

## APPENDIX C: SUMMARY OF 2004 NEEDS ASSESSMENT

This section expands upon Part 1 - Section 3 – Needs Assessment and provides more detail of the findings of the comprehensive needs assessment (*2004 Needs Assessment*) completed by the Newark EMA HIV Health Services Planning Council in 2004. This document was reviewed for the 2007-2009 Comprehensive Plan and is summarized below.

### Comparison of Title I Clients Receiving Title I Medical Care and Those Not Receiving Title I Medical Care

The purpose of this study was to determine if there were differences in the characteristics of uninsured Title I clients who were receiving Title I funded medical care, versus those not receiving such care. It was presumed that if such differences existed, these characteristics could help identify PLWHA more likely not to be in medical care. Using this information, service providers in the EMA could better target case management and outreach efforts to enroll PLWHA into medical care.

**Conclusions.** Gender and age are not strong predictors of receipt of Title I medical care by Title I clients with no reported source of health insurance. Clients participate in Title I medical care in proportion to their gender and age within the EMA's HIV epidemic. Race/ethnicity has some predictive value in that NonHispanic Whites without a reported source of health insurance are less likely to access Title I medical care. When NonHispanic Black PLWHA and Hispanic PLWHA were combined, they receive Title I medical care at a slightly higher proportion than their representation in the HIV epidemic. (Coding problems prevented analysis of these populations individually.) Geography – county/municipality of residence – as a client characteristic cannot be used to predict receipt of Title I medical care because a client can change county of residence but continue to receive medical care with the same provider and at the same location. However, geography may play an important role in predicting access to care when combined with other variables, such as poverty.

There appears to be a strong correlation between geographical areas with high levels of poverty and utilization of Title I medical care by those with no health insurance. Relative poverty of the general population within a geographical area appears to be the most accurate predictor of receipt of Title I medical care by PLWHA with no reported health insurance. The higher the percent of individuals living below poverty, the greater the utilization of Title I medical care by PLWHA with no source of health insurance. Since the purpose of Title I is to provide access to medical care as “payer of last resort” for PLWHA living below 300% of poverty, these data show that the Newark EMA is fulfilling this mandate, particularly for those under 100% of poverty most in need of assistance.

## Study of a Sample of Title I Clients Not Receiving Title I Medical Care to Determine Barriers to Care

The purpose of this study was to collect additional data from clients who did not receive primary medical care to learn about their health care beliefs and health care behavior. A 10% sample was to be surveyed of 957 Active Title I clients who did not appear to have any source of health insurance and who did not receive Title I medical care. The survey would ascertain whether they are receiving medical care for their HIV, and if not, the services needed to bring them into care. It was presumed that these individuals would be more likely than others to be brought into medical care because they have an existing connection to the Title I system through receipt of some service(s) from at least one Ryan White Title I provider. Unfortunately, problems were encountered with participants identified for the sample, and responses were not usable. A focus group was conducted to complete the study, but additional research was warranted.

## Assessment of Eight Populations with Special Needs

The Council studied eight special populations to meet the HRSA requirement of providing an updated assessment of their needs in the annual Title I grant application, the Council. The following five questions must be completed for each population. Focus groups of a total of 108 individuals were conducted for the following populations: (1) Youth (age 13-24), (2) Injection Drug Users (IDUs), (3) Substance Users who are not IDUs, (4) Men Of Color Who Have Sex With Men (MSM), (5) White/Anglo MSM, (6) Women of child-bearing age (13-44), (7) Older Adults (age 45+) and (8) Homeless. Geographical representation was the goal.

The final written reports in the 2004 Needs Assessment addressed two questions for every population: (1) Describe the HIV/AIDS service needs of individuals in this population who know their status and who are in HIV/AIDS primary medical care, and (2) Describe the extent to which members of this population group are not in a system of HIV/AIDS primary care and the barriers to care for those individuals. The purpose was to gather current information on the needs for medical care and other services of PLWHA who are receiving Title I medical care and those who are not receiving such care, and to establish a baseline for future EMA studies.

**Recommendations.** The following is a summary of the recommendations which can be used to help plan for services for 2007-2009.

Co-location of services to minimize the time and travel people need to invest in their care and increase service access and utilization.

