

2009 Ohio Statewide Coordinated Statement of Need

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

HIV/ AIDS Services
Planning Document

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I. Introduction

The first Ohio Statewide Coordinated Statement of Need (SCSN) document, developed in 1997, concentrated on methods to assess the needs of people living with HIV/AIDS (PLWHA) in Ohio. Quality Management staff from the Ohio Department of Health HIV Care Services Section (ODH/HCS) conducted research on nine archived needs assessments and found unreliable data and very little consistency. Through a series of planning meetings, the developers of the SCSN concluded that Ryan White Part B (formerly referred to as Title II) Consortia needed to conduct consistent annual needs assessments specific to their areas. In 2000, the updated SCSN focused primarily on the needs of Part B programs through an overview of the subsequent needs assessments provided by Consortia bodies across the state. Although the Consortia represent consumer interests statewide, the needs of other Ryan White Parts (formerly Titles) in Ohio were not significantly represented in the 2000 SCSN document, so the planning body concluded that the inclusion of other Ryan White Parts should be the goal for the 2003 SCSN document. The subsequent 2003 SCSN then expanded to examine the various issues across all Ryan White Parts in Ohio. The 2006 SCSN further updated and built upon the findings of the 2003 SCSN by including the needs of non-Ryan White-funded agencies serving PLWHA in Ohio.

II. Process for Updating Ohio's SCSN

During the last two years, the Ohio All Parts Group has made progress in convening with increased regularity. One of the primary projects of this group is to refine data collection and data sharing across all the parts in order to more accurately estimate unmet need in Ohio. During the 2009 revision of the SCSN it was determined that, in order to make the development of the SCSN a more collaborative process and to produce a document that would be responsive and useful to all of the Ryan White grantees in the state, the All Parts Committee was more readily suited to initiate and process the SCSN. This represents a change from the planning process in previous years, where the data and information collected was obtained solely from participating members of the statewide Ryan White CARE Coordination Council (RWCCC). The 2006 SCSN was drafted by Part B and finalized with approval from the RWCCC. This method revealed an imbalance in collecting statewide data and a concomitant loss of comprehensive data from all Ryan White Parts. Utilizing the All Parts Group to initiate the development of the SCSN has added to the comprehensive approach and has provided a change in perspective which has helped to clarify the design, use and scope of the SCSN.

The Steering Committee of the All Parts Group was responsible for drafting the scope of the SCSN, including the goals and priorities. The entire Group then reviewed and revised the resulting draft. After the approval of the full group, the SCSN was sent to the members of the Ryan White CARE Coordination Council. At the fall meeting of the RWCCC in September, 2008, the Council membership had an opportunity to voice their opinions and subsequently adopted the draft. Minor revisions were completed before the final document was sent electronically to all participants. The final version was made accessible through the ODH/HCS web site.

The following people participated in the development of the 2009 SCSN –

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Bev Kreiner, Consortium 6 – Akron Area Representative
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Vacancy, Ohio Department of Insurance
Vacancy, Ohio Commission on Minority Health
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Laurie Rickert, Administrator of Community-Based Programs
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The intent of this 2009 edition of the SCSN is to continue building upon the findings of the 2006 SCSN that reflected the needs of Ryan White Programs and non-Ryan White Programs serving PLWHA in Ohio.

III. Epidemiologic Profile of HIV/AIDS in Ohio

Sociodemographic Characteristics of General Population

According to 2007 estimates from the US Census Bureau, Ohio is composed of 88 counties with a population of 11,466,917, of which it is estimated that 85% are white, 12% are black, 2% are Hispanic, and 1.6% are Asian/Pacific Islander. The majority (67%) of Ohio's population is 25 years of age or older and 83% of residents in that age group are high school graduates.

Statewide, many of Ohio's communities face high rates of poverty, creating competition for social services. Rates of poverty higher than the statewide average of 13.1%¹ can be found across the state, in both urban and rural areas. Several examples of this show up in the Bureau of the US Census data. Compared to other urban areas in 2007 (among places with 250,000 or more people), the city of Cleveland ranked second in the nation of places with the highest rates of poverty, with an estimated 29.5% of people living in poverty.² The city of Cincinnati ranked tenth with an estimated rate of 23.5% of people in poverty in 2007. Among places that have between 65,000 and 249,999 residents, Youngstown, Ohio, ranks ninth in the nation of places with the highest rates of poverty, with an estimated 32.6% of people in poverty.³ Thirty-two counties, located across northeastern to southeastern Ohio, are designated Appalachian counties, and these areas contain a greater proportion of persons with incomes that fall below the federally defined poverty level (FPL). Statewide as of 2007, 13.1%⁴ of the population is estimated to have incomes that fall below the FPL, but twenty-five Appalachian counties are estimated to have greater than 14% of persons living below FPL, and twenty-two of those counties are estimated to have greater than 15% of persons living below FPL.⁵

Scope of HIV/AIDS Epidemic & Emerging Trends

HIV/AIDS has affected a wide range of persons in Ohio, including all gender, age, and racial/ethnic groups, as well as income and education levels, throughout all geographic areas in the state. All of the data presented in this section was prepared by Health Management Associates, using the most recent data available from the Ohio Department of Health's HIV/AIDS Surveillance Program.

¹ US Census Bureau, www.census.gov, "Income, Earnings, and Poverty Data From the 2007 American Community Survey," Table 10: Number and Percentage of People in Poverty and Percentage of People by Ratio of Income-to-Poverty Level in the Past 12 Months by State: 2007.

² US Census Bureau, www.census.gov, "Income, Earnings, and Poverty Data From the 2007 American Community Survey," Table 11: Percentage in Poverty in the Past 12 Months for Ten of the Highest and Lowest Poverty-Rate Counties and Places With 250,000 or More People: 2007.

³ US Census Bureau, www.census.gov, "Income, Earnings, and Poverty Data From the 2007 American Community Survey," Table 12: Percentage in Poverty in the Past 12 Months for Ten of the Highest and Lowest Poverty-Rate Counties and Places With 65,000 to 249,999 People: 2007.

