even more extreme with 42% uninsured and 32% covered by Medicaid. 16% of Ohio's uninsured are Black and 5% are Hispanic. From 2007-2009, the number of uninsured nonelderly individuals grew by 3.2% in Ohio compared to a national increase of only 1.7%. During the same time, employer-sponsored health insurance decreased by over 6% and Medicaid increased by 2.4%. In an analysis of the 2008 Ohio Family Health Survey by the Center for Community Solutions, compared to the percentage of uninsured whites (14%) and Asians (17%), a significantly higher proportion of blacks (nearly 30%) and Hispanics (nearly 23%) were uninsured in the statistical area (Cuyahoga, Lorain and Summit counties) at the time of the survey.[2]

1. Kaiser Family Foundation. State Health Facts.

2. Salling, M., Ahern, J., Lenahan, T. (2010). "An Analysis of Health Disparities in Northeast Ohio Using the 2008 Ohio Family Health Survey." The Center for Community Solutions.

Being uninsured or underinsured continues to be a major problem for PLWHA. The recent Needs Assessment of the Cleveland TGA found that of the newly diagnosed, 58% cited that they had no insurance whatsoever (see the chart below). Over 15 percent of this same group reported that they had delayed getting tested due to not having insurance.

TABLE #12: INSURANCE STATUS OF INDIVIDUALS LIVING WITH HIV/AIDS - PERCENTAGE OF NEEDS ASSESSMENT RESPONDENTS

INSURANCE TYPE	IN CARE	NEWLY DIAGNOSED
Medicare	18.6%	2%
Medicaid	35.1%	16%
Medicare/Medicaid		
Private Insurance	11.2%	18%
No Insurance	29.3%	58%
Other	28.7%	6%
TOTAL	**122.9%***	**100%**

**Multiple insurance statuses were selected by respondents*

Individuals living below the 2011 Federal Poverty Level: According to a recent analysis of preliminary census figures of the state of Ohio, a substantial increase in the number of Ohioans living in poverty occurred in 2010 when one out of every seven Ohioans was living in poverty.[3]

Data from the 2010 U.S. Census American Community Survey include the two largest counties within the TGA, with nearly 18% of Cuyahoga County residents and over 14% of Lorain County residents estimated to be living below 100% federal poverty level (FPL). It is estimated that as many as 60% of the TGA's population, or 1.3 million people, could fall in the category,

In the recent Cleveland TGA Needs Assessment, nearly 65% of In Care respondents reported incomes below $100% FPL and the vast majority of the remainder (24%) reported incomes below 200% FPL.

Trends in services and fiscal resources as a result of municipal and state budget cuts in HIV related and funded clinical and non-clinical services: Ohio's Medicaid program has undergone significant changes due to state budget cuts. Overall, state Medicaid cuts for the current bi-annual budget total an estimated $1.4 billion. The Cleveland TGA encompasses the largest county in the state (Cuyahoga) along with largest state population (Northeast Ohio), therefore the majority of the funding cut burden. Locally, and specific to HIV services the Cleveland Department of Public Health (CDPH) received an $84,000 reduction from the Community Development Block Grants (CDBG) and $214,000 funding reduction from ODH both impacting the HIV prevention program.

Specific concern for PLWHA related to the Ohio HIV Drug Assistance Program (OHDAP) occurred in June of 2010 that initially resulted in loss of eligibility for over 320 PLWHA, creating a waiting list and cuts to a program that served about 5,000 people in Ohio with HIV. OHDAP was able to restructure the program to eliminate waiting list numbers in the summer of 2011. This happened through changing the income eligibility criteria from 500% FPL to 300%, reducing/eliminating other Part B supportive services, and realizing revenue from pharmaceutical rebate programs While the program has improved this past year, it created gaps in some non-clinical services such as transportation assistance, emergency utilities and rental payments, and clinical services such as oral health. The Cleveland TGA continues to provide funding for medical transportation, housing services, and oral health for all clients residing in the TGA. However, the rest of the state of Ohio has had to do without these services or locate alternative funding resources.

3. "New Census Data on Ohio: Poverty Continues to Rise, Employer-Based Health Care Coverage Shrinks." Policy Matters Ohio. September 13, 2011.

iii. CAPACITY DEVELOPMENT NEEDS RESULTING FROM DISPARITIES IN THE AVAILABILITY OF HIV-RELATED SERVICES IN HISTORICALLY UNDERSERVED COMMUNITIES AND RURAL COMMUNITIES

As referenced throughout this document, the Cleveland TGA encompasses Northeast Ohio, including Cuyahoga County, the state's largest county. In addition, the TGA also represents five other surrounding counties (Lorain, Medina, Summit, Geauga and Lake). Some of these surrounding counties, primarily Lorain on the west and Medina in the southeast, are densely populated areas with no single metropolitan center. The numbers of providers throughout the rural regions of the TGA are limited. A PLWHA may need to travel as much as 117 miles round trip to the nearest provider for medical care, which is located in Cuyahoga. No public transportation or bus lines are available in these regions making the complexity of this matter severe. While the TGA has explored the possibility of funding providers specialized in HIV care, a study conducted in Lorain County in 2008 revealed that PLWHA preferred to travel to avoid stigma and confidentiality issues that can easily occur in the smaller regions. This poses a unique challenge for the TGA in ensuring treatment and supportive services that are easily accessible throughout its rural regions.

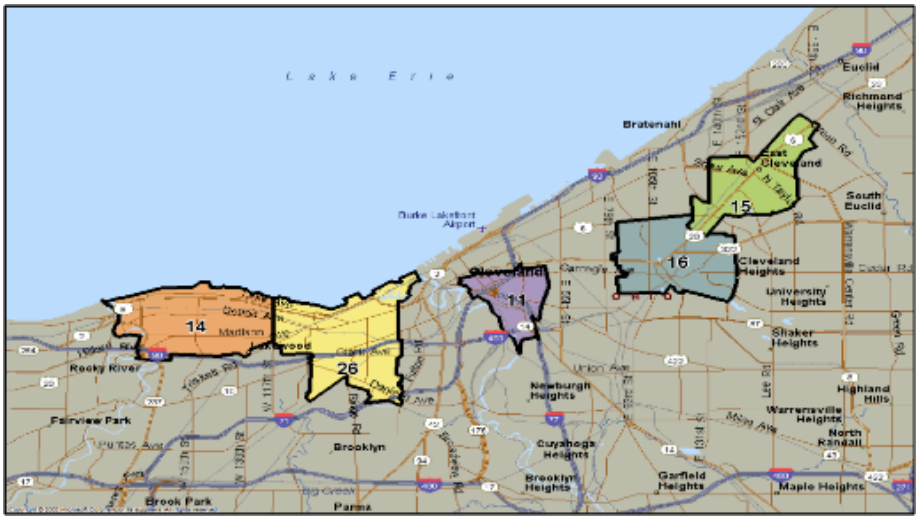
D. DESCRIPTION OF PRIORITIES FOR THE ALLOCATION OF FUNDS

- Size and demographics of the population of individuals with HIV/AIDS
- Needs of individuals with HIV/AIDS

According to the Ohio Department of Health, there are 1,391 PLWHA with an unmet need for primary medical care within the Cleveland TGA. The TGA's epidemiological profile shows that minority communities, aged and MSMs are disproportionately affected. The Needs Assessment Priority Setting Committee utilized data from the TGA's 2009 Out of Care Study to assist in the 2011 Priority Setting and Resource Allocation process. The study surveyed 24 PLWHA out of care to determine service barriers preventing them from accessing primary medical care. The 2009 Out of Care report utilized "geo-coding" which allowed the committee to target Ryan White services in areas of severe need. The map highlights zip codes within the TGA representing areas of Out of Care PLWHA. In order to reduce the unmet need within the TGA, the NA/PSC funded outreach services to engage PLWHA who are out of care.

Warm' colors represent high areas of out of care with cooler colors representing lower areas.

ZIP CODES WITH A HIGH UNMET NEED- 2009 CLEVELAND TGA OUT OF CARE STUDY



Considerations to needs of those persons unaware of their HIV status: The Cleveland TGA utilized the Center for Disease Control's Estimated Back Calculation (EBC) methodology to determine there are 1,069 HIV+ and Unaware individuals within the six county TGA. Further, the Unaware estimate was subdivided into the TGA's special populations based on the region's 2008 epidemiological profile. Sub-population analysis indicated that African American men who have sex with men are the largest Unaware subpopulation. In August 2010, the TGA completed a Newly Diagnosed Needs Assessment to further inform

HRSA's EIIHA requirement. This study accomplished two main goals: First, it provided insight into individuals who recently entered the care continuum by asking "what would have gotten you tested earlier". This information was cross-tabulated by the TGA's severe need groups which allowed the TGA to develop EIIHA strategies by special population. Secondly, the needs assessment data was used during the 2011 Priority Setting and Resource Allocation process to help determine service priorities and appropriate allocations in order to reduce the TGA's 'Unaware' population by 100 individuals. Based on the anticipated needs of the Unaware, the NA/PSC increased the allocation to Early Intervention Services to identify, inform, link and refer Unaware PLWHA into appropriate medical care.

PLWHA involvement in the priority setting and allocation process: The input of PLWHA regarding Planning Council priorities are elicited by the Council in several ways. First, the full Planning Council is made up of 37% PLWHA non-aligned, and 40% total. This percentage is maintained even with regard to turnover among volunteers. The representative body provides final approval of the priorities and allocation recommendations. Second, PLWHA serve on all Planning Council subcommittees. The Needs Assessment/ Priority Setting Committee (NA/PSC) is comprised of 40% consumers who represent the priorities of PLWHA. Third, Needs Assessment data, which drives program planning and allocation decisions, is collected solely from PLWHA. Fourth, the Planning Council's Executive Committee, which ratifies the recommendations for priority setting and allocations, is made up of 50% PLWHA. Consumer participation is encouraged whether or not they are voting members on the Planning Council. In the priority setting process, many CAAP members join the NA/PSC to review the priorities and allocations recommended prior to the Planning Council ratifying the priorities and allocations. This strengthens the validity of the process in the eyes of the PLWHA community.

For the TGA's Resource Allocation determination, epidemiological and demographic data from ODH and the TGA are reviewed to determine trends in the epidemic, predict future need and identify disproportionately affected populations. During the PSRA workshop, the Planning Council met and reviewed four data sets to determine the TGA's 2012 Service Priorities. The data sets were:

1.) 2011 In Care Needs Assessment
2.) 2011 Out of Care Needs Assessment
3.) 2011 Newly Diagnosed Needs Assessment
4.) 2010 Service Utilization data from the Ryan White Office

Each data set was weighted based on the committee's input to the relevance of the data source.

