

Cleveland TGA

In Care, Newly Diagnosed & Out of Care Needs Assessment

Report of Findings | June 2011



Cuyahoga Regional HIV Services Planning Council

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EXECUTIVE SUMMARY

GENERAL DEMOGRAPHICS OF THE TGA

The Cleveland, Lorain, Elyria TGA is comprised of six (6) Ohio counties with an estimated population of 2,192,408 in 2009. African Americans comprise 20% of the population and Latinos 4% of the TGA's population. Cuyahoga County, with 59% of the TGA population accounts for 82% of Persons Living With HIV/AIDS (PLWHA). Lorain and Medina counties (Western region) represent 22% of the TGA's population and 14% of PLWHA; Lake, Geauga and Ashtabula counties (Eastern region) represent 20% of the TGA's population and 5% of PLWHA. Poverty rates average 15% across the TGA; approximately 17% of the population has no health insurance, including Medicaid. The prevalence of tuberculosis and sexually transmitted infections is higher than the state's average, driven largely by high rates in Cuyahoga County, specifically the City of Cleveland.

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 63% 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 35% 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 to as far as 117 miles for a round trip (Ashtabula County).

DESCRIPTION OF THE CONTINUUM OF CARE

Service networks ensure access to and parity of HRSA core funded services (outpatient medical care, medical case management, HIV medications, mental health, substance abuse, and dental health). 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.

RELEVANCE OF THE TGA-WIDE COMPREHENSIVE NEEDS ASSESSMENT STUDY: REGIONAL COMPARISON OF NEW AND EXISTING HIV/AIDS CASES, 2009

Newly Diagnosed AIDS	EASTERN	CENTRAL	WEST	TGA
WHITE	57%	33%	34%	34%
AFRICAN AMERICAN	21%	58%	54%	55%
LATINO	21%	8%	12%	9%
OTHER	1%	1%	2%	2%
Newly Diagnosed HIV	EASTERN	CENTRAL	WEST	TGA
WHITE	53%	33%	35%	34%
AFRICAN AMERICAN	27%	59%	56%	57%
LATINO	20%	7%	10%	8%
OTHER		1%		1%
PLWA	EASTERN	CENTRAL	WEST	TGA
WHITE	75%	35%	38%	38%
AFRICAN AMERICAN	15%	55%	48%	52%
LATINO	9%	9%	14%	9%
OTHER	1%	1%	1%	1%
PLWH	EASTERN	CENTRAL	WEST	TGA
WHITE	70%	32%	31%	33%
AFRICAN AMERICAN	17%	58%	54%	56%
LATINO	7%	7%	14%	8%
OTHER	6%	3%	1%	3%

{ Source for all tables: Ohio Department of Health, HIV/AIDS Surveillance Program. Data as of Dec 31, 2009 }.

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 Latino PLWA, and the Eastern region (Ashtabula, Geauga and Lake counties) has the highest proportion of Anglo PLWAs.

Gender is almost identical with the exception of the Western Region, which has a higher percentage (29%) of female PLWAs. Age group shows the Western and Central region to have the only notable percentage of young (13-19) PLWAs, with the Eastern region having the oldest or ‘aged’ PLWAs (47%), nearly the same as the Central Region (46%).

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

RACE/ETHNIC GROUP

The group most disproportionately affected are African Americans. They consistently comprise 55% or more of newly diagnosed cases and 52% of People Living With AIDS and 56% People Living With HIV. The 50% or greater figure compares to their 20% representation in the overall population of the TGA, with 27% in Cuyahoga County. 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 “aged” 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%.

GENDER

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.

AGE GROUP

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 ‘aged’ (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 ‘aged’. 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 ‘aged’ (45+) newly diagnosed AIDS cases’, then the Eastern region with 14%.

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 (12% versus 10%), a negative trend not evident in the PLWH and PLWA trend lines.

COMPARISON WITHIN THE CLEVELAND TGA BY REGION

The TGA's Central region, consisting of Cuyahoga county, has the highest rates of the disease. For race/ethnic group among People Living With HIV, the highest region for Anglos is the Eastern region, for Latinos, the Western region and for African Americans, the Central Region. By gender, the only region displaying differences is the Western region with a high of 34% female PLWH compared to an average of 25% for the Central and Eastern regions. 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.

IN CARE SURVEY PROCESS

This needs assessment survey was conducted by Collaborative Research, LLC, during spring 2010 (for the Newly Diagnosed/New to Care needs assessment) and during spring 2011 (for the In Care and Out of Care needs assessments). The goal of the In Care survey assessment was to reach at least 200 of the entire In Care PLWHA population in the TGA who were currently receiving Ryan White funded care and services. Each survey respondent received a gift card for their participation.

EACH OF THE TGA'S SEVERE NEED GROUPS (SNGS) WERE WELL REPRESENTED IN THE 2010-2011 SURVEY PROCESS. THE SIX POPULATIONS WITH SPECIAL NEEDS IN THE CLEVELAND TGA INCLUDE:

1. MSMs
2. African Americans
3. Latinos
4. Minority women
5. IDUs
6. "Aged", defined as persons 45 or older.

These are also the populations most likely to be underrepresented in the Ryan White funded system of care. Data pertaining to each group has been gathered as part of the Needs Assessments.

OVERVIEW OF TGA-WIDE 'IN CARE' PLWHA STUDY FINDINGS

The 2010-2011 Annual Needs Assessment is comprised of large samples of 'In Care' PLWHA, 'New to Care' PLWHA and 'Out of Care' PLWHA surveyed in the Cleveland TGA. Need, Use, Gap & Barrier rankings were performed for both the "In Care" and Out of Care" PLWHA respondents. The "In Care" respondents' top expressed Needs, Uses, Gaps and Barriers for HIV-related services evidence a strong mix of core medical and supportive services:

THE IN CARE SURVEY RESPONDENTS RANKED THE FOLLOWING SERVICE NEEDS:

1. Primary Medical Care
2. Medications (HIV & non-HIV)
3. Housing Assistance
4. Nutrition/Food Assistance
5. Mental Health/Support Services

THE IN CARE SURVEY RESPONDENTS RANKED THE FOLLOWING SERVICE USES:

1. Primary Medical Care
2. Medications
3. Medical Transportation
4. Case Management
5. Nutrition Assistance/Food Bank tied with Mental Health/Support Services

THE IN CARE SURVEY RESPONDENTS RANKED THE FOLLOWING SERVICE GAPS (SERVICES "CAN'T GET"):

1. Medical Transportation
2. Medications
3. Housing Assistance tied with Nutrition/Food Assistance
4. Mental Health/Support Services tied with Employment/Job Assistance
5. Emergency Financial Assistance

THE IN CARE SURVEY RESPONDENTS RANKED THE FOLLOWING SERVICE BARRIERS ("HARD TO GET"):

1. Medical Transportation
2. Medication Assistance
3. Housing Assistance
4. Nutrition/Food Assistance
5. Emergency Financial Assistance

2011 ALL 'IN CARE' PLWHA NEED, USE, BARRIER, & GAP MATRIX

SERVICE CATEGORY DESCRIPTION	NEED RANK	USE RANK	GAP RANK	BARRIER RANK
Outpatient/Ambulatory Medical Care	1	1	NR	NR
Medication Assistance	2	2	2	2
Housing Assistance	3	6	3 tie	3
Nutrition/Food Assistance	4	5 tie	3 tie	4
Mental Health/Support Services	5	5 tie	4 tie	8 tie
Medical Transportation	6	3	1	1
Emergency Financial Assistance	7	10	5	5
Health Insurance/Disability Assistance	8	7	3 tie	8 tie
Employment/Job Assistance	9	NR	4 tie	7
Oral Health Care	10	9	NR	6
Substance Abuse Treatment - OP	11	8	NR	10 tie
Medical Case Management	12	4	NR	10 tie
Eye Care/Eye wear	NR	NR	5	9

IN CARE GAP REASONS:

Cut backs in funding	Not available
Don't accept my insurance	Not covered
Don't have access	Don't exist in this area
Don't meet standards of care	Long wait list
Don't qualify	Medicaid denied
I need to ask for more help	No money
Lack of information about what's available	Need help with job
No longer have them	Used up funds

IN CARE BARRIER REASONS:

Budget cut backs	Poor transit services	No computer
Need/Denied Medicaid	Limited houses	Not much available
Don't accept my insurance	Red tape	Only outpatient—need inpatient
Not available/accessible	Schedule conflicts	Unfamiliar with what is available
Wait list/waiting time too long	Lack of information	Too many restrictions
No financial help offered	Location	Hardly any bilingual services
No money	Denied SSDI	No cab fare
Not addressed locally	Do not qualify	My T cells are too high

OVERVIEW OF TGA-WIDE 'OUT OF CARE' PLWHA STUDY FINDINGS: 2011 OOC SERVICE NEEDS, USES, GAPS & BARRIERS

SERVICE CATEGORY	OOC NEED RANK	OOC USE RANK	OOC GAP RANK	OOC BARRIER RANK
Nutrition/Food Assistance	1	NR	NR	NR
Mental Health/Support Services	2	1 tie	NR	NR
Outpatient/ Ambulatory Medical Care	3 tie	NR	NR	NR
Medication Assistance	NR	NR	NR	NR
Housing Assistance	3 tie	NR	2 tie	2
Medical Transportation	3 tie	NR	1 tie	1
Substance Abuse Treatment	4 tie	NR	NR	NR
Medication Assistance	4 tie	1 tie	NR	3 tie****
Clothing	4 tie	NR	NR	NR
Faith/Family	4 tie	NR	NR	NR
Medical Case Management	NR	1 tie	NR	NR

SERVICE CATEGORY	OOO NEED RANK	OOO USE RANK	OOO GAP RANK	OOO BARRIER RANK
Health Information/Health Education/Referral	NR	NR	2 tie**	3 tie*****

Additional Gaps/Barriers Cited by the OOC Respondents:

*Gaps: *1 “Good Doctor who could get me meds that don’t make me sick”; “Doctor to explain disease”; **2 “Information about HIV and HCV”*

*Barriers: ***3 “Good care”, “Non-judgmental Doctor”, “Sensitive, knowledgeable HIV Doctor”; ****4 “Meds that don’t make me sick”; *****5 “More HIV education”, “Doctor to explain disease”*

OUT OF CARE GAP REASONS

- High Cost
- Not in Cleveland
- Rural area
- Not enough time by Doctor
- Stigma
- Economy
- Poor pay for MD

OUT OF CARE BARRIER REASONS

- Funding
- Out of Way
- Stigma
- Location
- Red Tape
- Rural Area
- Poor Pay for MD
- Economy

The service Gap/Barrier service rankings for the In Care and Out of care PLWHA listed in the tables below deserve special attention in the priority setting and resource allocation planning and decision making processes for the TGA.

SUMMARY OF BARRIER RANKINGS BY IN CARE & OUT OF CARE

RANKING	IN CARE BARRIERS	OUT OF CARE BARRIERS
1	Medical Transportation	Medical Transportation
2	Medication Assistance	Housing Assistance
3	Housing Assistance	Medication Assistance
4	Nutrition/Food Assistance	Primary Medical Care
5	Emergency Financial Assistance	Health Information/Health Education

SUMMARY OF GAP RANKINGS BY IN CARE & OUT OF CARE

RANKING	IN CARE BARRIERS	OUT OF CARE BARRIERS
1	Medical Transportation	Medical Transportation & PMC
2	Medication Assistance	Housing Assistance & Health Information/ Education/referral
3	Housing Assistance & Nutrition/Food Assistance & Health Insurance/Disability Assistance	NR
4	Mental Health/Support Services	NR
5	Eye Care/Eye wear	NR

CHAPTER 1: INTRODUCTION

BACKGROUND

Annual Needs Assessments are special studies in time conducted to determine the priority service needs, uses, barriers, and gaps in the continuum of care for People Living with HIV/AIDS (PLWHA). Results of this client-centered activity are used to establish service priorities, document the need for specific services, determine barriers to accessing care, provide baseline data for comprehensive planning including capacity building, and help providers improve the accessibility, acceptability, and quality of services delivered, especially to the designated ‘Severe Need Groups/Special Populations’.

The Cleveland TGA’s continuum of care has evolved into a robust and responsive medical model of HIV care and services delivery. Primary medical care is supported by a wide range of medically and socially supportive services, including substance abuse and mental health treatment services, medical and social services case management, emergency financial assistance, oral health care, transportation, outreach/ case finding and other services essential to facilitating PLWHA access to and retention in HIV primary medical care. The TGA’s ideal continuum of care facilitates optimal access to and full utilization of medical and supportive services. All of these services exist in the context of the five key goals of the U.S. Health Resources and Services Administration (HRSA): 1) improve access to care, 2) eliminate health disparities, 3) improve the quality of care, 4) assure cost effectiveness, and 5) improve health outcomes.

A comprehensive assessment of the service needs, uses, gaps and barriers of “In Care”¹, “New to Care” and

¹ 1. **CD4** – CD4 (T4) or CD4 + CELL COUNT and PERCENT.

2. **VIRAL LOAD TEST** - Test that measures the quantity of HIV RNA in the blood.

3. **ANTIRETROVIRAL DRUGS** - Substances used to interfere with replication or inhibit the multiplication of retroviruses such as HIV.

“Out of Care” PLWHA within the Cleveland TGA was conducted in the spring of 2010 and finalized in the spring 2011. 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 (using the Needs Assessment Client Survey (NACS) tools, in the Appendix).

RELEVANCE OF THE PART A COMPREHENSIVE “IN CARE” NEEDS ASSESSMENT

The targeted special population groups, their sub-populations and the TGA’s Severe Need Groups (SNGs) remain a major focus of study for the Planning Area. The Planning Council is continuously challenged in identifying the changing needs of the PLWHA community in order to best facilitate access, engagement and retention in care for all those living with HIV/AIDS in the service area. Based upon their disproportionate impact within the TGA, the ‘In Care’ needs assessment survey process and resulting report highlights the differing needs, uses, gaps and barriers to HIV primary medical care experienced by the Severe Need Groups of MSMs, African Americans, Hispanics/Latinos, minority women, IDUs and the “aged,” defined as persons 45 or older. The needs assessment survey questionnaires were administered through the Ryan White funded primary medical care providers, marketing the availability of the survey. Each PLWHA Respondent received a gift card for participating in the needs assessment study.

PLWHA

The Ohio Department of Health (ODH) 2009 AIDS Surveillance Report shows the following estimates of persons reported living with HIV/AIDS in the TGA by county. The six counties comprising the Cleveland TGA account for 26% of all cases reported in Ohio. The majority of cases (82%) in the TGA are in Cuyahoga County, 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.

CLEVELAND TGA: COUNTY LEVEL DATA, OHIO DEPARTMENT OF HEALTH

COUNTY	PLWHA AS OF DECEMBER 31, 2009	
	Number	Percentage
Ashtabula	57	1.3%
Cuyahoga	3,564	81.9%
Geauga	20	0.5%
Lake	122	2.8%
Lorain	550	12.6%
Medina	41	0.9%
TOTAL	4,354	100%

According to the grantee’s anonymous service records, the program served approximately 2,600 unduplicated individuals, or 79% of the TGA’s PLWHA during the past two grant years.

Examination of the infected community from 2005 to 2009 focuses on the TGA’s three major racial subgroups with refinement by demographic and disease transmission characteristics including age, gender and mode of transmission. Contrast is made separately for newly diagnosed HIV and AIDS cases (HIV and AIDS incidence), and people living with the disease (HIV and AIDS prevalence).

The table below (on the following page) demonstrates data provided by the ODH illustrating the impact of the epidemic on severe need populations in the Cleveland TGA for the time period ending December 31, 2009.

This table shows that the TGA’s minority populations 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 63% of the existing HIV disease burden.

RACE/ETHNIC GROUPS

The percentage of new AIDS cases decreased by 7% over the four-year period for African Americans, but increased by 6% for Whites. Latino fractions vacillated from a high of 12% in 2006 and 2007 and up to 12% again in 2008. Multiracial cases have slightly increased.

TREND OF NEW AIDS CASES BY RACE/ETHNIC GROUP IN CLEVELAND TGA, 2006-2009

SERVICE CATEGORY	2009		2008		2007		2006	
	PLWA	PLWH	PLWA	PLWH	PLWA	PLWH	PLWA	PLWH
White	37%	34%	38%	33%	38%	33%	37%	35%
African American	52%	55%	52%	55%	52%	56%	52%	57%
Latino	8%	9%	9%	8%	9%	8%	10%	7%
Asian	0.3%	0.5%	0.3%	0.4%				1%
Amer. Indian	0.1%	0.1%	0.2%	0.2%				
Multiracial	0.9%	0.6%	0.2%	3%	1%	3%	1%	1%
TOTAL	100%	100%	100%	100%	100%	100%	100%	100%

{ Source: Ohio Department of Health, HIV/AIDS Surveillance, Data as of December 31, 2009 } Disparities }

DISPARITIES

The percentage of PLWH and PLWA by race/ethnicity remained constant over the four years, with the exception of Latinos, in which PLWH are trending up 2 percentage points and PLWA trending down by the same figure.

2009 NEW AND EXISTING HIV/AIDS CASES BY RACE/ETHNICITY AND DISPARITIES

	WHITE	AFRICAN AMERICAN	LATINO
TGA (General Population)	78%	20%	4%
Newly Diagnosed Aids	31%	55%	11%
Newly Diagnosed HIV	33%	59%	7%
PLWA	37%	52%	9%
PLWH	34%	55%	8%
Disparity New HIV		35%	7%
Disparity New AIDS		39%	3%
Disparity Existing HIV		32%	5%
Disparity Existing AIDS		35%	4%

{ Source: : Ohio Department of Health, HIV/AIDS Surveillance Program. Data as of December 31, 2009 }

Comparison of the 2009 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 Latinos, to a lesser degree.

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 45 and older age band, now comprising 38% of new AIDS cases. The large 20-44 year age band is slowly decreasing in new diagnoses.

New HIV cases display a younger pattern, with 69% of cases (versus 59% for new AIDS cases) in the 20-44 age band, 25% among the 45 years of age and older (versus 38% for new AIDS cases) and 5% for 13-19 year olds (versus only 2% for new AIDS cases).

AGE GROUP AMONG INFECTED COMMUNITY IN CLEVELAND TGA, 2005-2009

SERVICE CATEGORY	2008		2007		2006		2005	
	PLWA	PLWH	PLWA	PLWH	PLWA	PLWH	PLWA	PLWH
AGE AT DX								
<13 years	0%	1%	1%	2%	1%	1%	1%	1%
13-19 years	0%	1%	3%	3%	1%	6%	1%	1%
20-44 years	40%	53%	40%	52%	45%	55%	55%	58%
45+ years	60%	46%	56%	46%	53%	38%	43%	36%
TOTAL	100%	100%	100%	100%	100%	100%	100%	100%

{ Source:: Ohio Department of Health, HIV/AIDS Surveillance Program. Data as of December 31, 2009 }

The percentage of both PLWH and PLWA among those 20-44 years of age has slightly decreased from 58% in 2005 to 53% in 2008 and 55% to 53%, respectively. During the same period the percentage of PLWH among those 45 years of age and older has increased from 36% to 46% and the percentage of PLWA over 45 has significantly increased from 43% of the cases to 60%. This is due to aging of the PLWHA and general populations in Cleveland compounded by high rates of AIDS and HIV incidence in the older age group. HIV/AIDS incidence among youth in Cuyahoga County increased 57% to 80 cases reported in 2007-2008 compared to 2004-2006. On average, four youth males are diagnosed with HIV to every one youth female. Youth represent about 30% of all incident diagnoses annually.