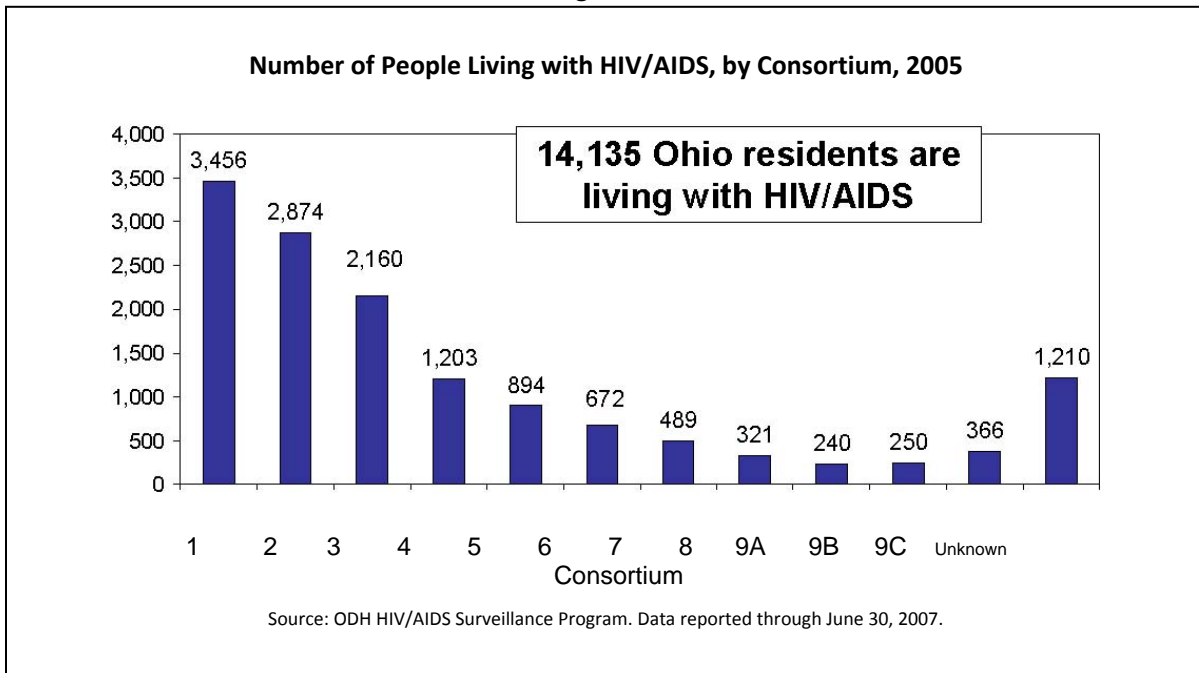
⁴ US Census Bureau, www.census.gov, "Income, Earnings, and Poverty Data From the 2007 American Community Survey," Table 10: Number and Percentage of People in Poverty and Percentage of People by Ratio of Income-to-Poverty Level in the Past 12 Months by State: 2007.

⁵ The most recent data available by county from the US Census Bureau are from 2007, "Small Area Income & Poverty Estimates for Ohio Counties." A table estimating all ages in poverty in 2007 is available in the state and county interactive tables at <http://www.census.gov/hhes/www/saipe/>.

People Living with HIV/AIDS

- Ohio is ranked as the 7th largest state by population and 16th largest in the reported number of people living with HIV/AIDS (PLWHA).⁶
- 14,135 Ohioans were living with HIV/AIDS as of December 2005, according to ODH surveillance data (Figure 1).
- A disproportionate share of PLWHA resides in two consortia – Cleveland (18% Ohio population vs. 24% PLWHA) and Columbus (14% Ohio population vs. 20% PLWHA).

Figure 1.



New AIDS Cases

- Ohio ranked 13th among states with the largest number of new AIDS cases reported in 2006.⁷
- 2,923 new cases of HIV/AIDS were diagnosed in Ohio from 2003-2005, according to ODH surveillance data.
- Nearly half of all new cases were diagnosed in two consortia, Cleveland (22%) and Columbus (27%).

Prevalence Rates of AIDS and HIV/AIDS

- Ohio ranked 30th among states with the highest AIDS cases per 100,000 population in 2006.⁸

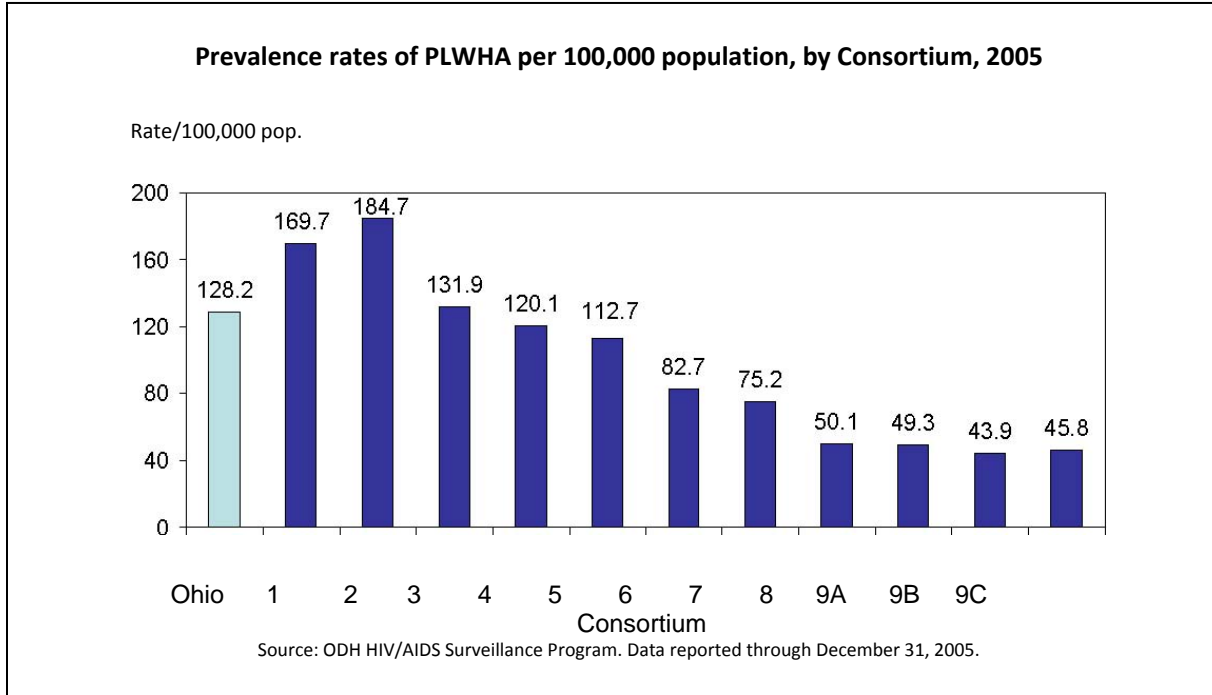
⁶ Kaiser Family Foundation statehealthfacts.org, "Reported number of AIDS cases, all ages, cumulative through 2006."

⁷ KFF statehealthfacts.org, "New AIDS cases, reported in 2006."

- The prevalence rate of PLWHA in Ohio was 128 per 100,000 population, as of December 2005, according to ODH surveillance data (Figure 2).

- Three consortia – Cleveland (170), Columbus (185), and Cincinnati (132) – have HIV/AIDS prevalence rates greater than the statewide rate.

Figure 2.



Characteristics of PLWHA by Gender, Age, and Race/Ethnicity

- Compared to the general population of Ohio, people recently diagnosed with HIV/AIDS and people living with HIV/AIDS are disproportionately male, and black (Table 4).

- People living with HIV are also disproportionately between ages 25 and 44 compared to the state’s general population, while people living with AIDS are disproportionately between ages 35 and 64 (Figure 3).

- The prevalence rate of HIV/AIDS among men (210 per 100,000 population) is four times greater than the rate among women (51) (Figure 4).

- The prevalence rate of HIV/AIDS is significantly higher among blacks (475) and Hispanics (313) compared to whites (77) and Asian/PI (39) (Figure 4).

⁸ KFF statehealthfacts.org, “AIDS case rate per 100,000 population, all ages, reported in 2006.”

