HIV TRAINING NEEDS REPORT FOR OHIO

Midwest AIDS Training + Education Center,
University of Illinois at Chicago

Fall 2018

Introduction

This report provides the results of the needs assessment for the state of Ohio. The needs assessment workgroup conducted a series of activities between January and September of 2018. These activities involved data collection from primary and secondary data sources, data analysis, and reporting of regional as well as local (state-level) results.

The needs assessment results in this report are organized by workforce category (i.e. clinical versus non-clinical providers, low volume/novice providers, minority & minority-serving providers) as well as by topics that deserve special attention (i.e. PrEP, Hepatitis C, and the opioid epidemic). The clinics that each LP selected as potential candidates for Practice Transformation are shown at the end of the report.

Data sources used for the needs assessment include the following:

Primary Data Sources	Secondary Data Sources
• Policy Training Advisory Council (PTAC) • Key Informant Interviews with clinical leaders of each state • AETC Local Partner Program Directors	• HIV Integrated Prevention and Care Plans • HIV Surveillance reports from state health departments and CDC • AETC PIF, ER, and ACRE IP data from FY17-18 • CDC_Atlas Plus interactive database • amfAR Opioid and Health Indicators database • HRSA Data Warehouse • The Robert Graham Center workforce projections

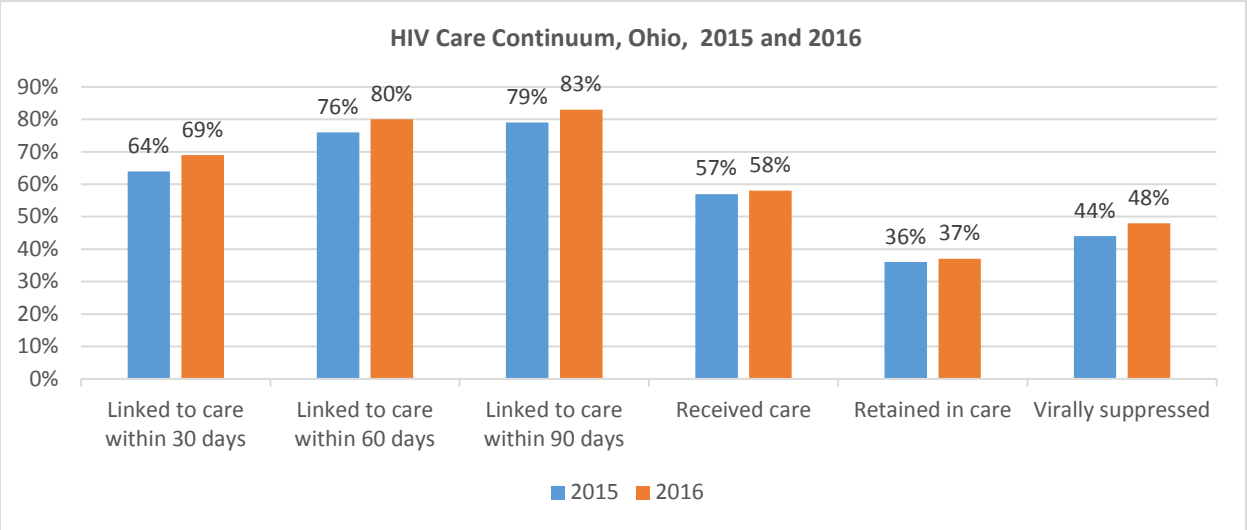
Epidemiology

Ohio is considered a high incidence state in the Midwest AETC region. The state accounts for 18% of the HIV prevalence rate as of 12/31/15 and 20% of new HIV infections in 2016 (Appendix, table 1). The rate of HIV infection among African Americans is almost ten times higher than the infection rate among whites in 2016 (Appendix, table 3). Ohio has the highest rate of drug-related deaths in the region and one of the highest rates of Hepatitis C incidence (Appendix, table 5). **Based on not yet published data from the Ohio Department of Health, the percentage of new HIV infections related to IDU is projected to be 36% in 2018.**

Care Continuum

Recently implemented changes in the reporting requirements for HIV surveillance resulted in Ohio's first statewide care continuum for 2015 and 2016. The percentages of people linked to care are based on the number of new diagnoses among persons aged ≥13 years in each year. The percentages of people receiving care, retained in care, and virally suppressed are based on the number of people aged ≥13 years who were living with HIV at the end of the previous year and still living in Ohio at the end of the reporting year. Receipt of care is defined as having at least one CD4 and/or viral load test during the year, while retained in care is defined as having at least two CD4 and/or viral load tests during the year. The care continuum shows that Ohio is doing a good job with linking newly diagnosed people to care within 90 days, but the numbers

for the remaining bars of the care continuum are below the national averages and the lowest in our region. This indicates that there is a substantial amount of unmet need (out of care) in Ohio.



The State of the HIV Workforce in Ohio

Reviewing Ohio's Integrated Plan for HIV Prevention and Care and summarizing data obtained from key informant interviews and members of PTAC revealed the following information about the state of Ohio's HIV workforce:

- The HIV workforce in Ohio is concentrated in academic hubs with only a few providers working outside of these hubs.
- Ohio's HIV workforce is affected by the retirement of existing providers and a shortage of new providers in the pipeline.
- New providers are not looking at HIV as a career choice. Issues such as stigma or the idea that it is a complicated disease play a role in this.
- Ohio needs to start building the HIV workforce by training students and residents, especially in family and internal medicine. There should be an HIV track in their training so that students understand that this is a normal part of primary care.
- There is a lack of racial diversity in the HIV workforce.
- There are no providers in the pipeline for rural southern Ohio. Dr. Ellis Frazier is the only HIV provider and at the age of 60, he is close to retirement. This area is seeing an increase in HIV infections among injection drug users and needs providers across the entire spectrum of HIV care and prevention.
- MATEC's Clinician Scholars Program is part of HIV workforce development, but MATEC-OH has trouble finding clinicians who are enthusiastic about it and participate.
- The HIV IPE project sparked a lot of interest among students at UC. One of the social work students who graduated from the program now works as a medical case manager at Dr. Kaul's clinic.

