

Sample EMA Unmet Need Estimate and Narrative

The following is a made-up unmet need estimate and narrative for an EMA in a large State with several EMAs that used linked databases for its estimate. The narrative follows, along with some boxed hints to guide you in the development of your own estimate and narrative.

Provide an explanation of the estimation methods, rationale, and any limitations.

Unmet Need Estimate and Assessment by EMA Y

As specified in the Program Guidance, EMA Y considers an individual with HIV/non-AIDS or AIDS to have an unmet need for care (or to be out of care) when there is no evidence that s/he received any of the following three components of HIV primary medical care during a defined 12-month time frame: viral load (VL) testing, CD4 count, and/or provision of anti-retroviral therapy (ART).

This section provides EMA Y's updated estimate and initial assessment of unmet need, both produced in collaboration with the State X (Title II grantee), the other two EMAs in the State, and with the Title III program operating in the EMA. There is no Title IV program in the EMA. Representatives of EMA Y participated in a statewide All-Titles Unmet Need meeting and formed an Unmet Need Working Group to develop a shared process for estimating unmet need. The group developed and executed a workplan, including deadlines and clearly defined roles and responsibilities.

This year's unmet need estimate is based on the same basic approach as the estimate provided in the FY 2005, application, but has been refined based on feedback from HRSA. The State and the EMAs shared their FY05 applications and individual grantee reports provided by HRSA, and used them in creating this year's workplan.

The State took the lead on updating the unmet need estimate. The estimate is provided in the attached Unmet Need Framework Table. All the data in the Framework table are for calendar year 2004.

Population Data: The State used surveillance data to prepare population estimates for HIV/non-AIDS and AIDS for the State overall and for each EMA, making upward adjustments of 5% to allow for under-reporting, based on a recent study by the State Health Department's Epi Unit. The State has had name-based HIV reporting since 1998. It was assumed that in-migration equals out-migration, and no adjustments were made in this area. State HARS data is routinely

Make sure that you consistently use the definition of unmet need provided by HRSA.

Explore opportunities for collaboration with other Titles and programs, and mention them in your narrative.

If you adjust your data, make sure you include the size of your adjustment and your reason.

no adjustments were made in this area. State HARS data is routinely checked against the State Death Registry, and in preparation for the FY 2006 application estimate, we also checked data for individuals diagnosed in or before 1995 against the National Death Index, which led to the removal from the surveillance database of 137 individuals who were found to have died out of State.

Care Patterns Data: The State and EMA used linked and unduplicated databases to estimate unmet need. In State X, lab reporting is required for CD4 counts below 200. Viral load reporting is voluntary and incomplete. Therefore the State matched and unduplicated CD4 data from HARS along with ADAP data using unique client identifiers. This year for the first time, Blue Cross Blue Shield (BCBS) (the largest private insurer in the State) provided data to a third party for unduplication, and a consultant was used to carry out the unduplication. The EMA provided the State with client-level data from its own Ryan White Title I-II client database, unduplicated with Title III data. Care patterns data in the Framework table therefore represent unduplicated data from HARS, ADAP, Ryan White Titles I, II, and III, and Blue Cross Shield.

Neither the State nor the EMA was able to obtain client-level data from the Department of Veterans Affairs (VA). Therefore, the EMA used the aggregate data provided on the VA website. To separate PLWA and PLWH/non-AIDS, we applied the same proportion found for the linked and unduplicated databases.

Findings: As the table indicates, the methodology used indicates that 1,900 people or 38% of PLWH/A in EMA Y were out of care in 2004. Unmet need was higher for PLWH/non-AIDS, who had an unmet need of 43%, compared to 30% for PLWA.

Limitations: Neither the State nor the EMA has been able to obtain data from Medicaid or Medicare, despite repeated efforts. The State has requested help from its HAB Project Officer, and hopes to have data from Medicaid for the FY 2007 application. In the meantime, we know that HARS laboratory tests do include tests from Medicaid-reimbursed providers. Information on people in private care is incomplete, although BCBS and HARS CD4 counts together provide a partial indication of individuals in private care. We recognize that the data are more complete for people with an AIDS diagnosis than for PLWH/non-AIDS, because the HARS lab reports are limited to people with an AIDS diagnosis and a current CD4 count below 200. As a result of these limitations, we believe that the unmet need estimate provided here overstates unmet need, particularly for PLWH/non-AIDS.