For the TGA's 2012 Resource Allocation determination, several data sources were used including:

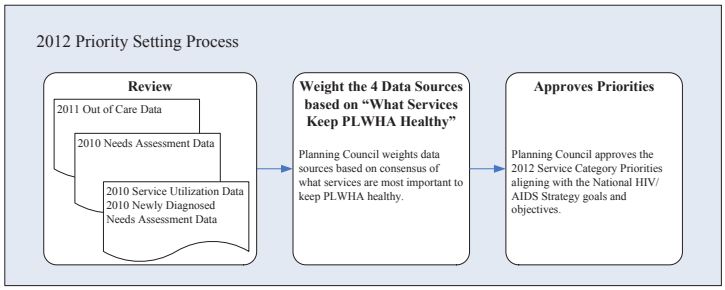
1.) Unduplicated client count by service category for 2008, 2009 and 2010;
2.) 2010 Cost per client by service category
3.) Units of service for 2010 and
4.) 2010 Allocated amount by service category.

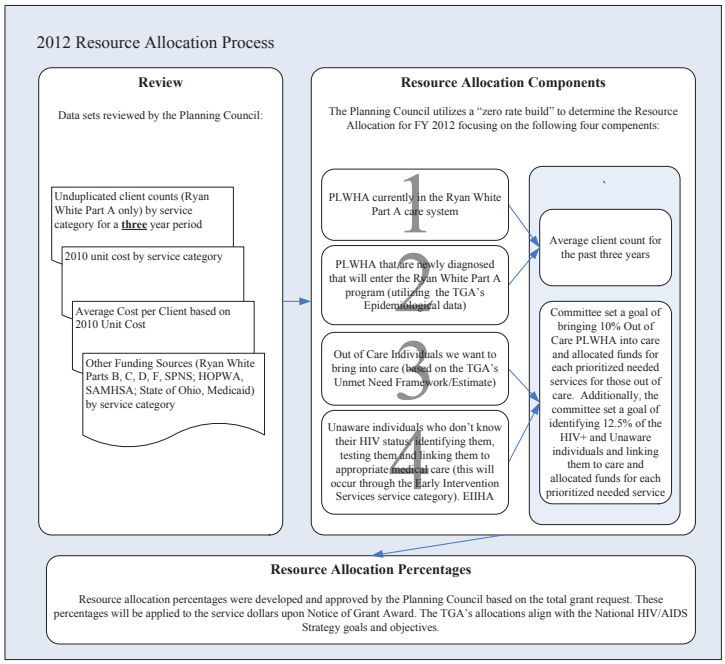
The purpose of reviewing year-over-data was to provide the Planning Council with trending data to show increases or decreases in the cost of care for each service category. The average cost per client for 2010 was one component used to determine the 2012 Resource Allocation. The second criterion was the anticipated number of clients to be served by each prioritized service category based on the following four components:

1.) Current number of clients in care (Maintain);
2.) Expected increase of new clients entering the TGA's continuum of care based on the TGA's epidemiological profile and (Anticipated Increase);
3.) The goal of bringing 10% Out of Care PLWHA into care (out of care into care);
4.) The goal of identifying 12.5% Unaware PLWHA and linking them to care (EIIHA).

Service utilization data, provided by the Ryan White Office, is used to help determine the TGA's Service Priorities. Needs Assessment data is used to identify particular gaps and barriers for emerging populations in order to reduce health disparities. The unmet need calculation enables the Planning Council to estimate the number of persons who need to be brought into care in order to increase access to core services and reduce disparities in access. The Unaware Estimate enables the Planning Council to estimate the number of people to identify, inform, link and refer to appropriate medical care.

The following graphics outline the Cleveland TGA's 2012 Priority Setting and Resource Allocation methodology:





E. DESCRIPTION OF GAPS IN CARE

A comprehensive assessment of the service needs of PLWHA has been undertaken in the Cleveland TGA annually for the past eight years. The Needs Assessments have sought to determine service gaps and barriers for PLWHA in the Ryan White funded System of Care, as well as PLWHA outside of any system of primary HIV care (i.e., had not received any primary HIV care in at least the previous 12 months). Each survey group is sampled to reflect the TGA's epidemiological profile. The Planning Council maintains a focus on Severe Need Groups including: MSMs, African Americans, Hispanics/Latinos, minority women, IDUs and the "aged," defined as persons 45 and older. In each Needs Assessment, service gaps, defined in the survey as services which were needed but not being provided, and service barriers, defined as obstacles to receiving needed services, were identified by various subgroups. The most recent Needs Assessment was conducted in the spring of 2010 and finalized in the spring of 2011 with a survey of individuals "in care," "newly diagnosed/new to care" and "out of care". This assessment of need included an "in care" survey questionnaire of PLWHA receiving Ryan White funded services, a "Newly Diagnosed/New to Care" survey questionnaire of PLWHA who were recently diagnosed and who recently entered primary medical care services (within the past year) and an "Out of Care" survey of PLWHA who know their HIV status and have either been absent from PMC for one year or longer or have never entered care. Results from the three surveyed populations are listed below:

In Care Needs Assessment Findings: A total of 203 PLWHA participated in the "in care" needs assessment. Demographics for this group included the following:

- Almost 76% were males, 23% females and less than 2% transgender individuals (M to F).
- Almost equal proportions reported gay (41%) and straight (44%) as their sexual orientation with just over 10% reporting as bisexual.
- The majority (60%) were African American, followed by 28% White, 6% Hispanic, 4% more than one race and 1% "other."
- The respondents were largely living in poverty: 85% reported that they were unemployed and 64.6% had incomes below $10,000.
- 30% had no health insurance and over a third had Medicaid.
- A substantial proportion of the in care survey respondent group reported having experienced homelessness at some time. Over 36% stated they had been recently homelessness, 16% within the past two years and 21% over two years ago. Nearly 10% were currently homeless at the time of the survey.

The risk exposure modes reported by respondents reflected similarities between the HIV transmission modes of the TGA's overall population of PLWHA, including the following: 50% MSM risk behavior, 24% heterosexual behavior; 10% MSM and IDU, 3% IDU, 4% sexual assault, 1% transfusion related, and 0.5% transmission from their mother with HIV/AIDS. Over 14% reported an unknown risk exposure.

The following were ranked as major service gaps that in care respondents "can't get": medical transportation, medications, housing assistance tied with nutrition/food assistance, mental health/supportive services tied with employment/job assistance and emergency financial assistance. The following were identified as "hard to get" services by in care respondents: medical transportation, medication assistance, housing assistance, nutrition/food assistance and emergency financial assistance.

Newly Diagnosed Needs Assessment Findings: According to the ODH, HIV/AIDS Surveillance data, there were 217 newly diagnosed individuals throughout the Cleveland TGA in 2009. The 52 respondents to the newly diagnosed survey comprised approximately 26% of the newly diagnosed within the past year. An important reason for undertaking the Newly Diagnosed needs assessment study was to determine effective strategies for reaching the unaware in the service area. Demographics for this group included the following:

- 86% were males, and 14% were females.
- 23% of respondents were white, 64% African-American, 5% Hispanic, 2% Asian, and 6% multi-race.
- Age groups reflected the full population-based data with the exception of a significantly higher portion of 20-29 year olds than in the epidemiologic reports (9% vs. 2%).
- The majority reported their sexual orientation as straight (58%), 25% reported bisexual and 17% reported gay.

Exposure categories cited included 55% MSM, 16% Heterosexual, 16% unknown, 4% IDU and 4% sexual assault. While almost half of the respondents reported learning their HIV status upon a voluntary request for testing, almost 27% received their diagnosis when in the hospital or ER for treatment of another condition. Almost 9% of the initial diagnoses were rendered as part of a street/community outreach testing event; less than 2% occurred during a regular physical exam; over 7% of women learned they were HIV positive as part of their prenatal care; and almost 4% of respondents tested positive in jail or prison.
Other major findings in this study included the following:

- Over 40% of the newly diagnosed respondents were not sure of how long they had been living with the disease prior to their initial diagnosis.
- The vast majority of respondents (86%) reported having heard HIV prevention messages prior to becoming tested and learning their HIV status. Of those who had heard messages, fifty percent found them helpful and fifty percent found them NOT helpful. The top four locations included TV/radio (67%), books/magazines/newspapers (46%), outreach workers (40%) and Internet websites (40%). Those who felt they were not helpful reported a lack of impact because they didn't think they were at risk for HIV and that the messages did not pertain to them.
- The Newly Diagnosed respondents reported a number of strategies that would prompt earlier testing, with over half reporting more information/education about risk and the benefits of testing and care. Over a quarter reported that having a peer to talk with them would have prompted earlier testing.

Out of Care Needs Assessment Findings: The unmet need estimate in 2010 indicates that 28% of all PLWHA are 'Out of Care' in the Cleveland TGA. A total of 24 PLWHA participated in the "out of care" needs assessment. Demographics for this group included the following:

- 50% were males, and 50% were females.
- 100% were over age 45.
- Two-thirds of the respondents were African American, 17% more than one race and 8.3% white and 8.3% Hispanic.
- The majority reported their sexual orientation as straight (58%), 25% reported bisexual and 17% reported gay.

Out of care respondents reported a wide span in years since their HIV diagnoses (between 1987 and 2007). Generally, the majority of respondents had not seen their PMC provider since 2010 (N=16); two since 2004, two since 2006, and four since 2009.

When asked about reasons for HIV testing, responses included: 29% tested as part of a routine physical exam; 25% were tested when in the hospital or ER for a health issue; 17% were tested at the request of their partner/friend, and an equal proportion (8%) reported getting tested by the courts, as part of an outreach testing event and through a voluntary request to be tested. Four percent were tested as part of routine prenatal care.

All 100% reported initial entry into care after receiving an HIV diagnosis, however, half delayed their entry by one year or more. The primary reasons included, not liking the way they were treated, depression, not feeling it was necessary, mistrust of doctors, and incarceration.

The following were selected the most often by out of care respondents as interventions that may be helpful in assisting them to re-enter care, including:

- If I get really sick (42%)
- Someone to go with me (42%)
- Peer support/someone to help me understand (42%)
- More information about services (42%)
- Better quality of services (42%)

The following were ranked as major service needs for the out of care population: nutrition/food assistance, mental health/sportive services, and outpatient/ambulatory medical care tied with housing assistance and medical transportation. The following reasons were cited for being out of care: high cost, do not live in Cleveland, rural area, not enough time given by doctor, stigma and economy.

F. DESCRIPTION OF PREVENTION AND SERVICE NEEDS

The City of Cleveland serves as the grantee for HIV & STD prevention dollars through the Cleveland Department of Public Health, Office of HIV/AIDS Services. The HIV Prevention services are delivered throughout 11 community service providers providing testing and counseling services. In addition 4.0 FTE Disease Intervention Specialists are responsible for following up on new HIV/STD diagnosed individuals and partner notification services. CDPH is responsible for the prevention and control of STDs throughout the Cuyahoga County region. The program supports and improves the ability of public health departments to (1) design, implement, and evaluate Comprehensive STD Prevention Systems (CSPS); (2) carry out the Syphilis Elimination Effort (SEE) program in designated high morbidity areas (HMAs) by enhancing activities to prevent, control and eliminate syphilis; and (3) implement the Gonoccocal Isolate Surveillance Project (GISP) in eligible jurisdictions. Part A works closely with the prevention programs throughout the TGA to ensure the continuum of care and address service needs that may arise.

