Briefing

Indiana Needs Assessments Related to HIV Prevention, 1998-2009

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Twenty six needs assessments related to HIV prevention were summarized for the Needs Assessment Committee of the Indiana HIV Prevention Community Planning Process to inform the planning for a comprehensive HIV prevention needs assessment. The summaries are found in the attachment to this document. Electronic copies of this and all source documents can be found at www.policyresourcegroup.com.

An effort was made to collect as many needs assessment documents as possible through literature review and networking with public health and community partners during March 2010. We could not locate the following known reports (cited elsewhere or mentioned): report focused on syringe exchange (funded by the Indiana AIDS Fund), North West HIV Service Assessment (dated 2000), 2005 Brother's United HIV Services Assessment and a report from Indiana's Medical Monitoring Project. Of the 26 documents included in this summary: 9 are focused on HIV prevention, 10 are focused on HIV services, and the remaining are focused on areas connected with HIV prevention: Prison inmate health, STD prevention, minority health, community health and homelessness. A few of the HIV related needs assessments focused on multiple issues such as dual diagnosis with HIV and chemical dependency, or risk for HIV among those with severe mental illness (herein noted as "SMI").

The needs assessments included in this summary were conducted between 1998 and 2009. For the purpose of the review, the dates associated with the needs assessment refer to the *year the data were collected*. In several cases, the reports were published months after the data were collected; and in some cases, more than one year following the data collection.

The table below displays a time line that demonstrates the progression of needs assessments, their target populations and core recommendations related to HIV prevention (directly or structurally). Ongoing discussion with the needs assessment committee and the CPG will reveal additional connections among the needs assessments.

Populations (alpha order)	**Year of Data Collection**									
	1998	**2000**	**2001**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**
Heterosexual Men		X	X						X	
Heterosexual Women		X	X						X	
Hispanic Men or Women		X	X				X (MSM)	X	X	
Incarcerated (Current or Recent)			X					X (Prison)	X	X
MSM			X						X	X
MSM of Color			X				X ?	X	X	X
People Living with HIV Disease (HIV and or AIDS)		X				X X			X	X
People with Mental Illness				X		X		X		

Populations (alpha order)	**Year of Data Collection**									
	1998	**2000**	**2001**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**
Race/Ethnic Minorities (Generally)			X	X	X	X X				
Rural Residents			X			X				
Sex Workers			X							
Substance Users including IDU		X X	X X			X (HIV/SA)			X	
Transgender (of Color?)							X	X		
Women of Color (mostly African American)			X				X		X	
Youth (LGBT and High School)	X LGBT		X unclear	X X (High School and SMI)		X (High School)		X (High School)		
Findings										
	1998	**2000**	**2001**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**
Health and Treatment Access Issues (Prevention and Care)					X	X X X	X	X (SMI)	X	X
Health Disparities (Race, Sexual Orientation)				X	X					X
Hepatitis C		X						X		X
Housing Transition or Homelessness		X	X							X X
Indiana's Lack of Health Investment					X					X
Language Barrier				X					X	
Mental Illness (mostly depression)		X	X	X (youth)		X (youth)		X (Youth)		X
Multiple Partners is Normative			X	X		X		X		X
Partner Violence				X (Youth)		X (Youth)		X (Youth)		
Provider Issues						X	X			X
STDs – Unmet Need					X					X
Stigma						X			X X	X
Substance Use/Dependence				X (Youth)	X	X (Youth)		X (Youth)		X

Recommendations (Stated by Document Authors)										
	1998	**2000**	**2001**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**
Address Stigma						X			X	X
Assure Cultural Competency and Relevance				X	X	X (LGBT)	X	X	X	X (all)
Condom Use – Increase			X							
Change Provider Behavior						X (care)	X (prev)	X	X	X
Hepatitis C: Test More and Improve Policy										X
Improve Education and Social Marketing								X	X	X
Increase Housing Options										X
Increase Substance Abuse and Mental Health Treatment			X						X	X
Increase Testing for HIV/STD/Hep			X						X	X
Initiate Syringe Exchange			X							
Link to Medical Care				X					X	X
Reduce Health Disparities				X						X
Reach People who are Out of Care									X	X
Shift Prevention Approach		X		X						X

Summary of Needs Assessments Related to HIV Prevention in Indiana

1998-2009

Needs assessments are ordered by the year that data were gathered. They are color coded to indicate the focus: HIV Services, HIV Prevention, Homelessness, STD, Minority Health Community Health, Mental Illness, Substance Abuse, Prison Inmate Health

1998

(1)

Focus	Title	Authors	Funder	Population
HIV Services	Indiana Youth Access Project *Journal Of Adolescent Health 1998; 23S:83–95*	Wright ER, Gonzalez C, Werner JN, Laughner ST, Wallace M; IUPUI	HRSA	LGBT Youth in Central Indiana

Purpose	Methods	Participants	Findings	Recommendations
Evaluation of a model to confront institutional barriers that limit access to HIV care services for LGBT Youth.	Survey	418 participants in a 3 year program.	Youth activities, peer support and an integrated system of care reduce barriers to HIV care for LGBT youth.	Recommend continued system integration given interconnected nature of young LGBT problems and HIV risk behaviors.