Figure 3.

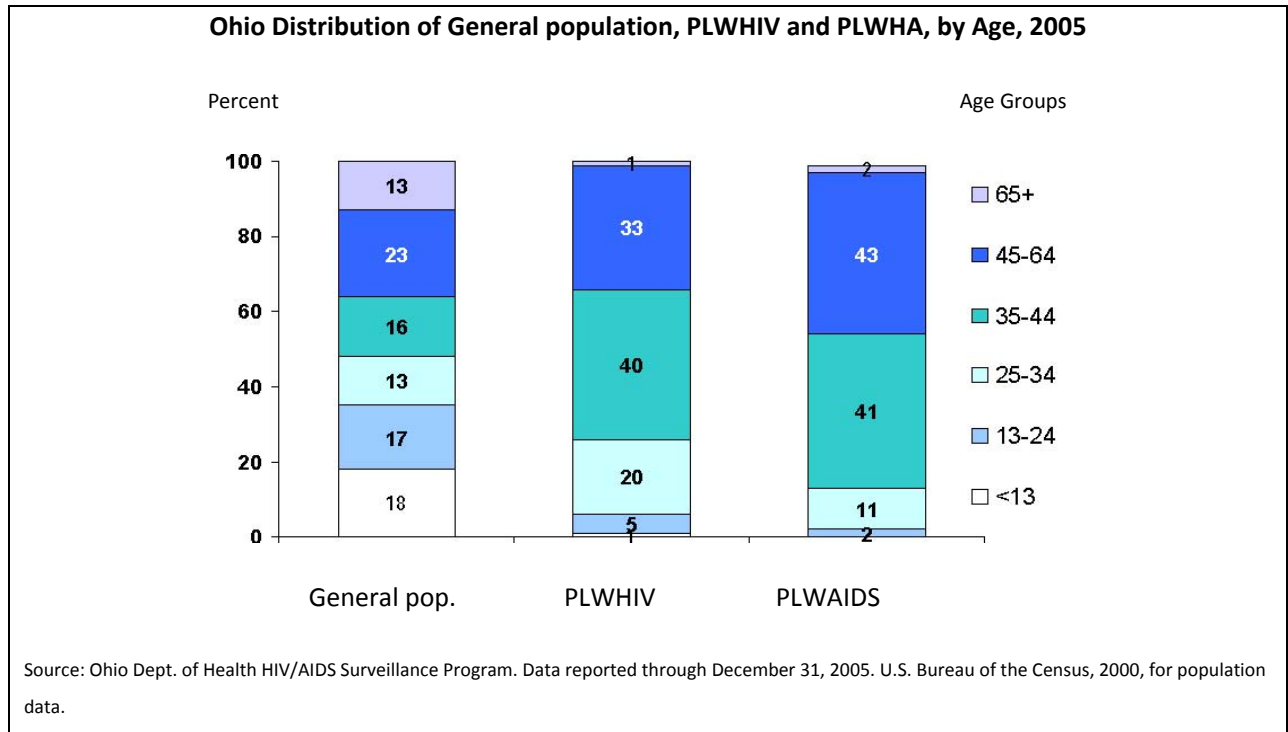
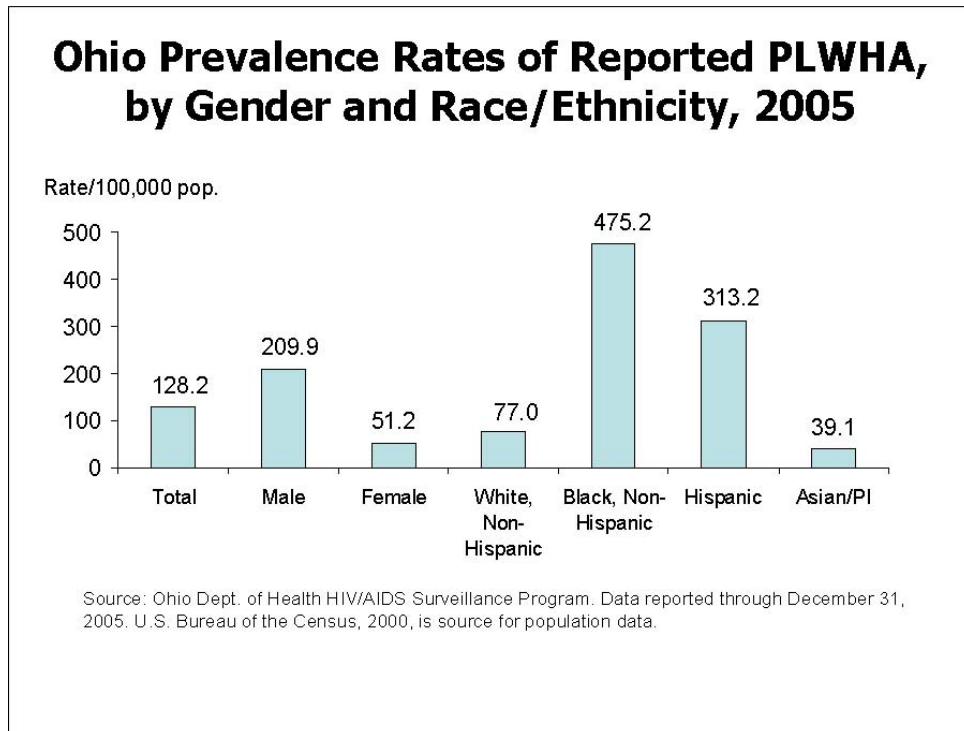


Figure 4.



Trends in HIV Infection

- Ohio’s five-year trend in HIV infection rates per 100,000 population was flat, overall, with a slight increase in rates for men and a slight decrease in rates for women (Figure 5).

- The five-year trend in HIV infection rates by age showed a slight increase in rates between 2001 and 2005 for ages 13-24 and 35+, and a slight decrease in infection rates for ages 25-34 (Figure 6).

Figure 5.