GENDER

Disparities for males exist in all three indicators—males have a higher proportion of new AIDS cases, PLWA and PLWH than their representation in the general population. For new AIDS cases, the trend continues to accelerate with males increasing by 7% over the four year period.

For existing cases, the trend-line for PLWA is a constant 80:20 proportion. For PLWH the trend shows decreases since 2005 by 3% in females living with HIV.

GENDER AMONG INFECTED COMMUNITY IN CLEVELAND TGA, 2005-2009

GENDER	2008		2007		2006		2005	
	PLWA	PLWH	PLWA	PLWH	PLWA	PLWH	PLWA	PLWH

	2008		2007		2006		2005	
Male	80%	79%	80%	79%	80%	81%	81%	72%
Female	20%	21%	20%	21%	20%	19%	19%	23%

{ Source:: Ohio Department of Health, HIV/AIDS Surveillance Program. Data as of December 31, 2009 }

EXPOSURE/TRANSMISSION CATEGORY

By exposure category, the Eastern and Central regions are predominantly MSM. The Western region has the highest IDU exposure, followed by non-reported risk, then heterosexual transmission. MSM transmission continued to significantly increase from 41% in 2005 to 51% in 2008 for newly diagnosed AIDS cases. IDUs experienced a stable state from 2003 to 2008. Heterosexual transmission is maintaining a stable 15% from 2006 through 2008. For newly diagnosed HIV cases, fully half of all new HIV cases are attributed to MSM, 12% to heterosexuals, 4% to IDU and 34% are other/unknown.

TRANSMISSION AMONG INFECTED COMMUNITY IN CLEVELAND TGA, 2005-2009

	2008		2007		2006		2005	
TRANSMISSION	PLWA	PLWH	PLWA	PLWH	PLWA	PLWH	PLWA	PLWH
MSM	52%	39%	51%	37%	50%	37%	49%	35%
IDU	11%	8%	11%	9%	12%	10%	13%	10%
MSM: IDU	5%	3%	6%	3%	6%	4%	6%	3%
Heterosexual	14%	12%	13%	12%	14%	10%	12%	10%
Other/ Unknown	18%	38%	19%	39%	18%	39%	20%	42%
TOTAL	100%	100%	100%	100%	100%	100%	100%	100%

{ Source:: Ohio Department of Health, HIV/AIDS Surveillance Program. Data as of December 31, 2009 }

PLWA

PLWA continue to be largely represented by MSM with steady increases of 3% from 2005 (49%) to 2009 (52%). PLWH rose by 4% for MSM from 35% in 2005 to 39% in 2008. IDU activity, whether IDU or MSM/IDU, has decreased for PLWH and PLWA. The large unknown/other fraction represents an obstacle to

determining causation. PLWH show large decreases in all categories with interpretation hampered by the 38-42% other/unknown percentage.

REGIONAL COMPARISON OF NEW AND EXISTING HIV/AIDS CASES, 2009

NEWLY DIAGNOSED AIDS				
NEW AIDS 2009	EASTERN	CENTRAL	WEST	TGA
White	57%	33%	34%	34%
African American	21%	58%	54%	55%
Latino	21%	8%	12%	9%
Other	1%	1%	2%	2%

NEWLY DIAGNOSED HIV				
NEW HIV 2009	EASTERN	CENTRAL	WEST	TGA
White	53%	33%	35%	34%
African American	27%	59%	56%	57%
Latino	20%	7%	10%	8%
Other		1%		1%

PEOPLE LIVING WITH AIDS				
PLWA 2009	EASTERN	CENTRAL	WEST	TGA
White	75%	35%	38%	38%
African American	15%	55%	48%	52%
Latino	9%	9%	14%	9%
Other	1%	1%	1%	1%

PEOPLE LIVING WITH HIV				
PLWH 2009	EASTERN	CENTRAL	WEST	TGA
White	70%	32%	31%	33%
African American	17%	58%	54%	56%
Latino	7%	7%	14%	8%
Other	6%	3%	1%	3%

{ Source:: Ohio Department of Health, HIV/AIDS Surveillance Program. Data as of December 31, 2009 }

RACE/ETHNIC GROUP

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

The groups most disproportionately affected are African Americans. They consistently comprise 55% or more of newly diagnosed cases and 52% of People Living With AIDS and 56% People Living With HIV. The 50% or greater figure compares to their 20% representation in the overall population of the TGA, with 27% in Cuyahoga County. Sixty percent (60%) of all newly diagnosed AIDS cases occur in the Central region, dominated by Cuyahoga County. 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 “aged” 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%.

GENDER

Gender is almost identical with the exception of Lorain County, which has a higher percentage (29%) of female PLWAs. Age group shows the Western and Central region to have the only notable percentage of young (13-19) PLWAs, with the Eastern region having the oldest or ‘aged’ PLWAs (47%), nearly the same as the Central Region (46%).

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.

AGE GROUP

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 ‘aged’ (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 ‘aged’. 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 ‘aged’ (45+) newly diagnosed AIDS cases’, then the Eastern region with 14%.

EXPOSURE CATEGORY

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. 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.

COMPARISON WITHIN THE CLEVELAND TGA BY REGION

The TGA’s Central region, consisting of Cuyahoga and Medina counties, has the highest rates of the disease. For race/ethnic group among People Living With HIV, the highest region for Anglos is the Eastern region, for Latinos, the Western region and for African Americans, the Central Region. By gender, the only region displaying differences is the Western region with a high of 34% female PLWH compared to an average of 25% for the Central and Eastern regions. 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.

UNDERREPRESENTED POPULATIONS IN PRIMARY MEDICAL 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. The majority also reported facing mental health or substance abuse challenges.

2009 RANKING OF HIV PREVENTION TARGET POPULATIONS BASED ON EPIDEMIOLOGICAL DATA IS:

1. Persons Living with HIV/AIDS
2. Black/African American Males (MSM, Bisexual)
3. Black/African American Heterosexual, Non-Intravenous Drug User Females
4. White Males (MSM, Bisexual)
5. Youth 13-24 years
6. Older Persons, age 50 and over, with HIV
7. Black/African American Heterosexual, Non-Intravenous Drug User Males
8. Intravenous Drug Users
9. Hispanics
10. White Heterosexual Males/Females

Co-morbidities: STIs and Tuberculosis: Sexually transmitted infections (STI) and tuberculosis (TB) rates in the TGA are consistently higher than the rest of the state. This is driven by high rates in every category in Cuyahoga County in the Central Region. Epidemiological literature demonstrates clear correlation between the transmission of HIV and the prevalence of STIs and TB in the population. Analyses by the City of Cleveland Department of Public Health for 2009 show that across the counties in the TGA, gonorrhea, Chlamydia and syphilis rates were statistically higher among Latinos and African Americans, two groups disproportionately affected by the epidemic.

Syphilis: This co-morbidity is of critical importance to the Cleveland TGA since it has struggled with the re-emergence of syphilis, a highly co-infected disease with HIV, for the past four years, with specific concern for young (13-19) African American MSM. An expanding outbreak of early syphilis (i.e. primary, secondary and early latent syphilis) among two populations in Cuyahoga County has brought together a coalition of city, county and state public health officials and involved parties. The populations at risk are 1) youth and young adults, ages 13-24, 2) heterosexual males and females, 90% of whom are Black and 2) MSM/bisexual males of all races and ethnicities. A total of 126 persons were reported in Cuyahoga County with early syphilis in 2009, the largest case count since the outbreak began in 2007. Eighty cases, (63.5%) were from Cleveland.

Youth are at highest risk for STIs: Over 40% of Chlamydia cases reported annually is among teens age 15 to 19. Gonorrhea rates are highest among those age 15 to 19 and 20 to 24. Since 2006, about 10 teens in Cuyahoga County were diagnosed with HIV each year.

POPULATIONS AT GREATEST RISK FOR SYPHILIS ARE:

1. Youth and young adults age 13 to 24 years, (47, or 37.6% of 126 cases in 2009)
2. MSM/bisexual males (56.3%, or 71 of 126), and
3. Heterosexual males and females (42.9%, or 54 of 126), most of whom were African American.

Over half (55%) of MSM/bisexual males had primary or secondary stage syphilis when diagnosed compared to only 36% of heterosexual males and females and 38% of youth age 13 to 24 years.

More cases are from the suburbs: Over a third (36.5%) of early syphilis cases reported in 2009 were from county residents living outside of Cleveland. In 2008, only 30% of early syphilis cases were from the suburbs, 70% from Cleveland. Cases were reported in 23 municipalities. Those with the largest increases from 2008 to 2009 were Euclid (from 1 to 8 cases); Cleveland Heights (from 3 to 6); Shaker Heights (0 to 5); East Cleveland (2 to 3). Also notable was Lakewood (5 cases in 2008 to 1 case in 2009).

Substance Abuse: The prevalence of substance abuse in the general population of the TGA is extrapolated from the federal Substance Abuse and Mental Health Services Administration's 2008 National Survey on Drug Use and Health. Fifteen percent of the general population is estimated to regularly use substances; over 22% admit binge drinking. Use of both alcohol and illicit drugs by PLWHA makes treatment complicated and costly. The resources necessary to find, engage and case manage such clients' increases costs to the public health system in the Cleveland TGA. Substance dependence and chronic abuse complicate adherence to rigorous treatment regimens. Substance use also keeps patients out of care entirely. The Comprehensive Needs Assessment in the TGA indicated that substance abuse is prevalent among PLWHA in the TGA, and that it has a significant impact on the epidemic. Particularly among those OOC - substance use - including injection drug use - was a major contributing factor in keeping them outside of the care system since it impacted their functioning, housing stability and transportation options. Fifty six percent (56%) of OOC survey participants indicated they had been referred for substance abuse treatment at some point; 27% of in-care respondents stated that they had been referred to treatment. Among those OOC, 8% indicated that substance abuse treatment would be necessary to help them enter or re-enter the care system.

Mental Illness: In 2008, the Substance Abuse and Mental Health Services Administration estimated the prevalence of severe, chronic mental illness to be as high as 9% among the adult population, or more than 199,000 adults in the TGA. Data from the Comprehensive Needs Assessment indicates that among persons who are OOC, the rate of mental illness is much higher: 41% had been referred for mental health treatment, yet only 3% of interview respondents indicated that mental health treatment would link them to care. This "disconnect" between a person's perception of their need for help and the reality of a debilitating mental illness indicates the need for identification, treatment and stabilization of a client's mental illness.

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 cites studies which indicate that the prevalence of HIV/AIDS among homeless people is between 3-20%. In addition to costs associated with meeting the housing needs of PLWHA, their medical care is compromised by instability. When they do present for treatment they are often sicker, and more costly to treat, further straining the public health system. According to the Comprehensive Needs Assessments,

among those who were in care, there was an 8% increase in homelessness. Among the OOC, 51% of respondents experienced homelessness or living in someone else's residence. Homelessness among the OOC population in the Cleveland TGA is most prevalent among those who have been incarcerated in the past three years, and have recently been released.

Cumulative Impact of Co-morbidities on the Cost and Complexity of Providing Care: The profile of PLWHA in the Cleveland TGA reveals a typical client who presents “late to care” with an increasingly complex set of physical, mental, economic and social challenges. Those living in poverty experience a myriad of challenges, including accessing transportation to medical appointments and maintaining proper nutrition. Clients who experience transient housing are unable to maintain treatment regimens, and are difficult to engage and track. Diseases common to aging are a significant issue for the TGA, particularly in the Eastern region— diabetes, hypertension, and cardiac problems – both mask and complicate HIV/AIDS treatment. Clients suffering from homelessness or mental health issues prove difficult to engage in a consistent manner. Those engaged in the use of drugs often prefer to remain “underground” due to the illegal nature of the activity. The uninsured, or underinsured, make significantly fewer visits to a physician, experience reduced access based on insurance status, and arrive for treatment “sicker” than those accessing primary care earlier. Access to Ohio Medicaid is diminishing, as state administrators eliminate categorical benefits and narrow eligibility criteria. A typical HIV/AIDS client requires HAART, physician visits, case management, transportation and other services. The director of the Special Immunology Unit at University Hospitals of Cleveland has provided an average cost breakdown for ambulatory HIV treatment.

ASSESSMENT OF EMERGING POPULATIONS WITH SPECIAL NEEDS

Six populations with special needs in the Cleveland TGA include: MSMs, African Americans, Latinos, minority women, IDUs and the “aged,” defined as persons 45 or older. These are also the populations most likely to be underrepresented in the Ryan White funded system of care. Data pertaining to each group has been gathered as part of the Needs Assessments. The grantee's cost and utilization data was used in combination with data from University Hospitals of Cleveland to develop a baseline estimated costs for delivering care to each group.

MSMs: Although MSMs are estimated to make up fewer than 10% of the TGA's general population, they are the largest single transmission group among new AIDS cases with 47% of the total. New HIV cases are 50% of the total HIV incidence. MSM constitute 51% of total PLWA and 38% of PLWH. MSM present as a complex group for two reasons. First, there is a bimodal age spectrum—under 20 years of age and over 45 years; believed to be due to the perception that youth are not at risk or that HIV medication can “cure” the disease. Second, ‘disguised’ MSMs who are bisexual or gay but do not disclose sexual orientation represent a difficult group to engage. Within MSMs, African Americans and Latinos are more frequently outside of the system of care. MSM indicate that their barriers to care are stigma around disclosure and access to prescription medications, particular among those whose incomes are too high to qualify for assistance. The primary service gap was housing. In the Comprehensive Needs Assessment, African American MSM, the second largest group in this category, cited that factors which contribute to OOC include the presence of STIs and other significant co-morbidities, as well as homelessness and being in the “aged” group. Among Latino MSMs, injection drug use was the most significant contributing factor to OOC, along with STIs, substance abuse and “remote location”. Estimated costs of delivering services to MSM are \$ 19,432.

African Americans: African Americans make up 54% of PLWHA in the TGA and are disproportionately affected by the epidemic, with 32% higher AIDS incidence than their proportion in the general population;

and 38% higher HIV incidence. There are 32% more PWLA than the general population and 36% more PLWH. They are statistically less likely to have health insurance and are more likely to live in poverty, and to be suffering from hypertension and diabetes, significantly complicating their care. African Americans frequently mention access to prescription medications as a service barrier. Service gaps identified by this group included dental care and affordable housing. Estimated costs for delivering services to African Americans are \$ 19,249.

Latinos: Latinos make up 12% of new AIDS cases and 9% of new HIV cases, 9% of PLWA and 8% of PLWH in the TGA. They most frequently exhibit non-disclosure of sexual practices and continued heterosexual transmission as well as active injection drug use, creating a barrier to receiving care. The TGA's Latino population may also experience challenges due to their status as undocumented citizens. Many PLWHA are transitory, particularly among the Puerto Rican community of the Western Region, traveling between Lorain, NYC and Puerto Rico, making it difficult to remain eligible for benefits, or experience continuity of care. Other challenges include discrimination/stigma, cost/worry about insurance, desire for "one stop shopping" for care, a perception that case managers "play favorites," and transportation. Service gaps for this group included food, some transportation, access to prescription medications (other than HIV), and language (particularly noted for Case Management) for monolingual PLWHA. Estimated costs for serving the TGA's Latino population include an increased (by 5%) average cost of care based on this group's tendency to be diagnosed in the later stages of HIV disease (AIDS) or to seroconvert within the first year of diagnosis, for a total of \$ 18,724.

Minority Women (MW): African American women represent the largest group of minority women in the Cleveland TGA with increased incidence of HIV, followed by Latinas, representing 23% of new AIDS cases, 19% of PLWA and 23% of PLWH. They present a complex challenge, since they are often monogamous and determine they are positive late in the disease and without knowledge of risk. Barriers for this group include access to prescription drugs (African Americans) and language (Latinas). Service gaps, or services which would enable minority women to enter care, include culturally competent and/or linguistically friendly providers— particularly case managers in the Western Region. Another factor in not accessing medical care among minority women is substance use – specifically IDU among Anglos and Latinas. Estimated costs for delivering services to Minority Women are \$18,471.

IDUs: Although they represent less than .1% of the general population, IDUs represent 8% of new AIDS cases and 2% of new HIV cases, 11% of PLWA, and 8% of PLWH. In the Cleveland TGA, IDU correlate highly with the Latino population, especially in the Western region. This group is the least adherent to the rigorous HIV medication and treatment regimen. They often present for care late, (with an AIDS diagnosis) with extensive co-morbidities, and frequently have a dual diagnosis of mental illness. Barriers to care for IDUs include an unwillingness to enter treatment, and complications (especially if co-infected with Hepatitis C). Service gaps include a lack of co-located substance abuse/methadone treatment and medical care, and 'friendly' medical providers willing to deal with non-adherence and concurrent substance use. Estimated costs of service delivery for IDUs are \$ 18,723.

Aged: Persons in the 45+ age group represent 38% of new AIDS cases and 25% of new HIV cases; 60% of PLWA and 50% of PLWH in the TGA. Early diagnosis of persons in this age group is confounded by other diseases of aging and by their and their medical provider's perception that they are not at risk. Barriers are problems with transportation, lack of health insurance, inability to obtain life insurance, a need for

financial assistance (since they were too old or disabled to obtain work), and need for emotional support, particularly from people their age. Service gaps were identified as transportation, insurance and housing. Estimated costs for serving the aged are \$18,595.

SERVICE COSTS BY SPECIAL POPULATION, 2009

	MSM	A/A	LATINO	MW	IDU	AGED	ALL
Baseline Medications HAART	\$16,000	\$16,000	\$16,000	\$16,000	\$16,000	\$16,000	\$16,000
Outpatient Ambulatory Medical Care	\$1,034	\$1,034	\$1,034	\$1,034	\$1,034	\$1,034	\$1,034
Supportive Service Needs	\$1,156	\$1,156	\$253			\$1,366	\$ 1,409
Oral Health		\$1,059					\$1,059
Medical Case Mgt.			\$195	\$195		\$195	\$195
Outpatient Substance Treatment	\$1,242		\$1,242	\$1,242	\$1,242		\$1,242
Mental Health Service					\$447		\$447
TOTAL COST	\$19,432	\$19,249	\$18,724	\$18,471	\$18,723	\$18,595	\$21,386

CHAPTER 2: IN CARE FINDINGS

INTRODUCTION

According to the Ohio Department of Health HIV/AIDS surveillance data report, the number of PLWH in the TGA as of June 30, 2010, was 1,990 and the total number of PLWA in the TGA as of June 30, 2010 was 2,023. This totals 4,013 cases of HIV/AIDS. According to the grantee's service records, the program served approximately 2,600 unduplicated individuals, or 79% of the TGA's PLWHA during the past two grant years. The survey participation goal of at least 5% of the total PLWHA in the service area was exceeded.

DEMOGRAPHICS

A total of 203 PLWHA participated in the “In Care” needs assessment study. Almost 76% were males; almost 23% females and less than 2% were transgender individuals (M to F).