2000

(2)

Focus	Title	Authors	Citation	Funder
HIV Services	State of Indiana HIV Needs Assessment Report	Cohen M., et al. Partnership for Community Health, NY	Report published in 2002 due to the bankruptcy of AIDServe	ISDH

Populations	Purpose	Methods	Participants
o HIV service providers o PLWHA: AA, Hisp, Het men and women, IDU o PLWHA out of care (not clear how recruited, participated)	o Identify barriers to HIV Care o Health Status o Unmet need for HIV services	o Secondary data analysis of epidemiologic data to estimate need for services. o Key informant interviews o Surveys. Oversampled women, Hispanic, heterosexuals, IDU o Focus Groups – Luther Consulting and ISDH conducted focus groups with Spanish translators o 10-15$ incentives o Trained interviewers	o Key informant interviews: medical and social service providers, special populations (see Table 2-3) o Survey of 404 PLWHA (June-Dec 2000). See Tables 2-1 and 2-2 of report. o Telephone surveys for rural populations or where transportation was a barrier. o 16 focus groups (providers, PLWHA: AA, Hisp, Het men and women, IDU)

2000 HIV Services Needs Assessment (Cont)

Findings
o 12% of participants reported being homeless some time in the last 2 years. (Of this group, just under half (48.9%) were IDU (incl MSM/IDU) and 20.5% were recently incarcerated). o 14% PLWHA were dx with Hepatitis C in the last year (higher for IDU, AA and Latino populations) o 56% reported mental illness diagnosis in the last year (just under half were diagnosed with depression) o 44% of participants had an AIDS diagnosis for more than 3 years o No major barriers to care *according to people currently in care.*

2001

(3)

Focus	Title	Authors	Funder	Populations
HIV Prevention	HIV Prevention Needs Assessment	Cohen M, Ovellana L, Reyes B, Stover B, Burcham B, Ros V. Partnership for Community Health	ISDH	o MSM: Anglo, Latino, African American o Hispanic men and women o SA and IDU o Women at risk and women of color at risk o Heterosexual men o Youth at risk (undefined) o "special populations": >55 yrs, women with families, rural, sex workers, incarcerated or recently released

Purpose	Methods	Participants
o Perceptions of prevention needs and unmet needs. o Identify gaps in services, service capacity. o Identify barriers to obtaining programs and services. o Sociodemographics, living arrangements, health care, health history (STDs, mental health) o Structural, normative, informational, psychological factors faced when adopting safer practices	o Surveys – Moderators: white lesbian, white MSM, Latina. "ethnic match through assistant peer facilitators" o Focus Groups o Trained community interviewers - but not clear whether they were used (no interviews reported).	o 449 surveys. Oversampled women, heterosexuals and communities of color. Adjusted based on Holmsberg's method of estimating vulnerable populations (1996) along with Epi data. o 14 Focus groups: adolescent men (10, Indy); Anglo MSM (8, Indy); Anglo rural men and women (11, Reelsville); AAMSM (10, Gary); Het SA AA/Anglo women (6, SB); Het Anglo/AA/Lat men (10, Ft. Wayne); Het IDU mix ethnic women (10, Ft. Wane); Het Mix ethnic women (4, Indy); Incarcerated* chem dep women Anglo/AA (9, Indy); Incarcerated* chem dep men Anglo/AA (8, Indy); Latino MSM (4, Indy); SA AA/Anglo men (8, Indy); SA AA/Anglo women (9, SB); Over 55 rural women Anglo/AA(1) (11, Richmond) [**NB:*** Not clear whether this focus group was among currently or recently incarcerated persons.]

2003

(4)

Focus	Title	Authors	Citation
HIV Prevention	Modeling HIV Risk in Highly Vulnerable Youth	Huba GJ et al.	Structural Equation Modeling, (2003) 10(4), 583–608

Populations	Purpose	Methods
Youth presenting for medical and psychosocial services at community health programs in select areas, including Indiana.	o Can you predict the HIV status of a client by modeling risk behaviors? o Which behavioral risks are markers for HIV status? What risk factors underlie their self reported behaviors and do they differentiate on their prediction of known HIV status?	Exploratory, confirmatory factor analysis

Participants	Findings	Recommendations
8,251 youth presenting for medical and psychosocial services at community mental health centers. Diverse geographically, sexual orientation, race/ethnic.	o 2 risk factors for predicting HIV among men: sex with men and a general risk factor o 3 risk factors for predicting HIV among women: sex with men, substance abuse, and high risky sex behavior o Risky sex and drug use co-occurred, so the question was whether they combined to affect HIV risk as a magnifying effect or mediating, or some other type of combination. The interrelationship among high risk behavior was stronger for MSM than for women.	Use this type of modeling to understand how common HIV risk behaviors combine to understand the urgency of a particular youth's need for HIV services.

(5)

Focus	Title	Authors	Populations
Minority Health	Healthy Indiana: A Minority Health Plan for the State of Indiana	Minority Health Advisory Committee, ISDH	Racial/ethnic populations disproportionately impacted by disease and health conditions in Indiana

Purpose	Methods	Findings	Recommendations
Measure the health status of minority populations and identify strategies to improve health.	o Secondary analysis of health data. o Input from community	o Disproportionate impact of HIV and AIDS among African American and Latino populations o Counties with the largest populations of race/ethnic minority residents: African American: Marion, Lake, Allen, St. Joseph, Vanderberg; Hispanic/Latino: Lake, Marion, Elkhart, Allen and St. Joseph.	o Increase number and service areas of community health clinics, Indian Health Service clinics o Reduce prevalence of HIV/AIDS among Indiana African American populations o Reduce prevalence of HIV/AIDS among Indiana Latino/Hispanic and African American populations

(6)

Focus	Title	Authors	Citation	Populations
HIV Prevention	Sexual Networks and HIV Risk of People with Severe Mental Illness in Institutional and Community-Based Care	Wright E, Gayman M	AIDS and Behavior, Vol. 9, No. 3, September 2005 (*data collected in 2003)*	People with severe mental illness (SMI) in community and hospital settings. Community Mental Health Centers (CMHC) and Psychiatric Hospitals.