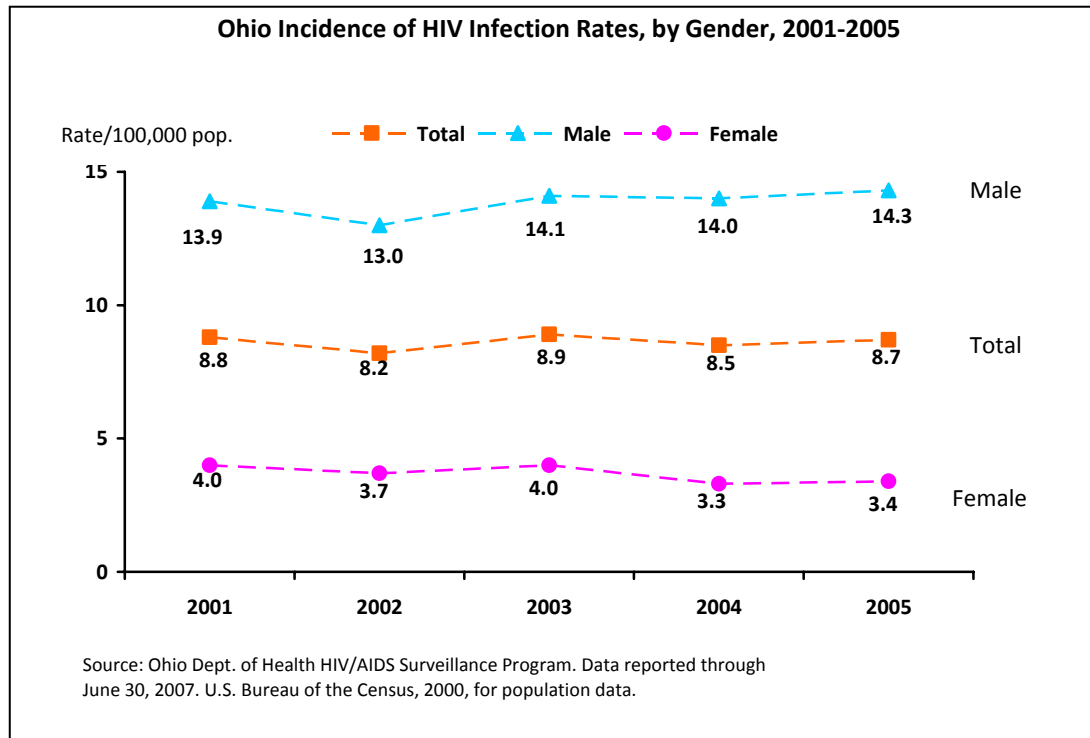
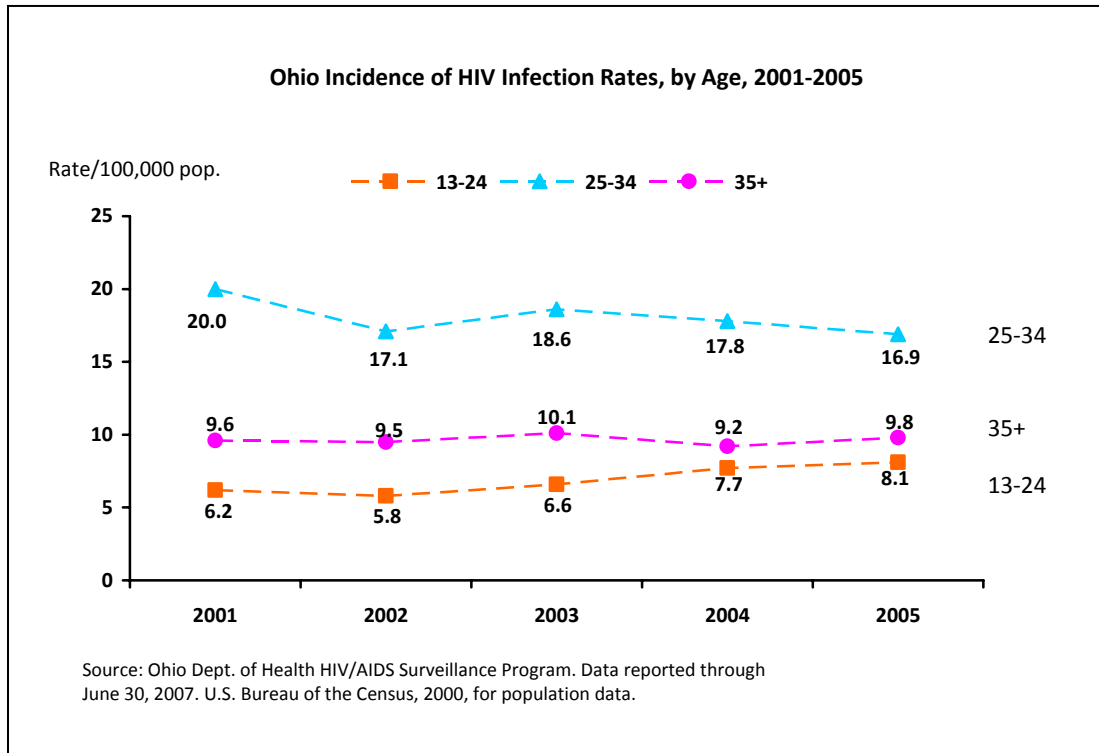


Figure 6.



Unmet Need for Primary Health Care⁹

- Based on HRSA criteria [and using 2002 data], 47% of Ohioans living with HIV/AIDS have an unmet need for primary health care¹⁰ (Figure 7). A greater percentage of people living with HIV (not AIDS) have unmet needs for primary health care (57%) than people living with AIDS (36%) (Table 1).

- The percentage of PLWHA with unmet primary health care needs ranges from a high of 61% in Youngstown to a low of 42% in Athens (Figure 7).

⁹ This section was prepared by HMA using the most recent Unmet Need report available (dated 2002). Revised estimates based on preliminary analyses will be discussed later in this document.

¹⁰ HRSA defines “unmet need” for primary health care for an individual with HIV or AIDS as no evidence of receiving one of the three components of HIV primary medical care during a defined 12-month timeframe: (1) viral load, (2) CD4 count, or (3) provision of anti-retroviral therapy.

Figure 7.