Training Needs of Low Volume and Novice HIV Providers

The training needs of low volume and novice providers who attended training events at one of MATEC's two LP's in Ohio during FY2017-2018 were assessed by analyzing their responses to the needs assessment question on the ACRE-IP form. Figure 2 in the Appendix shows the results of this analysis. Low volume and novice providers in Ohio indicated that they would like more training on mental health, transgender health, drug resistance, LGBTQ population, substance use, patients > 55 years, ART, and perinatal transmission. The discipline breakdown of the respondents helps clarify which professional disciplines were more likely to suggest each one of these training topics.

Training Needs of Minority/Minority-Serving HIV Providers

The training needs of minority and minority-serving providers who attended training events at one of MATEC's two LP's in Ohio during FY2017-2018 were assessed by analyzing their responses to the needs assessment question on the ACRE-IP form. Figure 3 in the Appendix shows the results of this analysis. Minority and minority-serving providers in Ohio indicated that they would like more training on mental health, transgender health, drug resistance, retention in care, substance use, ART, and patients > 55 years. The discipline breakdown of the respondents helps clarify which professional disciplines were more likely to suggest each one of these training topics.

Training Needs of the Clinical Workforce

The clinical HIV workforce includes physicians, nurse practitioners, pharmacists, physician assistants, and dentists. The following needs apply to the clinical workforce only. Needs that apply to both clinical and non-clinical providers are listed in a separate paragraph.

- Primary care providers need to be trained in HIV screening, testing, and prevention, as well as knowing the resources for linking HIV positive patients into care.
- Primary care providers (both physicians and NP's) need training in the basics of HIV care so that they feel comfortable providing primary care for HIV patients on ART, including being aware of the side effects.
- Target providers in FQHC's with training on HIV prevention as well as basic HIV care. It can be hard to engage these providers.
- Many low volume HIV providers are treating patients with older regimens. They need training in new regimens and resistance.
- Clinical providers need training in perinatal counseling and the new guidelines for using dolutegravir in pregnant women and women of childbearing age.

Training Needs of the Non-Clinical Workforce

The non-clinical HIV workforce includes nurses (RN), mental health professionals, substance abuse professionals, social workers, and case managers. The following needs apply specifically to the non-clinical workforce:

- Train the community partner organizations that provide training in mental health and substance abuse.
- There is a need for more mental health providers, case managers, and disease intervention specialists (capacity building) to be trained in issues that are faced by HIV patients. Rural areas often lack these kinds of social support services.

Training Needs of All HIV Providers (Clinical and Non-Clinical)

The following training needs apply to both the clinical as well as non-clinical HIV workforce in Ohio:

- All providers can benefit from cultural competency training so that patients, especially Latino's and African born people have access to culturally competent providers. This training should also include stigma around HIV, both among providers as well as among patients.
- Providers should be trained in how to integrate medical and social support services, particularly mental health and substance abuse, in one location to provide comprehensive HIV care across all the stages of the care continuum.
- Train providers at emergency departments and FQHC's in HIV prevention and testing services.
- Screening should be made a part of a routine healthcare exam.
- All providers need training in the roles of the interprofessional HIV care team and how working together can improve patient outcomes.

Training Needs around Prevention and PrEP

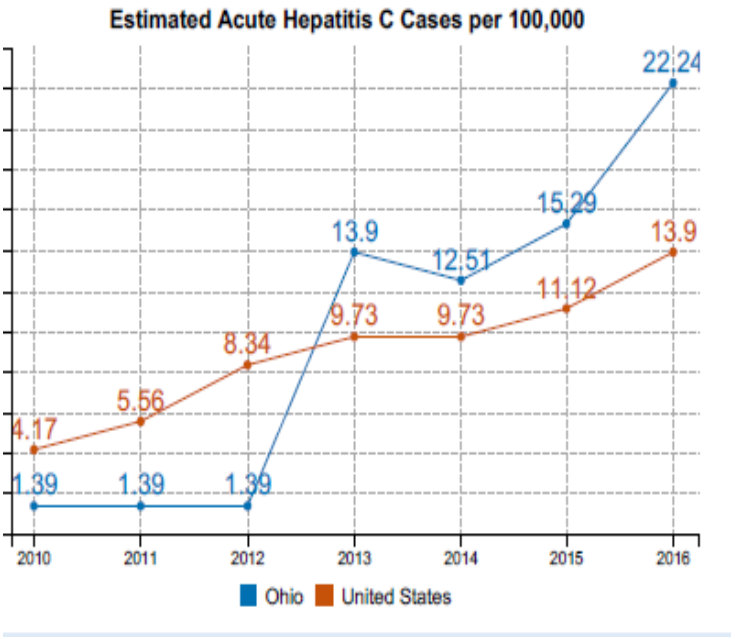
We asked key informants and members of PTAC specific questions about the needs in their state around PrEP and prevention. Based on the information they shared with us, we identified the following needs in Ohio:

- Train primary care providers such as nurse practitioners, general internists, and family practitioners in PrEP to increase access throughout the state.
- Train providers who are expressing an interest in taking up PrEP. Patients as well as providers need to be educated on PrEP so that they increase their interest in it.
- A new PrEP clinic will be started up at Caracole (case management agency for HIV patients in Cincinnati). OH-CIN should inform if they could play a role in training the staff.
- There is a need for PrEP providers at needle exchange programs as Ohio is seeing an increase in HIV among its IDU population, especially in Hamilton County. If injectable PrEP medication is approved, it would be great if a PrEP provider could provide it at the needle exchange van.
- Providers in rural areas that see increases in HIV and HCV as a result of the opioid epidemic need education in prevention and PrEP.