ARE YOU?		
ANSWER OPTIONS	PERCENT	COUNT
Male	75.9%	154
Female	22.7%	46
Transgender M to F	1.5%	3
TOTAL ANSWERED		203

Almost equal proportions of the In Care survey population reported gay (41%) and straight (44%) as their sexual orientation, with over 10% reporting bisexuality.

The risk exposure modes reported by the 2011 respondents reflect the HIV transmission modes of the TGA’s population of PLWHA, with 50% reporting MSM risk behavior; 24% Heterosexual behavior; 10% Sex with an IDU; 3% IDU; 4% sexual assault; 1% transfusion related; and 0.5% Mother with HIV/AIDS. Over 14% report an unknown risk exposure.

DO YOU KNOW HOW YOU MAY HAVE ACQUIRED HIV/AIDS? (PLEASE CHECK ALL THAT APPLY.)		
ANSWER OPTIONS	PERCENT	COUNT
Male sex w/ male	50.0%	95
Heterosexual sex	23.7%	45
Sex with drug user	10.0%	19
Sexual assault	3.7%	7
Injection drug use	2.6%	5
Transfusion	1.1%	2
Mother w/ HIV/AIDS	0.5%	1
While incarcerated	0.0%	0
Health Care Worker	0.0%	0
Unknown	14.2%	27

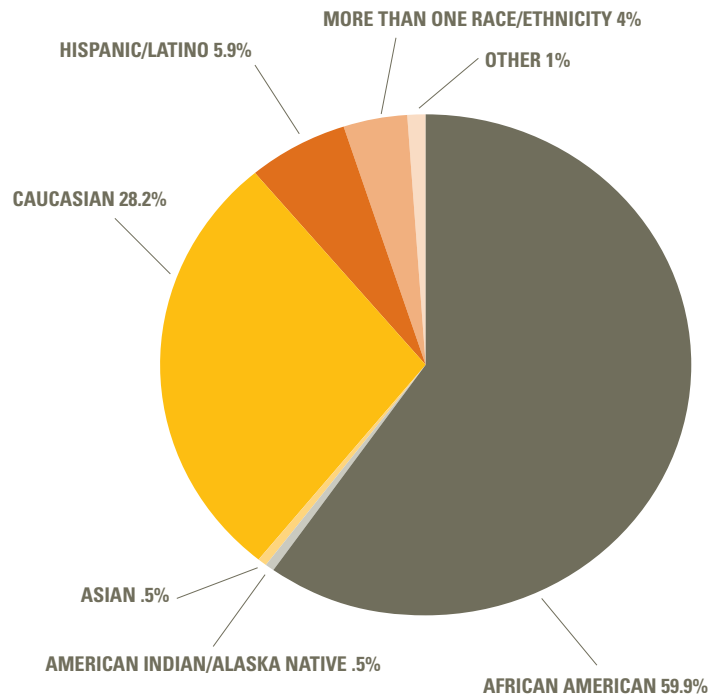
DO YOU KNOW HOW YOU MAY HAVE ACQUIRED HIV/AIDS? (PLEASE CHECK ALL THAT APPLY.)		
ANSWER OPTIONS	PERCENT	COUNT
TOTAL ANSWERED		190

As evidenced in the figure below, the majority of the In Care population is African American (60%), followed by 28% White, and 6% Hispanic/Latino, and 4% more than one race, with 1% “other”

EMPLOYMENT, EDUCATION & INCOME

Almost 15% of the In Care survey respondents report employment, with the remainder reporting unemployment. As evidenced below, the vast majority of respondents report poverty-level incomes at or below \$19,999 annually.

WHAT IS YOUR APPROXIMATE YEARLY INCOME?		
ANSWER OPTIONS	PERCENT	COUNT
\$0-9,999	64.6%	82
\$10,000-19,999	23.6%	30
\$20,000-\$29,999	4.7%	6



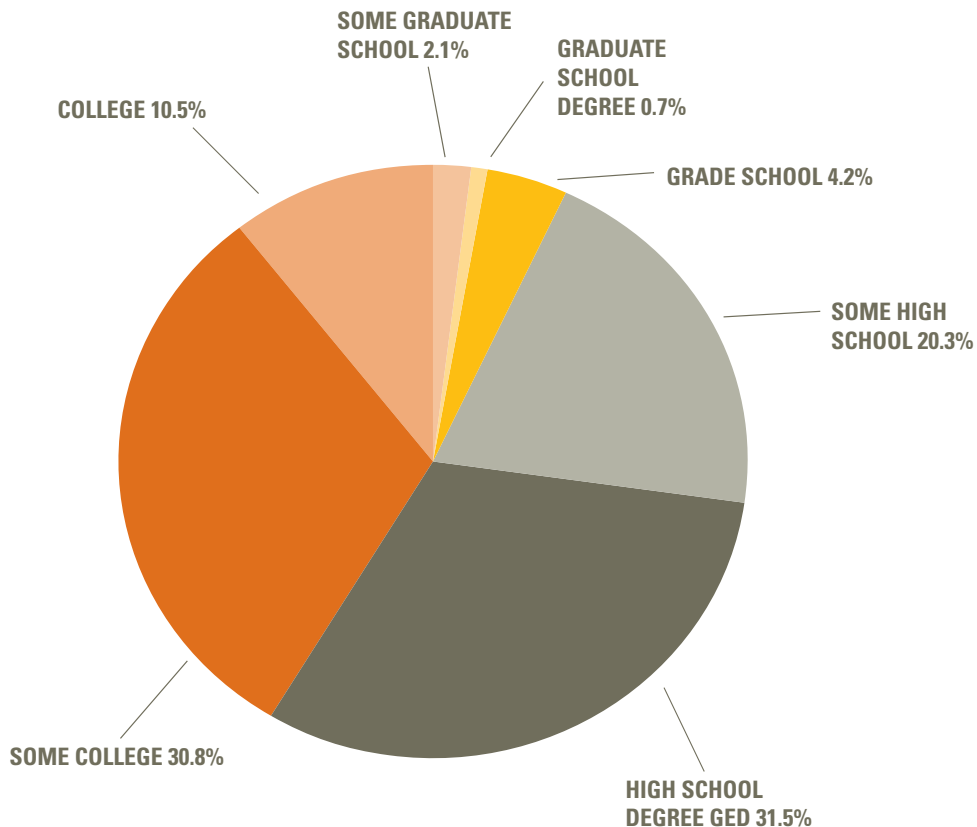
* NATIVE HAWAIIAN OR OTHER/PACIFIC ISLANDER 0% | OTHER 0%

WHAT IS YOUR APPROXIMATE YEARLY INCOME?		
ANSWER OPTIONS	PERCENT	COUNT
\$30,000-\$39,999	3.1%	4
\$40,000-\$49,999	3.1%	4
Over \$50,000	0.8%	1
TOTAL ANSWERED		127

Almost 25% or one quarter of the 2011 In Care respondents reports a high school or grade school education. An additional 32% report a GED and almost 31% report some college level course work. Almost 11% report a college degree; with 2% reporting some graduate work and 1% reporting a graduate level degree.

HEALTH INSURANCE

Almost 30% of the In Care survey respondents' report no health insurance coverage. Over 1/3 report Medicaid benefits; slightly more than 20% report Ryan White funding as their source of health coverage; almost 19% report Medicare; and over 10% report some form of private insurance coverage. "Other" responses included CARESOURCE, WELLSOURCE and OHDAP.



WHAT KIND OF HEALTH INSURANCE DO YOU HAVE?		
ANSWER OPTIONS	PERCENT	COUNT
Medicaid	35.1%	66
None	29.3%	55
Ryan White Part A	20.2%	38
Medicare	18.6%	35
Private Health Insurance through work/spouse's work	10.1%	19
Veteran's Administration	1.6%	3
Private Health Insurance, not through work	1.1%	2
COBRA (Insurance through my last employer)	0.0%	0
Other	6.9%	13
TOTAL ANSWERED		188

PREVIOUS OR CURRENT HOMELESSNES

WHAT KIND OF HEALTH INSURANCE DO YOU HAVE?		
ANSWER OPTIONS	PERCENT	COUNT
Never	54.1%	73
Been homeless over 2 years ago but not now	20.7%	28
Been homeless in past 2 years, but not now	15.6%	21
Currently Homeless	9.6%	13
TOTAL ANSWERED		135

A substantial proportion of the In Care survey respondent group reports familiarity with homelessness. Over 36% of the In Care respondents report having been recently homeless, with 16% in the past two years and almost 21% experienced a period of homeless more than two years ago. Almost 10% report current homelessness.

By SNG, IDU report the highest frequency of homelessness over two years ago (40%), followed by AA who report 21% homelessness in the past two years and 21% over two years ago, with 14% reporting current homelessness. Minority women report a high level of recent homelessness with 21% in past two years and 15% over two years ago. MSM report 10% homelessness in the past two years; 19% over two years ago; and 10% report current homelessness. The Hispanics report the lowest level of recent homelessness with 11% over two years ago and 0% current homelessness.

Regarding current housing status, 6% report staying in a shelter, 20% report temporary housing, staying with friends. The majority (almost 60%) rent their home and over 10% own their home. Those 5% of respondents that report “other” for current housing situation included reports of a boarding house, bouncing from house to house, hospice house, nursing home, and “streets”.

Year and Location of HIV/AIDS Diagnosis. Almost one-half of all In Care respondents report receiving their HIV diagnosis within the past five years since 2006 (49%). The remaining respondents report a wide variation in year of diagnosis, ranging from 1979 to 2005. Over 75% reported learning their HIV status since the advent of combination therapy in 1996. Of these, less than one-third or 31%, report receiving an AIDS diagnosis. Of the 143 who answered the question, 115 report Ohio as the state in which they learned their HIV status, with the remaining respondents’ reporting Georgia, Michigan, New York, California, Illinois, Texas, Nevada, Missouri, Maine, Pennsylvania, Puerto Rico and Nigeria. Fully 23% report receipt of their diagnosis in an emergency room. Over half or 52% acknowledge the receipt of partner notification, with 5% reporting they do not know if they received this service and 44% reporting they did not receive partner notification services.

QUALITY OF IN CARE STATUS

LAST DOCTOR VISIT AND LAST LAB MONITORING VISIT PATTERNS

VISIT TIME FRAME	DOCTOR	A/A	LATINO
Past 3 Months 12/10-3/11 <i>(Ideal 'In Care' Status)</i>	100	90	92
Past 4-6 Months 9/10-11/10 <i>(Satisfactory 'In Care' Status)</i>	24	33	31
Past 7-9 Months 6/10-8/10 <i>(Erratically 'In Care' Status)</i>	36	27	27

VISIT TIME FRAME	DOCTOR	A/A	LATINO
Past 10-12 Months 3/10-5/10 <i>(Fragile 'In Care' Status- At risk of Unmet Need)</i>	28	34	32
TOTAL 'IN CARE'	188	184	182
Technically 'Out of Care' <i>(Unmet Need in 2010)</i>	6	6	6
Out of Care > One Year-2009 <i>(OOC Since 2009 or before)</i>	4	1	1
TOTAL 'Out of Care'	10	7	7
GRAND TOTAL	198	191	189

The majority of respondents evidence an ideal pattern of HIV primary medical care attachment, with a minority evidencing an erratic or fragile engagement with primary medical care. Only four respondents report not seeing their HIV physician since 2009.

ANTIRETROVIRAL THERAPY

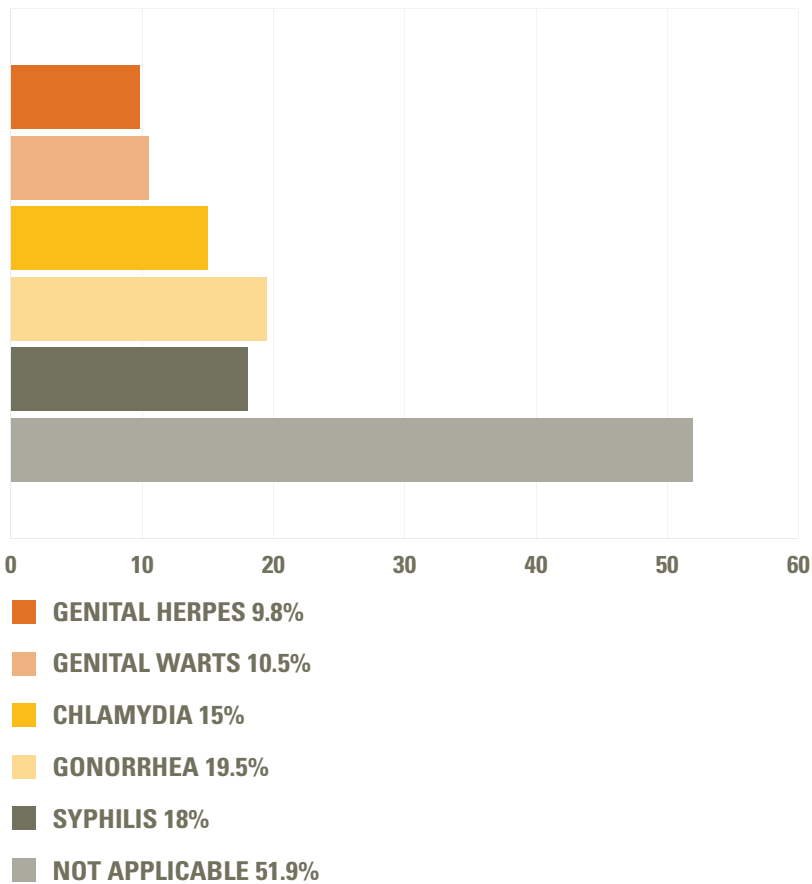
INSURANCE ARE YOU CURRENTLY TAKING ART (HIV) MEDICATIONS?		
ANSWER OPTIONS	PERCENT	COUNT
Yes	68.5%	135
No	28.9%	57
Don't know	2.5%	5
TOTAL ANSWERED		197

Over 2/3 or 69% of the In Care respondents report the receipt of antiretroviral therapy. A few respondents (N=5) report not knowing whether they are receiving ART.

MENTAL HEALTH DIAGNOSIS AND TREATMENT

Almost half of the In Care respondents (48%) report having been diagnosed with a mental health disorder, while 53% of the respondent group reports receiving treatment for these disorders. By SNG, Minority women report the highest frequency of behavioral health issues, with 51% reporting a diagnosis of mental health issues and 58% reporting treatment for same since their HIV diagnosis. IDU are distinguished as the only SNG reporting having received a lesser proportionate level of treatment for their diagnosed disorders (40% diagnosed versus 33% treated).

DIAGNOSIS &/OR TREATMENT FOR STI



Almost 20% of the In Care respondents report having been diagnosed and treated for Gonorrhea, and 18% for Syphilis, with 15% Chlamydia, 11% genital warts, and 10% genital herpes, indicating a fairly high level of sexually transmitted diseases within this cohort.

By SNG, Hispanics report the highest frequency of a Syphilis diagnosis (38%), followed by IDU (33%), AA (18%), MSM (14%), and Minority women (13%). African Americans report the greatest frequency of Gonorrhea (21%) followed by MSM at 19%, with Hispanics and Minority women reporting diagnosis and treatment for Gonorrhea at 13%, respectively. 100% of the IDU SNG reports the diagnosis of Hepatitis C, followed by 25% of the Aged; 20% of the AA, 19% Minority women and 17% MSM. None of the Hispanics reported a diagnosis of Hepatitis C.

DIAGNOSIS OR TREATMENT OF CHRONIC ILLNESSES OTHER THAN HIV

HAVE YOU EVER BEEN DIAGNOSED WITH OR TREATED FOR DISEASES OTHER THAN HIV?		
ANSWER OPTIONS	PERCENT	COUNT
High Blood Pressure	44.0%	40

HAVE YOU EVER BEEN DIAGNOSED WITH OR TREATED FOR DISEASES OTHER THAN HIV?		
ANSWER OPTIONS	PERCENT	COUNT
Thrush/Yeast Infection	24.2%	22
Hepatitis C	18.7%	17
Diabetes	18.7%	17
Hepatitis B	15.4%	14
Cancer	16.5%	15
Nerve Issues (epilepsy, neuropathy)	16.5%	15
Other (please list)	16.5%	15
Cardiac Problems/Heart Disease	11.0%	10
Hepatitis A	7.7%	7
Tuberculosis (TB)	8.8%	8
TOTAL ANSWERED		91

As evidenced in the table above, 44% of the In Care respondents report a diagnosis or treatment for high blood pressure. Almost one-quarter report a previous diagnosis of yeast infection; almost 19% report diabetes; another 19% report Hepatitis C; almost 17% report cancer and another 17% report nerve issues; and over 15% report Hepatitis B, evidencing a fairly high level of co-morbid illnesses.

RECENT JAIL OR PRISON STAY

A total of 5% of the In Care respondents report a recent jail stay and over 2% report a recent incarceration in prison. By SNG, there is great variation in the reports of recent jail stays, ranging from 0% for Hispanics to 33% for IDU. Fewer than half report an offer of HIV medical care upon release from jail/prison (at any point in time) while greater than 50% (21 of 40 total) report they were NOT offered a referral for HIV medical care or services upon exit from the penal system.

WHEN YOU WERE RELEASED FROM JAIL/PRISON, WERE YOU OFFERED HELP TO GET HIV MEDICAL CARE OR OTHER HIV-RELATED SERVICES?		
ANSWER OPTIONS	PERCENT	COUNT
Yes	15.7%	19
No	17.4%	21

WHEN YOU WERE RELEASED FROM JAIL/PRISON, WERE YOU OFFERED HELP TO GET HIV MEDICAL CARE OR OTHER HIV-RELATED SERVICES?

ANSWER OPTIONS	PERCENT	COUNT
Not Applicable	66.9%	81
TOTAL ANSWERED		121

LOCATION OF CLINIC/DOCTOR'S OFFICE

CLINIC/DOCTOR	#	CLINIC/DOCTOR	#
Metro Health	49	Mercy Infectious Disease Clinic	8
University Hospital	49	VA Hospital	6
Care Alliance	23	The Free Clinic	5
Cleveland Clinic	22		
Community Health partners	14		

USE OF ALCOHOL AND/OR OTHER SUBSTANCES

Fully 70% of the PLWHA respondents report the use of alcohol and/ or other substances.

DURING THE PAST 12 MONTHS, HOW OFTEN HAVE YOU USED ANY OF THE FOLLOWING SUBSTANCES?

ANSWERS	DAILY	WEEKLY	MONTHLY	RARELY	NEVER	COUNT
Alcohol	9	13	19	34	29	104
Cocaine	2	2	4	6	73	87
Crack	2	4	5	5	74	90
Crystal Meth/ Methamphetamine	0	0	0	0	83	83
Heroin	1	0	2	0	82	85

DURING THE PAST 12 MONTHS, HOW OFTEN HAVE YOU USED ANY OF THE FOLLOWING SUBSTANCES?						
ANSWERS	DAILY	WEEKLY	MONTHLY	RARELY	NEVER	COUNT
Marijuana or hash	13	5	7	16	55	96
Speedball	2	0	0	1	82	85
Tobacco	51	10	2	8	28	99
Other: Heroin, but now clean for 5 months						1
TOTAL ANSWERED						112

One quarter (51) of the respondents report daily use of tobacco, with less frequent reports of daily marijuana, alcohol, cocaine, crack, heroin or speedball use. More common are the reports of weekly or monthly use of some substances, including alcohol, marijuana, crack, cocaine, or heroin. There were no reports of crystal meth use within this population of respondents. Over 10% of the respondents report previous injection drug use; however none of the respondents reports current injection drug use. Only one respondent reported sometimes sharing needles. When sharing, one respondent reported always cleaning first and one respondent reported never cleaning/disinfecting their works prior to sharing needles.