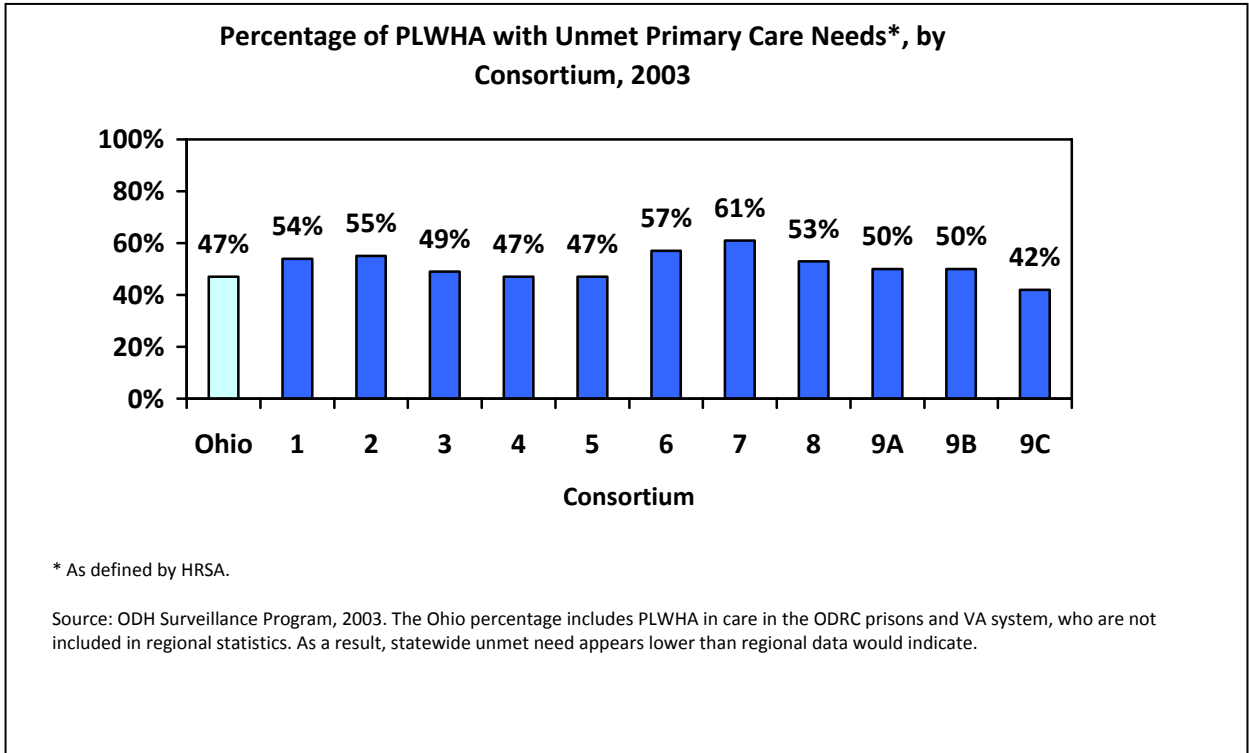


Table 1. Ohio Population and HIV/AIDS Epidemiological Profile

Area: Ohio	State Population 2000		Incidence				Prevalence					
			Reported HIV/AIDS Diagnosis 2003-2005				Reported Persons Living with HIV/AIDS as of December 31, 2005					
							Persons Living with HIV/AIDS			Current Disease Status		
										HIV (not AIDS)		AIDS
No.	%	No.	%	Rate	No.	%	No.	%	No.	%		
Gender												
Male	5,512,262	49%	2,294	78%	209.9	11,570	79%	5,694	77%	5,876	82%	
Female	5,840,878	51%	629	22%	51.2	2,989	21%	1,736	23%	1,253	18%	
Age												
<13	2,071,345	18%	14	0%	3.8	79	1%	45	1%	34	<1%	
13-24	1,873,538	17%	417	14%	27.8	521	4%	400	5%	121	2%	
25-34	1,519,894	13%	797	27%	150.2	2,283	16%	1,472	20%	811	11%	
35-44	1,805,316	16%	1,045	36%	325.9	5,884	40%	2,953	40%	2,931	41%	
45-64	2,575,290	23%	624	21%	214.9	5,534	38%	2,449	33%	3,085	43%	
65+	1,507,757	13%	26	1%	17.1	258	2%	111	1%	147	2%	

Table 1. (cont.) Ohio Population and HIV/AIDS Epidemiological Profile

Race/Ethnicity											
White, not Hispanic	9,621,819	85%	1409	48%	77.0	7,406	51%	3,706	50%	3,700	52%
Black, not Hispanic	1,339,820	12%	1351	46%	475.2	6,367	44%	3,350	45%	3,017	42%
Hispanic	217,123	2%	129	4%	313.2	680	5%	322	4%	358	5%
Asian/Pacific Islander	145,695	1%	18	1%	39.1	57	<1%	31	<1%	26	<1%
Am. Indian/AK Native	28,683	<1%	6	<1%	90.6	26	<1%	14	<1%	12	<1%
Unknown			10	<1%	*	23	<1%	7	<1%	16	<1%
Total	11,353,140	100	2,923	100%	128.2	14,559	100%	7,430	100%	7,129	100%
Unmet Need for Primary Health Care (CY 2002)						5,896	47%	3,687	57%	2,209	36%
Insurance Status											
Uninsured	11%										
Medicaid	17%										

Asterisk (*) indicates rates were not calculated for case counts <5, cases with unknown races ethnicity, cases with unknown gender.

Sources:

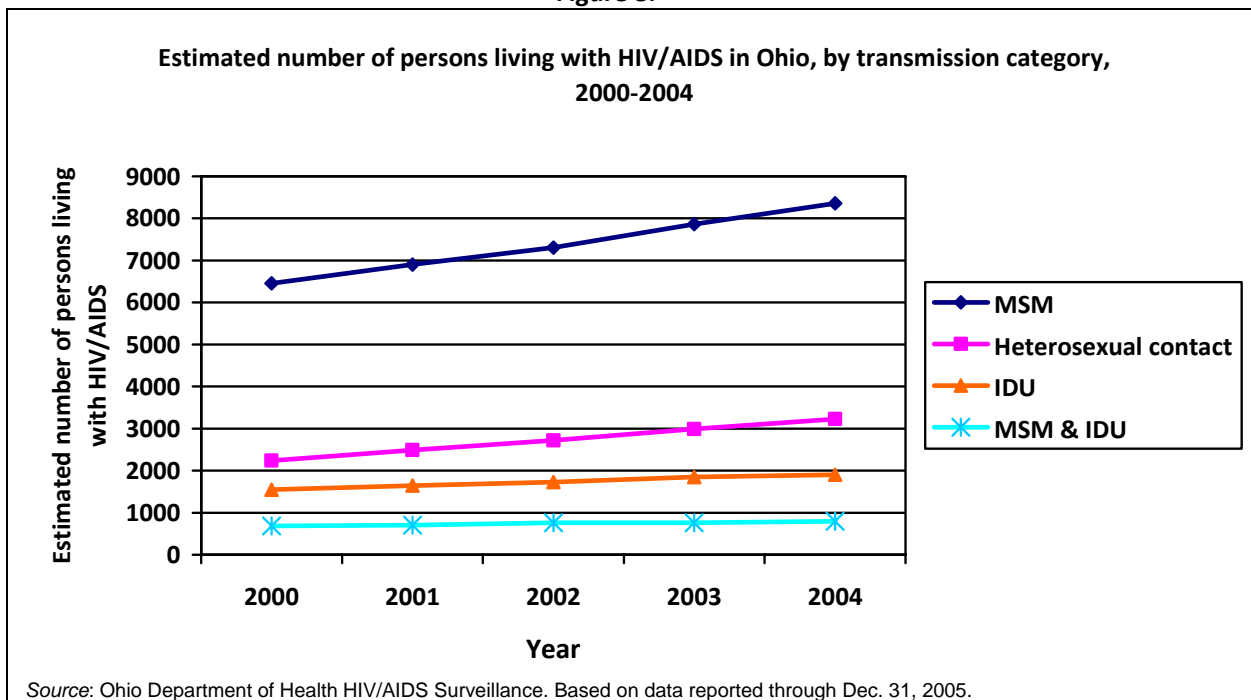
Ohio Department of Health HIV/AIDS Surveillance Program. Data reported through Dec. 31, 2005; Data reported through Dec 31, 2003 for unmet need.

Ohio Medicaid Report, Ohio Department of Job and Family Services. SFY 2003, January 2005 Update.

Ohio Family Health Survey, Ohio Departments of Job and Family Services, 2004; Census 2000, U.S. Bureau of the Census.

Ohio Department of Health's HIV/AIDS Surveillance epidemiological profile focuses on three modes of transmission: men having sex with men, injection drug use, and heterosexual contact. Male to male sex is the leading risk exposure for HIV among males in Ohio, followed by injection drug use and heterosexual contact (Figure 8). As a category, MSM and IDU accounts for the smallest percentage of diagnoses. Among females, heterosexual contact is the leading risk exposure, followed by injection drug use.

Figure 8.