Hepatitis C

In the United States, 25% of PLWH are co-infected with Hepatitis C (HCV). About 80% of PLWH who inject drugs also have HCV. HIV/HCV co-infection more than triples the risk for liver disease, liver failure, and liver-related death. Liver disease, most of it related to HCV and HBV, has become the leading cause of non-AIDS-related deaths among the HIV population. African Americans are twice as likely to have HCV as whites.[1]

Ohio's estimated acute HCV case rate per 100,000 is 22.2, which is almost twice the national average of 13.9 in 2016. The number of acute HCV cases in Ohio has surpassed the national average since 2013.



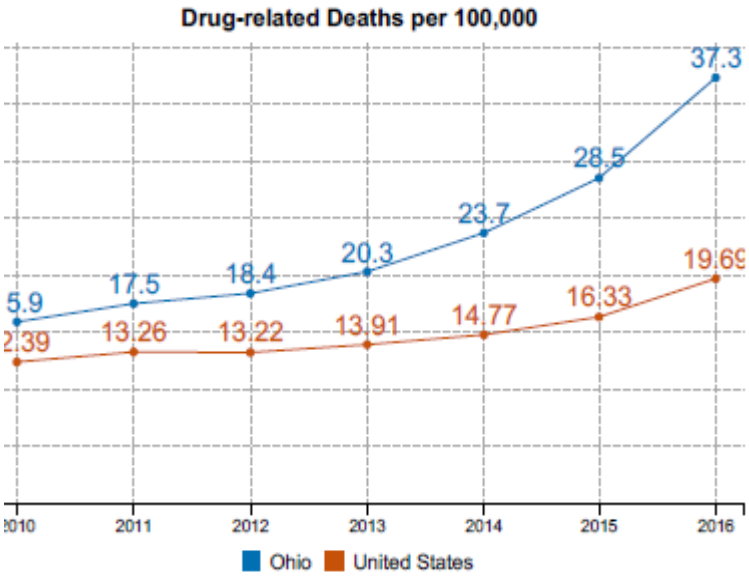
Source: http://opioid.amfar.org

Opioid Epidemic

Many of the Midwestern states have seen a sharp rise in the number of opioid-related overdose deaths since 2013. As the number of injection drug users continues to rise, the risk increases for the spread of infectious diseases such as HIV and HCV as a result of needle sharing. Several states in the country, including some in the Midwest, are seeing an increase in new HIV infections among white injection drug users.

Since 2013, Ohio has seen a sharp rise in the number of drug-related deaths that can be attributed to the opioid epidemic.

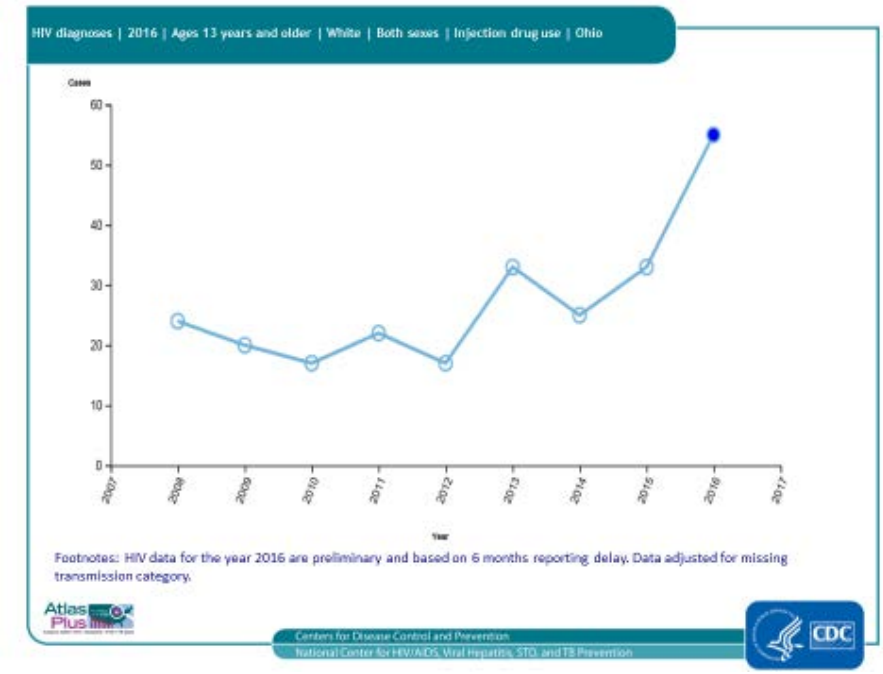
In 2016, Ohio reported 37.3 drug-related deaths per 100,000 compared to the national average of 19.69.