Purpose	Methods	Participants
What is the variation in sexual networks and HIV risk among clients with SMI in community and institutional care settings? (Responding to research about how social environments influence patterns of risk behaviors)	Structured interviews at 3 community mental health centers and 2 state psychiatric hospitals. Data gathered as part of the Indiana Mental Health Services HIV Risk Study. $25 incentive for completed interview.	401 people with SMI who received services at either a community mental health center or psychiatric hospital in Indiana

Findings

- Clients of community mental health center environments are more likely than hospitals to be currently sexually active and engaged in high risk behaviors. Hospital patients tended to have more transient sex with partners who also had a mental illness. Treatment settings may be a structural factor for HIV among people with severe mental illness.
- 70.1% were sexually active; however, 40% of the CMHC clients and 21.8% of the hospital clients had only 1 partner in the past 3 months. Hospital patient relationships tended to be shorter (1-2 years vs. over 6 years): 26.8% of hospital patients knew their current partner for less than 6 months. 46.8% of CMHC clients knew their partners for 6 years or longer.

2004

(7)

Focus	Title	Authors
Minority Health	A Health Needs Assessment Study of the Minority Population in Marion County. *Published in 2005*	Indiana Minority Health Coalition and Indiana University Bowen Research Center

Populations	Purpose	Methods
Minority populations in Marion County	o Identify real and perceived health related issues o Examine factors impacting health o Identify opportunities and initiatives to better meet the health needs	o Secondary analysis of birth and death certificate data, hospitalizations and health indicator data o Targeted population surveys to identify health issues, needs, values, beliefs o focus groups o key informant interviews

2004 Minority Health Needs Assessment (Cont).

Participants	Findings
238 survey participants	o Race/ethnic minorities perceived diabetes, AIDS/HIV and substance abuse to be part of the top 5 greatest health threats for their neighborhood. (Latinos were concerned about infectious disease more than African Americans) o 25% of African Americans and 40% of Hispanics indicated difficulty obtaining services of a doctor, nurse or other health professional in the past year. o Barriers for African Americans: lack of insurance, resources for co-payment or insurance, waiting too long for an appointment, waiting too long in the clinic office, staff rudeness or they were not helpful. o Barriers for Hispanic/Latinos: Lack of insurance, resources for co-payment or insurance, language barriers, not having a Social Security Number, or lack of transportation. o Focus group finding: STDs were among the top major health problems facing their communities. o Focus group: Access barriers: culture, patient-provider communication, lack of health knowledge, personal resources (money), system problems.

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Focus	Title	Authors	Populations	Purpose
Community Health	A Plan for Community Health Improvement 2004-2007	Indiana Medicine and Public Health Initiative	Indiana Residents	Establish a community health improvement plan - a 'call to action' focused on Indiana's preparedness, workforce and health challenges

Participants	Findings	Recommendations
11 regional community forums (2003); and a health summit (550 participants)	o Indiana was ranked 47th in the U.S. (98-99 FY) per capita distribution of state/local public health expenditures (Kelley School of Business/U.S. Census). o 75% state public health workforce lack formal education in public health o 46 Indiana public health workers per 100,000 population cf. to 138/100k population nationally or 76/100k population in Region 5. o Indiana ranks 40th in years of potential life lost based on health disparities; 42nd for YPLL for African Americans (Indiana Minority Health Plan, 2003)	o Health priorities for Indiana: personal health management, children and adolescent health promotion, access to quality health care, education and community based programs. o Common themes: coordinated, integrated data collection; evidence based models for public health interventions, comprehensive evaluation strategies, cultural competency training including bilingual education for all providers, sustained coalition building efforts using community assessment strategies to promote strong partnerships and collaboration.

2005
(9)

Focus	Title	Authors	Citation	Populations
HIV and Substance Abuse Services	HIV Provider Perspectives: The Impact of Stigma on Substance Abusers Living with HIV in a Rural Area of the United States	Yannessa JF, Reece M, Basta TB	AIDS Patient Care and STDs Volume 22, Number 8, 2008, 669-675	Rural Indiana clients who were diagnosed with HIV and chemical dependency (substance abuse) *based on the perceptions of their providers*

Purpose	Methods	Participants
o What are the issues of stigma surrounding HIV and Substance Abuse and their impact on the ability of care providers to create sustainable linkages to care for dually diagnosed people (HIV and Substance Abuse) in rural areas? o HIV provider perspectives on client retention and outcomes, challenges to effective counseling, client social networks, effectiveness of counseling and testing and how they affect linkages to sustainable care sources for rural clients.	30 minute phone or in-person interviews	Providers of Care: 39 HIV care coordinators/case managers from 11 (of the 15) HIV care coordination sites serving rural areas in Indiana

Findings	Recommendations
o Wide spread stigma among staff of medical facilities throughout the rural system of care. Multi-dimensional stigma in medical referral networks was the leading challenge: Verbal stigma: insults, loss of role or respect; global loss of resources (e.g. poorer quality of health care or non provided). o Client family stigma was still prevalent o Stigma was a major issue with medications adherence (See also Reif S, Golin S, Smith S (2005) Barriers to Accessing HIV/AIDS Care in North Carolina. AIDS Care; 2005 17:558-565.) o Rural physicians expressed stigma - expressed behaviors that discouraged future visits by the client (even if they were trained in the specialized area (e.g. secondary to HIV infection) o Staff of referred agency acted as a barrier to care even when the agency was officially linked to referral source. (e.g. staff were not gay or HIV friendly) o Disproportionate increase in rates of HIV/AIDS infection in rural areas and yet most areas lack services for residents with HIV. o Stigma was expected but just not to this extent given the information available. "Conservative cultural norms" mitigated the information. o [Editor's note: Stigma appeared to be HIV and gay focused; not focused on substance use or chemical dependency]	o New educational approaches that reduce stigma in medical venues. o Enhance policies that regulate provision of HIV related care in all areas (e.g. standardized assessments for MH and SA across all initial patient and client encounters when entering primary care or other federally funded HIV care; or establishing referral protocols that are mandated for funded programs to assure effective and non-stigmatized referrals.