IV. Findings from Needs Assessments and Other Related Documents

Needs Assessment

Part B contracted with Jim Werth, PhD, of the University of Akron to conduct a statewide survey assessing the needs of HIV-positive Ohioans. Dr. Werth and associates surveyed 1,090 PLWHA from across the state from May 2006 to April 2007. These data revealed the following needs of PLWHA, by category:

Core Services

Medical Services

- Reported Needs
 1. Lab work
 2. HIV-specific care
 3. Emergency care
 4. Other services, such as a regular check-up

- Reasons for not obtaining services
 1. Inability to afford care
 2. Other problems, such as concerns with providers
 3. No transportation
 4. Inability to find a provider

- Problems with providers
 1. Medical care provider was insensitive to needs or not culturally sensitive
 2. Fear of provider telling others about their HIV status
 3. Provider lacked knowledge about HIV/AIDS treatment
- Depression
 1. 40% had been told by a professional that they suffered from depression
 - a. 43% of European Americans were diagnosed with depression
 - b. 34% of African Americans had this diagnosis
 - c. 34% of all who indicated another race had this diagnosis

Medication

- Prevalence of prescribed medication for HIV/AIDS
 1. 66% of participants were taking medication
 2. 9.5% were not taking medication, though their doctors had recommended it
- Missing doses
 1. Over half reported missing at least one dose
 2. The most common reason for missing a dose was forgetting
- Payment
 1. Medicaid, Medicare, or Medicare Part D
 2. Ryan White programs such as the Ohio HIV Drug Assistance Program
- Reported Needs
 1. Way to pay for medications
 2. Other services, such as a way to pay for non-HIV/AIDS medications
 3. Assistance filling out applications for various medication assistance programs
 4. Transportation to pick up medication

Dental Services

- Reported needs
 1. Routine check-up or cleaning
 2. Cavities filled
 3. Extractions
 4. Other services, such as root canals
- Needs most difficult to obtain
 1. Check-up or cleaning
 2. Other services
 3. Extractions
 4. Cavities filled
- Reasons for not obtaining needs
 1. Not having the money to pay for dental services
 2. Concerns with the dental providers
 3. Inability to get appointments
 4. Lack of dentists in the areas in which participants live

Home Care Services

- Not applicable to majority and most who needed such services received them
- Needs most difficult to obtain
 1. Other services
 2. Help with errands
 3. Getting home health aide/homemaker services
 4. Home nursing care

Support Services

Transportation

- Reported needs
 1. Vouchers and tokens for public transportation (especially among African Americans)
 2. Car-related expenses.

Food Sources

- Reported needs
 1. Food vouchers or store certificates
 2. Public assistance
 3. Food banks or pantries
- Foods that were most difficult to obtain
 1. Meat
 2. Fresh fruits and vegetables

Social Support

- Sources
 1. Other people/groups/activities, such as religious and non-religious faith beliefs
 2. Professional providers
 3. Helping others or volunteering
 4. Healing weekends
 5. Internet chat groups
- Reported Needs
 1. Professional counseling
 2. Buddy services or support groups
 3. Healing weekends
 4. Other services, such as faith related counseling and support
- Needs most difficult to obtain
 1. Healing weekends
 2. Professional counseling
 3. Buddy services or support groups
 4. Other services
- Reasons for not obtaining services
 1. Not feeling comfortable asking for services
 2. Not being able to find services
 3. Other reasons, such as not being eligible
 4. Concerns with the service provider

Demographic

Current Living Situation

- Reported needs
 1. Help with utilities
 2. Help with rent or mortgage
 3. Help with finding housing

- Needs that were most difficult to obtain
 1. Help with rent or mortgage
 2. Help with utilities
 3. Help finding housing

Health Behaviors

- Risk behaviors
 1. Smoking cigarettes
 2. Drinking alcohol
 3. Using street (illegal) drugs

- Street drugs used since testing positive for HIV
 1. Marijuana
 2. Crack/cocaine
 3. Other drugs, such as heroin, acid, and PCP (a higher percentage than overall state data)
 4. Crystal methamphetamine

- Sexual risk behaviors
 1. "Other" behaviors, such as unprotected oral sex
 2. Unprotected anal sex
 3. Unprotected vaginal sex
 4. Sharing needles
 5. Using condoms none or some of the time

Insurance

- Types
 1. Medicaid or Medicare
 2. Ryan White programs
 3. Public assistance
 4. Private insurance was reported by less than 25%

Needs of Youth and/or Transitional Youth

Ohio AIDS Coalition and Camp Sunrise collaborated during 2008 to identify best practices in services for youth aged 13 to 24 in Ohio. The project is analyzing a subset of data collected as part of the aforementioned statewide needs assessment survey to specifically examine the responses of youth. Data from the most recently available Unmet Need report is also being analyzed for the youth age bracket. Finally, an online survey was sent to HIV medical case managers in Ohio to elicit their professional opinions on needs of youth and services available to youth at their agencies. The results of the survey are currently being analyzed by a contracted entity. A report should be available at the end of November, 2008. This report will inform program planning for youth around the state.

Systems Assessments

Parts A and B agreed to coordinate the subsequent assessment cycle by sharing deliverables for the contracting of a statewide systems assessment. Collaborative Research, LLC conducted a systems assessment between February and April, 2007 in the Cleveland TGA and Consortium 1. As stated in the report prepared by Collaborative Research, LLC, “a significant goal of this study [was] to thoroughly examine the historic, current and projected compatibility among funding streams, planning bodies and service delivery in the Cleveland area for PLWHA.” Findings of this systems assessment led to the following recommendations:

- Resolve HIV Case Management
- Fund transportation as first priority among support services
- Work collaboratively to resolve issue of access to HIV medications, other medications, and help with co-payments
- Determine together service definitions for new core services
- Address geographic location as an access issue
- Fortify quality management process and integrate with program/financial in the Cleveland TGA

Health Management Associates conducted a systems assessment between July 2007 and May 2008 across all remaining Consortia in the state. The broad purpose of this assessment was to analyze and describe the extent to which Ohio’s Part B infrastructure is responsive to the needs of people living with HIV/AIDS. The findings of this systems assessment led to the following recommendations to improve Part B system performance:

- Optimize the use of available resources
- Streamline program oversight and reporting
- Share data to improve system performance
- Provide consistent policy direction statewide
- Focus resources to address unmet needs

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

Statewide Concerns and Cross-cutting Issues

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

Unmet Needs

The HIV Care Services Section and HIV/STD Surveillance are currently revising the estimated number of unmet need cases in the state of Ohio. The previous unmet need study conducted in 2002 and referenced earlier in the epidemiology section estimated the percent of Ohioans living with HIV who were also receiving care to be about 53 percent. Based upon improved reporting systems and statistical processes, HIV/STD Surveillance now estimates that the number of Ohioans living with HIV who are receiving care to be about 82 percent.¹¹ HIV/STD Surveillance continues to refine this number and provide increasingly more accurate