Source: http://opioid.amfar.org

[1] https://www.cdc.gov/hiv/pdf/library_factsheets_HIV_and_viral_Hepatitis.pdf

As a result of the opioid epidemic, Ohio has seen a sharp increase in HIV infections among white injection drug users, predominantly in the southern part of the state. Over the past 3 years, an increasing number of new HIV infections have intravenous drug use as a risk factor. In 2018, the percent of new HIV infections related to IDU is projected to be 36%.[2] Ohio currently has 7 syringe exchange programs and 187 facilities that provide some Medication Assisted Treatment (MAT).



Source: https://gis.cdc.gov/grasp/nchhstpatlas/charts.html

Rural Counties at High Risk for HIV and HCV Outbreaks

The CDC has identified 220 counties at risk of HIV and/or HCV outbreaks as a result of the opioid epidemic. Ohio is home to 11 vulnerable counties, all located in the southern part of the state. These include Adams, Pike, Jackson, Meigs, Brown, Scioto, Vinton, Gallia, Athens, Clinton, and Highland Counties. Only Scioto currently offers a syringe exchange program.

With the highest rate of drug-related deaths in our region and an increase in HIV infection among white injection drug users, Ohio faces a critical need to train rural providers in HIV prevention and care to prevent new infections and provide care to the ones newly infected.

CDC Vulnerable Counties

Source: http://opioid.amfar.org/OH

[2] Ohio Department of Health – data not yet published.

Potential Practice Transformation Clinics

We asked our LP's to identify clinics in their state that could be potential candidates for Practice Transformation during the next grant cycle. While identifying these clinics, we asked the LP's to select clinics that would meet the strict criteria from the 2015 AETC guidance (existing criteria) as well as clinics that did not meet the existing criteria but would be excellent candidates if the criteria are loosened during the next grant cycle.

Ohio identified the following clinics as potential candidates for practice transformation work in the next grant cycle. The clinics in red are located in counties that have been identified by the CDC as "vulnerable counties" and would be of particular interest in light of the increase in new HIV infections related to the opioid epidemic.

Potential clinics that meet existing PT criteria	**Potential clinics that do not meet existing PT criteria**
1. Community Health Centers of Greater Dayton, Dayton 2. Crossroad Health Center, Cincinnati 3. Five Rivers Health Centers, Dayton 4. Primary Health Solutions, Middletown 5. Primary One Health, Columbus	1. Southeast Healthcare Services, Columbus 2. Equitas, Columbus 3. Hopewell Health Centers, Chillicothe 4. WinMed Health Services, Cincinnati 5. Highland Health Providers, Hillsboro 6. Compass Community Health, Portsmouth 7. CAO Family Health Centers, Ironton 8. Valley View Health Centers, Piketon

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APPENDIX

Table 1: HIV Incidence and Prevalence for 10 states in Midwest AETC Region, 2016						
	Population as of 12/31/2015		HIV Prevalence as of 12/31/2015		HIV Incidence in 2016	
State	Total population in numbers	Total Population as % of Midwest Region	HIV prevalence in numbers as of 12/31/15	HIV prevalence as % of Midwest Region as of 12/31/15	HIV incidence in numbers in 2016	HIV incidence as % of Midwest Region in 2016
IL	12,835,726	19%	35,441	31%	1,391	28%
IN	6,634,007	10%	10,741	9%	484	10%
IA	3,130,869	5%	2,427	2%	137	3%
KS	2,907,731	4%	2,830	2%	142	3%
MI	9,933,445	15%	14,615	13%	748	15%
MN	5,525,050	8%	7,803	7%	289	6%
MO	6,091,176	9%	11,887	10%	518	10%
NE	1,907,603	3%	2,040	2%	76	2%
OH	11,622,554	18%	20,709	18%	973	20%
WI	5,772,917	9%	5,916	5%	224	4%
Midwest	66,361,078	100%	114,409	100%	4,982	100%

Source: https://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-report-2016-vol-28.pdf

Table 2: People Living with HIV by State, Compared by Racial Population Percentages, as of 12/31/2015									
State	Total population in millions in 2015	White		AA, Black		Latino		Multiple Races	
		Number of People Living with HIV	Rate per 100,000	Number of People Living with HIV	Rate per 100,000	Number of People Living with HIV	Rate per 100,000	Number of People Living with HIV	Rate per 100,000
IA	3.12	1565	68.2	458	574	224	180.6	118	423.9
IL	12.86	9963	144.6	16508	1101.9	6629	405.7	1849	1527.8
IN	6.61	5410	120.5	3817	780.6	960	306.6	380	564.2
KS	2.91	1441	76.6	704	519.5	487	205.8	152	346.3
MI	9.92	4869	75.3	8294	736.4	811	230.6	500	378.2
MN	5.48	3812	100.3	2710	1141.7	778	392.4	248	362.3
MO	6.07	5615	135.7	5202	913.8	636	361.9	341	456.6
NE	1.89	1059	82.8	569	836.7	306	223.7	51	269.8
OH	11.61	9357	118.0	9072	783.1	1255	422.0	801	584.1
WI	5.76	2648	64.9	2177	772	817	304.6	163	305.4
US	321.22	298,373	174.2	404,375	1238.3	213,428	496.8	37810	890.0