G. DESCRIPTION OF BARRIERS TO CARE

- Routine testing (including any state or local legislation barriers)
- Program related barriers
- Provider related barriers
- Client related barriers

In 2010, changes were made to Ohio law allowing medical providers to provide routine HIV testing universally within their system as recommended by the CDC. Ohio went from an Opt In to an Opt Out recommended testing methodology. This change has not been widely adopted so education is needed to help medical providers adopt policies and procedures to conduct universal testing with an opt-out clause. Inclusion of HIV screening as part of chronic health screening panel for new patients, includes annual screenings, and testing on a more frequent basis if clients present with known risk (HCV, known active substance use, Sexually Transmitted Infections). The Grantee will promote universal testing in the TGA's five Part A funded primary care clinics.

The Cleveland TGA proposes two models of HIV testing to identify individuals who are unaware of their HIV status. The first is to provide Early Intervention Services with the expansion of universal HIV testing, per CDC recommendations. This model will focus on supporting the major medical systems throughout the TGA to integrate HIV testing into their standard panel of tests. Medical systems may have concerns about the need for extended post test and ongoing counseling/support for patients when they identify a new HIV infection, so they may be reluctant to offer universal testing. The grantee has supported local efforts to formalize this model within the major public county run hospital. The grantee funds an ID physician to facilitate the inclusion of HIV testing with the Epic EMR so that providers are prompted to provide the test. Early feedback has shown that -testing has increased because the prompt becomes a QA/QI issue for the providers. The county- run hospital already established a client navigation program (COMPASS) that fulfills the needs of the newly diagnosed, although this program will need to be expanded to address capacity as HIV testing goes to scale throughout the system.

The second model is to have RW Part A staff, providers, and the Planning Council's consumer subcommittee members participate in community based HIV testing efforts. Participation in targeted testing "fairs" and in community events and health fairs will utilize the TGA's geo-coding of PLWHA based on Needs Assessment responses. The providers will participate in large, free public HIV testing events so that unaware individuals can receive Early Intervention Services at diagnosis. These events target youth and other populations that are not otherwise seeking HIV testing. Ryan White staff and Planning Council consumer members will provide information to participants to encourage testing as well as linkage to service providers. This was very successful in FY2011 with consumers set up at tables next to the testing area with brochures and service directories. EIS providers will also work closely with Partner Counseling and Referral Services (PCRS) programming to ensure effective referral and support. Referral and support for linkage between testing/diagnosis and care is a critical opportunity to engage clients. In FY2010, more than 25,000 tests were conducted in the TGA with 97% of those tested referred to at least one core medical or support service. The TGA's COMPASS program is an excellent model for linking newly diagnosed to care and has shown that 86% of clients are engaged in primary care after 12 months of diagnosis. The statistic drops slightly to 84% after two years of diagnosis.

H. EVALUATION OF 2009 COMPREHENSIVE PLAN

2009-2012 GOALS & OBJECTIVES

GOAL #1 INCREASE ACCESS TO HEALTH CARE

Objective A: Increase access to services by 5% for PLWH
Activity 1.A.1. Implement Universal HIV Testing in Hospitals & ED in TGA
Activity 1.A.2. Support innovative strategies to engage clients in primary medical care

Objective B: Reduce lag time from positive diagnosis to care entry by 10% per year
Activity 1.B.1. Confirm points of entry, strengthen testing/counseling referrals to Care linkages
Activity 1.B.2. Perform 'Late to Care' study
Activity 1.B.3. Strengthen referrals to care
Activity 1.B.4. Ensure follow-up tracking strategies are used in referral confirmation

Objective C: Create Peer Counselor System
Activity 1.C.1. Develop peer counselor or navigator system to guide newly diagnosed to care and services
Activity 1.C.2. Assess feasibility of Community Health Worker to receive Medicaid reimbursement and certification
Activity 1.C.3 Position Peer Counselor System as development ground for Planning Council leadership

GOAL #1: SUCCESSES/CHALLENGES

- One medical provider has fully implemented Universal HIV testing within their health center(MetroHealth). Cleveland Clinic and University Hospital in currently in the process of launching implementation
- The Planning Council identified EIS and Outreach as service priorities and allocated funding accordingly to support contracted providers in developing innovative strategies to identify and engage PLWHA into care.
- Prevention, EIS, and Outreach personnel meet on a quarterly basis to discuss progress of set strategies, ensure referral and linkage mechanisms as well as to discuss any barriers that may arise.
- Peer/Navigator programs are effectively taking place at two provider agencies (MetroHealth and LCGHD).
- Effective as of January 2011, Planning Council instituted the Consumer AIDS Advocacy Panel as a sub-committee to PC in order to ensure peer participation as part of the planning body.
- The TGA has incorporated the CareWare Referral database in order to facilitate the referral process amongst Part A providers. A notable accomplishment for the TGA is the institution of CareWare in 2011. Prior to 2011, all providers submitted manual monthly reports. Provider data was then entered into CareWare by the grantee. Providers are now able to enter their data directly into the CareWare system allowing real time reporting of data and reducing the grantee's administrative burden in complying with RSR requirements.
- In 2010, issues related to Medical Transportation were brought up to the attention of the Planning Council. PC held a series of Town Hall meetings to discuss the issues and potential solutions to remedy this barrier to getting PLWHA to their medical appointments. As a result of these discussions, PC decided to develop a Medical Transportation Service policy. The TGA now provides gas cards and/or bus passes to and from medical appointments. This transportation support is managed by RW directly to better administer resources. In addition, PC worked with the local regional transit system (RTA) to get clients signed up for senior/disability passes at a lower cost per bus ride.

GOAL # 2: REDUCE OR ELIMINATE DISPARITIES

Objective A. Reduce Out of Care levels for Special Populations in TGA by 2-5%
Activity 2.A.1. Evaluate all core services for care entry
Activity 2.A.2 Continuously assess demographic profile of Part A clients to ensure special populations access care in timely manner

Objective B. Address underlying Mental Health & Substance Abuse Issues
Activity 2.B.1. Identify and implement models to address co- morbidities
Activity 2.B.2. Engage partners to address inpatient and outpatient substance abuse treatment modalities towards the implementation of best practices.

Objective C. Reduce further spread of HIV infection
Activity 2.C.1. Ensure provider risk assessment/reduction
Activity 2.C.2. Co-Convene annual joint HIV prevention and care providers meeting
Activity 2.C.3. Determine best practices in integration of secondary HIV prevention, care and services

GOAL #2: SUCCESSES/CHALLENGES

- Quarterly Provider meetings with Prevention, EIS, and Outreach ensure focused efforts to special populations and innovative strategies for the unaware/out of care populations. Process and best practices have been identified and are continuously evaluated.
- The ADAMHS Board is a funded provider for Mental Health/Substance Abuse for Cuyahoga County. Provider agencies outside of the Board's network can also become Part A providers. This expands the TGA's ability to provide services.
- On an annual basis, the Planning Council reviews and analyzes demographic profile/State City Epi data in order to ensure that services and funding categories are properly aligned.
- Quality measures have been established for testing, treatment and prevention at primary care settings. This is also monitored through the quality provider audits for both Medical Case Management and Ambulatory Outpatient Medical Care to ensure its done at least annually.
- In 2011, the PC approved the TGA's standards for AOMC, Oral Health, Medical Case Management, Mental Health, Early Intervention Services and Substance Abuse (Residential and Outpatient). The PC Quality Improvement committee is continuing to develop standards for all funded service categories.

GOAL # 3: CONTINUALLY IMPROVE THE QUALITY OF SERVICES PROVIDED IN THE CONTINUUM OF CARE

Objective A. Refine expectations of service delivery
Activity 3.A.1. Update Standards of Care for each service
Activity 3.A.2. Outline process of care in system-wide Standards

Objective B. Intensively support Medical Case Management
Activity 3.B.1. Conduct assessment of MCM provider capacity and capability to convert to medical model
Activity 3.B.2. Integrate MCM with PMC and core services

GOAL #3: SUCCESSES/CHALLENGES

- In 2011, the TGA began establishing/refining its Standards of Care. The process began with the development of standards for core services, this will be followed by supportive services until Standards have been established for all categories. Currently, seven Standards of Care have been established for AOMC, MCM, Oral Health, EIS, Mental Health, Substance Abuse (Residential and Outpatient)

- During the 2010 OHDAP crisis, the PC was able to pull together with providers and develop a temporary medication assistance program in order to fill the gap due to the state cuts. A mechanism was developed in order to assist any PLWHAs that were placed on the waiting list or deemed ineligible through Part B. The ability of the TGA to be responsive to such funding cuts ensured that individuals affected by these changes in the TGA did not face interruption to care.

- During the 2010 Part B funding crisis, Part A was able to step in to ensure that Medical Case Management positions were not impacted by cutbacks. In 2009, the TGA only funded 5.0 FTE's. At the end of 2011, 9.0 FTE positions were funded. Ensuring the capacity of MCMs ensures the continuous efforts to improve the quality of services of PLWHA throughout the TGA. In addition, all funded MCM providers with the exception of one are in facilities that also provide primary medical care.

GOAL # 4: IMPROVE COST-EFFECTIVE SERVICE DELIVERY AT CLIENT LEVEL

Objective A. Review service utilization data
Activity 4.A.1. Ensure Voice of Consumer in planning

Objective B. Coordinate all funding streams, especially Ryan White entities
Activity 4.B.1. Explore the use of standardized fee schedules (i.e. Medicaid Usual, Customary, Reasonable)
Activity 4.B.2. Integrate and standardize, to degree possible, funding methodology among Ryan White Parts

GOAL #4: SUCCESSES/CHALLENGES

- All funded providers throughout the TGA utilize Medicaid/Medicare rates for all reimbursable services. RW dollars are utilized as payor of last resort.

- It has been determined that the cost reimbursement structure across parts is the same but the standards of care differ. All parts have been discussing this issue and are committed to working together to ensure that services are not duplicated but complimentary.

- Ohio's Medicaid program has undergone significant changes due to state budget cuts. Overall, state Medicaid cuts for the current bi-annual budget is an estimated $1.4 billion. The Cleveland TGA encompasses the largest county in the state (Cuyahoga) along with largest state population (Northeast Ohio), therefore the majority of the funding cut burden. Locally, and specific to HIV services the Cleveland Department of Public Health (CDPH) received an $84,000 reduction from the Community Development Block Grants (CDBG) and $214,000 funding reduction from ODH both impacting the HIV prevention program. Specific concern for PLWHA related to the Ohio HIV Drug Assistance Program (OHDAP) occurred in June of 2010 that initially resulted in loss of eligibility for over 320 PLWHA, creating a waiting list and cuts to a program that served about 5,000 people in Ohio with HIV. OHDAP has been able to restructure the program through changing the income eligibility criteria from 500% FPL to 300%, reducing other Part B supportive services, and realizing revenue from pharmaceutical rebate programs.