USE, NEED, BARRIER & GAP RANKING

A Need, Use, Barrier and Gap ranking was developed for all Cleveland TGA survey respondents, with rankings developed for each special population. The 2011 HIV/AIDS Needs Assessment provides a “snapshot” of community service uses, needs, barriers, and gaps as expressed by consumers of HIV related services in the service area. The rankings of the Needs Assessment are displayed for all ‘In Care’ respondents, with separation by Special Population, and are defined as:

Use: Number of ‘In Care’ client survey respondents who indicated service use in the past year

Need: Number of ‘In Care’ client survey respondents who stated “I currently need this service.”

Barrier: Number of ‘In Care’ client survey respondents who indicated that a service is ‘Hard to Get’.

Gap: Sum of ‘In Care’ client survey respondents who answered ‘Yes’ to Need and ‘No’ to availability of that service.

THE IN CARE SURVEY RESPONDENTS RANKED THE FOLLOWING SERVICE NEEDS

1. Primary Medical Care
2. Medications (HIV & non-HIV)
3. Housing Assistance

4. Nutrition/Food Assistance
5. Mental Health/Support Services

THE IN CARE SURVEY RESPONDENTS RANKED THE FOLLOWING SERVICE USES

1. Primary Medical Care
2. Medications
3. Medical Transportation
4. Case Management
5. Nutrition Assistance/Food Bank tied with Mental Health/Support Services

THE IN CARE SURVEY RESPONDENTS RANKED THE FOLLOWING SERVICE GAPS (SERVICES “CAN’T GET”)

1. Medical Transportation
2. Medications
3. Housing Assistance tied with Nutrition/Food Assistance
4. Mental Health/Support Services tied with Employment/Job Assistance
5. Emergency Financial Assistance

THE IN CARE SURVEY RESPONDENTS RANKED THE FOLLOWING SERVICE BARRIERS (SERVICES “HARD TO GET”)

1. Medical Transportation
2. Medication Assistance
3. Housing Assistance
4. Nutrition/Food Assistance
5. Emergency Financial Assistance

2011 ALL ‘IN CARE’ PLWHA NEED, USE, BARRIER, & GAP MATRIX

SERVICE CATEGORY	NEED RANK	USE RANK	GAP RANK	BARRIER RANK
Primary Medical Care	1	1	NR	NR
Medication Assistance	2	2	2	2

SERVICE CATEGORY	NEED RANK	USE RANK	GAP RANK	BARRIER RANK
Housing Assistance	3	6	3 tie	3
Nutrition/Food Assistance	4	5 tie	3 tie	4
Mental Health/Support Services	5	5 tie	4 tie	8 tie
Medical Transportation	6	3	1	1
Emergency Financial Assistance	7	10	5 tie	5
Health Insurance/Disability Assistance	8	7	3 tie	8 tie
Employment/Job Assistance/ Stable Income	9	NR	4 tie	7
Oral Health Care	10	9	NR	6
Substance Abuse Treatment	11	8	NR	10 tie
Case Management	12	4	NR	10 tie
Eye care/Eye wear	NR	NR	5 tie	9

NEED, USE, GAP, BARRIER RANKINGS BY SNG

1. MSM PLWHA (N=95)

The top five service Needs reported by the MSM SNG include: 1) Medication Assistance; 2) Primary Medical care; 3) Housing Assistance; 4) Nutrition/Food Assistance; and 5) Mental Health/Support Services tied with Medical Transportation.

Their top five service Uses include: 1) PMC; 2) Case Management; 3) Medication Assistance; 4) Medical Transportation; and 5) Mental Health/Support Services.

MSM report the services they can't get (Gaps) as: 1) Nutrition/Food Assistance tied with Employment/Job Assistance; 2) Housing Assistance tied with Mental Health/Support Services and Health Insurance/Disability Assistance.

The top ranking service Barriers expressed by MSM include: 1) Medical Transportation; 2) Medication Assistance; 3) Housing Assistance tied with Nutrition/Food Assistance; 4) Mental Health/Support Services tied with Employment/Job Assistance tied with Oral Health Care; and 5) EFA tied with Health Insurance/Disability Assistance.

MSM PLWHA (N=95)

SERVICE CATEGORY	TOTAL 2011 PLWHA NEED RANK	MSM NEED RANK	MSM USE RANK	MSM GAP RANK	MSM BARRIER RANK
Primary Medical Care	1	2	1	NR	NR
Medication Assistance	2	1	3	NR	2
Housing Assistance	3	3	9	2 tie	3 tie
Nutrition/Food Assistance	4	4	6	1 tie	3 tie
Mental Health/Support Services	5	5 tie	5	2 tie	4 tie
Medical Transportation	6	5 tie	4	NR	1
Emergency Financial Assistance	7	7	11	NR	5 tie
Health Insurance/ Disability Asst	8	9	8	2 tie	5 tie
Employment/Job Assistance/Stable Income	9	6	NR	1 tie	4 tie
Oral Health Care	10	10	10	NR	4 tie
Substance Abuse Treatment	11	NR	7	NR	NR
Case Management	12	8	2	NR	6 tie
Eye care/Eye wear	NR	NR	NR	NR	6 tie

+MSM Gaps: *Massage therapy, Meds Delivery, Spiritual support, Therapy Dog Assistance*

+ MSM Barriers: *Lack of knowledge how to locate support groups, Cost of care-(meds, insurance, visits, gas), Massage therapy for neuropathy, SSI/SSDI assistance, Social Workers' lack of knowledge of how the system works, Assistance due to changes in frequency of re-application*

2. AFRICAN AMERICAN PLWHA (N=101)

As evidenced below, the top five service Needs reported by African American PLWHA include: 1) Medication Assistance; 2) Primary Medical Care 3) Nutrition/Food Assistance; 4) Housing Assistance; and

5) Mental Health/Support Services tied with Medical Transportation.

The AA PLWHA's top five services Uses include: 1) PMC; 2) Case Management; 3) Medication Assistance; 4) Medical Transportation; and 5) Mental Health/Support Services.

Top ranking service Gaps for this disparately impacted SNG include: 1) Medical Transportation; 2) Housing Assistance; 3) Nutrition/Food Assistance; and numerous services tied for #4 Gap rankings, including: PMC, Medication Assistance, Mental Health/Support Services, Health Insurance/Disability Assistance, Employment Assistance, and Eyewear/Eye care.

Top ranking service Barriers include: 1) Medication Assistance tied with Medical Transportation; 2) Housing Assistance; 3) Employment Assistance; 4) Nutrition/Food Assistance; and 5) Eyewear/Eye care.

AFRICAN AMERICAN PLWHA (N=101)

SERVICE CATEGORY	TOTAL 2011 PLWHA NEED RANK	AA NEED RANK	AA USE RANK	AA GAP RANK	AA BARRIER RANK
Primary Medical Care	1	2	1	4 tie	6 tie
Medication Assistance	2	1	3	4 tie	1 tie
Housing Assistance	3	4	7 tie	2	2
Nutrition/Food Assistance	4	3	6	3	4
Mental Health/Support Services	5	5 tie	5	4 tie	NR
Medical Transportation	6	5 tie	4	1	1 tie
Emergency Financial Assistance	7	6	9 tie	NR	NR
Health Insurance/Disability Asst	8	8	8	4 tie	6 tie
Employment/Job Assistance/Stable Income	9	7	NR	4 tie	3
Oral Health Care	10	NR	9 tie	NR	6 tie
Substance Abuse Treatment	11	10	7 tie	NR	6 tie

SERVICE CATEGORY	TOTAL 2011 PLWHA NEED RANK	AA NEED RANK	AA USE RANK	AA GAP RANK	AA BARRIER RANK
Case Management	12	9	2	NR	6 tie
Eye care/Eye wear	NR	NR	10	4 tie	5

+ AA Gaps: Medication delivery, Massage therapy services

+AA Barriers: Clothes, Massage therapy for neuropathy, Legal advocacy, Child care, SSDI/SSI assistance, Life insurance, School assistance, Social Worker's knowledge about how the system works, Assistance due to changes in frequency of re-application

3. MINORITY WOMEN PLWHA (N=46)

The top five service Needs expressed by Minority Women include: 1) Medication Assistance; 2) PMC; 3) Nutrition/Food Assistance; 4) Mental Health/Support Services; and 5) Housing Assistance.

Services reported as most frequently Used by this SNG include: 1) Primary Medical care; 2) Medication Assistance; 3) Case Management; 4) Medical Transportation; and 5) Nutrition/Food Assistance.

The top ranking service Gaps reported by Minority Women include: 1) Medication Assistance; followed by numerous #2 tied service Gap rankings, including: Housing Assistance, Nutrition/Food Assistance, Mental Health/Support Services, Medical Transportation, Health Insurance/Disability Assistance, and Oral Health Care.

The top five service Barriers reported by this SNG include: 1) Medical Transportation; 2) Medication Assistance tied with Oral Health Care; 3) Nutrition/Food Assistance; 4) PMC tied with EFA, Health Insurance/Disability Assistance, Employment/Job Assistance, Eye Care, and Interpreter/Translation Assistance.

MINORITY WOMEN PLWHA (N=46)

SERVICE CATEGORY	TOTAL 2011 PLWHA NEED RANK	MW NEED RANK	MW USE RANK	MW GAP RANK	MW BARRIER RANK
Primary Medical Care	1	2	1	NR	4 tie
Medication Assistance	2	1	2	1	2 tie
Housing Assistance	3	5	6 tie	2 tie	NR
Nutrition/Food Assistance	4	3	5	2 tie	3

SERVICE CATEGORY	TOTAL 2011 PLWHA NEED RANK	MW NEED RANK	MW USE RANK	MW GAP RANK	MW BARRIER RANK
Mental Health/Support Services	5	4	7 tie	2 tie	NR
Medical Transportation	6	6	4	2 tie	1
Emergency Financial Assistance	7	7	7 tie	NR	4 tie
Health Insurance/Disability Asst	8	8	6 tie	2 tie	4 tie
Employment/Job Assistance/Stable Income	9	11 tie	7 tie	NR	4 tie
Oral Health Care	10	9	NR	2 tie	2 tie
Substance Abuse Treatment	11	10	6 tie	NR	NR
Case Management	12	NR	3	NR	NR
Eye care/Eye wear	NR	NR	NR	NR	4 tie
Interpreter/Translation Assistance	NR	11 tie	7 tie	NR	4 tie

+ MW Gaps: Information about services, Social events

+MW Barriers: Power scooter, Legal assistance, Child care, Life insurance, SSI/SSDI assistance, Toiletries, Home help, Social events

4. HISPANIC PLWHA (N=12)

The top ranking service Needs expressed by Hispanic PLWHA include three #1 Need rankings: Medication Assistance, Housing Assistance and Nutrition/Food Assistance, followed by 2) Medical Transportation; and numerous #3 ranked Needs including: PMC, Mental Health/Support Services, EFA, Health Insurance/Disability Assistance, Employment/Job Assistance, Oral Health care, and Interpreter/Translation Assistance.

Their top ranking services Uses include: 1) PMC tied with Nutrition/Food Assistance and Case Management; 2) Housing Assistance tied with Mental Health/Support Services and Medical Transportation; 3) Medication Assistance tied with Health Insurance/Disability Assistance and Interpreter/Translation Assistance. There were no #4 or #5 Use rankings reported by the Hispanic SNG.

Their top ranking service Gaps include: Medication Assistance and Oral Health Care. Service Barriers reported by the Hispanic PLWHA include: 1) Medical Transportation; 2) Oral Health Care; 3) Medication Assistance tied with Health Insurance/Disability Assistance, Employment/Job Assistance and Interpreter/Translation Assistance.

HISPANIC PLWHA (N=12)

SERVICE CATEGORY	TOTAL 2011 PLWHA NEED RANK	HIS NEED RANK	HIS USE RANK	HIS GAP RANK	HIS BARRIER RANK
Primary Medical Care	1	3 tie	1 tie	NR	NR
Medication Assistance	2	1 tie	3 tie	1 tie	3 tie
Housing Assistance	3	1 tie	2 tie	NR	NR
Nutrition/Food Assistance	4	1 tie	1 tie	NR	NR
Mental Health/Support Services	5	3 tie	2 tie	NR	NR
Medical Transportation	6	2	2 tie	NR	1
Emergency Financial Assistance	7	3 tie	NR	NR	NR
Health Insurance/Disability Asst	8	3 tie	3 tie	NR	3 tie
Employment/Job Assistance/Stable Income	9	3 tie	NR	NR	3 tie
Oral Health Care	10	3 tie	NR	1 tie	2
Substance Abuse Treatment	11	4	NR	NR	NR
Case Management	12	NR	1 tie	NR	NR
Eye care/Eye wear	NR	NR	NR	NR	NR
Interpreter/Translation Assistance	NR	3 tie	3 tie	NR	3 tie

+ MW Gaps: Information about services, Social events

+MW Barriers: Power scooter, Legal assistance, Child care, Life insurance, SSI/SSDI assistance, Toiletries, Home help, Social events

2. AFRICAN AMERICAN PLWHA (N=101)

The AA PLWHA's top five services Uses include: 1) PMC; 2) Case Management; 3) Medication Assistance; 4) Medical Transportation; and 5) Mental Health/Support Services.

Top ranking service Gaps for this disparately impacted SNG include: 1) Medical Transportation; 2) Housing Assistance; 3) Nutrition/Food Assistance; and numerous services tied for #4 Gap rankings, including: PMC, Medication Assistance, Mental Health/Support Services, Health Insurance/Disability Assistance, Employment Assistance, and Eyewear/Eye care.

Top ranking service Barriers include: 1) Medication Assistance tied with Medical Transportation; 2) Housing Assistance; 3) Employment Assistance; 4) Nutrition/Food Assistance; and 5) Eyewear/Eye care.

AFRICAN AMERICAN PLWHA (N=101)

SERVICE CATEGORY	TOTAL 2011 PLWHA NEED RANK	AA NEED RANK	AA USE RANK	AA GAP RANK	AA BARRIER RANK
Primary Medical Care	1	2	1	4 tie	6 tie
Medication Assistance	2	1	3	4 tie	1 tie
Housing Assistance	3	4	7 tie	2	2
Nutrition/Food Assistance	4	3	6	3	4
Mental Health/Support Services	5	5 tie	5	4 tie	NR
Medical Transportation	6	5 tie	4	1	1 tie
Emergency Financial Assistance	7	6	9 tie	NR	NR
Health Insurance/Disability Asst	8	8	8	4 tie	6 tie
Employment/Job Assistance/Stable Income	9	7	NR	4 tie	3
Oral Health Care	10	NR	9 tie	NR	6 tie
Substance Abuse Treatment	11	10	7 tie	NR	6 tie
Case Management	12	9	2	NR	6 tie
Eye care/Eye wear	NR	NR	10	4 tie	5

+ AA Gaps: Medication delivery, Massage therapy services

+AA Barriers: Clothes, Massage therapy for neuropathy, Legal advocacy, Child care, SSDI/SSI assistance, Life insurance, School assistance, Social Worker's knowledge about how the system works, Assistance due to changes in frequency of re-application

3. MINORITY WOMEN PLWHA (N=46)

The top five service Needs expressed by Minority Women include: 1) Medication Assistance; 2) PMC; 3) Nutrition/Food Assistance; 4) Mental Health/Support Services; and 5) Housing Assistance. Services reported as most frequently Used by this SNG include: 1) Primary Medical care; 2) Medication Assistance; 3) Case Management; 4) Medical Transportation; and 5) Nutrition/Food Assistance.

The top ranking service Gaps reported by Minority Women include: 1) Medication Assistance; followed by numerous #2 tied service Gap rankings, including: Housing Assistance, Nutrition/Food Assistance, Mental Health/Support Services, Medical Transportation, Health Insurance/Disability Assistance, and Oral Health Care.

The top five service Barriers reported by this SNG include: 1) Medical Transportation; 2) Medication Assistance tied with Oral Health Care; 3) Nutrition/Food Assistance; 4) PMC tied with EFA, Health Insurance/Disability Assistance, Employment/Job Assistance, Eye Care, and Interpreter/Translation Assistance.

MINORITY WOMEN PLWHA (N=46)

SERVICE CATEGORY	TOTAL 2011 PLWHA NEED RANK	MW NEED RANK	MW USE RANK	MW GAP RANK	MW BARRIER RANK
Primary Medical Care	1	2	1	NR	4 tie
Medication Assistance	2	1	2	1	2 tie
Housing Assistance	3	5	6 tie	2 tie	NR
Nutrition/Food Assistance	4	3	5	2 tie	3
Mental Health/Support Services	5	4	7 tie	2 tie	NR
Medical Transportation	6	6	4	2 tie	1
Emergency Financial Assistance	7	7	7 tie	NR	4 tie

SERVICE CATEGORY	TOTAL 2011 PLWHA NEED RANK	MW NEED RANK	MW USE RANK	MW GAP RANK	MW BARRIER RANK
Health Insurance/ Disability Asst	8	8	6 tie	2 tie	4 tie
Employment/Job Assistance/Stable Income	9	11 tie	7 tie	NR	4 tie
Oral Health Care	10	9	NR	2 tie	2 tie
Substance Abuse Treatment	11	10	6 tie	NR	NR
Case Management	12	NR	3	NR	NR
Eye care/Eye wear	NR	NR	NR	NR	4 tie
Interpreter/Translation Assistance	NR	11 tie	7 tie	NR	4 tie

+ MW Gaps: Information about services, Social events

+MW Barriers: Power scooter, Legal assistance, Child care, Life insurance, SSI/SSDI assistance, Toiletries, Home help, Social events

4. HISPANIC PLWHA (N=12)

The top ranking service Needs expressed by Hispanic PLWHA include three #1 Need rankings: Medication Assistance, Housing Assistance and Nutrition/Food Assistance, followed by 2) Medical Transportation; and numerous #3 ranked Needs including: PMC, Mental Health/Support Services, EFA, Health Insurance/ Disability Assistance, Employment/Job Assistance, Oral Health care, and Interpreter/Translation Assistance.

Their top ranking services Uses include: 1) PMC tied with Nutrition/Food Assistance and Case Management; 2) Housing Assistance tied with Mental Health/Support Services and Medical Transportation; 3) Medication Assistance tied with Health Insurance/Disability Assistance and Interpreter/Translation Assistance. There were no #4 or #5 Use rankings reported by the Hispanic SNG. Their top ranking service Gaps include: Medication Assistance and Oral Health Care. Service Barriers reported by the Hispanic PLWHA include: 1) Medical Transportation; 2) Oral Health Care; 3) Medication Assistance tied with Health Insurance/Disability Assistance, Employment/Job Assistance and Interpreter/Translation Assistance.