Source: https://gis.cdc.gov/grasp/nchhstpatlas/tables.html

Table 3: Number of HIV Diagnoses by State, Absolute Numbers and Rates per 100,000, (2016)								
State	White		AA, Black		Latino		Multiple Races	
	Number of HIV diagnosis	Rate per 100000	Number of HIV diagnosis	Rate per 100000	Number with HIV diagnosis	Rate per 100000	Number with HIV diagnosis	Rate per 100000
IA	72	3.1	43	51.9	10	7.8	4	13.7
IL	284	4.2	741	49.6	291	17.5	28	22.4
IN	190	4.2	217	43.9	55	17.0	7	10
KS	77	4.1	32	23.6	23	9.5	5	11
MI	234	3.6	430	38.2	46	12.7	19	13.9
MN	116	3.0	129	52.3	23	11.1	6	8.4
MO	207	5.0	248	43.3	40	22.0	11	14.2
NE	38	3.0	15	21.7	16	11.3	2	10.1
OH	380	4.8	499	42.8	52	16.9	29	20.4
WI	78	1.9	109	38.4	24	8.7	8	14.4
US	10329	6.0	17450	52.9	9750	22.2	871	19.8

Source: https://gis.cdc.gov/grasp/nchhstpatlas/tables.html

Table 4: HIV/AIDS Prevalence, Number of Ryan White Providers, Number of Community Health Centers (CHCs) providing HIV Care, and Number of Unique Facilities/Providers reporting CD4 and Viral Load in 10 Midwestern States (2015)				
State	# of PLWHA as of December 31, 2015[3]	# of Ryan White providers as of December 31, 2015[4]	# of CHCs providing clinical HIV care as of December 31, 2015[2]	# of unique facilities or providers reporting CD4 and viral load in 2015[5]
Illinois	35,441	121	37	318 facilities
Indiana	10,741	21	20	N/A
Iowa	2,427	10	11	80 facilities
Kansas	2,830	11	13	88 facilities
Michigan	14,615	36	33	N/A
Minnesota	7,803	20	15	85 facilities
Missouri	11,887	27	19	352 providers
Nebraska	2,040	17	6	121 providers
Ohio	20,709	38	36	267 providers
Wisconsin	5,916	22	13	581 providers
Total 10 states	114,409	323	203	571 facilities 1,321 providers

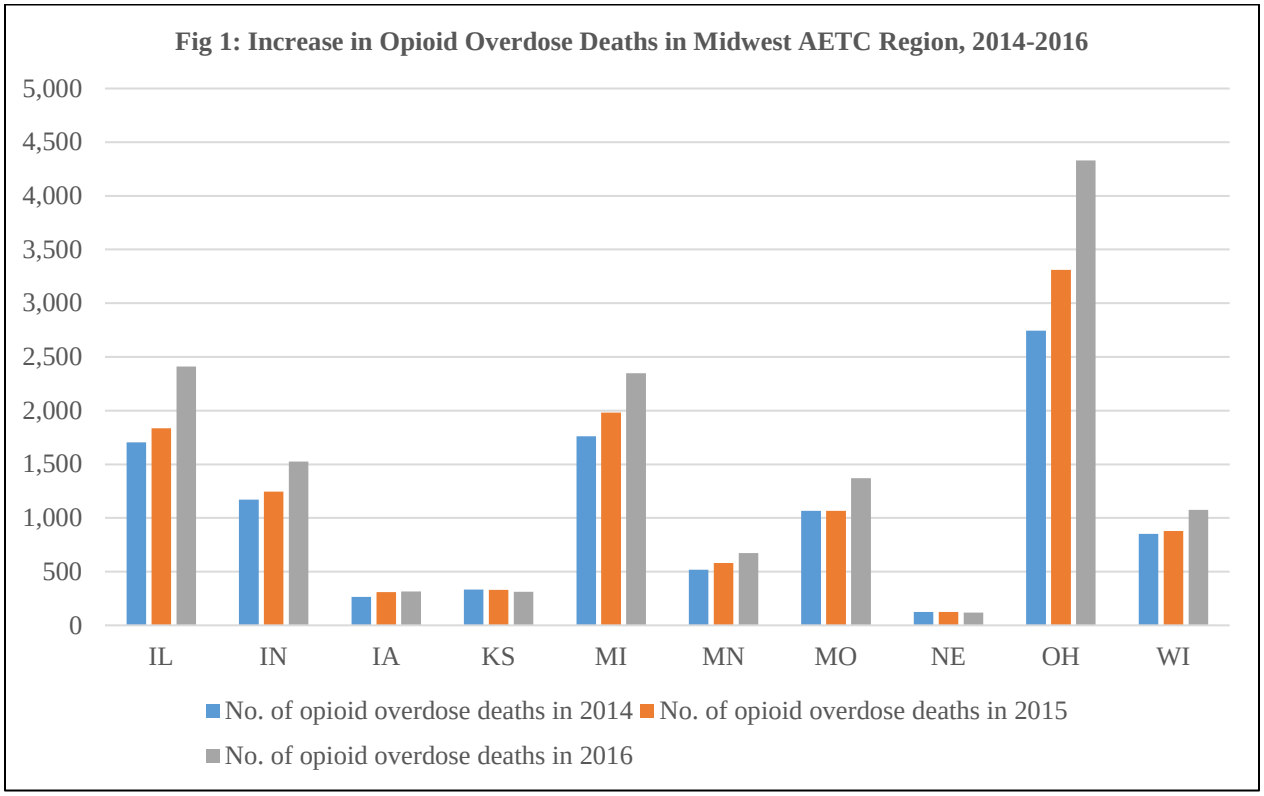
[3] Centers for Disease Control and Prevention, HIV Surveillance Report, Volume 28. Diagnoses of HIV Infection in the United States and Dependent Areas, 2016. https://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-report-2016-vol-28.pdf

[4] Health Resources and Services Administration, Data Warehouse. Accessed 4/9/2018. https://datawarehouse.hrsa.gov

[5] Data provided by State Health Departments upon MATEC's request.