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Focus	Title	Authors	Funder	Populations
HIV Services	Report of HIV Services Needs Assessment Survey	Luther Consulting	ISDH	Clients receiving HIV services in Indiana (10 regions). See table 1 for listing

Purpose	Methods	Participants
o Identify barriers to care, gaps in services, and hardship status. o Gaps in services: number of days/times experienced particular hardship (e.g. days gone hungry or unable to get food or missed a doctor's appointment).	ISDH staff administered survey among clients receiving HIV services	550 participants: 79.8% male; 1.5% transgender; 83.5% had been in care coordination for more than 12 months. 58.6% earned less than $12,000/year.

Findings	Recommendations
Obtaining medications remains problematic for survey participants. Issues include transportation and financial resources for co-pay.	[Editor's Note: Not sure why Indiana is not measuring 'out of care' populations by comparing lab reports with testing data? See: Meyerson BE, Klinkenberg WD, Perkins D, Laffoon BT. Who's In and Who's Out: Use of Primary Medical Care Among People Living with HIV. American Journal of Public Health 2007; 97:744-749; Perkins D, Meyerson BE, Klinkenberg WD, Laffoon BT (2008). Assessing HIV Care and Unmet Need: Eight Databases and a Bit of Perseverance. AIDS Care, 20 (3): 318-326]

2006

(11)

Focus	Title	Authors	Citation
HIV Prevention	HIV Prevention Gap Analysis and Resource Inventory	Students at IU South Bend	Reported in the 2008 Needs Assessment Committee Narrative. *Source document not found.*

Populations	Purpose	Methods
Providers of HIV prevention services in Indiana	o Review and update the HIV prevention services resource guide with greater focus on target populations and population specific prevention activities o Can providers describe the populations they serve and specific services for these populations?	Contact (how?) of funded agencies.

2006 HIV Prevention Needs Assessment (Cont.)

Participants	Findings	Recommendations
HIV Prevention Funded Agencies	o Only 2 organizations (northern Indiana) could answer the questions o No specific HIV prevention interventions were mentioned o No specific populations were identified as a service cohort or focus o No culturally relevant descriptions of services were provided	o Evaluation of process used to allocate resources o Evaluation of expected outcomes from prevention service providers o Assess all HIV prevention service providers for the ability to provide and conduct culturally competent HIV prevention services

(12)

Focus	Title	Authors	Citation	Funder
HIV prevention	Indiana HIV Prevention Needs Assessment Final Report	Luther JB, Luther A, Apple J	*published in 2007*	ISDH

Populations	Purpose	Methods
High Risk populations or populations of interest: Latino MSM, African American women who engage in high risk behavior and transgender persons.	Prevention needs, barriers to services, high risk behaviors	o Surveys. Distribution through venues identified by the CPG and through care coordination sites o Focus Groups o Recruitment through agencies and organizations identified by CPG

Participants	Findings	Recommendations
o Survey participants: Latino MSM (n=36, mostly in northern Indiana) o Focus groups in Indianapolis, SB, Elkhart, Gary, Evansville among African American women who engage in high risk behaviors o Focus groups among transgender person (where?)	o **Latino MSM** (14 of the 36, (39%) identified as having sex only with women): Access to HIV information is limited; prevention activities should be in group settings with focus on exercising and sports as venues; interventions should focus more on sexual risk behaviors and less on drug and alcohol abuse o **Latino MSM risk:** 12/36 (33%) attended a bathhouse at least once; 5/36 (14%) attended sex parties. 22/36 (62%) were HIV+ [skewed due to recruitment venue] **BUT/AND:** 67% (24/36) *never asked the HIV status of their partners.* o **African American women with high risk behaviors:** prevention activities should incorporate music with festivals and carnivals, involve church community and provide testimonials from African American women with HIV o **Transgender:** Agencies, clinics, etc need to make effort to be more trans friendly; transgender individuals could be test providers for their populations; include glamorous events; specifically address trans community vs. addressing community as an appendage of gay and lesbian communities	o [Editor's note: Need to explore further the self identification of Latino MSM given that 39% of survey respondents reported only sex with women] o Spanish education and outreach materials should be available in bathhouse venues

2007
(13)

Focus	Title	Authors	Funder	Populations
HIV Prevention	Youth Risk Behavior Survey Results (Indiana High School Survey) Trend Analysis Report 2005-2007; *included '03*	ISDH	CDC	Indiana high school students

Purpose	Methods	Participants
What are the trends in reported behavioral risks among high school youth? Study includes (among other things) sexual health risks, drug/alcohol risks, violence experiences and risks	Survey among Indiana High Schools who participate in the Youth Risk Behavior Survey.	Indiana High School Students in 9th-12th grades from participating school districts (not available)

Findings

- **Violence:** % of students hit, slapped or physically hurt on purpose by boyfriend or girlfriend in the past 12 months: 11.7 (2003), 12.5 (2005), 11.6 (2007). Among African American students: 14.7 (2003), 15.3 (2005), 16.5 (2007)
- **Depression:** % students who felt so sad or hopeless almost every day for 2 weeks or more in a row that they stopped doing some of the usual activities in the past 12 months: 25.5 (2003), 27.3 (2005), 27.5 (2007)
- **Alcohol:** % Students who had one or more drinks in the past 30 days: 44.9 (2003), 41.4 (2005), 43.9 (2007); and % who had more than 5 in a row within 2 hours in the past 30 days: 28.9 (2003), 24.6 (2005), 28.2 (2007)
- **SEX:** % Students who had sex (ever): 48.8 (2003), 44.5 (2005), 49.1 (2007); **African American** students: 71.4 (2003), 58.9 (2005), 66.3 (2007) had sex with more than 1 partner in the past 3 months: 38.0 (2003), 34.6 (2005), 37.0 (2007). **African American students:** 53.6 (2003), 45.1 (2005), 47.8 (2007)
- **Condom Use:** (for those having sex with more than 1 partner in the past 3 months (see above), % who used a condom during the last sex encounter: 55.4 (2003), 62.6 (2005), 57.1 (2007)

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Focus	Title	Authors	Funder	Populations	Purpose
Prison Inmate Health	Survey of the Status of Inmate Health in the State Prison System	Health Finance Commission, Indiana Legislative Services Agency	state of Indiana	Adults and youth in Indiana prisons during 2002-2007	To document the health status of adults and youth in the Indiana state prison system.