GOAL # 5: IMPROVE EFFECTIVENESS OF CONTINUUM OF CARE & SERVICES

Objective A. Inform & Educate Consumers of Resources
Activity 5.A.1. Ensure Voice of Consumer in planning
Activity 5.A.2. Revise and distribute Resource Directory for Providers.

Activity 5.A.3. Refine Resource Directory in Electronic Offering at Cuyahoga County website and provide both disc and book formats to providers Populations
Activity 5.A.4. Use 211-line for resource and referral

Objective B. Evaluate core & support service models
Activity 5.B.1. Explore expanding Primary Medical Capacity with Weekend hours (defray use of local EDs, allow for continuous, HIV-specific care)
Activity 5.B.2. Focus on chronic issues related to support services (i.e. Housing, Home Delivered Meals) and conduct meetings to determine means to integrate service provision with 'outer ring' or mainstream service providers.
Activity 5.B.3. Focus on issues regarding fully spending of needed services (i.e. Mental Health, Drug/Alcohol) at the root of many secondary HIV prevention and co-morbidities.

GOAL #5: SUCCESSES/CHALLENGES

- Consumer participation is core of all planning components for the TGA. Consumers contribute greatly to all PC functions. Such functions include determining need assessment study focus, priority setting, resource allocation, standards of care, comprehensive plan, etc. Monthly trainings take place at each PC meeting to ensure that consumers are well informed of their role in PC as well as have a good understanding of the RW legislation.

- The Consumer AIDS Advisory Panel (CAAP) works diligently to ensure the promotion of the TGA its providers and services. CAAP works in unison with the Membership and Outreach sub-committee to ensure marketing and outreach activities throughout the jurisdiction. The resource guide is printed annually and is also available electronically with regular updates. Currently, a Spanish version of the resource guide is being developed to be issued electronically.

- An assessment was made to determine if the patient population needed evening and weekend hours. Needs Assessment data demonstrated that the majority of in-care clients do not work therefore prefer traditional business hours for their medical appointments. Hours in which services are delivered are appropriate for our client population, however this can be re-visited at any time if deemed necessary.

- In 2010 a series of town hall meetings were held to discuss transportation to medical appointments. This provided an opportunity to examine available resource and best strategies to address need related to this service. A transportation policy was developed as a result of these meetings. In 2011 focus has been placed on housing services and resources available. The TGA is currently working with the local HOPWA Grantee, service providers and consumers to best align this category and establish a Standard of Care.

GOAL # 6: COORDINATE PLANNING EFFORTS

Objective A. Coordinate Care & Service Planning
Activity 6.A.1. Conduct Joint Needs Assessment with other Ryan White Entities
Activity 6.A.2. Consolidate Part B Consortium Planning Activities with Part A in Cleveland TGA

Objective B. Coordinate Funding Sustainability Planning
Activity 6.B.1 Engage in Educational Activities with Stakeholders, PC members and broader community
Activity 6.B.2 Update and Clarify Issues Regarding Systems Mechanisms and the Reauthorization Process

GOAL #6. SUCCESSES/CHALLENGES

- The Planning Council for the TGA ensures more than one third consumer participation and promotes consumers taking on leadership roles. All PC sub-committees have at least one consumer co-chair. Consumers are an integral part of all responsibilities and activities carried out by the planning body.

- Monthly training sessions are held at each PC meeting to ensure knowledge of the RW legislations, address systems mechanism and provides up to date information on the reauthorization process, particularly with the upcoming health care reform legislation.

- The TGA played a significant role in the Ohio statewide needs assessment and SCSN planning process. Data gathered through the studies conducting in the TGA were utilized in the planning.

- In 2010 the Part B Consortium was discontinued as part of the funding cuts and ODAP crisis

- The Planning Council oversees the an annual assessment of administrative mechanism. Results of the assessment is discussed as well as way to remedy any areas needing improvement. These efforts are led by the Strategy & Finance sub-committee.

- The RW administrative team has successfully made modifications to the RFP process. RFP's are now issued in early fall,

with proposals due in November prior to the March program year start. Having the RFP and proposal in so early on, allows the administrative team to have an idea on the number of providers, services and dollar amount being requested in response to the RFP. They are then able to conduct site visits and have meaningful discussions with providers on their proposed services for the upcoming year. Having the proposals submitted and site visits conducted early on allows for decreased time of the contract process once funds are received by the grantee. In addition, starting in 2011, the RFP is for a two-year with a condensed proposal submission the second year. This reduces the administrative burden of both the grantee and providers, reduces the duplication of information yet allow for appropriate modifications in programming and budget from year to year.

- Ongoing challenges for the TGA is related to the timing in which funding are awarded from HRSA. In 2010 the jurisdiction received two partial awards throughout the program year. In 2011, funds were awarded six months after the program year began. In 2011, the EIIHA-EIS category was added. Because of the funding delay, this gave little to no opportunity for these services to be effectively developed and implemented. When funds are not fully issued at the beginning of the program year, contracts are delayed, amendments throughout the year are common and reallocations happen with more frequency creating an administrative burden coupled with the impact to service delivery

II. WHERE DO WE NEED TO GO?

A. PLAN TO MEET CHALLENGES IDENTIFIED IN THE EVALUATION OF THE 2009 COMPREHENSIVE PLAN

Challenge: Delayed funding awarded in FY2011
Response: Due to such funding delay the EIS category had a late start in the program year. FY2012 funding has been issued in whole at the beginning of the year. This will ensure a timely execution of contracts and full implementation of services.

Challenge: Part B OHADAP Funding Crisis
Response: The TGA was responsive in addressing the gaps in services caused by the state funding cuts and were successfully able to ensure a mechanism for all PLWHA's within the TGA to have no interruption to care as a result. While Part B currently has a zero waiting list, updates are provided on a monthly basis at PC meetings in order to stay abreast of any changes that may impact our jurisdiction.

B. 2012 PROPOSED CARE GOALS: 2012-2015 WORK PLAN

GOAL 1: ASSURE ACCESS TO THE CONTINUUM OF HIV/AIDS CARE IN THE CLEVELAND TGA THROUGH COORDINATION OF MEDICAL CARE AND SUPPORT SERVICES BY STRENGTHENING LINKAGES BETWEEN SERVICES, PROVIDERS AND THROUGH THE IDENTIFICATION OF EMERGING POPULATIONS.

OBJECTIVES	ACTION STEPS	EVALUATION METHOD	RESPONSIBLE PARTY
1A. Ensure a priority-based allocation for each program year to address the service needs of people living with HIV and AIDS.	1A(1). Conduct annual priority setting and allocate resources accordingly.	PRSA	PC-Strategy & Finance
	1A(2) Monitor services utilization against priority ranking.	Monthly utilization reports Grantee	PC-Strategy & Finance
1B. Ensure availability of resource guide of client-based services.	1B(1). Update resource guide on annual basis.	Resource Guide (electronic & hard copy)	PC-Membership & Outreach
	1B(2). Distribute and monitor usage of resource guide.	Distribution log, PC Website traffic monitoring (analytics)	PC-Membership & Outreach
1C. Structure services and track referrals within the continuum of care to systematically address HIV prevention, medical care, substance abuse and support needs among people living with HIV/AIDS.	1C(1). Implement referral link in Careware.	CareWare Database	Grantee
	1C(2). Implement continuing education plan for Contracted Providers.	Training agenda/sign-in sheets	Grantee
1D. Strengthen the continuum of care from prevention to care and treatment through increased coordination and collaboration between prevention and Ryan White planning bodies and agencies.	1D(1). Conduct quarterly EIS/Prevention Meetings.	Meeting agenda/ minutes	Grantee, PC-QIC
	1D(2). Maintain links to prevention and other HIV service programs through cross-membership on committees.	CareWare data, PC reflectiveness	Grantee, PC-Membership & Outreach
1E. Support provision of services, through continual education and technical assistance.	1E(1). Conduct an assessment of sub grantee technical assistance needs.	Monitoring tools	Grantee, QIC, Grantee
	1E(2). Follow up and evaluate technical assistance support provided to contracted providers.	TA/Training log	Grantee
	1E(3). Survey educational needs of PC.	Survey data	PC- CAAP

GOAL 2: ENSURE HEALTH CARE MAINTENANCE AND TREATMENT ADHERENCE OF THOSE ALREADY IN THE CARE SYSTEM BY REDUCING BARRIERS.			
OBJECTIVES	**ACTION STEPS**	**EVALUATION METHOD**	**RESPONSIBLE PARTIES**
2A. Increase the number of people living with HIV/AIDS that are engaged in primary medical services at the end of year three.	2A(1). Strengthen EIS and Outreach provider programs.	QI Monitoring	PC-QIC
	2A(2). Ensure that EIS individuals are successfully linked to medical case managers in less than 12 months from entering care.	CareWare QI Monitoring	Grantee PC-QIC Contracted Providers
2B. Increase the number of clients with HIV infection who had two or more CD4 T/viral load counts performed.	2B(1). Increase the number of newly diagnosed entering AOMC within 3 months of their initial diagnosis.	CareWare QI Monitoring	Grantee PC-QIC Contracted Providers
2C. Increase the number of clients with treatment-adherence counseling.	2C(1). Ensure the provision of treatment adherence counseling by AOMC and MCM providers.	CareWare QI Monitoring	Grantee PC-QIC Contracted Providers
2D. Ensure clients have access to community programs providing support services to maintain healthcare engagement.	2D(1). Focus on core funded services with note of disparities in service utilization to ensure health care engagement throughout safety net services.	CareWare referrals/ case notes	Grantee PC-QIC Contracted Providers
GOAL 3: ASSESS AND ADDRESS THE UNMET NEEDS OF SPECIAL POPULATIONS BECOMING INFECTED WITH HIV AND PEOPLE LIVING WITH HIV WHO ARE NOT CURRENTLY IN CARE.			
OBJECTIVES	**ACTION STEPS**	**EVALUATION METHOD**	**RESPONSIBLE PARTY**
3A. Increase linkages with point-of entry agencies to identify, refer and engage out-of-care people living with HIV.	3A(1). Collaborate with prevention and testing providers to ensure immediate linkage to AOMC of newly diagnosed individuals.	Annual QI Site Visits	Grantee Contracted Providers (EIS/MCM)
	3A(2). Utilize EIS staff to ensure initial linkages to care and supportive services.	Directory M&O Committee activities	QIC Contracted Providers (EIS/MCM)
	3A(3). Promote RW services through the services directory and other outreach efforts.	Directory M&O Committee activities	PC- Membership & Outreach Committee
3B. Increase the number of special populations accessing primary medical services and having medical case management at the end of year three.	3B(1). Ensure collaboration between EIS and medical case management.	QI Monitoring	Grantee PC-QIC
	3B(2). Ensure that clients have at least two medical visits a year.	CareWare QI Monitoring	Grantee PC-QIC
	3B(3). Follow up with clients that have been out of care for six months.	CareWare QI Monitoring	Contracted Providers (Outreach)
	3B(4). Establish a patient retention plan for the TGA.	Retetion Plan	Grantee PC-QIC