Table 5: Drug-related deaths, HCV incidence, HIV incidence, and HIV prevalence rates in 10 Midwestern States and the United states, 2015-2016				
States	Drug-related deaths per 100,000 in 2016	Acute HCV cases per 100,000 in 2015	New HIV diagnoses per 100,000 in 2016	HIV prevalence per 100,000 as of 2015
IA	10.0	N/A	5.1	93.5
IL	18.8	2.8	12.9	330.1
IN	23.0	30.6	8.8	195.7
KS	10.8	7.0	5.9	118.6
MI	23.6	15.3	8.9	174.6
MN	12.2	12.5	6.2	171.3
MO	22.5	5.6	10.0	234.0
NE	6.3	1.4	4.9	131.6
OH	37.3	22.2	9.9	212.5
WI	18.6	25.0	4.6	122.0
US	19.7	13.9	14.7	362.3

Source: http://opioid.amfar.org



Source: https://www.cdc.gov/drugoverdose/data/statedeaths.htm

Table 6: Syringe Exchange Programs and Facilities Providing Some Medication Assisted Treatment (MAT) in 10 Midwestern States in 2018		
States	Syringe Exchange Programs in 2018	Facilities providing MAT (2018)
IA	1	29
IL	9	178
IN	7	108
KS	0	42
MI	4	121
MN	10	89
MO	2	107
NE	0	19
OH	7	215
WI	15	101

Source: http://opioid.amfar.org

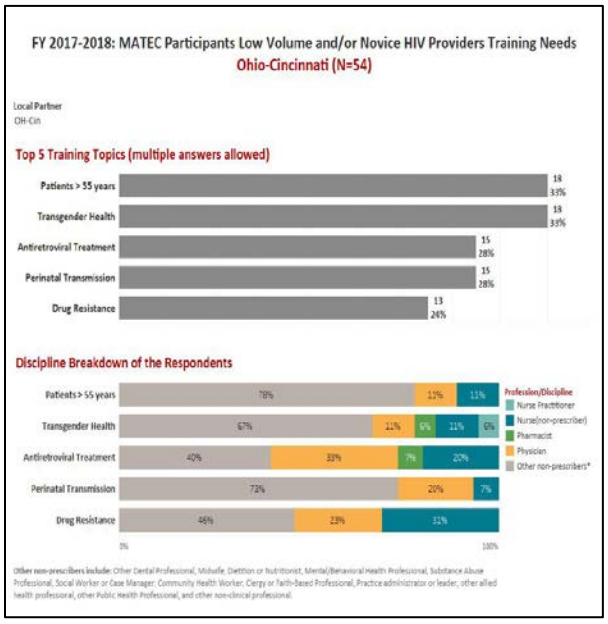
Table 7: Additional PCPs needed in 10 Midwestern States by 2030			
State	Additional PCPs required by 2030	% increase compared to state's current PCP workforce	Current population to PCP ratio
Illinois	1,063	12%	1462:1
Indiana	817	20%	1659:1
Iowa	119	5%	1507:1
Kansas	247	13%	1561:1
Michigan	862	12%	1400:1
Minnesota	1,187	28%	1258:1
Missouri	687	18%	1564:1
Nebraska	133	11%	1489:1
Ohio	681	8%	1482:1
Wisconsin	942	22%	1364:1

https://www.graham-center.org/rgc/publications-reports/browse-by-topic/workforce.html

Table 8: Number of Health Professional Shortage Areas (HPSAs), Medically Underserved Areas (MUAs), and Medically Underserved Populations (MUPs) in 10 Midwestern States, HHS Regions V and VII, and the United States in 2018				
Region/ State	Population Estimate as of 1/7/2017[1]	Number of HPSAs for Primary Care (as of 4/4/2018)	Number of MUAs (as of 4/4/2018)	Number of MUPs (as of 4/4/2018)
United States	325.7 million	7,176	3586	426
HHS V and VII	66.6 million	1,831	935	96
Illinois	12.8 million	234	147	17
Indiana	6.7 million	159	45	22
Iowa	3.1 million	132	87	1
Kansas	2.9 million	169	90	14
Michigan	10.0 million	361	89	11
Minnesota	5.6 million	128	97	10
Missouri	6.1 million	250	115	5
Nebraska	1.9 million	111	81	1
Ohio	11.7 million	150	114	13
Wisconsin	5.8 million	137	70	4

[1] United States Census Bureau, Annual Estimates of the Resident Population for the United States, Regions, States, and Puerto Rico: April 1, 2010 to July 1, 2017. https://www.census.gov/data/tables/2017/demo/popest/state-total.html

Fig 2: Training Needs of Low Volume and Novice Providers in Ohio during FY 2017-18