Methods	Participants	Findings
o Secondary analysis of adult intake data from 2002-2006 o Analysis of one day 'snapshots': Analysis of health services reports from Correctional Medical Services from Dec 2006-May 2007 for adult and youth populations (clinical encounters, community hospital data, infirmary, laboratory, chronic care, hepatitis care, off site specialty care, women's health, pharmacy, altercations, mortality)	o People living in the 22 adult correctional institutions (with total population as of January 2007 of 25,237). 91.8% were male, 57.1% white, 38.2% African American, 3.8% Hispanic. Average age at intake was 32.2 yrs; average current age of adult prison population is 35.9 years. o There are 7 youth detention facilities for 996 people as of January 1, 2007. 85.2% are male, 57.8% white, 31.4% African American, 6.4% Hispanic. The average age at intake is 16 years old. Current average age is 16.8 years. The longest length of stay is 15 months. 26% of prison population is serving a term of over 20 years. 20.1% are serving a term of 2-5 year; 22.7 % are serving a term of 5-10 years.	o Cause of death among prison population which occur more frequently than in general population: liver disease and AIDS. Leading causes of death among prison populations: Heart disease, cancer, liver disease, AIDS, respiratory disease. o **Hepatitis C:** 11.6% of new adult admissions were infected with Hepatitis C. 18.5% of chronic health issues addressed each month were hepatitis; 3.6% were for 'infectious disease'; and 1.5% were for HIV/AIDS. Average of 45 newly diagnosed Hepatitis C cases per month among prison populations. 0.4% of new youth detention center admissions were Hepatitis C positive o HIV: Less than 1% of admissions were HIV+ (HIV and Hep C testing on admission). Men were 1% HIV+; Women were .7% HIV+. .3% for girls (boys were less than .1%)

[Editor's note: Beginning September 2002, the Department of Corrections is required to report to the General Assembly the number of individuals tested for HIV and Hepatitis C; and the numbers who are positive for HIV and Hepatitis C. Correctional medical services was the medical contractor for prison health services from September 1, 2005 to August 31, 2009. Prior to that Prison Health Services was the contractor.]

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Focus	Title	Authors	Citation
HIV Prevention And Mental Illness	HIV Prevention Services for Adults with Serious Mental Illness in Public Mental Health Care Programs	Wright, Eric R., Dustin E. Wright, and Anthony H. Lawson.	Journal of Prevention & Intervention in the Community Vol. 33, No.1/2, 2007, pp. 63-77

Purpose	Methods	Participants
o Measure the types, frequency and client level correlates of HIV prevention services provided to people with Severe Mental Illness (SMI) in five public mental health programs (Community Mental Health Centers and Psychiatric Hospitals) o	o Secondary data analysis of Indiana Mental Health Services HIV Risk Study Data gathered from face to face interview with clients in programs for severe mental illness (SMI) at 3 community mental health centers (CMHC) and 2 state psychiatric hospitals. o Three classifications of HIV prevention services: HIV prevention education; HIV counseling and case management; HIV prevention skills training and support. o Measured client perception about how often they believed they received these services and had talked about sexuality or HIV related issues with members of their primary treatment team.	369 people ages 18-55 years and diagnosed with severe mental illness (SMI) who were receiving services from either a community mental health center or a psychiatric hospital in Indiana.

Findings

- Less than 1/3 of the clients received HIV prevention services. Those who were identified as 'higher risk" (e.g. HIV+, currently sexually active, more acutely mentally ill/hospitalized) received prevention services more frequently; however, their gender and service setting (CMHC vs. hospital) influenced the types and frequency of these services.
- HIV prevention skills training and support was the least likely of HIV prevention services to be provided (compared with HIV counseling and case management and HIV prevention education).

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Focus	Title	Authors	Citation	Funder	Populations
STD Prevention	Show Me the Money: State Contributions Toward STD Prevention, 2007	Meyerson BE, Gilbert LK	J Public Health Management Practice, 2010, 16(3), 232–239.	CDC	States (Indiana included)

Purpose	Methods	Findings	Recommendations
Measure state investment in STD prevention for state fiscal year 2007 (baseline)	Survey of state STD, Hepatitis, Immunization and Laboratory Directors	o Despite the history of STDs and syphilis outbreaks of recent times, Indiana does not contribute to its STD prevention effort sufficiently. o % of state funding in the STD budget = 6.5% (compared to a national average of 25.8%) o Per capita state funding for STD prevention in Indiana - $0.02 (national average of $0.23)	Increase state investment in STD prevention.

2008
(17)

Focus	Title	Authors	Populations
HIV Prevention	Needs Assessment Committee Narrative (part of the Indiana Comprehensive HIV Prevention Plan for 2008-2010)	Debra Stanley, CPG Needs Assessment Committee	o Priority populations (those contributing substantially to new HIV infections in Indiana) o Year 1 (2008): focus on PLWHA, African Americans, Transgender populations, women, Hispanic/Latinos, MSM, and African populations. Year 2 (2009): focus on Corrections, prevention providers, urban and rural communities and community (not clear what 'community' means) o Emphasis on sub populations of high risk for which there is little or no recorded information: African American Transgender MSM (Indianapolis and Gary), African American Women (Gary, Ft. Wayne, Indianapolis, Elkhart), Correctional populations based on community corrections target areas (Vigo, St. Joseph counties), Populations currently outside HIV service delivery system (out of care?)

