Unmet Need Section of the
FY 2010 HRSA Application

- **Assessment of Unmet Need:**
- **Demographics of people living with HIV/AIDS and aware in the Atlanta EMA as of December 31, 2007, as detailed in the most recent Needs Assessment**: Data showed that there were 19,128 people living with HIV/AIDS in the EMA. Further, the HIV/AIDS epidemic in the Atlanta EMA is predominantly among males 14,746 (77%), African Americans 13,306 (70%), people 37 years of age and older 14,280 (75%) and MSM 7,636 (40%). PLWA (65%) had higher unmet need than PLWH (55%). The PLWH non-AIDS population showed some differences among some of the population variables. Specifically, while males still comprise the majority of PLWH non-AIDS (73%), the proportion of females living with HIV non-AIDS (27%) is noticeably higher than among those living with AIDS (20%). The proportion of African Americans/African Americans living with HIV non-AIDS (73%) still represents the largest racial group, slightly larger than among PLWA (68%). PLWH non-AIDS also appear to be younger, with people 37 years of age and older comprising 60% of all PLWH non-AIDS compared to 84% of PLWA. The most commonly reported risk among PLWH non-AIDS is men having sex with men (39%); however, a large proportion of individuals did not report a risk (42%).

- Location: SEATEC is currently working with the DCH, Epidemiology Unit HIV/AIDS Team to conduct an analysis of the location of persons who know their HIV status and are not in care. This component of the study should be completed by December 2009. Geographic data are available through the zip code variable of the CAREWare and Medicaid databases, outreach workers, and CT sites. These data, when cross-tabulated with geographic data related to concentrations of high comorbidities (STIs, teen pregnancy rates, etc.) will provide valuable information for planning for future services.

- **Service needs, gaps and barriers to care: From the results of the unmet need analysis**, it is clear that getting individuals into HIV primary care must be a priority. In the 2008 Consumer Survey, consumers reported using medical and information services at high rates in the past 30 days (primary medical care – 77% and antiretroviral medications – 73%). Dental care (46%) was the most frequently reported service needed but not received. The most commonly reported barriers for consumers were personal (26%), followed by information (19%) and capacity (16%). Additional analysis revealed that capacity (20%) and (20%) barriers were reported by consumers earning and annual income less than 100% of the federal poverty level. Information barriers were reported more frequently by Hispanics (33%), women (31%), and especially women of childbearing age (37%). Personal barriers, the most commonly reported of all barriers, experienced the highest statistically significant rates for men (28%). Finally, survey participants stating that they began process were more frequently those that could not remember their most recent viral load (13%) or those who experienced trouble with housing in the past 12 months (10%). Participants were asked screening questions regarding substance abuse and mental health. Of the participants that completed the

screening (313), 80 (26%) consumers were in need of additional substance abuse assessment and 136 (39%) were in need of additional mental health assessment.

In the 2003 Consumer Survey, Hispanics and individuals who were diagnosed in the previous three years were found to have higher service gap levels. Hispanics most frequently reported: they did not know about the service or there was not enough of it available; a lack of translation services; and, a belief that citizenship is needed to receive services as barriers. The barriers more likely to be reported included lack of information or not knowing the service existed and personal issues. Males and African Americans reported information and personal barriers most frequently; females reported not finding enough of the service and information barriers most frequently while Whites reported not enough service, information and personal barriers. Overall, barriers associated with unmet need were predominantly related to lack of information or not knowing about the service, the way the system of care was functioning, or lack of available service.

- **Efforts to find people not in care and get them into primary care:** The Atlanta EMA is approaching finding people not in care and getting them into primary care in several ways. The EMA requires that individuals must demonstrate enrollment in primary care prior to receiving other Part A funded services such as medical case management, oral health services, home delivered meals, etc.[1] Second, the EMA is examining unmet need for HIV care among subpopulations and working with agencies which target those subpopulations to help enhance existing outreach efforts through client tracking and other methods. Finally, Part A is working with Part B and the Counseling and Testing (CT) program to develop a coordinated plan to identify and link newly positive individuals into care. The EMA will continue to work on identifying and addressing barriers that clients face in accessing primary care services. To address reported information barriers, the EMA will use the medical case management screening process to provide clients with information about available services through on-site peer counseling and medical case management services. As additional persons are brought into primary care, the Council will evaluate the impact on the continuum to ensure the availability and accessibility of comprehensive services. For FY10, the EMA has requested $88,000 to continue the African American Outreach Initiative to bring HIV+ and aware African Americans into care.
- **The results of the Unmet Need Framework were used in planning and decision making about priorities, resource allocations and the system of care:** Information from the 2007 Unmet Need Study is included in other sections of the application as required. In addition to the demographics of the population identified in CY07, information was considered from the EMA's extended analysis of the CY03 Ryan White client population to help focus planning, priorities decision making, resource allocations and the system of care. Three levels of services were examined. Level I services represent primary medical care, Level II services include other medical services and Level III services include support services. Receipt of other medical (Level II) and support services (Level III) among CAREWare clients in the EMA indicated that health education/risk reduction was the most used service (36%) followed by case management (33%) and emergency financial services (33%). Some of the least used services were

[1] It is recognized that some clients will need to access substance abuse or mental health services prior to entry into primary care. An individualized service plan must be developed which spells-out the steps to be undertaken to have the client enrolled within three months.

childcare and hospice/home health care (each used by <1% of all clients). Examining use of these services by disease stage reveals some differences in patterns of use between PLWH non-AIDS and PLWA. Most services were more likely to be used by PLWA than PLWH non-AIDS, particularly medical case management (58% vs. 27%), nutritional counseling (18% vs. 9%), food bank/home delivered meals (26% vs. 14%) and psychosocial support services (26% vs. 13%). Comparisons were also made in the receipt of other medical core and support services between those receiving HIV primary care (care) and those not receiving such care (no care). Most services were more likely to be used by those receiving HIV primary care than those who were not regardless of HIV status, in particular mental health services, medical case management and nutritional counseling.

Based in part on the Unmet Need results, primary care retained its #1 ranking and the allocation was increased with an emphasis on bringing people into care. Primary care services include treatment adherence and health education/risk reduction as standards of care. Disease status was also considered in allocations, specifically looking at the different levels of service utilization based on the progression of HIV disease. In addition, the Council recognized that as additional PLWH are brought into care, there would be a corresponding need for allocations to other core services which facilitate access to and retention in care such as Oral Health, Substance Abuse, Mental Health and Medical Case Management services.

Unmet Need results also supported the continuation of currently funded components of the care system including: activities to track individuals lost to care and bring them back into care (e.g., phone calls and letters after missed appointments, outreach to physically locate individuals, etc.), and linkages to care for individuals testing positive through Part A primary care sites, Part C early intervention clinics, and at HIV counseling and testing sites.