HISPANIC PLWHA (N=12)

SERVICE CATEGORY	TOTAL 2011 PLWHA NEED RANK	HIS NEED RANK	HIS USE RANK	HIS GAP RANK	HIS BARRIER RANK
Primary Medical Care	1	3 tie	1 tie	NR	NR
Medication Assistance	2	1 tie	3 tie	1 tie	3 tie
Housing Assistance	3	1 tie	2 tie	NR	NR
Nutrition/Food Assistance	4	1 tie	1 tie	NR	NR
Mental Health/Support Services	5	3 tie	2 tie	NR	NR
Medical Transportation	6	2	2 tie	NR	1
Emergency Financial Assistance	7	3 tie	NR	NR	NR
Health Insurance/ Disability Asst	8	3 tie	3 tie	NR	3 tie
Employment/Job Assistance/Stable Income	9	3 tie	NR	NR	3 tie
Oral Health Care	10	3 tie	NR	1 tie	2
Substance Abuse Treatment	11	4	NR	NR	NR
Case Management	12	NR	1 tie	NR	NR
Eye care/Eye wear	NR	NR	NR	NR	NR
Interpreter/Translation Assistance	NR	3 tie	3 tie	NR	3 tie

5. IDU PLWHA (N=5)

The top ranking service Needs reported by the IDU SNG include: 1) PMC; 2) Medication Assistance tied with Housing Assistance and Substance Abuse Treatment; and 3) Case Management.

The top ranking service Uses reported by the IDU SNG fairly mirrors these top ranked Needs: 1) PMC; 2) Medication Assistance; 3) Case Management; and 4) Housing Assistance tied with Substance Abuse Treatment.

The IDU SNG reported no services that they cannot get (service Gaps). The single service Barrier reported by this SNG includes Medication Assistance.

(The sample of IDU PLWHA respondents was small, so these Need, Use, Gap, & Barrier rankings may not equitably represent all of the In Care IDU.)

IDU PLWHA (N=5)

SERVICE CATEGORY	TOTAL 2011 PLWHA NEED RANK	IDU NEED RANK	IDU USE RANK	IDU GAP RANK	IDU BARRIER RANK
Primary Medical Care	1	1	1	NR	NR
Medication Assistance	2	2 tie	2	NR	1
Housing Assistance	3	2 tie	4 tie	NR	NR
Nutrition/Food Assistance	4	NR	NR	NR	NR
Mental Health/Support Services	5	NR	NR	NR	NR
Medical Transportation	6	NR	NR	NR	NR
Emergency Financial Assistance	7	NR	NR	NR	NR
Health Insurance/ Disability Asst	8	NR	NR	NR	NR
Employment/Job Assistance/Stable Income	9	NR	NR	NR	NR
Oral Health Care	10	NR	NR	NR	NR
Substance Abuse Treatment	11	2 tie	4 tie	NR	NR
Case Management	12	3	3	NR	NR
Eye care/Eye wear	NR	NR	NR	NR	NR

6. AGED PLWHA (N=77)

The top ranking service Needs of the Aged SNG most closely resemble the entire In Care PLWHA rankings

and include: 1) PMC; 2) Medication Assistance; 3) Housing Assistance; 4) Nutrition/Food Assistance; and 5) Medical Transportation.

The Aged PLWHA's reported service Uses include: 1) PMC; 2) Medication Assistance; 3) Medical Transportation tied with Case Management; 4) Nutrition/Food Assistance; and 5) Mental Health/Support Services.

The top ranking service Gaps reported by the Aged include: 1) Medical Transportation; 2) Housing Assistance; 3) Medication Assistance tied with Nutrition/Food Assistance and EFA; 4) Primary Medical Care tied with Mental Health/Support Services tied with Employment Assistance and Eye care. (The #4 Gap rankings were reported by only 1 Aged PLWHA).

The top ranking service Barriers for the Aged include: 1) Medical Transportation; 2) Medication Assistance; 3) Housing Assistance; 4) Nutrition/Food Assistance; and 5) Employment/Job Assistance.

AGED PLWHA (N=77)

SERVICE CATEGORY	TOTAL 2011 PLWHA NEED RANK	AGED NEED RANK	AGED USE RANK	AGED GAP RANK	AGED BARRIER RANK
Primary Medical Care	1	1	1	4 tie	NR
Medication Assistance	2	2	2	3 tie	2
Housing Assistance	3	3	6	2	3
Nutrition/Food Assistance	4	4	4	3 tie	4
Mental Health/Support Services	5	6	5	4 tie	8 tie
Medical Transportation	6	5	3 tie	1	1
Emergency Financial Assistance	7	9 tie	7 tie	3 tie	7
Health Insurance/Disability Asst	8	8	7 tie	4 tie	8 tie
Employment/Job Assistance/Stable Income	9	7	8 tie	4 tie	5
Oral Health Care	10	11 tie	NR	NR	6

SERVICE CATEGORY	TOTAL 2011 PLWHA NEED RANK	AGED NEED RANK	AGED USE RANK	AGED GAP RANK	AGED BARRIER RANK
Substance Abuse Treatment	11	10	7 tie	NR	NR
Case Management	12	9 tie	3 tie	NR	NR
Eye care/Eye wear	NR	NR	NR	4 tie	9 tie
Interpreter/Translation Assistance	NR	11 tie	8 tie	NR	9 tie

+ *Aged Gaps: Housekeeping assistance, Massage therapy, Social events, Shopping for food, Therapy Dog Assistance*

+ *Aged Barriers: Clothes, Massage therapy, Toiletries, School assistance, Knowledge of how system works, Legal assistance*

CHAPTER 3: NEWLY DIAGNOSED/NEW TO CARE FINDINGS

INTRODUCTION

A special focus of the Cleveland TGA Planning Council in 2010 was to better understand and respond to the complex HIV prevention and service needs of the emerging Severe Need Group: the Newly Diagnosed/New to Care PLWHA. The newly diagnosed cases of HIV/AIDS continue to grow at alarming rates, and therefore, represent a population of substantial concern to the Cuyahoga Regional HIV Services Planning Council.

This special needs assessment study was undertaken to determine the priority service needs, barriers, and gaps in the continuum of care for ‘Newly Diagnosed/New to Care PLWHA. A special focus of this needs assessment study was to perform an in-depth survey of the HIV risk behaviors and prevention needs of this SNG population, along with survey items intended to clarify what system level changes may be necessary in order to strengthen the prevention-to testing-to care linkages, so that persons living with HIV disease and Unaware may learn their HIV status and be assisted in entering care at earlier stages of their disease process.

A comprehensive assessment of the HIV care and prevention service needs, gaps and barriers of the emerging population of ‘Newly Diagnosed/New to Care’ PLWHA within the Cleveland TGA was conducted in the spring of 2010. This assessment of need included the quantitative review and analysis of data for all newly entering PLWHA over the last project year, along with a qualitative survey of the ‘Newly Diagnosed’ (defined as having received a first diagnosis of HIV or AIDS in past year). A new and comprehensive survey tool was developed, inclusive of detailed survey items relative to the complex HIV prevention and care needs, uses, barriers and gaps for the Newly Diagnosed/New to Care PLWHA in the TGA. The results of the study are intended to better inform planners of improved strategies to reach and serve the Unaware of HIV diagnosis in the service area.

The target sample size was 50-74 PLWHA diagnosed in the past year with representation from the entire Cleveland TGA Regions. While newly diagnosed respondents were challenging to identify and recruit due

to stigma, shock with their diagnosis, and difficulty understanding use of the data, over a three-month period there were 56 respondents who participated in the survey. Incentives were offered for completion of the survey in the amount of \$10 to Giant Eagle market.

THE SURVEY INSTRUMENT REQUESTED INFORMATION ON EIGHT (8) DIFFERENT CATEGORIES:

6. Demographics
7. HIV Acquisition
8. HIV Testing
9. HIV Disclosure
10. Delay of Entry Into Testing/HIV Medical Care
11. HIV Pathway To Care & Supportive Services
12. Current 'In Care' Practice and CD4 At Diagnosis
13. Risk Reduction

Results of this client-centered activity will be used to establish Ryan White funded service priorities, document the need for specific prevention and care services, determine barriers to accessing HIV testing and care, provide baseline data for comprehensive prevention and care planning including capacity building, and help providers improve the accessibility, acceptability and quality of both prevention and care services that are delivered to this special population'.

EPIDEMIOLOGY OF NEWLY INFECTED PLWHA

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 newly diagnosed within the past year.

COMPARISON OF NEWLY DIAGNOSED STUDY RESPONDENTS (2010) TO FULL POPULATION (2009)

	NEWLY DIAGNOSED (IN LAST YEAR)	NEWLY DIAGNOSED (WITHIN LAST YEAR)	NEWLY DIAGNOSED (ODH, 2009)
	SAMPLED STUDY 2010	FULL POPULATION	TGA Regional data
GENDER			
Male	86%	66.5%	79%
Female	14%	32.5%	21%

	NEWLY DIAGNOSED (IN LAST YEAR)	NEWLY DIAGNOSED (WITHIN LAST YEAR)	NEWLY DIAGNOSED (ODH, 2009)
RACE/ ETHNIC			
Caucasian	23%	29%	34%
African-American	64%	39%	56%
Latino/a	5%	30%	12%
Asian/Pacific Islander	2%		
Multi-Race	6%	0.7%	2% (other)
TRANSMISSION			
IDU	4%	30.7%	8%
MSM	55%	36.5%	39%
Heterosexual	16%	30.4%	12%
Sexual Assault	4%		
Unknown	16%	0%	38%
Other	6%	0%	3%
AGE			
0-12	0%	0%	0%
13-19	9%	1.9%	1%
20-29	46%	21.1%	18%
30-39	14%	23.2%	25%
40-49	18%	26.9%	29%
50+	13%	26.9%	27%

An important reason for undertaking this Newly Diagnosed needs assessment study is to better understand how to devise effective strategies for reaching the Unaware in the service area. Sub-groups most likely to be HIV positive and Unaware in the Cleveland TGA are African Americans, MSM, Males, and those over 45 years of age. In addition, the alarming rise in sexually transmitted infections, especially syphilis, among young MSM (13-19 years of age) merits inclusion of this group. Since males are predominately affected by the disease and are part of every sub-group, they will be included in the strategies and plans for each group.

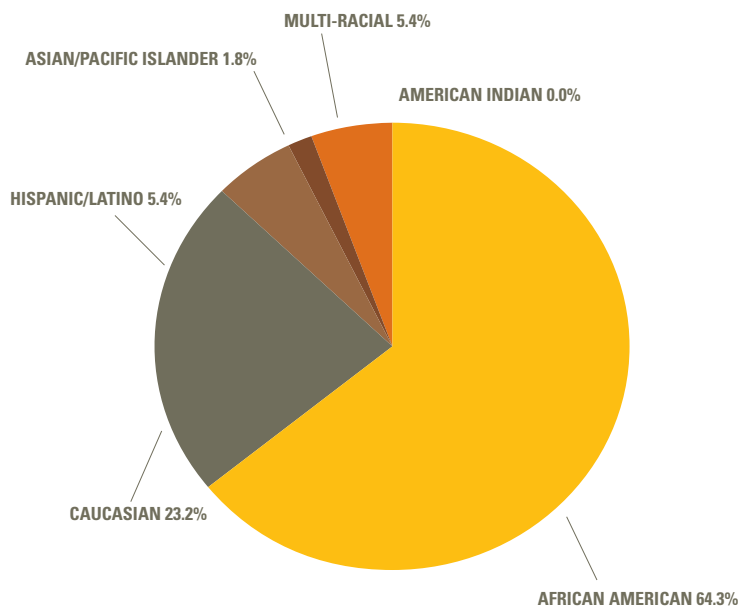
COMPARISON OF SUB-GROUPS BY CARE STATUS, 2009

	A	B	C	D
Sub-Group	Existing HIV/AIDS	New HIV/AIDS	Out of Care PLWHA	Unaware of HIV+
Males	79% (3,429)	76% (555)	77% (867)	79%(845)
African American	54% (1,320)	57% (418)	69% (777)	54% (577)
45 years+	54% (2,369)	31% (227)	77% (867)	54% (577)
MSM	51% (2,222)	47% (345)	47% (529)	48% (513)
13-19 years	.5% (21)	.6% (4)	1% (11)	1% (11)

{ Sources: A. Epidemiologic Profile for 6-county Cleveland TGA from ODH; 2009 B. Epidemiologic Profile for Cleveland TGA, 2008 & 2009; C-2009 Out of Care study using estimated Unmet Need derived in 2009; D-CDC back calculation using 2008 Existing HIV cases.}

1). DEMOGRAPHICS OF NEWLY DIAGNOSED

Respondents included a significantly higher number of males than females (86% versus 14%), as compared with epidemiologic trends and full population based data. Lower responses by Caucasians (23%), much higher responses by African Americans (64%), and equivalent fractions of Latino/a respondents and the multiracial occurred (5.4% respectively).

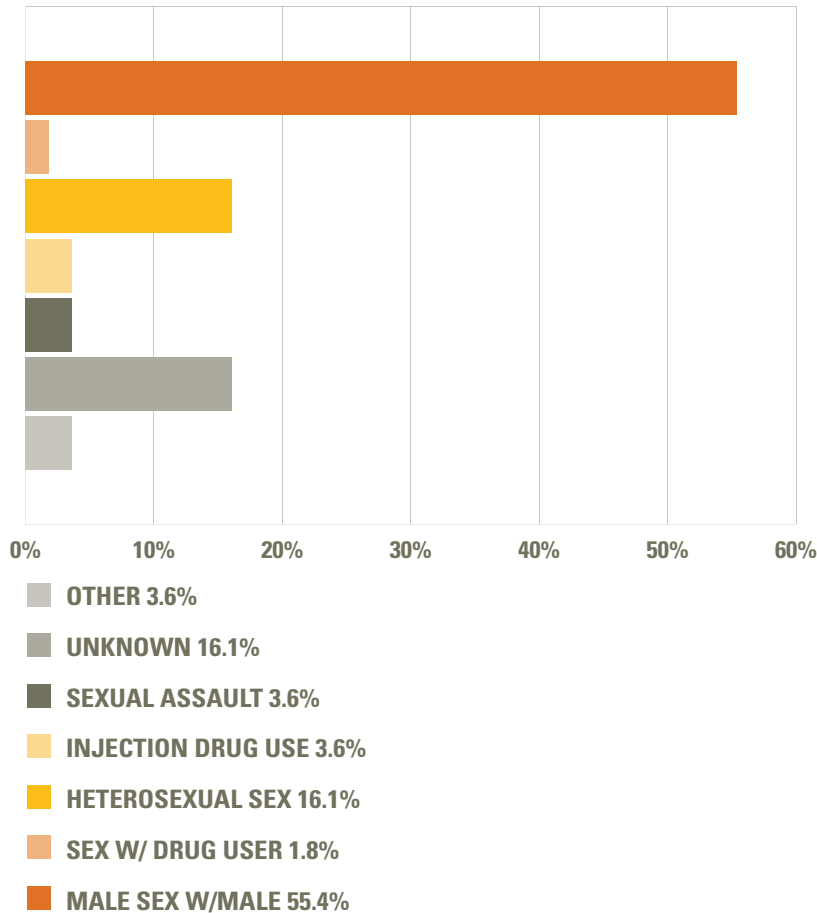


Age groups reflected the full population-based data, with the exception of a significantly higher fraction of 20-29 year olds than the in epidemiologic reports (9% vs. 1.9%).

2). HIV ACQUISITION

Transmission risk modes reported by study respondents approximate the estimated or known reported risk modes, with relatively high levels of unknown risk (>16%).

QUESTION 5: DO YOU KNOW HOW YOU MAY HAVE ACQUIRED HIV/AIDS?



3). HIV TESTING

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.

NEWLY DIAGNOSED HIV TESTING CIRCUMSTANCES

Fifty percent (50%) of the Newly Diagnosed respondents report they voluntarily requested testing in order to learn their status. An additional 11% wanted to be tested to confirm their suspicion that they were positive and 11% sought testing after having unprotected sex with an HIV positive sexual partner. Another 14% got tested after learning a friend tested positive, and 7% got tested after their partner tested positive. Only 9% reported not feeling well as their motivator for testing.

“Other” reasons included:

- Partner tested positive
- A friend who works at an outreach center
- When I donated plasma

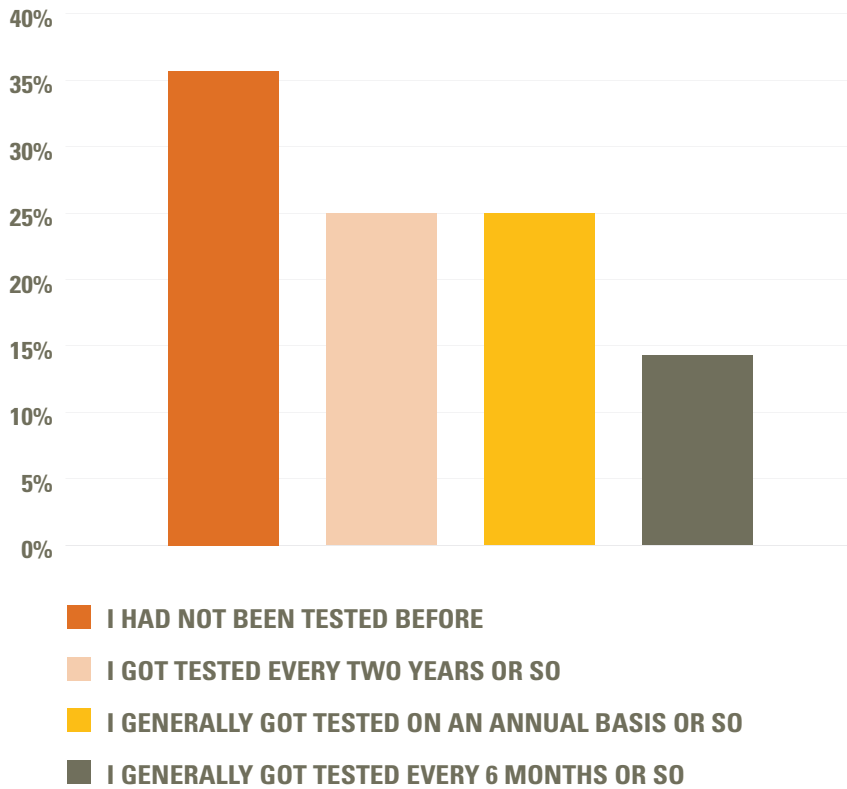
NEWLY DIAGNOSED REASONS TO TAKE HIV TEST

IF YOU VOLUNTARILY REQUESTED A TEST FOR HIV, WHAT PROMPTED YOU TO GET TESTED FOR HIV?		
ANSWER OPTIONS	PERCENT	COUNT
I needed screening and/or treatment for an STD	4.5%	2
A friend tested positive	13.6%	6
My partner asked me to get tested	6.8%	3
My partner tested positive	6.8%	3
I wanted to know my status	50.0%	22
I had unprotected sex with someone who was HIV positive	11.4%	5
I wanted to confirm my suspicion that I was positive	11.4%	5
I did not feel well and thought I should get checked for HIV	9.1%	4
Other	15.9%	7

NEWLY DIAGNOSED FREQUENCY OF HIV TESTING

Respondents reported the frequency of testing prior to their confirmatory diagnosis. Over one-third of respondents had never submitted to an HIV test prior to their initial diagnosis. Equal proportions (25% each, respectively) reported regularly testing every 6 to 12 months. A minority (14%) reported testing every two years prior to their diagnosis. Fully 1/3 (33%) were diagnosed with AIDS upon their initial diagnosis, evidencing a significant late-to-care pattern.