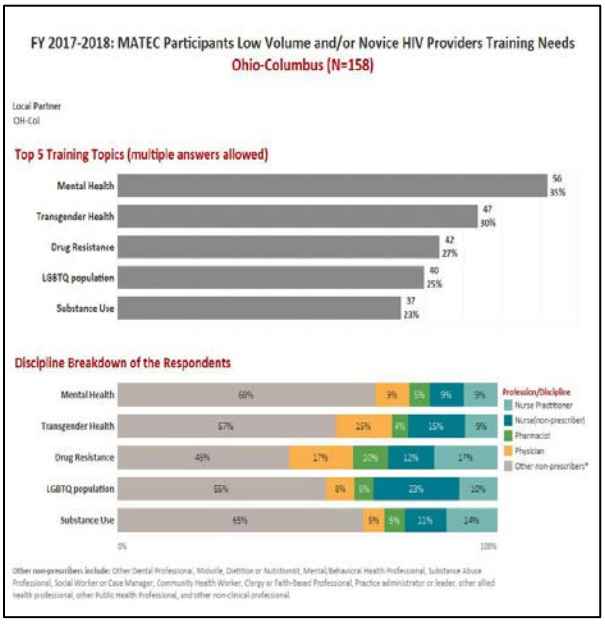
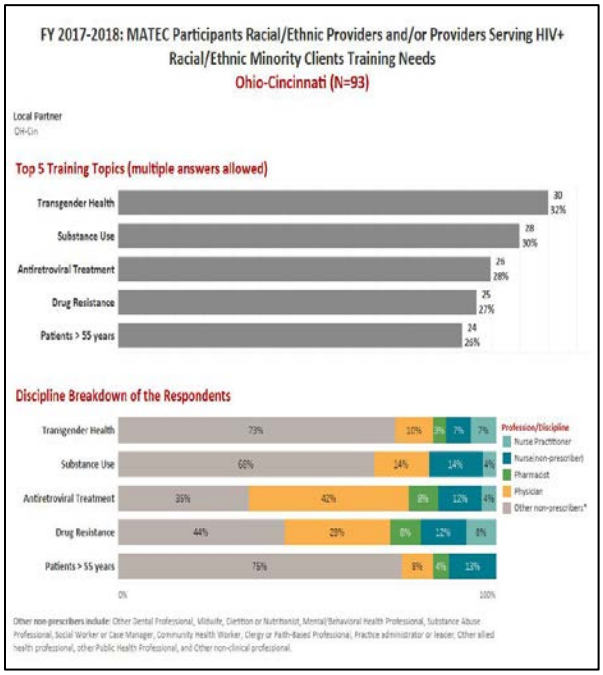


Fig 3: Training Needs of Minority and/or Minority Serving Providers in Ohio during FY 2017-18



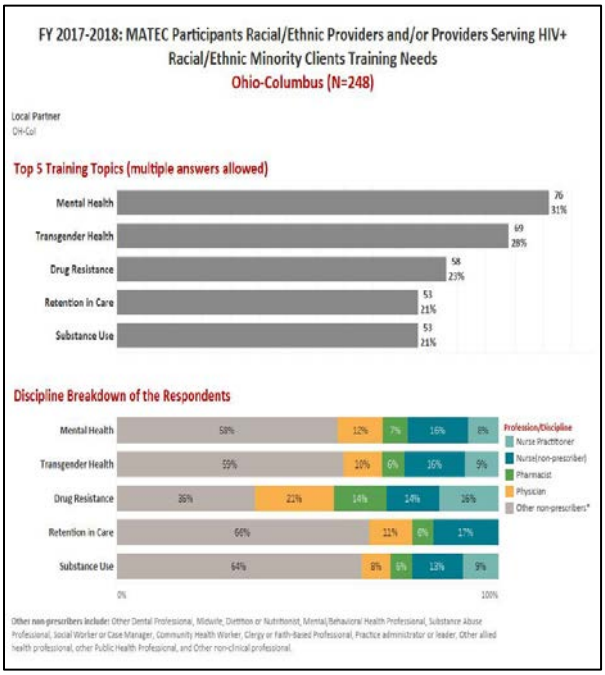
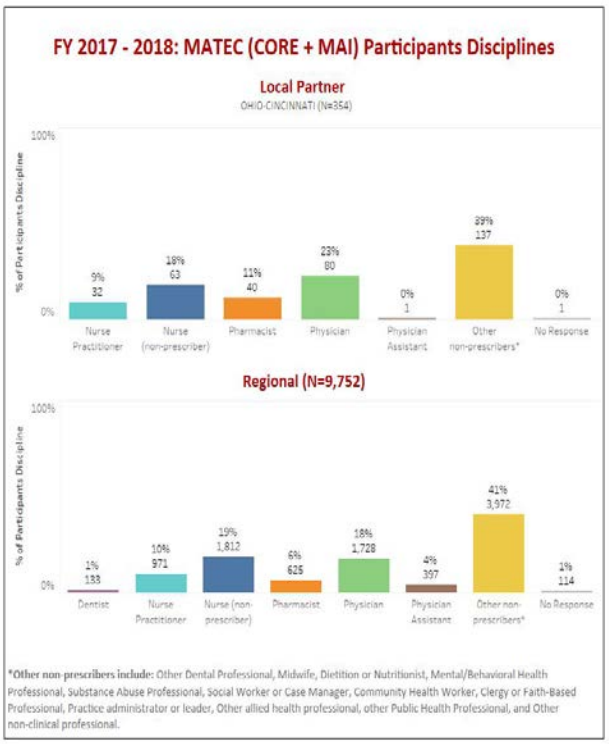


Fig 4: CORE and MAI Participants by Discipline in Ohio and Midwest Region during FY 2017-18