¹¹ Unmet need was determined by removing each of the following groups known to be receiving care (a CD4 or viral load or receiving antiretroviral therapy within the past 12 months) from the total number of known living cases in Ohio:

estimates.¹² It is important to note the 2009 Part B grant application reported an unmet need of 59 percent. This estimate is based on the stricter HRSA definition of unmet need, which defines “in care” as having received a CD4 count, viral load, or antiretroviral medication within the previous twelve-month period. The All Parts Group will be using both methodologies for determining unmet need to monitor changes over time.¹³

One of the projects of the All Parts Group is to further refine the estimate of unmet need (in addition to identifying areas for quality improvement initiatives with medical providers) by identifying clients served by multiple grantees and unduplicating those numbers. The initial step in this objective has been to centralize the data reported by each Ryan White grantee in the 2007 RDR (Appendix 1). Some of the grantees were also able to send unique client identification numbers to Part B to compare client enrollments and examine the number of clients in common. Plans to move forward will include developing methods to share data that can be compared for unduplication, such as using the national identifier (for the client level data reporting). Part B is in the initial stages of enhancing its current web-based database to include a portal for medical providers that would enable physicians to submit client level data in real time directly to the database. This program would also allow access for other Ryan White Parts as well as HIV/STD Surveillance, which will enhance the ability of HIV Care and Surveillance to share and compare data.

Priorities related to Unmet Need:

- Strategies to work with laboratories around the state to obtain CD4 and Viral Load testing data about PLWHA in Ohio.
- Strategies to identify the estimated 18% of people living with HIV/AIDS in Ohio who are not known to be receiving primary care services.
- Strategies to move those 18% of PLWHA into care, if they are not already.
- Strategies to identify the percent of people diagnosed with HIV and not in care who are youth and/or transitional youth.¹⁴

Emerging Trends

Ohio’s unique geographic and cultural landscapes contribute toward the variety of sub-populations across the state. Furthermore, each consortium recognizes these sub-populations relative to their locations and attempts to address their unique needs through community planning processes. Despite this fact, there continues to be an increase in new diagnoses among minority populations based on race, ethnicity, gender, age, and sexual orientation. The All Parts Group has suggested defining a goal for the coming year that will look ahead at the demographics of the population of new patients. Based on trends that are being documented now across the state, the All Parts Group wants to predict, anticipate, and prepare for the needs

prisoners; PLWHA who have ever had a CD4 count; PLWHA who have ever had a Viral Load test following HIV diagnosis; PLWHA receiving ART or PCP Prophylaxis; those with AIDS diagnosis after HIV diagnosis; PLWHA whose current address is not Ohio; PLWHA enrolled in a clinic; PLWHA enrolled in a clinical trial.

¹² The unmet need estimate does not reflect those persons who are unaware of HIV status; only PLWHA who have been diagnosed as HIV-positive and reported to Surveillance are included in determining the estimate.

¹³ This section describing the estimate of unmet need as submitted in the 2009 Part B grant application was added in February, 2009, after the 2009 SCSN was submitted to HRSA. The All Parts Group decided to include both estimates with an explanation of methodologies rather than exclude either.

¹⁴ Youth refers to persons aged 13 to 24 years; transitional youth refers to the subgroup of persons generally aged 18 to 24 who are young adults living independently or semi-independently.

of the influx of clients in the near future. Over the next year, the group plans to profile the demographics of new infections statewide within the last couple of years as well as the demographics of new enrollments across all Parts. A comparison of these data will enable the All Parts Group to plan well with respect to ensuring Ohio's resources are distributed accordingly to the emerging client population's needs. An example of this profile is represented in the table in Appendix 1. A breakout of client income levels as reported in the 2007 RDR of grantees is included in the table. When compared to the general population of Ohio, where 13.1%¹⁵ of the population has an income at or below the Federal Poverty Level (FPL), the population of PLWHA served by Ryan White Programs in Ohio has disproportionately lower incomes. Even as compared to the elevated levels of poverty seen across the state, the Ryan White client population faces higher levels of poverty, often with over half of clients seen living at or below the FPL.

Because the disproportionate growth in HIV-positive diagnoses among underserved populations continues, the identification of the needs of these groups will position Ohio to predict and hopefully respond in a timely manner to the barriers these groups face. Ohio's Ryan White Parts continue to develop their Quality Management programs and even work to synchronize their efforts with a statewide Quality Management plan. Incorporating a proactive response to the needs of underserved populations who are quickly becoming the majority of cases will ensure that as many HIV-positive Ohioans who need assistance will have access to quality medical services.

Priorities related to Emerging Trends in Underserved Populations

- Provider recruitment and training related to the needs of and services available to people living with HIV/AIDS in Ohio, with a focus on cultural competence, confidential care and decreasing stigma associated with HIV disease.
- Identification and retention in care of the harder to reach populations of people living with HIV/AIDS across the state, including transgendered persons, prisoners, immigrants, youth and/or transitional youth, and older adults.
- Transportation options for consumers to access services, especially in rural areas of the state.
- Funding to meet increasing needs related to housing, transportation, nutrition and dental care.

Challenges and Critical Gaps

Access to Services

Ensuring access to services for all PLWHA continues to be a challenge that Ohio HIV service providers face. Today's funding climate in the state increases the difficulty for organizations to continue providing services at the current level in the future. Reductions in funding levels for public and private social service programs creates bigger gaps for Ryan White grantees to fill in as benefits and services are scaled back. Coordination among the Parts is therefore crucial to ensure that not only are services not being duplicated, but that other appropriate resources are also used first.

Additional challenges were also identified through the needs assessments referenced earlier. These issues include poverty, the need for better health and dental insurance coverage, a lack of awareness of services among consumers -particularly in rural areas - and a lack of food sources. Many areas of the state continue to struggle with housing issues. Adequate, affordable housing is still difficult to obtain in many places.

¹⁵ US Census Bureau, www.census.gov, "Income, Earnings, and Poverty Data From the 2007 American Community Survey," Table10: Number and Percentage of People in Poverty and Percentage of People by Ratio of Income-to-Poverty Level in the Past 12 Months by State: 2007.

Transportation continues to be a problem for many consumers, especially in rural areas of the state where there is a lack of access to adequate public transportation. The top barriers to accessing needed transportation were cited as: being unable to pay for it, physical limitations, and that the needed transportation service was unavailable. Dental care has been consistently identified as an unmet need and a cross-cutting issue across the state since 2003. Mental health issues and access to services, especially accessing affordable mental health and substance abuse treatment in a reasonable amount of time, continues to create barriers to service for many PLWHA across Ohio.

The All Parts Group continues to meet quarterly to discuss progress on shared challenges. Frequently challenges relate to sharing data within the context of HIPAA and overcoming obstacles created by incompatible data types. Unduplicating records of clients served by each Part or agency has been a primary component of the discussion over the past year. As mentioned previously, Part B is in the preliminary stages of expanding its web-based database to increase the coordination of data among all Parts, Surveillance and medical service providers. It is expected that a portal that can accommodate all of these key organizations will further streamline data analysis, reporting, and ultimately improve the quality of client care.

Priorities related to access to core services

- Ensure access to all core services by integrating systems and services into a cohesive model that seeks to enroll and keep clients in care.
- Strategies to increase the number of HIV-related service providers who will accept new patients living with HIV/AIDS, especially dental care and substance abuse treatment.
- Strategies to utilize existing providers that are currently underused.