QUESTION 16: HOW MANY TIMES WERE YOU TESTED FOR HIV BEFORE YOU TESTED POSITIVE



REASONS FOR DELAYING HIV TESTING

IF YOU DELAYED GETTING TESTED FOR HIV, WHAT WERE YOUR REASONS FOR NOT GETTING TESTED?	
ANSWER OPTIONS	PERCENT
Felt well	33.3%
Not ready to know	17.8%
No insurance	15.6%
Not ready to deal with it	13.3%
Concerns about confidentiality/privacy	11.1%
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%
Other Reasons for Delaying Getting Tested for HIV	20.0%

A third of respondents (33%) stated that they delayed confirmatory testing because they ‘felt well’ and another 1/3 were ‘not ready to know’ or ‘not ready to deal with the diagnosis’. A high proportion of respondents ‘didn’t feel that they could be HIV positive or at risk’. Almost 16% delayed testing due to lack of health insurance. Other reasons for delay included fear of stigma (9%); concerns about confidentiality (11%); and worry about how to disclose their status if positive (9%).

ESTIMATED PERIOD OF TIME LIVING WITH HIV PRIOR TO DIAGNOSIS

HOW LONG DO YOU THINK YOU MAY HAVE BEEN LIVING WITH HIV BEFORE YOU RECEIVED YOUR FIRST POSITIVE TEST?	
ANSWER OPTIONS	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%

Over 40% of the Newly Diagnosed respondents report not really knowing how long they may have been living with HIV disease prior to their initial diagnosis. Almost 11% report that they think they were HIV positive for more than one year, and over 5% estimate they were positive for more than 2-3 years prior to confirming their HIV status. Over 42% believe they were living with HIV for a period of less than one year prior to their diagnosis.

Fully 65% of the Newly Diagnosed respondents reported the receipt of Partner Notification Services (while 35% reported the absence of this service).

EXPOSURE TO PREVENTION MESSAGES PRIOR TO TESTING/DIAGNOSIS

IF YES, WHERE DID YOU SEE/HEAR THESE HIV PREVENTION MESSAGES?		
ANSWER OPTIONS	PERCENT	COUNT
TV or radio	66.7%	32
Books, magazines, newspapers	45.8%	22
Other HIV/AIDS providers such as prevention workers, street outreach	39.6%	19
Internet web-sites	39.6%	19

IF YES, WHERE DID YOU SEE/HEAR THESE HIV PREVENTION MESSAGES?		
ANSWER OPTIONS	PERCENT	COUNT
My doctor or other health care provider	35.4%	17
Friends or family	22.9%	11
Internet chat rooms	8.3%	4
Support groups	8.3%	4
Other	8.3%	4
TOTAL		48

The vast majority of respondents (86%) report having heard HIV prevention messages prior to becoming tested and learning their HIV status. The locations where they received these HIV prevention messages included TV/Radio (67%); books/magazines/newspapers (46%); outreach workers (40%); internet websites (40%) and chat rooms (8%); friends/family (23%); and doctors’ offices (35%). Only 50% of respondents reported these messages were helpful in increasing their HIV risk awareness and reducing their risk.

For the 50% of the Newly Diagnosed respondents who answered in the affirmative that these prevention messages were helpful, the respondents offered the following reasons in support of their usefulness:

- **54.2%** > Yes, that is how I learned I might be at risk for HIV
- **33.3%** > Yes, that is why I got tested for HIV
- **12.5%** > Yes, that is how I started using condoms
- **16.7%** > Yes, that is how I learned where I could get free condoms
- **16.7%** > Yes, Other

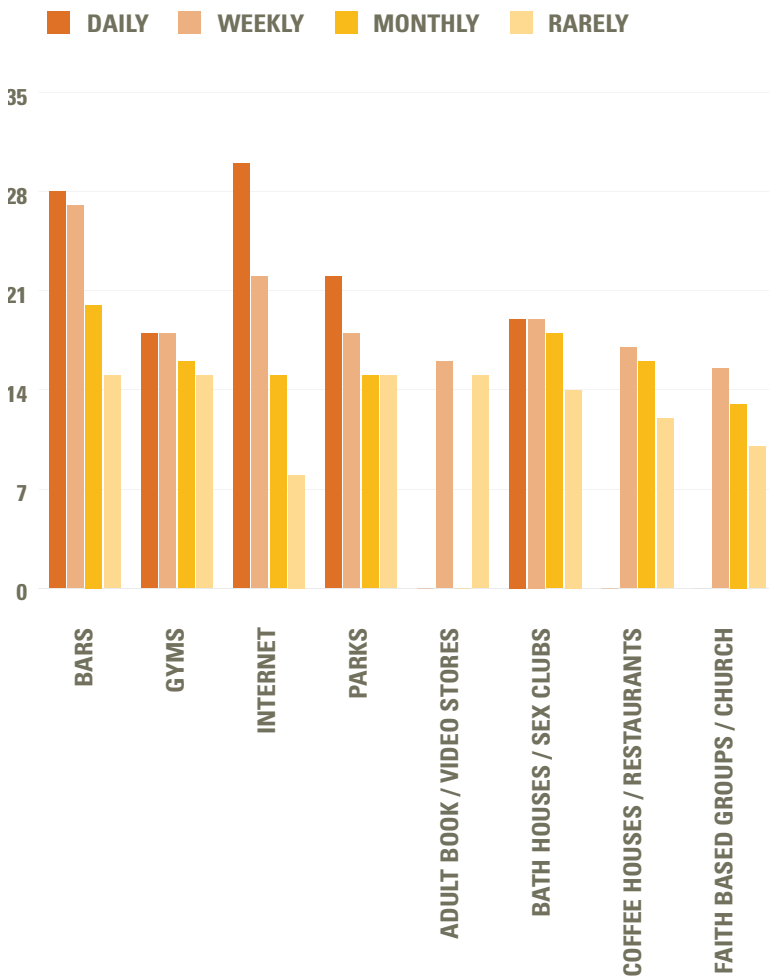
For the 50% who reported that the prevention messages they had been exposed to were NOT helpful, the respondents reported the reasons for the lack of impact of the messages included that “they did not think they were at risk for HIV” or “the messages did not pertain to them”.

SERVICES THAT WOULD HAVE PROMPTED EARLIER HIV TESTING

WHAT SERVICES WOULD HAVE HELPED YOU GET TESTED EARLIER?		
ANSWER OPTIONS	PERCENT	COUNT
More information/health education on why I should get tested	51.2%	22
A peer to talk with about it	25.6%	11
Mental health counseling at the point of testing positive	14.0%	6

WHAT SERVICES WOULD HAVE HELPED YOU GET TESTED EARLIER?		
ANSWER OPTIONS	PERCENT	COUNT
Being clean and sober	14.0%	6
An advocate to come with me to get tested	14.0%	6
Transportation assistance	4.7%	2
Other (please specify): School, private men's club and education in Africa	7.0%	3
TOTAL		43

QUESTION 37: HOW OFTEN DID YOU VISIT THE FOLLOWING PLACES TO MEET WITH SEX PARTNERS



The Newly Diagnosed respondents report a number of strategies that would prompt earlier testing, with over half (51%) reporting more information/education about risk personalization and the benefits of

testing and care. Over ¼ reports that having a peer to talk with would prompt earlier testing and another 14% report that having an advocate accompany them for testing would have motivated an earlier test and diagnosis. The availability of mental health counseling at the time of testing was recommended by 14% of the Newly Diagnosed respondents and another 5% reported transportation assistance would have made a difference to getting tested earlier.

The vast majority of respondents affirmatively report encouraging their partners to become tested for HIV (84%).

4). HIV DISCLOSURE

Given the importance of partner notification in preventing secondary transmission and the high rates of seroprevalence discovered through social networks, two questions were asked regarding the relationships of the newly diagnosed. When asked if they had tried to find sexual partners in the past three-years, 55% responded 'Yes'. For those who responded yes, a follow up question was provided regarding the locations where they sought to meet potential partners.

As evidenced in the figure above, daily/weekly frequenting of bars, internet web-sites, parks, bath houses, coffee houses and faith-based groups are reported by the newly Diagnosed as locations where they regularly seek to meet sexual partners. The internet is the most widely used vehicle for meeting sexual partners, lending credence to its use as an effective outreach tool to MSM.

5). REASONS FOR DELAYING ENTRY INTO HIV MEDICAL CARE

THE RESPONDENTS OFFERED THE FOLLOWING REASONS FOR DELAYING HIV TESTING AND ENTRY INTO CARE:

- Not ready to deal with it
- Felt well
- Fears about others finding out their HIV status
- Worry about how to tell partner/family
- General stigma surrounding HIV disease
- Fears of discrimination
- Concerns about confidentiality
- Lack of health insurance

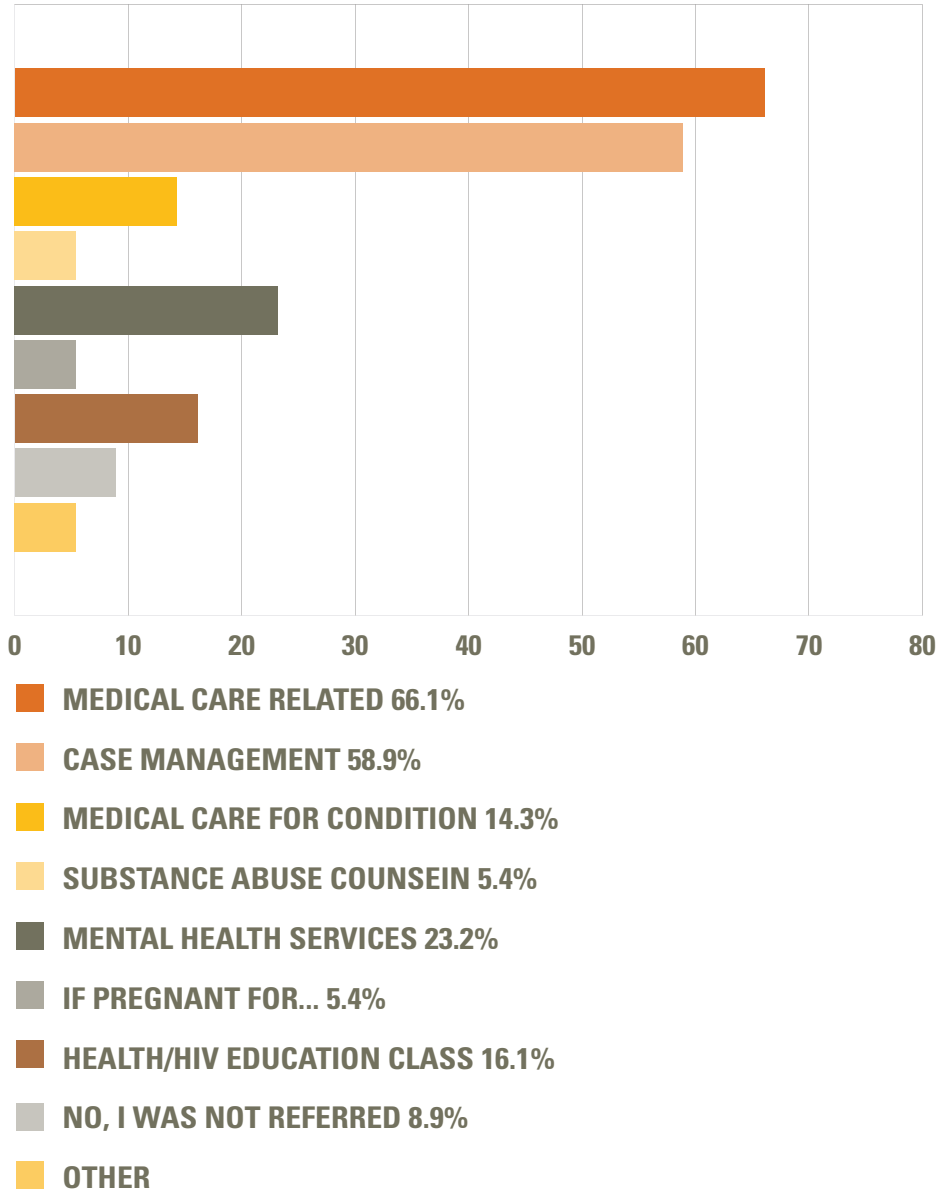
6). HIV PATHWAY TO CARE

Fully 66% or 2/3 of the Newly Diagnosed report receiving a referral for HIV medical care and 59% report a referral for case management. Over 23% received a referral for mental health services. Almost 9% report not receiving any service referrals upon their initial diagnosis.

7). CURRENT 'IN CARE' PRACTICE AND CD4 AT DIAGNOSIS

The Newly Diagnosed report accessing their primary medical care services at numerous locations within the TGA, with the most frequently reported including Metro Health, University Hospital, Community Health Partners, Care Alliance and the Cleveland Clinic.

CURRENT PMC LOCATION



WHAT CLINIC/DOCTOR'S OFFICE DO YOU GO TO FOR YOUR HIV?	
ANSWER OPTIONS	PERCENT
Metro Health	26.8%
University Hospital	17.9%
Community Health Partners	16.1%
Care Alliance	16.1%
Cleveland Clinic	14.3%
The Free Clinic	3.6%
Veteran's Administration (VA)	0.0%
Other (name)	5.4%

CD4 CELL COUNT AT TIME OF DIAGNOSIS

AT THE TIME OF YOUR HIV DIAGNOSIS, WHAT WAS YOUR CD4 CELL COUNT?	
ANSWER OPTIONS	PERCENT
> 500	16.4%
between 200-500	27.3%
< 200	32.7%
I don't know	18.2%
I haven't had labs yet	5.5%

As evidenced above, approximately 1/3 of the Newly Diagnosed received an AIDS diagnosis upon their initial testing, evidencing a significant late to care pattern. Additionally, over 27% of this Newly Diagnosed cohort report initial CD4 cell counts of less than 500 at the time of diagnosis.

MOST RECENT CD4 CELL COUNT

WHEN WAS THE LAST TIME YOU SAW A DOCTOR TO TREAT YOUR HIV/HAD A CD4 COUNT?	
ANSWER OPTIONS	PERCENT
Within the last month	50.0%

WHEN WAS THE LAST TIME YOU SAW A DOCTOR TO TREAT YOUR HIV/HAD A CD4 COUNT?	
ANSWER OPTIONS	PERCENT
Three to six months	46.0%
Longer than six months	4.0%

The vast majority of the Newly Diagnosed evidences a satisfactory initial attachment to care, with 96% reporting their most recent Primary Medical Care visit within the past 1-6 months.

CURRENT ART

ARE YOU CURRENTLY TAKING ART (HIV) MEDICATIONS?	
ANSWER OPTIONS	PERCENT
Yes	50.9%
No	45.5%
Don't know	3.6%

Slightly more than half of the Newly Diagnosed report current ART.

CO-MORBIDITIES OF THE NEWLY DIAGNOSED

Fully one-third of the respondents report having been diagnosed with a mental health disorder and 21% report having been diagnosed and/or treated for substance use/abuse. Over half of the respondents (54%) report diagnosis and treatment for an STI and 27% report treatment for another chronic illness.

HEALTH INSURANCE STATUS OF NEWLY DIAGNOSED

DO YOU CURRENTLY HAVE HEALTH INSURANCE?		
ANSWER OPTIONS	RESPONSES	CLEVELAND'S ADULT POPULATION 2009
None	58%	49%
Private health Insurance (Humana, Aetna, etc.)	18%	18%
Medicaid	16%	20%
Medicare	2%	5%

DO YOU CURRENTLY HAVE HEALTH INSURANCE?		
ANSWER OPTIONS	RESPONSES	CLEVELAND'S ADULT POPULATION 2009
Medicaid/ Medicare		7%
Other	6%	1%

As evidenced in the comparison table below, this cohort of Newly Diagnosed respondents is more heavily uninsured than the adult population in Cleveland (58% un-insurance versus 49%), and fewer respondents report the acquisition of Medicaid or Medicare benefits than that of the general population.

CHAPTER 4: OUT OF CARE SURVEY FINDINGS

RELEVANCE OF THE PART A COMPREHENSIVE "OUT OF CARE" NEEDS ASSESSMENT

The unmet need estimate in 2010 indicates that 28% of all PLWHA are 'Out of Care' in the Cleveland TGA. Four (4) subgroups exist among the 'Out of Care', two of whom do not technically adhere to the HRSA definition of at least one year not accessing primary medical care, but do shed insight into the 'Out of Care' issue. The four (4) groups are: 1) Newly diagnosed (risk of 'ever' attaching to care); 2) Those at 'risk of going Out of Care' (over 6 months not accessing primary medical care, display warning signs of non-compliance with treatment regimens); 3) the 'Technically Out of Care' (over 12 months not accessing primary care); and, 4) the Never in Care.

According to the most recently available data, the following table depicts the number and proportion of PLWHA who are 'In Care' and 'Out of Care' in the Cleveland TGA.

THREE YEAR TREND OF UNMET NEED IN CLEVELAND TGA, 2007-2009			
	2007	2008	2009
	1,288 (31%)	1,135 (28%)	1,126 (28%)
COMPARISON IN CARE TO OUT OF CARE, CLEVELAND TGA			
	A	B	C
	% IN CARE	% OUT OF CARE	EPI (PLWHA)
GENDER			
Male	70%	89%	75%

THREE YEAR TREND OF UNMET NEED IN CLEVELAND TGA, 2007-2009			
	2007	2008	2009
	1,288 (31%)	1,135 (28%)	1,126 (28%)
COMPARISON IN CARE TO OUT OF CARE, CLEVELAND TGA			
	A	B	C
	% IN CARE	% OUT OF CARE	EPI (PLWHA)
Female	29%	11%	25%
Transgender	1%		
HIV STATUS			
HIV+	78%	88%	51%
AIDS	22%	12%	49%
AGE GROUP			
20-29	13%	6%	
30-39	35%	33%	
40-49	42%	56%	
50-59	10%	5%	
RACE/ETHNIC			
AA	56%	56%	54%
WHITE	32%	29%	35%
HISPANIC	8%	11%	9%
Multi-Race	4%	4%	2%

According to the Ohio Department of Health HIV/AIDS surveillance data report, the number of PLWH in the TGA as of June 30, 2010, was 1,990 and the total number of PLWA in the TGA as of June 30, 2010 was 2,023. This totals 4,013 cases of HIV/AIDS.

An unduplicated total of 1,410 PLWA and 1,477 PLWH were reported to meet the definition of “In-Care” during the specified time period (calendar year 2009.) This leaves a total of 580 (29%) of those with AIDS

and 546 (27%) of those with HIV “not-in-care” according to the HRSA definition for calculating unmet need.