GOAL 4: REDUCE DISPARITIES IN CARE, ACCESS AND SERVICES AMONG EMERGING SUB-POPULATIONS AND HISTORICALLY UNDERSERVED COMMUNITIES.			
OBJECTIVES	**ACTION STEPS**	**MEASURE**	**RESPONSIBLE PARTIES**
4A. Assess disparities in care among historically underserved groups and emerging sub-populations.	4A(1). Re-evaluate special needs groups on an annual basis.	PSRA Process Needs Assessments TGA Epi profile	CareWare/GIS overlay Grantee PC-Strategy & Finance
	4A(2). Utilize GIS to target outreach and EIS activities in disperse communities.	CareWare/GIS overlap	Grantee
4B. Ensure that resources allocated address the needs assessed in terms of service gaps and historically underserved groups.	4B(1). Utilize local needs assessment data to determine gaps in care.	Needs Assessment Data	Grantee PC-Strategy & Finance Committee PC-Quality Improvement Committee
	4B(2). Conduct the annual PSRA process and ensure it addresses the identified gaps.	PSRA allocations/ process	Grantee PC-Strategy & Finance
	4B(3). Focus efforts on awareness of services, locations hours.	RFP Service Directory	Grantee PC-Membership & Outreach
	4B(4). Ensure cultural competency of service providers by providing training opportunities.	Training log	Grantee
4C. Identify potential service providers to overcome geographical disparities in care.	4C(1). Recruit potential providers that have the capabilities and expertise addressing gaps in care.	CareWare QI Monitoring	Grantee Contracted Providers Medical Case Managers EIS/Outreach Coordinators

GOAL 5: GUARANTEE QUALITY OF HIV HEALTH SERVICES BY GATHERING APPROPRIATE DATA, MONITORING CONSISTENTLY WITH STANDARDS AND GUIDELINES FOR THE HIV MEDICAL CARE AND SUPPORT SERVICES THROUGH ONGOING QUALITY IMPROVEMENT INITIATIVES.			
OBJECTIVES	**ACTION STEPS**	**EVALUATION METHOD**	**RESPONSIBLE PARTIES**
5A. Develop and implement Standards of Care for services categories according to the most recent information about medical care, treatment and support services.	5A(1). Gather and analyze program data in the development and refinement of standards of care for each funded category.	Standards of Care Monitoring tools	Grantee PC-QIC
	5A(2). Conduct key informant interviews with other grantees through research on best practices.	Research notes	Grantee PC-QIC
	5A(3). Engage PC and community partners in development of Standards through pod session and provider feedback sessions.	POD agenda/sign-in Provider feedback notes	Grantee PC-QIC
5B. Ensure compliance with established measurable outcomes for Part A funded service categories.	5B(1). Implement effective monitoring process for quality, program and fiscal.	Monitoring tools Assessment of Administrative Mechanism	Grantee PC-Strategy & Finance
5C. Review quality improvement plan and establish QI initiatives.	5C(1). Develops QI plan for the TGA outlining specific annual initiatives.	TGA-wide QI Plan	Grantee PC-QIC
	5C(2). Ensure that contracted providers have a QI plan for evaluation of the program.	Provider QI Plans QI Monitoring	PC-QIC

C. GOALS REGARDING INDIVIDUALS AWARE OF THEIR HIV STATUS, BUT ARE NOT IN CARE (UNMET NEED)

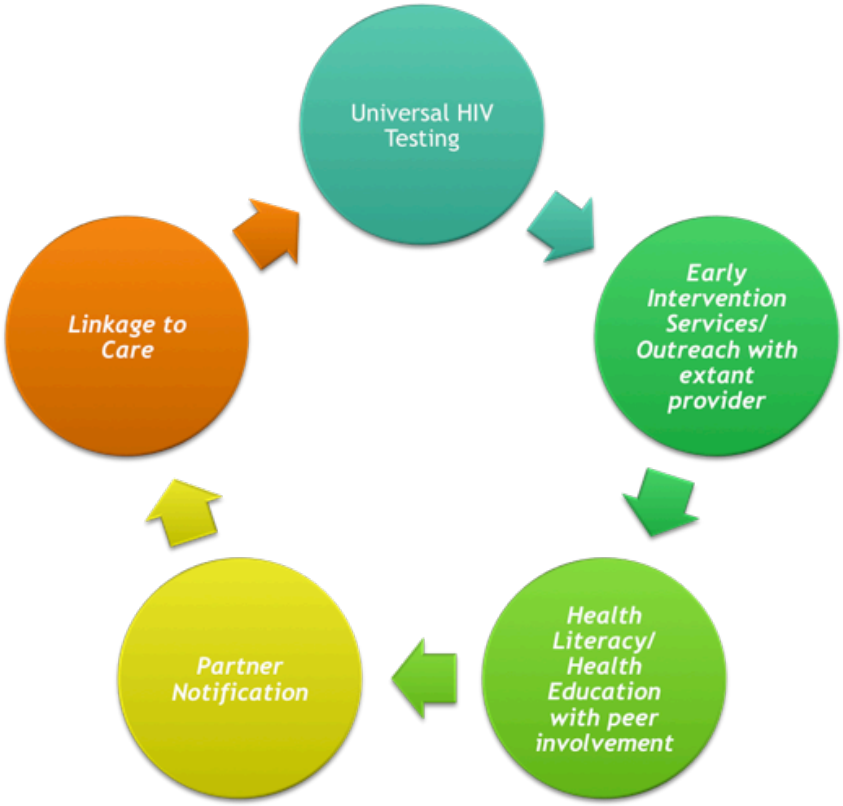
The Cross Part Collaborative (Part A, B, C providers) ensures coordinated efforts through referrals of positive individuals to medical care, medical case management and supportive services. All services providers have access to the Part A Resource Directory in order to facilitate the linkage and referral process throughout the region into services. DIS staff is aware of services provided through the HIV/AIDS care network, as they are often one of the fist points of contact to newly diagnosed clients. DIS is able to easily provide detailed information on providers and the care system as a whole.

Linking individuals recently informed of their HIV positive status to medical includes partnerships with Local Partners and Hospitals, Ryan White Part A and C, RW providers, Counseling & Testing Centers, Substance Abuse Treatment and Mental Health Centers, Prevention Services, and Planning Council. Specific activities that the TGA has set include the following:

- EIS Counselors work with Medical Case Managers at high positivity Counseling and Testing sites to assist in Informing Newly Diagnosed, referring and linking to Primary Care and EIS workers to provide HIV education component
- Referrals are made by linkage specialist (EIS staff) that works closely with CDC funded testing in Emergency Department setting
- The provision of medical transportation assistance
- Linkage agreements with key points of entry (FQHC, ERs, Ex-offenders programs, teen clinics and Planned Parenthood)
- Linkage agreements with SA and MH facilities
- Enhanced CAREWare Referral Activities that allow improved electronic tracking, linkage and reporting documentation
- Referrals from Rural county health departments to TGA's Ryan White Continuum of Care

D. GOALS REGARDING INDIVIDUALS UNAWARE OF THEIR HIV STATUS (EIIHA)

The strategy to identify and attach unaware individuals to care involves the following five primary mechanisms:



1. UNIVERSAL HIV TESTING

NHAS Goal: Reducing New HIV Infections; Expand targeted efforts to prevent HIV infection using a combination of effective, evidence-based approaches.

TGA Goal: Increase the number of individuals who are aware of their HIV status. Ohio law changed in 2010 allowing medical providers to provide routine HIV testing universally within their system as recommended by the CDC. Ohio went from an Opt In to an Opt Out testing methodology. This change has not been widely adopted so education is needed to help medical providers adopt policies and procedures to conduct universal testing with an opt-out clause. Inclusion of HIV screening as part of chronic health screening panel for new patients, annual screenings, and testing on a more frequent basis if clients present with known risk (HCV, known active substance use, Sexually Transmitted Infections). The Grantee will promote universal testing in the TGA's four Part A funded primary care clinics. The Cleveland TGA proposes two models of HIV testing to identify individuals who are unaware of their HIV status. This first is to provide Early Intervention Services with the expansion of universal HIV testing, per CDC recommendations. This model will focus on supporting the major medical systems throughout the TGA to integrate HIV testing into their standard panel of tests. Medical systems may have concerns about the need for extended post test and ongoing counseling/support for patients when they identify a new HIV infection, so they may be reluctant to offer universal testing. The grantee has supported local efforts to formalize this model within the major public county run hospital. The grantee funds an ID physician to facilitate the inclusion of HIV testing with the Epic EMR so that providers are prompted to provide the test. Early feedback has shown that testing has increased because the prompt becomes a QA/QI issue for the providers. The county- run hospital already established a client navigation program (COMPASS) that fulfills the needs of the newly diagnosed, although this program will need to be expanded to address capacity as HIV testing goes to scale throughout the system. The second model is to

have RW Part A staff, providers, and the Planning Council's consumer subcommittee members participate in community based HIV testing efforts. Participation in targeted testing "fairs" and in community events and health fairs will utilize the TGA's geo-coding of PLWHA based on Needs Assessment responses. The providers will participate in large, free public HIV testing events so that unaware individuals can receive Early Intervention Services at diagnosis. These events target youth and other populations that are not otherwise seeking HIV testing. Ryan White staff and Planning Council consumer members will provide information to participants to encourage testing as well as linkage to service providers. This was very successful in FY2011 with consumers set up at tables next to the testing area with brochures and service directories. EIS providers will also work closely with Partner Counseling and Referral Services (PCRS) programming to ensure effective referral and support. Referral and support for linkage between testing/diagnosis and care is a critical opportunity to engage clients. In FY2010, more than 25,000 tests were conducted in the TGA with 97% of those tested referred to at least one core medical or support service. The TGA's COMPASS program is an excellent model for linking newly diagnosed to care and has shown that 86% of clients are engaged in primary care after 12 months of diagnosis. The statistic drops slightly to 84% after two years of diagnosis.

2. EARLY INTERVENTION SERVICES/OUTREACH WITH EXTANT PROVIDER

NHAS Goal: Reducing HIV-Related Health Disparities; Improve access to prevention and care services for all Americans.

TGA Goal: Increase the number of HIV positive individuals who are in medical care.
Provide EIS and outreach services through the significant network of homeless service providers, public housing estates, and communities with healthcare inequality through the region's major medical systems and local Federally Qualified Health Centers. The purpose of this network is to conduct extensive outreach with HIV testing among the homeless, underinsured, isolated public housing residents and in the local jail among incarcerated individuals to increase awareness of HIV status. Currently, RW Part A funds an EIS provider that works with inmates within 90 days of discharge from the County jail. This provider works with inmates to provide: 1) testing (not funded by Part A), 2) health literacy/ education (for both unaware but high risk and HIV positive individuals) 3) referral to services for both HIV negative but high risk and HIV positive individuals) and 4) linkage to outpatient/ambulatory medical care, HIV medication access and treatment adherence to the rigorous regimens required for PLWHA. All but two of the Early Intervention Services/Outreach providers are Ambulatory/Outpatient Medical Care providers through Part A. One of the remaining providers is a local public health agency serving the TGA's eastern region covering all the rural areas.