Purpose	Methods
o Where do you get HIV related info? Where would you like to get HIV related info? o Do you know where to get tested for HIV? o Have you ever been tested? Did you go back for results? If you have never been tested, why not? o Have you talked about HIV with: partner, family, friends? Is it hard to talk about HIV to: doctors, family, friends? Why? o Who is most at risk for HIV infection? Do you believe yourself to be at risk? Why or why not? o Do you use drugs and/or alcohol? While having sex? o Do you use condoms? If yes, why? If not why? o Are there any barriers to accessing prevention services?	o Qualitative, in-depth needs assessments that are participatory in design (e.g. members of the target population are engaged in the planning, design and implementation of the needs assessments. o Involve populations, community service providers and increase technical expertise provided by partner researchers o Learn from the experience of target populations, observations from community service providers and the technical expertise of researchers.

Recommendations

o Meaningfully include members of the target population in the planning and implementation of needs assessments
o Effectively cultivate relevant services based on the understanding of barriers to prevention services

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Focus	Title	Authors	Funder	Populations
HIV Services	Needs Assessment for the HIV/AIDS Population in Central Indiana	Zollinger TL, Kochhar K, Aktepy SL. Indiana University Bowen Research Center	Health and Hospital Corporation of Marion County	o Persons living with HIV/AIDS in Marion County o Women, substance users, recently incarcerated populations, Hispanic immigrants, HIV+ in suburban areas surrounding Indianapolis, MSM

Purpose	Methods	Participants
o Real/perceived health related issues o Barriers related to entry, remaining in care, and treatment adherence o Opportunities and initiatives to address the barriers	o Focus Groups: 5 sessions (90-120 minutes) o Key Informant Interviews o 20$ incentive in gift certificates	o Focus groups (PLWHA and providers) N=41 o 26 key informant interviews with providers, care coordinators and out of care clients (#, %?)

Findings	Recommendations
o Stigma, denial, lack of awareness and support = barriers to entering care. o Language barriers persist for Hispanic clients.	o Remove system barriers: Improve interaction and communication between providers and patients, increase awareness of services and how to access, increase number of providers o Develop programs and initiatives to ensure access to basic, social, educational knowledge and employment (services) o Expand basic and specialized medical care o Reach people who are HIV+ but out of care o Increase screening - hospital based: expand Wishard model to Methodist; add a mobile unit; increase screening generally

2009

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Focus	Title	Authors	Funder	Populations
HIV Prevention	HIV Prevention Gap Analysis, 2009	Bryant D, Brown W	ISDH (CPG)	Targeted populations in areas of the state underrepresented in the planning process: 10 counties: Elkhart, St. Joseph, Delaware, Henry, Jay, Randolph, Wayne, Marion, Monroe, Vigo

Purpose	Methods
o What populations are targeted for your services? o What are the resources for services? o What are your program/services, and populations served by them? o What is the referral process?	o Constructivist, emancipatory, non-linear analysis o Telephone surveys with three attempts (to replicate access)

2009 Gap Analysis (Continued)

Findings	Recommendations
o 85 agencies contacted, 29 agencies could not be reached (were 'incomplete'): 27 of the agencies were in Marion County, 2 in Monroe County o For those agencies that could be reached, hold time was 5-15 minutes. No clear waiting cues such as music or message on hold. o Agencies generally could not provide in-depth information about the populations they serve. "We serve everyone." o Data report forms were complicated (reported by agencies) o Gap in language and terminology between service providers and the CPG o There is no clarity about the linkage to care following HIV testing o Referring referrals: Clinton, Dubois, Fayette, Grant, Harrison, Jay, Jefferson, Marshall, Montgomery, Warren, Washington, White: Sometimes referring to three counties and losing clients in mazes and voicemails; only to refer them elsewhere.	o Convene a summit of key providers linking those agencies who are in a referral chain of 3 or more agencies. o Study further: what happens to people lost in referrals?

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Focus	Title	Authors	Funder	Populations
HIV Services	Indiana Consumer Survey (part of the 2009 HIV Services Needs Assessment)	Foote C, Pessagno R, Lynn S	ISDH (CHSPAC)	PLWHA in Indiana

Purpose	Methods	Participants
To measure barriers to care and service needs	o 35 question survey - mailed or picked up at care coordination sites. o Community based participatory research model o Mailed 2,500 surveys (100 in Spanish). Delivered 800 surveys (50 in Spanish) to ISDH funded care coordination sites	o 746 persons living with HIV/AIDS. 36 Spanish language surveys were returned. o Survey participants represent 25% of the people receiving care in Indiana in the last 12 months, and 8% of the people living with HIV/AIDS in Indiana o Return rates aligned with care recipients by zip code

Findings
o 85% were in care coordination for the past 12 months. 39% receive Medicare services; 31% Medicaid services; ISDH funds care for 42%. o Fairly stable cohort in terms of housing, food and services. o Co-payments remain an issue for medications access for 45% of participants. They mentioned having medications access issues at least 1-3 times per year. o 3,042 people are currently receiving HIV care coordination services. This represents 33% of the people in Indiana who presumably know their HIV status (e.g. are among the 9,253 people who have been reported as having HIV disease to ISDH)

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Focus	Title	Authors	Funder	Populations
HIV Services	Indiana Provider Survey (part of the 2009 HIV Services Needs Assessment)	Foote C, Pessagno R, Lynn S	ISDH (CHSPAC)	PLWHA in Indiana through the perspectives of providers of service.