The initial and significant burden is attaching persons to care immediately upon a positive HIV diagnosis. Individuals tend to not enter care until they ‘feel sick’. In cultures that tend to not disclose or accept illness, particularly ones that are sexually transmitted or incurred due to injection drug use, this pattern exerts a dual deterrent to entering care. The ‘late to care’ pattern as evidenced by seroconversion to an AIDS diagnosis within a year of being diagnosed HIV-positive is most pronounced among African-Americans, Hispanics, Injection Drug Users, Other Substance Users and the Incarcerated/Recently Released.

Upon entry to primary medical care, the reasons for detachment include inability or unwillingness to maintain a rigorous treatment regimen (one in which adherence should be 94% or more to attain optimal benefit), side effects of HIV medications, the high cost of drugs or the co-payment related to HIV medications, and the pressure of other subsistence needs such as employment, housing and transportation to either access primary medical care or in lieu of paying for primary medical care.

Key points along the Continuum of Care can be assessed in a study specific to the ‘Out of Care’ to confirm that these are the risk flags for PLWHA considering abandoning their care regimen. Flags include erratic appointment compliance (missing three or more appointments); tendency to not disclose issues, repeated concerns about medication regimens and drug resistance that may be flags for non-compliance with medication regimens. Questioning PLWHA that are ‘Out of Care’ about their decision to abandon primary medical care will better highlight these risk points.

The Never in Care are one of the most troubling and least known subgroups. This group evidences confidentiality/privacy concerns, interest in alternative medicine and other resistance issues related to initial attachment to care upon positive HIV diagnosis. Subgroups exist within the ‘Never in Care’ including PLWHA who self-manage (majority are long-term survivors and wary of HIV medications from the first generation of HIV drugs such as AZT), the ‘unconnected’ which includes undocumented citizens, the Incarcerated/Recently Released, Injection Drug Users and some Substance Abusers. The Never in Care frequently do not wish to expose themselves to any legal ramifications nor change their current patterns of behavior. Entering medical care is perceived as an exposure risk.

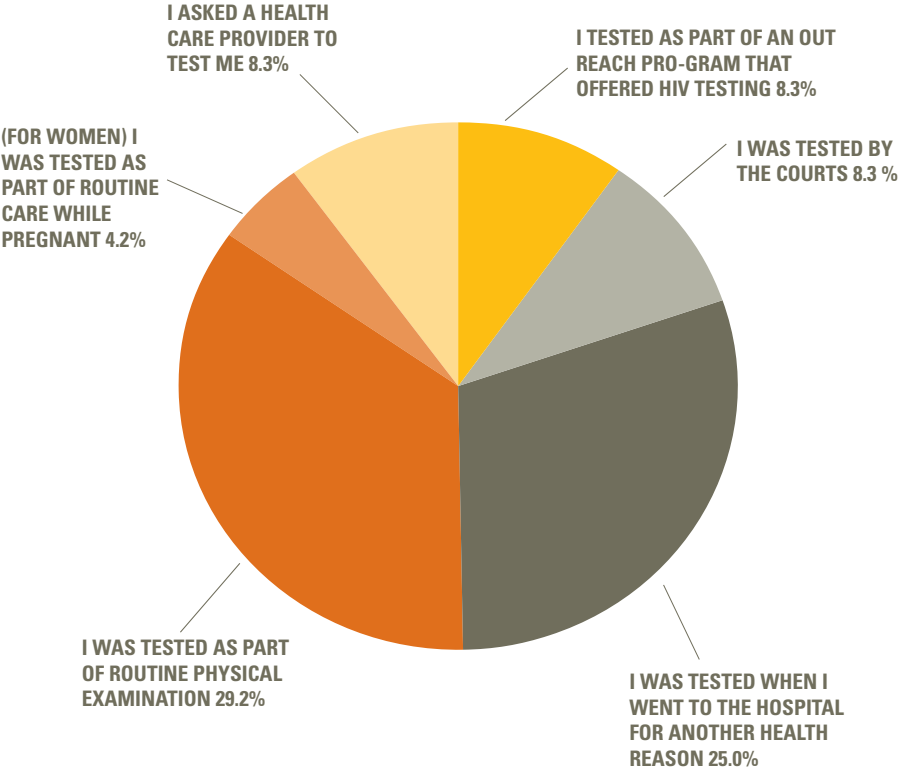
PROJECT DESIGN FOR THE ‘OUT OF CARE’ PLWHA NEEDS ASSESSMENT STUDIES

OBJECTIVES OF THE COMPREHENSIVE ‘OUT OF CARE’ NEEDS ASSESSMENT STUDY:

1. To identify the extent and types of service Needs among “Out of Care” PLWHA in the Cleveland TGA service area; and
2. To identify the service Gaps and Barriers to care as perceived by PLWHA with unmet need in the Cleveland TGA.

The sample for surveying the ‘Out of Care’ population was first determined by establishing a 95% confidence interval (CI) for a representative sampling of the estimated number of PLWHA with unmet need in the Cleveland TGA. The survey process was designed to target as high level participation as possible among the severe needs groups, including African Americans, Hispanics, MSM, Minority Women, IDU, and the Aged.

Based upon the total number of ‘Out of Care’ the 95% CI required that at least 50-100 ‘Out of Care’



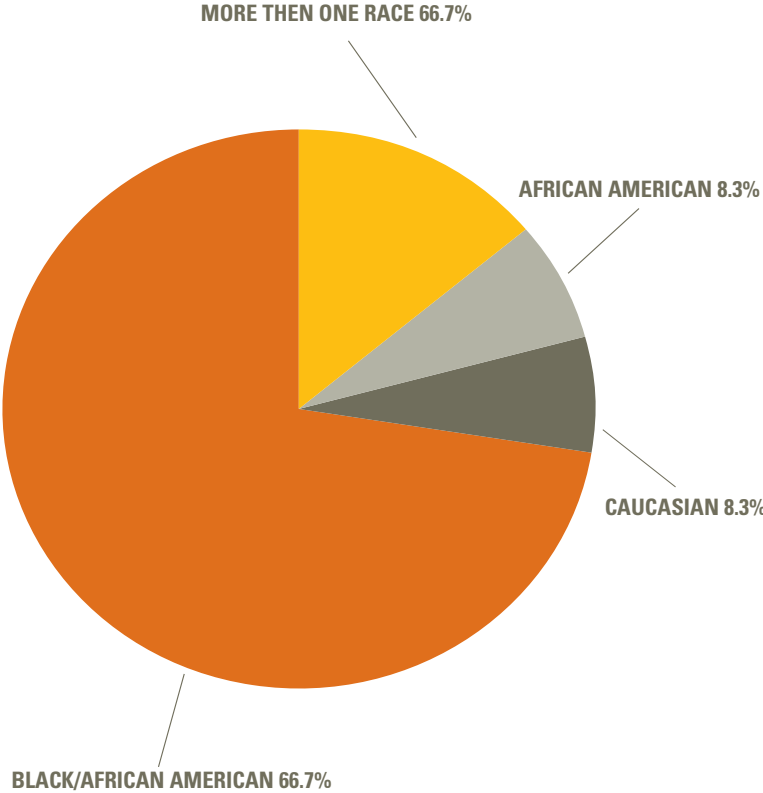
* I WAS TESTED WHEN I TRIED TO DONATE BLOOD 0.0%

Survey Respondents be targeted. The unmet need survey process was implemented under the direction of Collaborative Research. The survey site for the survey process included the local testing/counseling sites, food banks, homeless shelters, and Ryan White funded service providers, in order to access those PLWHA who are not receiving any Ryan White funded services; to access those PLWHA accessing only supportive services; and to access those PLWHA just returning to RW funded primary medical services in order to ensure the widest possible level of participation among this difficult to reach population of potential survey participants. The actual number of ‘Out of Care’ respondents was 56 and each received a \$10 gift card for participating in the survey process.

OUT OF CARE FINDINGS

DEMOGRAPHICS OF OOC RESPONDENTS

A total of 24 respondents participated in the 2011 survey; 50% were male and 50% female, with 100% among the “aged” or >45 years of age. Two-thirds of the respondents were African American; almost 17% reported more than one race; and equal proportions described their race/ethnicity as either white or Hispanic (8.3% respectively).



* NATIVE HAWAIIAN OR OTHER/ PACIFIC ISLANDER 0%

All of the OOC respondents report English as their first language.

The majority of the OOC respondents report their sexual orientation as straight (58%); with one quarter reporting bi-sexuality (25%); and almost 17% report their sexual orientation as gay.

RELATIONSHIP STATUS

WHAT IS YOUR CURRENT RELATIONSHIP STATUS?			
ANSWER OPTIONS	YES	THIS PERSON IS/WAS HIV+	RESPONSE COUNT
Single	12	0	12

WHAT IS YOUR CURRENT RELATIONSHIP STATUS?			
ANSWER OPTIONS	YES	THIS PERSON IS/WAS HIV+	RESPONSE COUNT
Legally married	0	0	0
Common law	6	2	6
Partnered	4	4	4
Separated	0	0	0
Divorced	2	0	2
Widow/Partner died	0	0	0
TOTAL			24

One quarter of the OOC respondents report an intimate relationship with another HIV positive individual. Half are single; 6 report a common law marriage; 4 are partnered; and 2 are divorced.

YEAR AND LOCATION OF HIV DIAGNOSIS

The OOC respondents report a wide span in years of HIV diagnosis, from 1987 to 2007, with a median year of HIV diagnosis around the year 2000. All 100% of the OOC respondents report receiving their HIV diagnosis in the state of Ohio.

LENGTH OF TIME SINCE LAST PMC VISIT/ENGAGEMENT IN CARE

Two of the OOC respondents report last seeing their PMC provider in 2004; two reported last PMC visit in 2006; four report their last visit in 2009; and the remainder (N=16) report being out of care since 2010. Virtually the same responses were obtained to the questions regarding last time they took ART and last time they had a CD4 or viral load lab test.

REASONS FOR HIV TESTING

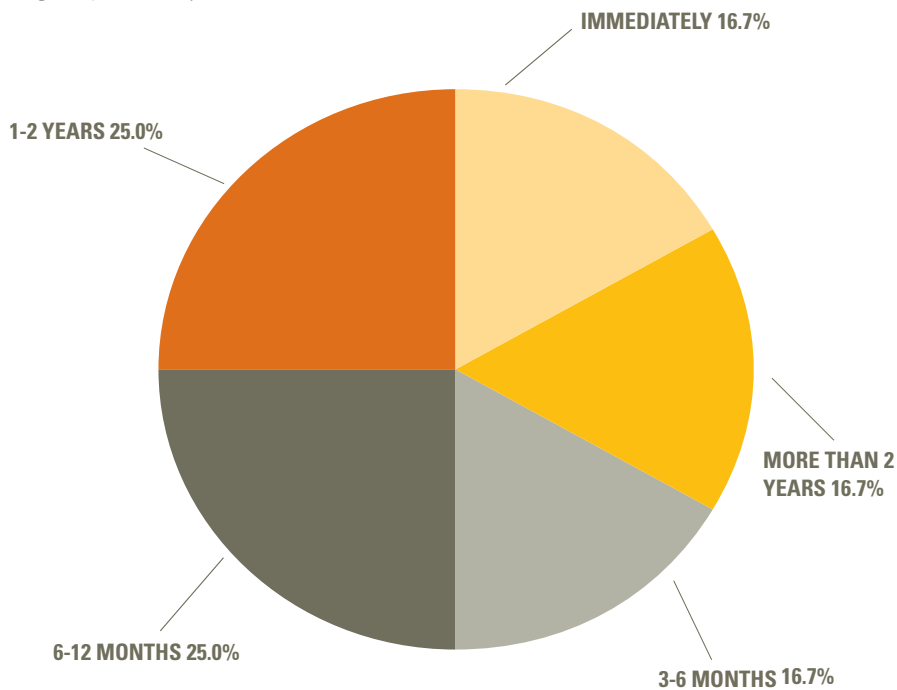
The reasons offered by the OOC respondents as to why they were tested for HIV included: 29% tested as part of a routine physical exam; 25% were tested when in the hospital or ER for treatment of another health issue; 17% were tested at the request of their partner/friend; an equal proportion (8%) report getting tested by the courts, as part of an outreach testing event, or through a voluntary request to be tested. Another 4% were tested as part of routine prenatal care.

REFERRAL FOR CARE & SERVICES

WHEN YOU FOUND OUT YOU WERE HIV POSITIVE, WERE YOU REFERRED FOR ANY OF THE FOLLOWING SERVICES?		
ANSWER OPTIONS	PERCENT	COUNT
I was not referred for any services	16.7%	4
I was referred for medical care (from a doctor/ nurse)	33.3%	8
I was referred for medical care for a condition other than HIV	16.7%	4
I was referred for substance use counseling/treatment	8.3%	2
I was referred for mental health services (other than SA)	16.7%	4
I was referred for case management services	16.7%	4
I don't know or don't remember	8.3%	2
Other	0.0%	0
TOTAL ANSWERED		24

DELAY INTO CARE ENTRY

All 100% report initial entry into care, however half delayed their entry by one year or more. As evidenced below, the primary reasons for their delay included “did not like the way I was treated” or “was depressed” (67%, respectively); followed by “did not think I needed it” or “don’t trust doctors” (17% respectively); with 17% reporting they were in jail at the time.



REASONS FOR DELAY

IF YOU DID NOT SEEK MEDICAL CARE FROM A DOCTOR OR NURSE WITHIN 1 YEAR OF FINDING OUT YOU WERE HIV POSITIVE, PLEASE INDICATE THE REASONS WHY		
ANSWER OPTIONS	PERCENT	COUNT
Couldn't afford it	0.0%	0
Didn't need medical care	0.0%	0
Couldn't get transportation	0.0%	0
Didn't know where to go to get medical care	0.0%	0
Don't trust doctors	16.7%	2
Didn't think I needed it	16.7%	2
I was depressed	66.7%	8
Didn't like the way I was treated	66.7%	8
I feel good/healthy	0.0%	0
Other (please specify) in jail	16.7%	2
TOTAL ANSWERED		12

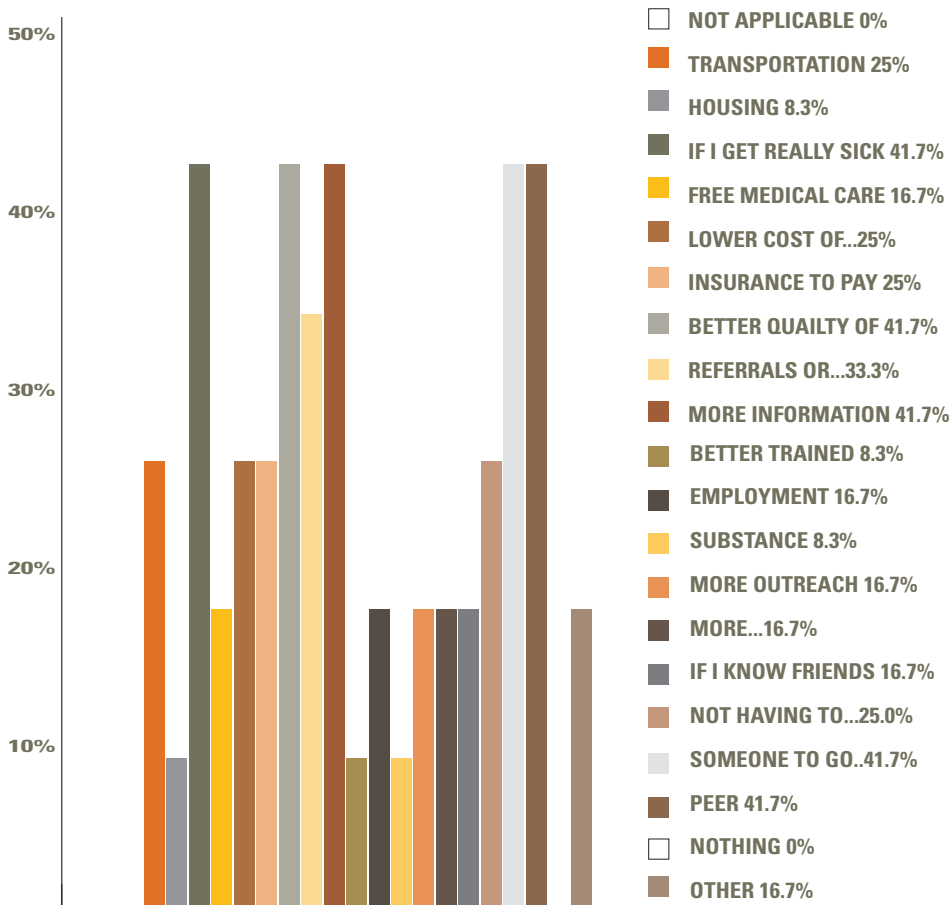
REASONS FOR OOC STATUS

IF YOU HAVE NOT HAD MEDICAL CARE IN MORE THAN 6 MONTHS FOR YOUR HIV, TELL US WHY		
ANSWER OPTIONS	PERCENT	COUNT
I do not think that I need medical care now because I am not sick	8.3%	2
I feel better than I did	25.0%	6
I am undetectable	8.3%	2
I do not think that medical care would do me any good	8.3%	2
I have not found a place that I feel comfortable going	8.3%	2
I don't have transportation to get to medical care appointments	16.7%	4
I do not know where to go for medical care	8.3%	2

IF YOU HAVE NOT HAD MEDICAL CARE IN MORE THAN 6 MONTHS FOR YOUR HIV, TELL US WHY		
ANSWER OPTIONS	PERCENT	COUNT
I had problems with medication	33.3%	8
I use alternative treatments	8.3%	2
I can't afford medical care now	8.3%	2
I get anxious about going to a doctor or nurse about HIV	8.3%	2
Other : Sick child; lazy; a lot going on	16.7%	4
TOTAL ANSWERED		24

The top ranking reasons supplied by the OOC respondents to explain why they have not recently been engaged in primary medical care include: “I had problems with medication” (33%); “I felt better than I had previously felt” (25%); reasons including “sick child”, “lazy” and “a lot going on in my life” (17%); and “I did not have transportation to get to medical appointments (17%).

PROMPTS TO CARE RE-ENTRY



The OOC respondents offer numerous interventions that they believe may be helpful in assisting them to re-enter care, including:

- ◉ 25.0% > Transportation
- ◉ 41.7% > If I get really sick
- ◉ 25.0% > Lower cost of medical care/medicines
- ◉ 41.7% > Better quality of services
- ◉ 33.3% > Referrals or advice from someone I trust
- ◉ 41.7% > More information about services
- ◉ 25.0% > Not having to wait so long for appointments
- ◉ 41.7% > Someone to go with me
- ◉ 41.7% > Peer support/someone to help me understand

Other prompts include medication-related issues, primarily the receipt of more information on managing side effects and/or medications that can be better tolerated.