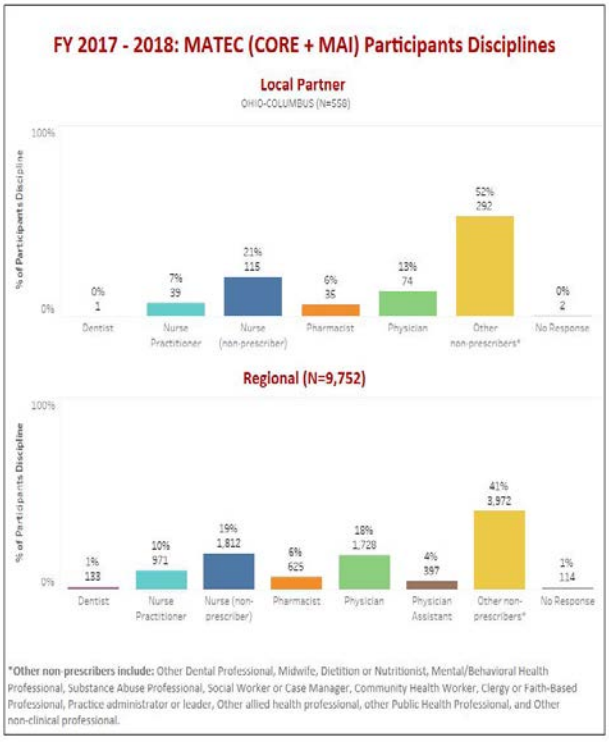
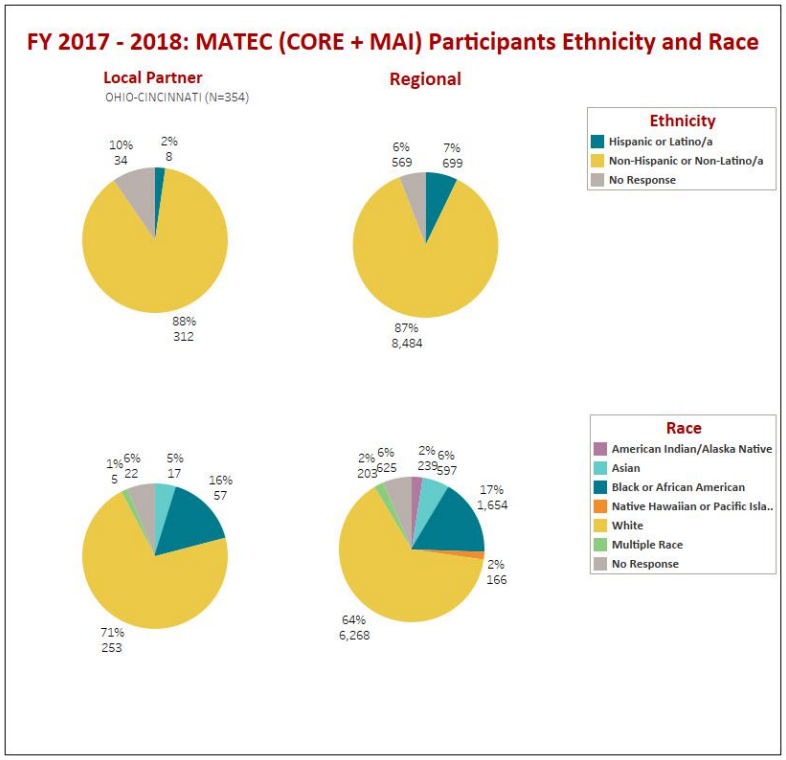


Fig 5: CORE and MAI Participants by Race and Ethnicity in Ohio and Midwest Region during FY 2017-18



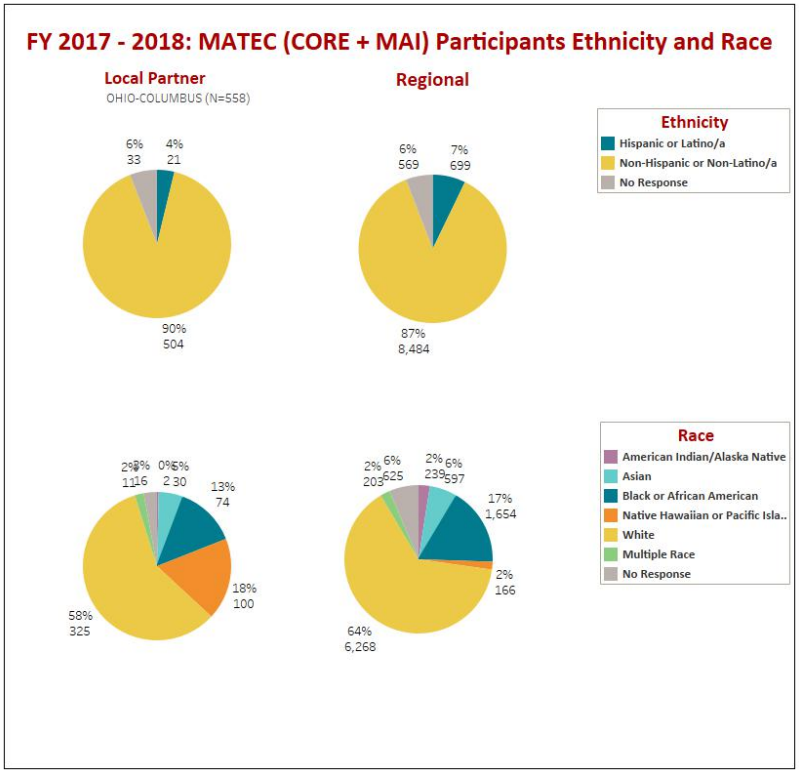


Fig 6: Map of employment zip codes of MATEC trainings who are working in Ohio