Purpose	Methods	Participants
To measure barriers to HIV care and services from the perspective of providers	Survey of HIV service and clinical care providers	111 HIV service and clinical care providers in Indiana (45% care coordinator/social worker, 19% clinical care provider, 17% program manager or director, 4% HIV testing specialist, 4% pharmacist, 3% special populations specialist, 8% other). Table on pg. 8 of report displays the regional response.

Findings	Recommendations
o Top 5 reasons people do not get into HIV medical care: Drug and alcohol addiction 59%, Payment issue or no insurance 57%, Readiness to deal with diagnosis 53%, Homelessness or housing instability 45%, Do not know their status 23% o 76% of providers track referrals made to agencies for mental health and addiction services (geographic distribution not clear) o Biggest problem faced when providing care to clients: drug coverage 42%, transportation 26%, mental illness/substance abuse 17%, housing service 14% o Other issues with primary care access: *prompt care after HIV diagnosis.* There is a lack of infectious disease providers, insensitive providers in rural areas (openly gay or trans clients). o Issues with mental health and substance abuse treatment: lack of available services, harm reduction philosophy is lacking, services for multiple diagnoses: HIV, mental illness and substance abuse.	o Increase public awareness about HIV and risk o Increase education about access to testing and treatment. The message about getting tested for HIV is not loud enough o Increase safe sex education in middle schools o Need for focus groups to learn more from particular populations: youth (13-24 years) 44%, people with alcohol and chemical dependencies 42%, Women 38%, People with mental illnesses 37%, people who are homeless or in housing transition 36%, Hispanic/Latino populations 35%, People who are incarcerated or recently released 34% o Address stigma in halfway houses in Ft. Wayne and in Community Mental Health Centers and among other mental health and chemical dependency service providers o Need more substance abuse treatment resources

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Focus	Title	Authors	Funder	Populations
HIV Services	Statewide Comprehensive Plan including a Statewide Coordinated Statement of Need, 2009-2012	ISDH	ISDH	People living with HIV/AIDS in Indiana

Purpose	Participants
o Thorough description of HIV service delivery system as implemented, along with a statement of need across service delivery systems. Includes Ryan White Parts A, B, C, and F. o *See 2009 Indiana provider and consumer surveys for statements of need.*	o Providers of Ryan White Parts A, B, C and F services o Persons living with HIV/AIDS o Other community members

Findings

- o 55% of those living with HIV disease have AIDS
- o Priority services reflect the 6 HRSA Ryan White Care priority services: primary medical care, HIV medications, oral health, case management, mental health treatment, substance abuse treatment. Indiana adds housing and transportation services to these services.
- o Challenges to care access: waiting list for part B medical services

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Focus	Title	Authors	Funder	Populations
HIV Services	Ryan White provider capacity and capability report, Indianapolis TGA	Health and Hospital Corporation of Marion County	Health and Hospital Corporation of Marion County	PLWHA via provider survey

Purpose	Methods	Participants
Extent to which HIV-related services in the area are accessible, available, and appropriate for people living with HIV (PLWHA) in the Indianapolis Transitional Grant Area (TGA).	survey among providers of Ryan White Part A and/or C services in the TGA	21 providers responded to the survey

Findings

- o The system of care appeared to be able to absorb more clients, however, wait times for new clients to get into services were more than 2 weeks for all medical case management providers.
- o Surveyed providers were well prepared to serve a diverse group of clients. Over a third reported specifically targeting services towards a particular vulnerable population group; all of the providers employed at least one strategy for serving clients that were non-native English speakers.
- o The vast majority of providers (77%) indicated that their clients had difficulties keeping their appointments. About half (48%) felt that their clients had difficulties getting transportation to their organization, 19% felt that their clients had difficulties accessing care due to physical disabilities, and 62% felt that substance abuse and mental health issues were barriers for clients remaining engaged in care. Agencies felt that clients were reluctant to seek services due to financial barriers such as co-pays, spend down, or services being uncovered (71%), stigma or fear of disclosing their status (60%), undocumented immigration status (47%), and cultural norms (25%).

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Focus	Title	Authors	Populations	Purpose
HIV Services	Application Narrative and Statement of Need for Indianapolis TGA (Ryan White Part A)	Health and Hospital Corporation of Marion County	People living with HIV/AIDS in the Indianapolis Transitional Grant Area (TGA); eligible for Ryan White Part A services	Statement of need for Ryan White Part A services within Indianapolis transitional grant area.

Methods	Findings
o *See survey among providers of Ryan White Part A and/or C services in the TGA* o *See: Needs Assessment for the HIV/AIDS Population in Central Indiana (2008)*	o 74% of HIV-positive people newly diagnosed in 2000 to 2006 received their first CD4 count within a year of their diagnosis. o MSM: Although MSM make up about 4% of the population of the TGA, they accounted for over half (57.7%) of the HIV/AIDS cases in 2008. They also accounted for majority of newly diagnosed HIV infections in the TGA, and are at increased risk for substance abuse. o Formerly Incarcerated: Indiana Department of Correction (IDOC) has a population that averages 25,000, and 15,000 individuals are released each year. These recently released individuals often face a myriad of issues while attempting to re-establish themselves in society, including problems with substance abuse, housing instability, stigma, and varied situations that influenced their initial entry into the prison system. On average, about 1% of the IDOC population is HIV-positive. Thus, about 150 PLWH are released in Indiana each year with a large proportion being released back in Indianapolis. Of all PLWH in the TGA at the end of 2008, 4.7% were diagnosed with HIV for the first time in a correctional facility. Of people diagnosed with HIV for the first time in 2008, 12 (4.9%) were diagnosed in a correctional facility. For the first nine months of 2009, there were 193 inmates who self-reported being HIV-positive during their intake at a MC Jail Arrestee Processing Center. o Homeless and in Housing Transition: For PLWH/A who are homeless, treatment engagement and compliance are often interrupted as a result of their unstable living situations. HIV-positive individuals who are homeless are also believed to be sicker than their housed counterparts. Of the 1,454 homeless people counted in Indianapolis in January 2009, 11 (0.8%) reported to those doing the count that they were HIV-positive. Based on these data, there may be anywhere from 45 to 539 PLWH/A in the TGA who are homeless at any given time.