3. HEALTH LITERACY/HEALTH EDUCATION WITH PEER INVOLVEMENT

NHAS Goal: Reducing New HIV Infections; educate all Americans about the threat of HIV and how to prevent it.

TGA Goal: Increase the number of HIV negative individuals referred to services that contribute to keeping them HIV negative. EIS providers conduct community level health education campaigns to raise awareness about the continued presence and impact of HIV in the community and to stem secondary transmission of the virus. Providers will involve peers in outreach, educating individuals about HIV and living with HIV as well as navigating the system of care, and coaching support. Opportunities for testing will be incorporated into these campaigns to ensure individuals not aware of their status can become aware of their status and link to care if HIV positive.

4. PARTNER NOTIFICATION

NHAS Goal: Reducing New HIV infections; achieving a more coordinated national response to the HIV epidemic.

TGA Goal: Increase the number of individuals who are aware of their HIV status.
HIV is a reportable communicable disease in Ohio, so all medical providers (hospitals, blood banks, for-profit labs, etc.) are required to report new infections to the local health district (LHD) and the Ohio Department of Health (ODH). Medical providers are responsive to their need to report cases, however there is limited support from the providers to encourage the newly diagnosed to cooperate with the LHD's disease intervention specialists (DIS) and to encourage patients to share their sexual partner's contact information with DIS. A complicating factor in partner notification is the anonymity of sexual partners via the Internet. Through regular quarterly meetings with prevention, testing, and care providers the local DIS staff have the opportunity to reinforce the vital need for Partner Counseling and Referral Service (PCRS) and allow identification of known individuals at risk. In CY2010, the DIS unit assisted 97 newly diagnosed individuals to get linked to care. In addition, 57 partners were notified and tested. Of the partners notified, two additional individuals tested positive for HIV. With continued communication through quarterly meetings, the Cleveland TGA is confident that the providers will access DIS to be more successful in FY2011 and on. It is important to note that the co-chair of the Planning Council is the Director of the Local Health Department responsible for PCRS. She is a vocal advocate for expansion of PCRS to enhance linkage to treatment and care.

5. LINKAGE TO CARE

NHAS Goal: Increasing Access to Care and Improving Health Outcomes for People Living with HIV; establish a seamless system to immediately link people to continuous and coordinated quality care when they learn they are infected with HIV.

TGA Goal: Increase the number of HIV positive individuals who are in medical care.
All RW Part A providers will 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 not alone in the navigating the system of care. In FY2010, there were 110 newly diagnosed HIV positive individuals. Of those, 108 were successfully linked to care at several medical facilities including all of the Ryan White Part A Outpatient/Ambulatory Medical Care providers.

E. PROPOSED SOLUTIONS FOR CLOSING GAPS IN CARE

In order to ensure effective solutions to close gaps in care, the TGA will concentrate efforts in the following activities:

1. Annual needs assessments and/or sub-studies on services and/or special populations to identify barriers to care. Such data will drive setting priorities and the allocation of services.
2. Focus efforts on ensuring that PLWHA (newly diagnosed and in care) are aware of the continuum of services, locations, hours of operation and eligibility /benefits provided throughout the TGA.
3. Ensure a mental health assessment, to include a depression screening, as part of initial assessment for recently diagnosed and return to care individuals.

F. PROPOSED SOLUTIONS FOR ADDRESSING OVERLAPS IN CARE

The TGA has established extensive collaboration with all HIV/AIDS services funders and providers. This prevents the overlap and/or duplication of services between programs and providers. Methods by which this collaboration occurs include the following:

1. Planning Council membership is representative of the following community partners: City of Cleveland HIV Services (CDC Prevention and HOPWA), Part B and C, Regional Advisory Group, Housing Advisory group (PAHA), case medical management network and local foundations.
2. Close collaboration with both Part C local providers to ensure that services are complimentary.
3. Close collaboration with HIV Prevention and DIS to ensure that services are complimentary.

G. COORDINATED EFFORTS TO ENSURE OPTIMAL ACCESS TO CARE

Part B Services, including the AIDS Drug Assistance Program (ADAP) - The Grantee has contracts with four providers that are also funded through Part B. Part B funds Medical Case Managers in the Cleveland TGA. Part A and B staff met to discuss the specific agencies that each would fund and ensured there was no duplication. The clients are assigned to specific medical case managers so there is a clear distinction of clients served by each part. In addition, the Part B provider, Ohio Department of Health, funds many of the testing, prevention and medical case management functions at community based organizations within the Cleveland TGA.

Data collection and sharing will occur in several ways—through quarterly provider meetings to share Outreach, Testing, Counseling (Health Literary/Education), Referral and Linkage data; through databases used by the selected EIS provider, Medical Case Managers and Outpatient/Ambulatory Medical care providers; through linkage reports from Medical Case Managers reporting follow-up of referred PLWHA to care; and through review of Viral Load reporting by the Ohio Department of Health and their laboratory databases.

A CAREWare coordination project among all Ryan White Parts in the State of Ohio is in the implementation stage this year with expectations to be in full production for FY2012. Information will be shared in one CAREWare system administered by the

State. All Ryan White grantees will share information into this system and the State will compile aggregate reporting as well as customized reporting for all grantees. In addition, a representative from the Part B office is a member of the Planning Council and provides updates at each meeting. The participation of Part B in Planning Council is instrumental in the collaboration between parts.

Part C Services - Both Ryan White Part C providers in the Cleveland TGA also receive Part A funding for Early Intervention and Outreach services. In addition, both providers are medical facilities that provide core services including primary medical care. Part C providers are able to make clear distinctions of clients served by the nature of the target populations for the Part C funding. One provider works with locally incarcerated individuals and clearly identified how and when a client would be served by Part C and when they could be linked to Part A services. In the same way, the Part C resources marry with the Part A funding at the second provider. The provider uses Part C to assist insured patients meet their co-pays and deductibles and Part A for uninsured patients. This method helps to ensure low-income individuals receive the care they need without feeling the financial burden that otherwise may prevent them from seeking continued care.

Part D Services - Services are provided statewide throughout Ohio to women and children, however there are currently no Part D providers throughout the TGA.

Part F Services - Currently there are no Part F funded services throughout the TGA.

- **Providers (Non-Ryan White Funded, including private providers) -** The TGA is currently identifying private providers throughout the six-county area in order to expand current services being provided, particularly in rural areas. Sole providers as well as services that are being under utilized despite the unmet need of such services are also placing attention on services categories that are currently being provided.

Prevention Programs including; Partner Notification Initiatives and Prevention with Positives Initiatives – The City of Cleveland serves as the grantee for the prevention funding through the Cleveland Department of Public Health, Office of HIV/AIDS Services. The HIV Prevention services are delivered throughout 11 community service providers providing testing and counseling services. Data collection and sharing will occur in the same ways as outlined in coordination efforts with Ryan White Part B –through quarterly meetings to share Outreach, Testing, Counseling (Health Literary/Education), Referral and Linkage data; through databases used by the selected EIS provider, Medical Case Managers and Outpatient/Ambulatory Medical care providers; through linkage reports from Medical Case Managers reporting follow-up of referred PLWHA to care; and through review of Viral Load reporting by the Ohio Department of Health and their laboratory databases. Prevention/intervention providers complete de-identified ODH Opscan forms with State for planning and resource allocation purposes. This information will be shared with the providers in the TGA to assist with coordination.

Cuyahoga County has a very effective Disease Intervention Program. Once a person has been diagnosed with HIV or an STD, a report of the positive individual is generated by the testing provider and submitted to the Disease Intervention Specialist (DIS) office via fax or mail from the testing agency to the DIS. The report is then entered into ODRS (Ohio Disease Reporting System). A record is created for a DIS to follow the client for partner services. DIS follow up occurs within 24-48 hours of the record creation. During the DIS client interview, discussions related to sexual partners, and appropriate follow up with those partners takes place. DIS then notifies partners that have been exposed and encourage them to get tested. Client is linked into medical care (medical evaluation to include initial T-Cell count, viral load, STD, and condition compromising the immune system of that individual). Referrals to supportive services are also entered into the ODRS. Patient tracking is kept whether the patient kept their appointment and if they prescribed Anti-retro viral medications.

- **Substance Abuse Treatment Programs/Facilities -** The Cleveland TGA has substance abuse and mental health treatment providers that receive federal, state and local dollars. However, funding for both substance abuse and mental health services were significantly cut in the recent state budget. Cuyahoga County's tax levy provides local funding to substance abuse and mental health treatment systems. In addition, Part A funds are used to contract with the Alcohol and Drug Abuse Mental Health Services Board (ADAMHS), ensuring treatment services available at over fifty certified treatment providers. In turn, the Board reimburses sub-contracted providers for services provided to non-Medicaid clients with HIV/AIDS.

- **STD Programs -** The City of Cleveland serves as the grantee for HIV & STD prevention dollars through the Cleveland Department of Public Health, Office of HIV/AIDS Services. The HIV Prevention services are delivered throughout 11 community service providers providing testing and counseling services. In addition 4.0 FTE Disease Intervention Specialists are responsible for following up on new HIV/STD diagnosed individuals and partner notification services. CDPH is responsible for the prevention and control of STDs throughout the Cuyahoga County region. The program supports and improves the ability of public health departments to (1) design, implement, and evaluate Comprehensive STD Prevention Systems (CSPS); (2) carry out the Syphilis Elimination Effort (SEE) program in designated high morbidity areas (HMAs) by enhancing activities to prevent, control and eliminate syphilis; and (3) implement the Gonoccocal Isolate Surveillance Project (GISP) in eligible jurisdictions.

- **Medicare -** All contracted providers that are also contracted to provide services under Medicare. Providers are required to verify the consumer's HIV/AIDS status, insurance status, and eligibility for any third party billing/reimbursement. As part of the intake process, each provider is expected to complete an intake form for each eligible Part A consumer in order to receive reimbursement for services provided. The anonymous intake form addresses third party reimbursements and verifies that Part A is payer of last resort.

- **Medicaid -** All contracted providers that are also contracted to provide services under Medicaid; with the exception of the Free Medical Clinic of Greater Cleveland, which has a Medicaid waiver per HRSA. Same as with Medicare, providers are required to verify the consumer's HIV/AIDS status, insurance status, and eligibility for any third party billing/reimbursement. As part of the intake process, each provider is expected to complete an intake form for each eligible Part A consumer in order to receive reimbursement for services provided. The anonymous intake form addresses third party reimbursements and verifies that Part A is payer of last resort.

- **Children's Health Insurance Program -** The Ohio expanded Medicaid program, called Healthy Start, covers pregnant women and children who live at or below 200% of the federal poverty level. Healthy Start, in conjunction with coverage for children under SCHIP has resulted in virtually no children without health insurance in the TGA. Comprehensive primary care is provided through these health insurance programs, so that the small number of HIV+ children in the TGA does not rely on Part A for primary medical care and medication assistance.

- **Community Health Centers (CHC)** - There are three community health centers in Cuyahoga County of which one is a contracted provider of Part A, and also receives Part C. There is one additional CHC in Lorain County. As safety net providers, CHC's play a key role in the early identification of PLWHA. Efforts for collaboration are ongoing to ensure coordination in care.