Goals

- Develop strategies to reach underserved populations with information on access to HIV medical care and HIV medical case management.
- Identify disparities among subpopulations and develop strategies to ensure access to HIV-specialized care in all geographical regions of the state.
- Develop consistent data collection processes and systems statewide in order to draw valuable comparisons and standardize the needs assessment efforts across agencies.
- Increase and maintain efforts toward effective collaboration among all Ryan White Parts (and non-Ryan White agencies serving PLWHA) in Ohio.
- Work to identify the 18% of people living with HIV/AIDS in Ohio who are not receiving primary care services. (Determine whether they are in care through a different source [e.g., private care paid by private insurance] or, if not receiving care, identify strategies to get them into care.)
- Work to describe the utilization patterns of medical HIV care of the 82% of persons in care in terms of the epidemic and emerging cases.
- Focus on the quality of HIV care using clinical quality measures and data reports as quality tools.
- Anticipate the demographics of the emerging patient base (i.e., prepare for the change in client needs relative to demographics of new clients & newly diagnosed).
- Coordinate services among Ohio Ryan White grantees to maintain service levels within a climate of service reduction by other public and private services.

VI. Summary and Conclusions

Ohio Ryan White grantees and local service providers will continue their work to coordinate services and data statewide. Each Part will use the priorities and goals outlined in the SCSN to develop program plans to be discussed in their respective planning documents, such as the Comprehensive Services Plan (CSP).

Needs assessment activities and data collection mechanisms will be revised to get more informative and accurate data. One objective of this process will be to achieve statewide implementation of HRSA clinical quality measures. Data sharing through the All Parts Group will enhance quality improvement measures related to these data. Focusing on the quality of HIV care using the clinical quality measures is a statewide priority for the coming years.

The All Parts Group will examine the demographics of new clients as well as the demographics of the clients identified as having unmet need. This will in turn lead to the development of specific strategies to meet the goals identified in the SCSN. Strategies to increase data sharing will also be explored.

In conclusion, the development of this document is the initial stage in a movement to increase coordination among all Ryan White Parts in Ohio. The All Parts Group expressed a desire to compile a Statewide Coordinated Statement of Need that will be functional, be reflective of the work happening around the state, and be responsive to the needs of the Parts. Significant changes were made to the format and scope of the SCSN, and it is expected that future revisions will build upon these modifications. With direction from the All Parts Group, the SCSN should continue to reflect the progress of the service coordination of that group, and intermittent reports should be developed to link the 2009 SCSN to the 2012 SCSN.

Appendix 1.

Comparison of 2007 RDR values across Ohio grantees

Agency	Total no. HIV+ clients ¹⁶	# clt w/med CM visits	# clt w/outpt med visit	# clt w/mental health services	# clt w/sub abuse outpt svcs	#/% clt <=100% of FPL ¹⁷	#/% clt 101-200% of FPL	#/% clt 201-300% of FPL	#/%clt >300% FPL	#/% clt unknown/unreported hh income
ODH - OHDAP clients	4380 ¹⁸									
ODH - other Part B clients			Approx 400 ¹⁹ 375 ²⁰			194 52%	138 37%	38 10%	4 1%	1 <1%
AIDS Taskforce of Greater Cleveland (Parts A/B)	1076	1076				958 89%	97 9%	8 1%	4 <1%	9 1%
Violet's Cupboard (Parts B/C)	627	627	627	<i>unknown</i>		298 48%	103 16%	71 11%	92 15%	63 10%
Columbus AIDS Task Force (Parts B/C)	1934	1100	1108	287	39	1267 66%	477 25%	157 8%	33 2%	0 0%
MetroHealth Medical Center (Parts A/B)	1141	507	963	18		--	--	--	--	1141 100%
Proyecto Luz (Parts A/B)	234	234				188 80%	44 19%	2 1%	0 0%	0 0%
University Hospitals of Cleveland (Parts A/B/C)	1050	542	991	17		454 43%	140 13%	59 6%	35 3%	362 34%

¹⁶ HIV-positive clients and HIV-indeterminate clients under two years of age are include in this column. Indeterminate numbers are also included when reporting all other counts, including household income.

¹⁷ Some percentages may not add to 100 due to rounding.

¹⁸ Fiscal Year 2007. Includes clients also enrolled in Case Management.

¹⁹ Estimated 1500 paid med visits a year; 400 is the remaining no. of visits part B pays for when add up the other part B agencies reporting no. of med visits.

²⁰ Oral health care offered as reported on the 2007 RDR.

University of Toledo Medical Center (Parts C/D)	662	622	662	352	0					
Cincinnati Health Network (Part C)	1816 ²¹	1079 ²²	1816	339	108					
Portsmouth City Health Department (Part C)	105	105	<i>unknown</i>	<i>unknown</i>	<i>unknown</i>					
Care Alliance (Part C/SPNS)	86	75	14	10	30					
Cuyahoga County Commissioners (Part A)	4627									
Comprehensive Care Center (Part C)	195	82	193	48	0	135 69%	37 19%	9 5%	6 3%	5 3%
Other Part B CM agencies ²³	3487	2981		276	8	2052 59%	821 24%	241 7%	69 2%	304 9%
FACES clinic (Parts C/D)	300	297	259	52	0					
						5546 55%	1857 18%	585 6%	243 2%	1885 19%
<i>Cuyahoga County Commissioners (Part A)</i>	<i>4,627</i>									
<i>AIDS Taskforce of Greater Cleveland</i>	<i>1,076</i>	<i>1,076</i>	<i>0</i>	<i>0</i>	<i>0</i>					
Alcohol and Drug Services Board	30	0	0	0	27					
Camp Sunrise	9	0	0	0	0					
Community Health Partners	150	144	137	0	0					
Cuyahoga County Community Mental Health Brd.	12	0	0	12	0					

²¹ There are approx. 90 clients included in this figure who live in Northern Kentucky.

²² There are approx. 200 clients included in this figure who live in Northern Kentucky.

²³ AIDS Resource Center Ohio, Area Agency on Aging District 7, Athens AIDS Task Force, Columbus Public Health, Family Service Agency, HIV Community Services of North Central Ohio, Southeast, Inc., Stop AIDS, The Woodlands, and Trillium Family Solutions.

Cuyahoga County Dept. of Senior & Adult Services	70	0	0	0	0					
Free Medical Clinic of Greater Cleveland	126	126	126	0	0					
Hospice of the Western Reserve	5	0	0	0	0					
Lake County General Health District	109	109	0	0	0					
MetroHealth Medical Center	1,125	507	963	18	0					
Proyecto Luz	234	234	0	0	0					
The Cleveland Clinic Foundation	532	97	532	0	0					
University Hospitals of Cleveland	1,045	542	991	17	0	454	140	59	35	362
Total			5,336							
Clients shared by Parts A & B	2631									
Clients shared by Comprehensive Care Center and Part B	148									
Clients shared by UH and Part B	678									
Clients shared by FACES and Part B	138									
Clients unduplicated statewide	12338									