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Focus	Title	Authors	Funder	Populations
HIV Prevention	HIV (STDs, STIs, and Viral Hepatitis) Prevention and Men who have Sex with Men (MSM) Needs Assessment May 2009-February 2010	Bailey MM, Livermon X, Thompson J, Kraus G, Dieter KE, Battani P	ISDH	MSM

Purpose	Methods	Participants
Identify the HIV/STD and Viral Hepatitis prevention needs of MSM by focusing on issues emerging from MSM themselves including the sexual practices of MSM.	o Focus groups to identify conceptual categories of need. Dr. Bailey conducted all focus groups (African American gay male) for the exception of Allen County o Surveys at clubs, bars, pride events	o 7 Focus groups: MSM from Lake County, St. Joseph County (South Bend), Allen County (Ft. Wayne), Marion County, Vanderberg County (Evansville) - the 5 areas with highest prevalence of HIV disease per 2007 epidemiologic data. o 393 survey participants - surveys collected from pride events, gay bars and clubs. Survey demographics: 50% Anglo, 30% Black/African American, 4.8% Latino, 7.1% mixed race/ethnicity

Findings

- The groups that are disproportionately impacted by HIV and other STDs and STIs are MSM, African American MSM, and MSM in age groups 20-29 and 30-39
- **HIV status:** 28 of the survey participants (7.1%) did not know their HIV status, or were unsure of it; 83 of the survey participants (21.1%) reported being HIV+. People 40 years or older were *7 times more likely* to report being HIV+.
- **Sexual Practices:** Association was found between HIV status and sexual practices, but not with the practice of anal sex with a condom. (e.g. Raw anal/bottom intercourse whether partner ejaculate inside or not; versus anal intercourse using a condom). On average, MSM ages 13-24 were the most sexually diverse and reported engaging in more risk behaviors than any other age group.
- **HIV Testing:** HIV testing behavior correlated with relationship status: those who were HIV negative and in a relationship tended not to test for HIV. Men over the age of 40 tended not to test for HIV. *Testing continues to be stigmatized.*
- **Substance Use:** Men who reported using substances (did not indicate what kinds) also reported testing more recently than others. Over one third of MSM ages 13-24 reported using substances during sex, followed by one-third of MSM ages 40 and older. For instance, a considerable number of MSM reported using substances while in a group sex situation. 65% of MSM who engage in group sex also indicate substance use of some kind.
- **Multiple partners:** African American and Latino MSM were more likely to report having more than 2 sex partners. Participants who indicated 2 or more male sexual partners also indicated, on average, more of a likelihood to engage in high risk sexual practices (i.e. raw anal/bottom, raw anal/top, raw anal/bottom/partner pulls out, raw anal/bottom/partner ejaculates inside).
- MSM are more likely to be co-morbidly infected with HIV and other STDs and STIs

2009 HIV Prevention Needs Assessment Among MSM (Cont).

Recommendations
o Redress the overemphasis placed on singular approaches to HIV prevention by taking into consideration the kind of sex that MSM have and tailoring prevention efforts to meet their stated needs o Emphasize need for prevention services and testing resources among both HIV negative and positive MSM. It is necessary for positive MSM to continue testing regularly for other STDs and STIs. o Gather more information about the sexual practices of MSM (and by implication of other populations as well). More information is needed about what MSM do sexually in order to intervene in the rapid increase of HIV infection among this population. o State of Indiana, prevention programs have focused heavily on condom use at the exclusion of advocating for a diverse range of risk reductive sexual options for MSM. MSM are not abstaining from sexual activity nor are they using condoms consistently. Instead, many MSM reported having multiple sexual partners and engaging in raw receptive anal intercourse with ejaculation o Change social attitude toward sex and reduce stigma (develop comprehensive sexual education curricula, initiate social marketing campaigns, provider education and regulation) o Reduce barriers to prevention services and information: (social marketing in traditional and non traditional venues; culturally relevant information and materials, access to testing) o **Viral Hepatitis**: Improve viral hepatitis reporting and surveillance (Hepatitis B and C in both acute and non acute phases. Document all cases and do not delay reporting until 5 cases have occurred per current policy)

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Focus	Title	Authors	Funder	Populations
Homelessness	Indianapolis Homeless Count 2009 Shows More Families Homeless	Littlepage L. Indiana University Purdue University at Indianapolis Center for Health Policy	Coalition for Homelessness Intervention and Prevention	Homeless individuals in Marion County

Purpose	Methods	Participants
Point-in-time count of homeless individuals in Marion County	o Meetings and focus groups with providers and homeless advocates to identify count venues o Interview/surveys with individuals encountered in the count process o Point in Time Count, January 9, 2009	o Individuals living in shelters, transitional housing programs, found at emergency rooms, libraries, parks, abandon buildings, other public places o This survey did not include people who are 'doubled up' (e.g. living with friends or family members on a temporary basis).

Findings	Recommendations
o 1,454 people were identified as homeless on January 9, 2009. o 605 of these people were from 213 families (with 359 children). o Loss of employment was the #1 reason for homelessness. Alcohol and or drug addiction was the #2 reason. o 50% of the homeless population was African American; 36% was Anglo, 6% Hispanic/Latino. 2/3 of the homeless population is male: 70% of adults and 53% of children o Per McKinney-Vento definition of 'doubled up': Likely over 4,000 people who are in a major housing transition, but don't meet HUD definition of homeless.	o Increase affordable housing options and services for families o Expand access to services that address chronic substance abuse and mental illness.