Not every state has a statewide Ryan White database, but local ones can also be linked and unduplicated to provide data.

If you need assistance getting Medicaid data, contact your HAB Project Officer for help.

Demographic Analysis: While working on our unmet need estimate, we also collected demographic information from surveillance and Ryan White data to do a partial demographic analysis of people not in care. The databases we used include information on gender, race/ethnicity, age, and place of residence (ZIP code). Findings from that analysis are provided in the Demographic Analysis table. The data indicate that PLWH/non-AIDS, women, African Americans, and Latinos are over-represented among people not in care.

If you are able, collect demographic information while collecting data to use in demographic or "subpopulation" analysis.

Assessing and Addressing Unmet Need: The EMA Y Planning Council received a half day of training on unmet need in May 2005, and the Needs Assessment Committee, with the assistance of the Health Planner, will be working collaboratively with the Title III program and with a number of consumer leaders to identify and interview people who are not in care. The focus will be to determine their most important service gaps and their barriers to care. The summer 2005 data presentation prior to priority setting included a discussion of unmet need including the demographic analysis, and this information contributed to a decision to allocate some Minority AIDS Initiative (MAI) funds for FY 2006 for a new targeted outreach and casefinding initiative targeting African Americans, Latinos, and women.

Mention any work that the grantee or planning body has done around assessment of unmet need and how this information has been used in decision making.

Unmet Need in EMA Y– 2004

	Value	Data Source
Population Sizes		
A. Number of persons living with AIDS (PLWA), 2004	2000	2004 HARS adjusted by 5% for delayed reporting
B. Number of persons living with HIV (PLWH/non-AIDS/aware), 2004	3000	2004 HARS adjusted by 5% for delayed reporting
Care Patterns		
C. Number of PLWA who received the specified HIV primary medical care services in 2004	1400	Linked and unduplicated databases (all – 2004): HARS lab reports, ADAP, local EMA RW client databases, and BCBS, plus proportional share of aggregate VA data
D. Number of PLWH/non-AIDS/aware who received the specified HIV primary medical care services in 2004	1700	Linked and unduplicated databases (all – 2004): HARS lab reports, ADAP, local EMA RW client databases, and BCBS, plus proportional part of aggregate VA data
Calculated Results		
E. Number and percent of PLWA who did not receive the specified HIV primary medical care services	600 (30%)	A – C (E/A)
F. Number and percent of PLWH/non-AIDS/aware who did not receive the specified HIV primary medical care services	1300 (43%)	B – D (F/B)
G. Total number and percent of HIV+/aware not receiving the specified HIV primary medical care services (quantified estimate of unmet need)	1900 (38%)	E + F (G/(A+B))

Make sure to include your completed Framework Table showing values, data sources, and calculations. Do not use shading – it is hard to read when photocopied.

EMA Y Demographic Analysis of People in and Out of Care, 2004

Characteristic	#1: HIV+/aware Population	#2: Number with Met Need	#3: Number with Unmet Need	#4: % of Unmet Need Population	#5: % of Category with Unmet Need	#6: % of Total HIV+/aware Population
Total	5000	3100	1900	100%	38%	100%
<u>HIV or AIDS</u>						
PLWA	2000	1400	600	32%	30%	40%
PLWH/non-AIDS	3000	1700	1300	68%	43%	60%
<u>GENDER</u>						
Male	3750	2360	1390	73%	37%	75%
Female	1250	740	510	27%	41%	25%
<u>RACE/ETHNICITY</u>						
White (non-Latino)	2000	1430	570	30%	27%	40%
African American (non-Latino)	2250	1280	970	51%	43%	45%
Latino	700	360	340	18%	49%	14%
N/R	50	30	20	1%	20%	1%
				100%		100%