Educational programs for providers to help them understand the needs of the clients they serve, treat HIV+ individuals with more respect, and help them communicate better with their clients.

Empowerment and educational workshops for PLWHA to increase self-advocacy to ensure quality care to help clients communicate with their service providers.

Establish real role models, such as people from the community, for people at high risk. (Youth did not feel that Magic Johnson was a good model because they do not consider him a

reflection of their community.) A real role model would have more success encouraging people to get tested and/or getting people into medical care.

Improve coordination of services between agencies, to reduce drop outs, especially for people dealing with mental health issues, substance abuse, and/or who are homeless.

Improve housing services, because housing provides PLWHA with the necessary level of stability to access medical services. Housing is needed for youth currently living on the streets.

Offer more incentives to encourage people living with the virus to access care.

Increase advocacy at the community level to help people connect into medical care.

MSM groups discussed the need for and suggested development of internet discussion forums where HIV+ individuals (gay men, MSM) could share information on living with HIV/AIDS.

Intervention Programs for youth to show the realities of living with HIV/AIDS.

Linguistic competence – more interpreters for people who do not speak English but for people who have limited reading abilities as well. Alternatives to interpreters.

More night services for people who work or go to school and cannot access services offered between 9:00 a.m. and 5:00 p.m.

More reliable safe transportation. Lack of transportation as a major barrier to medical care.

More support groups should be developed, some which are population-specific (e.g., older adults) and not only arranged by mode of transmission.

Needle Exchange. The distribution of clean needles would help control the epidemic.

Peer navigation programs would link PLWHA who have experience navigating the system of care and services with newly diagnosed individuals and those trying to enter the care system.

Targeted outreach programs individually designed to reach specific populations, e.g., young MSM, older adults, and substance users.

Location of services - anonymity. Many people may not access services because buildings are associated with HIV/AIDS. Youth recommended service locations without this association.

## Reduced Health Disparities in the Veterans' Administration System of HIV Health Care and Applicability to Access to Care in the Newark EMA

The goal of this study was to determine whether the Veterans' Administration (VA) system of HIV medical care reduces health disparities and improves access to care, particularly among racial/ethnic minorities, and whether this system can serve as a model for other HIV medical care in the EMA. The specific objectives were to determine (1) whether fewer health disparities exist in access to [HIV] care, and if so, (2) the reasons, and (3) whether the lessons for delivery of health care services can be transferred to non-VA systems as "best practices." The Newark EMA grantee has a contract with the East Orange VA Hospital to provide supportive services of nurse case management, transportation and other services to the **VA HIV Health Clinic**. It is estimated that the clinic serves 500+ PLWHA who are veterans residing in the Northern New Jersey region. The Council was to utilize the contractual relationship between the grantee and East Orange VA Hospital to obtain information.

There are limits on the VA Model of Health Care. Free health care is available only for veterans with lower incomes in top priority eligibility groups; others must contribute toward the cost of care. While patients can receive most of their medical services "under one roof", the VA does not ensure supportive services such as housing and nutritional needs. Without supportive services provided by Ryan White Title I, patients could not access "one-stop shopping". As with other providers, the HIV Clinic must establish relationship for coordination of care through interpersonal contact, not only through the VA electronic medical records system.

**Conclusions.** The Veteran's Affairs New Jersey Health Care System has components that other primary medical care providers in the Newark EMA can learn from. These include: (1) "one-stop shopping" where they can receive most, if not all, services at the same location; (2) the requirement that all HIV+ patients see an Infectious Disease specialist (versus a family practitioner or other physician) which helps to ensure that patients are receiving the same standard and quality of care; (3) a system-wide VA electronic medical records system which ensures that patients' records follow them throughout a hospital system, and (4) clinical reminders (in the EMR) which enable physicians to manage the health care needs of a large number of patients and those with co-morbid diseases, such as diabetes or Hepatitis C. (For large hospitals, a similar medical records system would help ensure continuity and quality of care. The software used by the VA is available for free through the Freedom of Information Act and is reportedly extremely user friendly.) The VA's efforts to bring the newly diagnosed into medical care and provide consistent patient follow-up also is an example of how other primary medical care providers could increase the compliance of their patients.