REASONS WHY OOC STAY OUT OF CARE

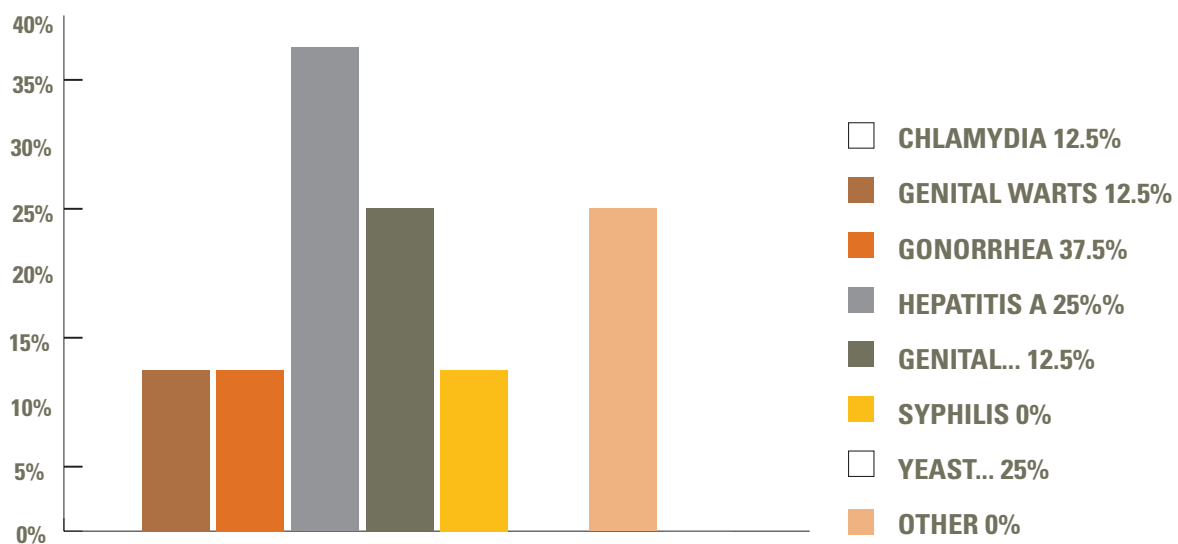
WHY DO YOU THINK PEOPLE DON'T GET MEDICAL CARE FOR HIV?		
ANSWER OPTIONS	PERCENT	COUNT
Worried that other people will find out/fear of telling someone else	25.0%	6
Cannot speak English very well	8.3%	2
Feel healthy	41.7%	10
Can't afford it	33.3%	8
Don't have transportation	41.7%	10
Couldn't get an appointment	16.7%	4
Drugs	25.0%	6
Don't want to take HIV medications	58.3%	14
Don't believe they are HIV+	16.7%	4
Other: Bad care experience; denial	16.7%	4
TOTAL ANSWERED		24

SUBSTANCE USE

DURING THE PAST 12 MONTHS, HOW OFTEN HAVE YOU USED ANY OF THE FOLLOWING SUBSTANCES?						
OPTIONS	DAILY	WEEKLY	MONTHLY	RARELY	NEVER	COUNT
Alcohol	0	4	3	2	3	12
Cocaine	0	1	0	0	5	6
Crack	0	0	0	0	5	5
Crystal Meth/ Methamphetamines	0	1	0	0	5	6
Heroin	0	0	0	0	5	5
Marijuana or hash	0	0	0	2	5	7
Speedball	0	0	0	0	5	5
Tobacco	1	0	0	0	4	5
TOTAL ANSWERED						24

While 38% of the OOC respondents report the use of various substances, the frequency of use is not as much as one might think. Alcohol is the most frequently reported substance that is reported as used on a weekly or monthly basis by four and three respondents, respectively. Cocaine is reported by one respondent and used on a weekly basis. Crystal meth is also reportedly used weekly by one respondent. Two OOC respondents report the rare use of marijuana. Eighteen percent of the OOC respondents report the previous use of injection drugs, but none now, and when they were using injection drugs, none report sharing works with others.

DIAGNOSIS WITH STIS OTHER THAN HIV



The OOC respondents report a fair amount of co-morbidity with STIs, most frequently reporting the previous diagnosis and treatment of Gonorrhea (38%), Hepatitis (25%), and Yeast (25%).

DIAGNOSIS OF OTHER CHRONIC ILLNESSES

HAVE YOU EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING?		
ANSWER OPTIONS	PERCENT	COUNT
Diabetes	20.0%	4
Hearth Problems	10.0%	2
High blood pressure	20.0%	4
Hepatitis	10.0%	2
High Cholesterol	15.0%	3
Lung/breathing problems	10.0%	2
Neuropathy	30.0%	6
Problems with thought or memory	10.0%	2
Emotional problems	20.0%	4
Other: "Stress"	10.0%	2
TOTAL ANSWERED		20

The most frequently reported chronic illnesses include neuropathy, diabetes, hypertension (high blood pressure) and emotional problems. Interestingly, none of the OOC respondents reports a diagnosis of cancer, TB, kidney or liver problems, or PCP pneumonia. Fully 58% report taking medications other than ART for the management of these chronic illnesses, and most frequently report drugs for diabetes, cholesterol, heart and high blood pressure medications, mental health medications and medications for Hepatitis C.

100% of the OOC respondents report an HIV/not AIDS diagnosis and 50% report the receipt of services other than medical services, while 50% of the OOC respondents report no medical or other services.

USE, NEED, BARRIER & GAP RANKING

A Need, Use, Barrier and Gap ranking was developed for all Cleveland TGA OOC survey respondents. The 2011 HIV/AIDS Needs Assessment provides a "snapshot" of community service uses, needs, barriers, and gaps as expressed by Out of Care consumers in the service area. The rankings of the Needs Assessment are

displayed for all 'Out of Care' respondents, and are defined as:

Use: Number of 'In Care' client survey respondents who indicated service use in the past year

Need: Number of 'In Care' client survey respondents who stated "I currently need this service."

Barrier: Number of 'In Care' client survey respondents who indicated that a service is 'Hard to Get'.

Gap: Sum of 'In Care' client survey respondents who answered 'Yes' to Need and 'No' to availability of that service

THE OUT OF CARE SURVEY RESPONDENTS RANKED THE FOLLOWING SERVICE NEEDS:

1. Nutrition/Food Assistance
2. Mental Health/Support Services
3. PMC tied with Housing Assistance, Medical Transportation
4. Substance Abuse Treatment tied with Medication Assistance, Clothing, and Faith & Family

THE OUT OF CARE SURVEY RESPONDENTS RANKED THE FOLLOWING SERVICE USES:

1. Mental Health/Support Services tied with Medication Assistance and Case Management

THE OUT OF CARE SURVEY RESPONDENTS RANKED THE FOLLOWING SERVICE GAPS ("CAN'T GET"):

1. Primary Medical Care tied with Medical Transportation
2. Housing Assistance tied with Health Information/Health Education

THE OUT OF CARE SURVEY RESPONDENTS RANKED THE FOLLOWING SERVICE BARRIERS ("HARD TO GET"):

1. Medical Transportation
2. Housing Assistance
3. Medication Assistance tied with Primary Medical Care and Health Information/Health Education

2011 OOC SERVICE NEEDS, USES, GAPS & BARRIERS

SERVICE CATEGORY	OOC NEED RANK	OOC USE RANK	OOC GAP RANK	OOC BARRIER RANK
Nutrition/Food Assistance	1	NR	NR	NR
Mental Health/Support Services	2	1 tie	NR	NR
Primary Medical Care	3 tie	NR	NR	NR

SERVICE CATEGORY	OOB NEED RANK	OOB USE RANK	OOB GAP RANK	OOB BARRIER RANK
Medication Assistance	NR	NR	NR	NR
Housing Assistance	3 tie	NR	2 tie	2
Medical Transportation	3 tie	NR	1 tie	1
Substance Abuse Treatment	4 tie	NR	NR	NR
Medication Assistance	4 tie	1 tie	NR	3 tie****
Clothing	4 tie	NR	NR	NR
Faith/Family	4 tie	NR	NR	NR
Case Management	NR	1 tie	NR	NR
Primary Medical Care	NR	NR	1 tie*	3 tie***
Health Information/Health Education	NR	NR	2 tie**	3 tie*****
Interpreter/Translation Assistance	NR	11 tie	8 tie	NR

*Additional Gaps: *1 “Good Doctor who could get me meds that don’t make me sick”; “Doctor to explain disease”; **2 “Info about HIV and HCV”;*

*Additional Barriers: ***3 “Good care”, “Non-judgmental Doctor”, “Sensitive, knowledgeable HIV Doctor”*

*****4 “Meds that don’t make me sick” *****5 “More HIV education”, “Doctor to explain disease”*

OOB GAP REASONS

- High Cost
- Not in Cleveland
- Rural area
- Not enough time by Doctor
- Stigma
- Economy
- Poor pay for MD

OOB BARRIER REASONS

- Funding
- Out of Way
- Stigma
- Location
- Red Tape
- Rural Area
- Poor Pay for MD

CHAPTER 5: RECOMMENDATIONS FOR COMPREHENSIVE PLAN

IN CARE PLWHA

I. ADDRESS THE TOP RANKING SERVICE GAPS OF THE SPECIAL POPULATIONS

CLEVELAND TGA: ALL PLWHA VERSUS SPECIAL POPULATION SERVICE GAPS		
GAPS	ALL	MSM
GAP #1	Transportation	Nutrition / Food Assistance & Employment / Job Assistance
GAP #2	Medication Assistance	Housing Assistance & Mental Health / Support Services
GAP #3	Housing Assistance & Nutrition / Food Assistance & Health Insurance / Disability Assistance	NR
GAP #4	Mental Health / Support Services & Employment / Job Assistance	NR
GAP #5	Emergency Financial Assistance & Eye Care	NR
GAPS	AFRICAN AMERICANS	MINORITY WOMEN
GAP #1	Medical Transportation	Medication Assistance
GAP #2	Housing Assistance	Housing Assistance & Nutrition / Food Assistance & Mental Health / Support Services & Medical Transportation & Health Insurance / Disability Assistance & Oral Health Care
GAP #3	Nutrition/Food Assistance	NR
GAP #4	PMC & Medication Assistance & Mental Health / Support Services & Employment / Job Assistance & Eye Care	NR
GAP #5	NR	NR
GAPS	HISPANICS	IDU
GAP #1	Medication Assistance & Oral Health Care	NR
GAP #2	NR	NR

CLEVELAND TGA: ALL PLWHA VERSUS SPECIAL POPULATION SERVICE GAPS		
GAP #3	NR	NR
GAP #4	NR	NR
GAP #5	NR	NR
GAPS	AGED	
GAP #1	Medical Transportation	
GAP #2	Housing Assistance	
GAP #3	Medication Assistance & Nutrition / Food Assistance & Emergency Financial Assistance	
GAP #4	PMC & Mental Health / Support Services & Health Insurance / Disability Assistance & Employment / Job Assistance & Eye Care	
GAP #5	NR	

2. ADDRESS THE TOP RANKING SERVICE BARRIERS OF THE SPECIAL POPULATIONS

CLEVELAND TGA: ALL PLWHA VERSUS SPECIAL POPULATION SERVICE BARRIERS		
BARRIERS	ALL	MSM
BARRIER #1	Medical Transportation	Medical Transportation
BARRIER #2	Medication Assistance	Medication Assistance
BARRIER #3	Housing Assistance	Housing Assistance & Nutrition / Food Assistance
BARRIER #4	Nutrition / Food Assistance	Mental Health / Support Services & Employment / Job Assistance & Oral Health Care
BARRIER #5	Emergency Financial Assistance	EFA & Health Insurance / Disability Assistance
BARRIERS	AFRICAN AMERICANS	MINORITY WOMEN
BARRIER #1	Medication Assistance & Medical Transportation	Medical Transport
BARRIER #2	Housing Assistance	Medication Assistance & Oral Health Care

CLEVELAND TGA: ALL PLWHA VERSUS SPECIAL POPULATION SERVICE BARRIERS		
BARRIER #3	Employment / Job Assistance	Nutrition / Food Assistance
BARRIER #4	Nutrition / Food Assistance	PMC & EFA & Health Insurance / Disability Assistance & Employment / Job Assistance & Eye Care & Interpreter / Translation Assistance
BARRIER #5	Eye Care	NR
BARRIERS	HISPANICS	IDU
BARRIER #1	Medical Transport	Medication Assistance
BARRIER #2	Oral Health Care	NR
BARRIER #3	Medication Assistance & Health Insurance / Disability Assistance & Employment Assistance & Interpreter / Translation Assistance	NR
BARRIER #4	NR	NR
BARRIER #5	NR	NR
BARRIERS	AGED	
BARRIER #1	Medical Transportation	
BARRIER #2	Medication Assistance	
BARRIER #3	Housing Assistance	
BARRIER #4	Nutrition / Food Assistance	
BARRIER #5	Employment / Job Assistance	

NEWLY DIAGNOSED PLWHA

HIV ACQUISITION

MSM behavior consistently continues to be the predominant means of acquiring the virus amongst newly diagnosed throughout the Cleveland TGA (55%). It is imperative that education, prevention and risk reduction strategies be tailored to positively impact these individuals and that they be successfully disseminated to this population. EIS initiatives should be geared to addressing this disparaging finding.

HIV TESTING

The majority of respondents (44%) learned of their HIV status by requesting to be tested by their providers. It is strongly recommended that medical providers consider making HIV testing a universal screening item within routine medical visit and laboratory exams and consider implementing the 'opt out' model. Such a model will ensure that more individuals know their status, addressing firsthand the issue the unknown/unaware. The secondary way respondents learned of their status (27%) was through an emergency room visit for the treatment of another condition. The TGA should consider creative ways to collaborate with the emergency room staff to ensure necessary systems are in place for linking newly diagnosed individuals into the service delivery system. Another useful means of reaching and testing persons at high risk for HIV disease is to offer HIV testing within the Ryan White funded clinics and case management offices, with offers of free testing to partners, friends and spouses of positive patients/clients. Expanded use of peer outreach/peer mentors is also recommended, given the survey findings and effectiveness of this model.

HIV DISCLOSURE

While 65% of all respondents were offered partner notification services and 87% encourage their partners to get tested and know their status, additional assurances can be implemented amongst providers to ensure that newly diagnosed individuals understand the importance and legal ramifications to disclosing their status. Given the high frequency of internet use among PLWHA, implementation of an internet-based chat room for peer outreach to MSM, offering anonymous testing and offers to accompany individuals for testing should be piloted.

DELAY OF ENTRY INTO MEDICAL CARE

While the majority of respondents access medical care upon learning of their positive status, 33% of the newly diagnosed respondents have been given an AIDS diagnosis and over 32% had CD4 T-cell count at <200 upon their initial diagnosis. These findings indicate that the disease has far progressed going undiagnosed for an undetermined period of time. In addition, newly diagnosed individuals are sicker due to their low t-cell counts. Increased testing throughout primary care settings and community-wide initiatives as well as education regarding the benefits of testing and earlier diagnosis coupled with disease de-stigmatization strategies will ensure additional individuals are aware of their status and begin treatment earlier in their disease process.

PATHWAY INTO CARE AND SUPPORTIVE SERVICES

Survey findings reflect a solid system for linkage to care throughout the Cleveland TGA. However, 33% of respondents reported having received a mental health disorder diagnosis and 21% have been diagnosed and/or treated for substance abuse. Recognizing the limited availability of providers in the areas of behavioral health and substance abuse in the service area, coupled with the fact that over 58% of respondents report having no insurance, it becomes crucial for the TGA to address how such services will be rendered in a cost effective and dignified manner to these individuals. Given the high co-morbidity of these disorders among the PLWHA population in the service area, in combination with the reported transportation barriers, it would be ideal if the mental health and substance abuse treatment services may be co-located within primary medical care and case management service sites to the fullest extent possible.

OUT OF CARE PLWHA

ADDRESS SERVICE GAPS & BARRIERS OF OUT OF CARE PLWHA

The Out of Care survey respondents ranked the following service GAPS (“can’t get”):

1. Primary Medical Care tied with Medical Transportation
2. Housing Assistance tied with Health Information/Health Education

The Out of care survey respondents ranked the following service BARRIERS (“hard to get”):

1. Medical Transportation
2. Housing Assistance
3. Medication Assistance tied with Primary Medical Care and Health Information/Health Education

RECOMMENDED PRIORITY STRATEGIES TO OPTIMISE UTILIZATION AND RETENTION IN CARE

Linkage to, engagement with and retention of newly/recently diagnosed/out of care persons in HIV primary medical care is essential for providing access to ART to delay disease progression and improve quality of life, especially critical for PLWHA whose immune systems are already seriously compromised. Retention in care has the added benefit of preventing further transmission of HIV by promoting safer sex and drug use practices.

SUGGESTED STRATEGIES FOR NEWLY DIAGNOSED PLWHA

Improved links and system navigation between prevention and care, such as:

1. Locating HIV Testing programs in HIV primary clinics, with aggressive offers of testing to the Patients’ sexual and drug-using partners, spouses, and friends
2. Expanded use of rapid testing in clinical and outreach testing settings
3. Expanded use of peer outreach testing specialists to locate and test other high risk individuals within their own unique social networks
4. Implementing same day referrals into primary medical care upon testing positive, especially from ER settings
5. Use of peer mentors/system navigators to ease transition into care and assist with navigation of care systems, accompany patients to appointments as needed, and help with reducing barriers to care
6. Implementing service need level assessments which target those persons newly entering care who are most likely to drop out or be most challenging to retain in care, and creating intensive care coordination plans to enhance engagement/retention.
7. Assess funded providers for training needs relative to relationship building and skills development relative to engaging, validating and partnering as key patient engagement and retention strategies, and tailored to meet the unique needs of the special populations

SUGGESTED STRATEGIES FOR PLWHA RECEIVING SOME SERVICES BUT NOT PRIMARY MEDICAL CARE

Improved Linkages between Supportive and Primary Care Services

1. Case Managers and other Support staff who provide services should implement routine follow-up strategies to inquire about and encourage entry/re-entry into primary medical care for ‘erratically’ in care.
2. Case Managers and Therapists should ensure that the necessary supportive services are provided to stabilize the person’s life situation (i.e., stable housing, food, 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 Therapists 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 speciality care services
7. Strengthen peer outreach to ensure engagement/retention linkages with the most underserved and most likely to disengage.

SUGGESTED STRATEGIES FOR PLWHA WHO HAVE DROPPED OUT OF CARE

Improved Provider-Patient Partnerships and Collaborations with Peers

1. Primary Care providers should make appointment reminder calls; facilitate transportation assistance; regularly reassess changing needs; and implement/maintain “no-show” tracking and follow-up protocols
2. At least biannually, Primary Medical providers should examine patient lists to determine who has not returned for care and initiate telephone and/or letter contact and/or peer outreach with individuals to encourage them make appointments and encourage re-entry into care
3. Expand use of peer advocates/peer outreach to locate, help reduce barriers and facilitate re-entry into care
4. Focus on reducing known barriers to care and resolving gaps in the continuum of care, including community-wide strategies for reducing HIV-related stigma

SUGGESTED STRATEGIES FOR PLWHA NEVER IN CARE

Peer-facilitated Linkages between Points of Entry/Testing/Counseling & Primary Care

5. Active follow-up by Testing/Counseling agency to maintain contact and confirm entry into care
6. Peer Outreach to specific populations and locations, including homeless shelters, drug treatment centers, etc
7. Regular marketing of primary care services' availability and directions on making referrals with all points of entry staff and agencies
8. Social marketing efforts regarding benefits of care and treatment and wide distribution of resource guides
9. Co-location of primary medical care services with mental health and substance abuse treatment/ rehabilitation services
10. Co-location of HIV PMC, medical specialty and other medical care wherever possible.

APPENDICES

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SURVEY INSTRUMENTS