III. HOW WILL WE GET THERE?

A. STRATEGY TO CLOSE GAPS IN CARE

GOAL 4	ADDRESS AND REDUCE DISPARITIES IN CARE, ACCESS AND SERVICES AMONG EMERGING SUB-POPULATIONS AND HISTORICALLY UNDERSERVED COMMUNITIES SO PEOPLE LIVING WITH HIV RECEIVE APPROPRIATE MEDICAL CARE AND SOCIAL SUPPORT SERVICES.		
OBJECTIVES	**ACTIVITIES**	**RESPONSIBLE PARTY**	**EVALUATION METHOD**
4B. Ensure that resources allocated address the needs assessed in terms of service gaps and historically underserved groups	4B(1). Utilize local needs assessment data to determine gaps in care 4B(2). Conduct the annual PSRA process and ensure it addresses the identified gaps 4B(3). Focus efforts on awareness of services, locations hours 4B(4). Ensure cultural competency of service providers by providing training opportunities	Grantee PC-Strategy & Finance Committee PC-Quality Improvement Committee	Needs Assessment PSRA process
4C. Identify potential service providers to overcome geographical disparities in care.	4C(1). Recruit potential providers that have the capabilities and expertise addressing gaps in care	Grantee Contracted Providers Medical Case Managers EIS/Outreach Coordinators	CareWare QI Monitoring

The most recent Cleveland TGA Out of Care needs assessment process was utilized to identify service gaps among this group of PLWHA. Improved linkages between supportive and primary care services will be carried out by the implementation of the following efforts:

1.) Medical Case Managers and other support staff will implement routine follow-up strategies to inquire about and encourage entry/re-entry into primary medical care for 'erratically' in care.
2.) Medical Case Managers will ensure that the necessary supportive services are provided to stabilize the person's life situation (i.e., stable housing, food, transportation) and then help ensure that these services are extended to facilitate entry into and retention in care, as indicated, especially for those PLWHA assessed as 'fragilely' in care.
3.) Expansion of Spanish speaking Medical Case Managers and Primary Care Providers and/or interpreters in settings where substantial numbers of non-English speaking PLWHA receive services
4.) Perform a cultural awareness/sensitivity assessment with all RW funded providers and offer trainings to ensure cultural competency and age-appropriate delivery of services among funded providers.
5.) Strengthen mental health and substance abuse treatment and primary medical care linkages; consider co-location of these services wherever possible and ensure ongoing on-site support for PLWHA with mental health and substance abuse co-morbidities
6.) Co-locate, to the extent possible, HIV PMC and other primary medical and specialty care services.
7.) Strengthen peer outreach to ensure engagement/retention linkages with the most underserved and most likely to disengage.

The TGA's needs assessment data was used during the 2012 Priority Setting and Resource Allocation process to help determine service priorities and appropriate allocations in order to reduce the TGA's unaware population by 12.5%. Utilizing the CDC's Estimated Back Calculation methodology, the TGA's Unaware population is 1157. The Planning Council's FY '12 goal of 12.5% reduction of Unaware PLWHA exceeds the National HIV/AIDS Strategy: By 2015, increase from 79% to 90% the percentage of people living with HIV who know their serostatus.

B. STRATEGY TO ADDRESS THE NEEDS OF INDIVIDUALS AWARE OF THEIR HIV STATUS, BUT ARE NOT IN CARE

Persons who are aware of their HIV+ status but remain Out Of Care (OOC) in the Cleveland TGA are 1) newly diagnosed; 2) those who have been in care at some point, but have not accessed HIV care in at least the past twelve months or 3) those who have never been in care. OOC persons are likely to be significantly more fragile, with higher rates of co-morbidities, homelessness and isolation—by virtue of residing in rural areas, lacking transportation, or being undocumented citizens.

Through the most recent needs assessment conducted in the TGA with the aware/out of care, the following were ranked as major service needs for the out of care population: nutrition/food assistance, mental health/sportive services, and outpatient/ambulatory medical care tied with housing assistance and medical transportation. The following reasons were cited for being out of care: high cost, do not live in Cleveland, rural area, not enough time given by doctor, stigma and economy. Goal #3 of this plan outlines the TGA's strategy in addressing the needs/barriers to care of aware/out of care PLWHA.

GOAL 3	ASSESS AND ADDRESS THE UNMET NEEDS OF SPECIAL POPULATIONS BECOMING INFECTED WITH HIV AND PEOPLE LIVING WITH HIV WHO ARE NOT CURRENTLY IN CARE.		
OBJECTIVES	**ACTIVITIES**	**RESPONSIBLE PARTY**	**EVALUATION METHOD**
3A. Increase linkages with point-of entry agencies to identify, referral and enter out- of-care people living with HIV	3A(1). Collaborate with prevention and testing providers to ensure immediate linkage to AOMC of newly diagnosed individuals 3A(2). Utilize EIS staff to ensure initial linkages to care and supportive services 3A(3). Promote RW services through the services directory and other outreach efforts	Grantee PC- Membership & Outreach Committee Contracted Providers (EIS/MCM)	CareWare QI Monitoring
3B. Increase the number of special populations accessing primary medical services and having medical case management at the end of year three.	3B(1). Ensure collaboration between EIS and medical case management 3B(2). Ensure that clients have at least to medical visits a year 3B(3). Follow up with clients that have been out of care for six months 3B(4). Establish a patient retention plan for the TGA	Grantee Contracted Providers AOMC/Medical Case Managers EIS/Outreach Coordinators	CareWare QI Monitoring

C. STRATEGY TO ADDRESS THE NEEDS OF INDIVIDUALS UNAWARE OF THEIR HIV STATUS

The TGA's needs assessment data is used during the Priority Setting and Resource Allocation (PRSA) process to help determine service priorities and appropriate allocations in order to reduce the TGA's unaware population by 12.5%. Utilizing the CDC's Estimated Back Calculation methodology, the 2011 TGA's Unaware population is 1157. The Planning Council's FY '12 goal of 12.5% reduction of Unaware PLWHA exceeds the National HIV/AIDS Strategy: By 2015, increase from 79% to 90% the percentage of people living with HIV who know their serostatus. Estimations of unaware individuals for the TGA will be established for subsequent years through the PSRA process.

GOAL 3	ASSESS AND ADDRESS THE UNMET NEEDS OF SPECIAL POPULATIONS BECOMING INFECTED WITH HIV AND PEOPLE LIVING WITH HIV WHO ARE NOT CURRENTLY IN CARE.		
OBJECTIVES	**ACTIVITIES**	**RESPONSIBLE PARTY**	**EVALUATION METHOD**
3A. Increase linkages with point of entry agencies to identify, referral and enter out- of-care people living with HIV	3A(1). Collaborate with prevention and testing providers to ensure immediate linkage to AOMC of newly diagnosed individuals 3A(2). Continue efforts with AOMC providers on institution 'opt out' testing procedures 3A(3). Promote RW services through the services directory and other outreach efforts	Grantee PC- Membership & Outreach Committee PC-Quality Improvement Committee Contracted Providers (EIS/ MCM)	CareWare QI Monitoring

D. STRATEGY FOR ADDRESSING THE NEEDS OF SPECIAL POPULATIONS

All of the Unaware populations targeted by the EIIHA strategy are historically underserved and/or have disparity issues and are the populations that continue to be newly diagnosed in disproportionate percentages. African Americans make up 54% of the TGA's unaware population and have the highest percentage of males between 13 and 19 and 45+ that are unaware. Men who have sex with men (MSM) account for 47% of the unaware population and have high incidence between ages 13 and 19 and 45+. In addition, they have a higher incidence of substance abuse. Hispanics share the high incidence of substance abuse as well as a higher share of incidence of heterosexual men and women with the HIV virus. Specific strategies to address the barriers as well as targeted outreach and early intervention strategies are designed to attract these subpopulations to minimize the disparities in access. Six populations have been identified with special needs in the Cleveland TGA. They include: 1) MSMs; 2) African Americans; 3) Hispanics; 4) Minority Women; 5) IDUs and; 6) 45+. The grantee's cost and utilization data was used to develop baseline-estimated costs for delivering care to each group.

GOAL 4	ADDRESS AND REDUCE DISPARITIES IN CARE, ACCESS AND SERVICES AMONG EMERGING SUB-POPULATIONS AND HISTORICALLY UNDERSERVED COMMUNITIES SO PEOPLE LIVING WITH HIV RECEIVE APPROPRIATE MEDICAL CARE AND SOCIAL SUPPORT SERVICES.		
OBJECTIVES	**ACTIVITIES**	**RESPONSIBLE PARTY**	**EVALUATION METHOD**
4A. Address disparities in care particularly among historically underserved groups.	4A(1). Re-evaluate special needs groups on an annual basis 4A(2). Utilize GIS to target outreach and EIS activities in disperse communities	Grantee Planning Council	PSRA Process Needs Assessments
4B. Ensure that resources allocated address the needs assessed in terms of service gaps and historically underserved groups	4B(1). Conduct the annual PSRA process and ensure it addresses the identified gaps 4B(2). Utilize local needs assessment data to determine gaps in care 4B(3). Focus efforts on awareness of services and locations hours 4B(4). Ensure cultural competency of service providers by providing training opportunities	Grantee Planning Council Grantee PC-Membership & Outreach Committee	PSRA Process Needs Assessments PSRA Process Assessment of Administrative Mechanism Training Log Services Directory

E. COORDINATED EFFORTS TO ENSURE OPTIMAL ACCESS TO CARE PROPOSED

As noted in Section II G of this plan, the Cleveland TGA has established coordination with Ryan White B and C, private providers, local prevention and partner notification programs, mental health and substance abuse programs, Medicare/Medicaid, SCHIP, community health centers and other safety net providers and social services programs. Please refer to Section II G of this plan of details on specific efforts

F. HEALTHY PEOPLE 2020 HIV OBJECTIVES

HEALTHY PEOPLE 2020 OBJECTIVES AND RELATION TO 2012-2015 COMPREHENSIVE PLAN

HEALTHY PEOPLE 2012 OBJECTIVES	CLEVELAND TGA GOALS
HIV-2 Reduce new (incident) HIV infections among adolescents and adults HIV-11 Increase the proportion of persons surviving more than 3 years after a diagnosis with AIDS HIV-13 Increase the proportion of persons living with HIV who know their serostatus	Assure access to the continuum of HIV/AIDS Care through coordination of medical care and support services; strengthen linkages between services providers and identification of emerging populations
HIV-9 Increase the proportion of new HIV infections diagnosed before progression to AIDS	Ensure health care maintenance and treatment adherence of those already in the care system reducing barriers and promoting the best utilization of all available resources
HIV-10 Increase the proportion of HIV-infected adolescents and adults who receive HIV care and treatment consistent with current standards	Assess and address the unmet needs of special populations becoming infected with HIV and people living with HIV who are not currently in care
HIV-13 Increase the proportion of persons living with HIV who know their serostatus	Address and reduce disparities in care, access and services among emerging sub-populations and historically underserved communities so people living with HIV receive appropriate medical care and social support services
HIV-10 Increase the proportion of HIV-infected adolescents and adults who receive HIV care and treatment consistent with current standards	Guarantee quality of HIV health services by gathering appropriate data, monitoring consistency with standards and guidelines for the HIV medical care and support services through the promotion quality improvement initiatives

Source: Healthy People 2020 http://www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicId=22

G. STATEWIDE COORDINATED STATEMENT OF NEED (SCSN)

This plan was developed alongside the Ohio Statewide Coordinated Statement of Need, with input from the Cuyahoga Regional TGA Part A Planning Council and staff. Data from needs assessments and special studies conducted by the TGA was heavily utilized in gaining insight into unmet need within our jurisdiction and contributed to the development of the SCSN goals. The 2012 SCSN goals are as follows:

OHIO STATEWIDE COORDINATED STATEMENT OF NEED 2012 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 RW Programs through scenario-based planning
Goal 2: Increase sustainability of services while maintaining and improving excellent client care

ACCESS TO CARE

Goal 3: Improve system literacy
Goal 4: Address through delivery of care the aging concerns across the spectrum for both youth/transitional youth and older PLWHA
Goal 5: Continue to address stigma and its impact on testing, access to care, and outcomes of care.

COLLABORATION AND SERVICE COORDINATION

Goal 6: Link consumer advisory group to Part B Advisory Board and formalize communication with consumers.
Goal 7: Ensure access to all core services by integrating systems and services into a cohesive model that seeks to enroll and keep clients in care.

DATA

Goal 8: Analyze and publish data deposited into the All Parts Database
Goal 9: Focus on the quality of HIV care using clinical quality measures and data reports as quality tools.
Goal 10: Examine technology as an overarching influence on service delivery.

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 prevention and care to get at-risk persons tested, connected to care, and retained in care.

H. AFFORDABLE CARE ACT

The TGA and its Planning Council is keeping them in the forefront of the ACA development, as it becomes a reality through implementation in 2014. Strategic partnerships are currently underway specifically related to expanding the number of contractor providers throughout the six-county area. Contracted providers are already Medicaid providers, therefore able to support additional individuals that may become eligible as a result of the ACA.

I. NATIONAL HIV/AIDS STRATEGY (NHAS)

The goals and workplan outlined for the TGA address all of the National HIV/AIDS Strategies and are engrained in every aspect of the services rendered through RW services. Below are the 2012-2015 goals for the TGA along with its respective NHAS:

2012-2015 Goal #1 - Assure access to the continuum of HIV/AIDS Care through coordination of medical care and support services; strengthen linkages between services providers and identification of emerging populations. NHAS: Increase the number of newly diagnosed entering AOMC within.

2012-2015 Goal #2 - Ensure health care maintenance and treatment adherence of those already in the care system reducing barriers and promoting the best utilization of all available resources. NHAS: Increase the proportion of Ryan White HIV/AIDS Program clients who are in continuous care.

2012-2015 Goal #3 - Assess and address the unmet needs of special populations becoming infected with HIV and people living with HIV who are not currently in care. NHAS: Increase access to care and optimizing health outcomes for people living with HIV.

2012-2015 Goal #4 - Address and reduce disparities in care, access and services among emerging sub-populations and historically underserved communities so people living with HIV receive appropriate medical care and social support services. NHAS: Reduce HIV-related health disparities.

2012-2015 Goal #5 - Guarantee quality of HIV health services by gathering appropriate data, monitoring consistency with standards and guidelines for the HIV medical care and support services through the promotion quality improvement initiatives. NHAS: Increase the proportion of Ryan White HIV/AIDS Program clients who are in continuous care.

J. UNANTICIPATED CHANGES IN THE CONTINUUM OF CARE AS A RESULT OF BUDGET CUTS

The TGA is not anticipating any state or local budget cuts. However, the staff and Planning Council are committed to being responsive of the needs of PLWHA and will be responsive in the event that unprecedented cuts occur.

IV. HOW WILL WE MONITOR PROGRESS?

A. PLAN TO MONITOR AND EVALUATE PROGRESS

The plan to monitor and evaluate the five (5) goals, sixteen (16) objectives, and 35 action steps involves coordinated efforts during each program and fiscal year by the responsible parties/entities over the established work plan related to the 2012-2015 Comprehensive Plan for the Cleveland TGA. The grantee and Planning Council will ensure the monitoring and evaluation of the plan. The PC sub-committees will monitor the progress towards goals as it relates to the sub-committees functions. Such activities are listed in the Planning Council Activities Timeline (PCAT) and is updated annually.

B. EARLY IDENTIFICATION OF INDIVIDUALS WITH HIV/AIDS (EIIHA) INITIATIVE

The Strategy & Finance committee on a monthly basis to ensure proper implementation of this new category as well as utilization will closely monitor the EIS Service Category utilization. Such review will be incorporated in the 2013 Priority Setting and Resource Allocation (PSRA) process and subsequent years as the services prove to be effective in achieving EIIHA objectives.

C. TIMELINE FOR IMPLEMENTING THE MONITORING AND EVALUATION PROCESS

OBJECTIVES/ACTIVITIES	TIMETABLE			RESPONSIBLE PARTY
	2012	2013	2014	
GOAL #1				
1A. Ensure a priority-based allocation for each program year to address the service needs of people living with HIV and AIDS.	•	•	•	Planning Council
1B. Ensure availability of resource guide of client-based services.	•	•	•	Grantee/ PC
1C. Structure services and track referrals within the continuum of care to systematically address HIV prevention, medical care, substance abuse and support needs among people living with HIV/AIDS.	•	•	•	Grantee/Contracted Providers
1D. Strengthen the continuum of care from prevention to care and treatment through increased coordination and collaboration between prevention and Ryan White planning bodies and agencies.	•	•	•	Grantee/Planning Council/ Contracted Providers
1E Support provision of services, through continual education and technical assistance.	•	•	•	Grantee/QIC
GOAL #2				
2A. Increase the number of people living with HIV/AIDS that are engaged in primary medical services at the end-of year-three.	•	•	•	Grantee/ Contracted Providers
2B. Increase the number of clients with HIV infection who had two or more CD4 T cell counts performed.	•	•	•	Grantee/ Contracted Providers
2C. Increase the number of clients with treatment-adherence counseling.	•	•	•	Grantee/ Contracted Providers
2D. Ensure clients have access to community programs providing support services to maintain healthcare engagement.	•	•	•	Grantee/Providers/PC

OBJECTIVES/ACTIVITIES	TIMETABLE			RESPONSIBLE PARTY
	2012	2013	2014	
GOAL #3				
3A. Increase linkages with point of entry agencies to identify, referral and enter out- of-care people living with HIV	•	•	•	Grantee/Providers/PC
3B. Increase the number of special populations accessing primary medical services and having medical case management at the end-of year-three	•	•	•	Grantee/Contracted Providers
GOAL #4				
4A. Address disparities in care particularly among historically underserved groups and emerging sub-populations	•	•	•	Grantee/PC
4B. Ensure that resources allocated address the needs assessed in terms of service gaps and historically underserved groups	•	•	•	Grantee/PC
4C. Identify potential service providers to overcome geographical disparities in care	•	•	•	Grantee/PC
GOAL #5				
5A. Develop and implement Standards of Care for services categories according to the most recent information about medical care, treatment and support services	•	•	•	Grantee/PC (QIC)
5B. Ensure compliance with established measurable outcomes for Part A funded service categories	•	•	•	Grantee/Contracted Providers
5C. Review quality improvement plan and establish QI initiatives	•	•	•	Grantee/PC (QIC)

D. MONITORING AND EVALUATION PLAN

A. IMPROVED USE OF RYAN WHITE CLIENT LEVEL DATA

With the implementation of CAREWare in 2011, the Grantee will utilize the performance module as a source of client-level data collection. This enables the grantee to have the capability to collect the required HAB measures as well as new changes such as possible NQC measures. The Cleveland TGA is improving its overall ability to collect client-level data through the CAREWare reporting system. This system collects all of the client-level data required by HRSA/HAB, including all the Performance Measures recommended by HRSA. This includes the following client-level data: HIV Status, AIDS Status, Viral Load, CD4 Count, whether the client is on ARVs and core medical and support services. Through the use of internal processes built into the software, providers are able to, with the client's permission, share information on the client's health and service status. This improves our ability to provide the best care possible to our clients.

B. USE OF DATA IN MONITORING SERVICE UTILIZATION

CAREWare data is currently used to monitor service utilization. This data, in addition to being used for annual Priority Setting and Resource Allocation (PSRA), will be analyzed to determine variances in service utilization among special populations. Attention will be focused on core-funded services, with further analysis of trends or reasons why special populations vary from all PLWH in service use.

C. MEASUREMENT OF CLINICAL OUTCOMES

The Cleveland TGA has implemented a comprehensive Clinical Quality Management (CQM) Program whose purpose is to enhance quality of care for Ryan White Part A recipients by achieving goals utilizing all HAB quality management standards. The Clinical Quality Management (CQM) program enables the Part A grantee and Planning Council to monitor fiscal performance, program standard compliance, quality of clinical care and health outcomes of care interventions for Part A funded services. The mission of the CQM program is to provide information to the Planning Council for use in the Priority Setting and Resource Allocation (PSRA) process and to the Part A grantee to use in improvement methods for quality and availability of services. This information assists in further refining processes for administering the grant at the programmatic level. The goal of the Cleveland TGA's CQM program is to assist in the development and maintenance of a comprehensive continuum of accessible HIV/AIDS related care that: 1) consistently meets and exceeds minimum Public Health Standards and 2) strives to meet the best practices on behalf of all PLWHA across service disciplines and providers.

OUTPATIENT AND AMBULATORY HEALTH SERVICES

OUTCOME	INDICATOR	DATA COLLECTION METHOD
Reduced rate of clients with progression to AIDS in the measurement year	90% of clients have had 2 or more CD4 T-Cell counts performed at least 3 months apart during the measurement year	Chart Abstraction & Internal Database
Reduced rate of opportunistic infection in the measurement year	90% of clients will be prescribed ART if CD4 falls below 350	Chart Abstraction & Internal Database
Reduced rate of HIV-related emergency room visits in the measurement year	90% of clients have two or more medical visits at least 3 months apart in the measurement year	Chart Abstraction & Internal Database
Reduction in the rate of cervical cancer in the female HIV-infected population	100% of women with HIV infection have a Pap screening in the measurement year	Chart Abstraction & Internal Database

Indicators are measured during clinical chart reviews using a sampling methodology that corresponds with the suggested sizes given through the National Monitoring Standards technical assistance webinar: 100% of 50 clients or less, 25-50% of 51-100 clients, 10% of 101-999 clients, and/or 3-5% of 1000+ clients. Unique client IDs are randomly selected prior to the site visit and generated using the data collection system. The QI committee reviews outcome measures from annual quality management audits to determine what technical assistance can be provided to improve health outcomes.