

## Appendix A: Profile Data Sources

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### AIDS Surveillance

**Overview:** AIDS is a reportable condition in all states and territories. AIDS cases have been reportable since the early 1980s and cases have been defined according to the CDC case definition. In Ohio, physicians are required to report diagnoses of AIDS. In addition, reporting laws were expanded in 2002 to include laboratory and physician reporting of CD4 T-lymphocyte cell counts of less than 200 or 14 percent. The AIDS surveillance system was established to monitor incidence of the disease and the demographic profile of the AIDS cases; describe the modes of HIV transmission among persons diagnosed with AIDS; guide the development and implementation of public health intervention and prevention programs; and to assist in the evaluation of the efficacy of public health interventions. AIDS surveillance data are also used to allocate resources for Ryan White HIV/AIDS Treatment Extension Act.

State and local health departments actively solicit disease reports from health care providers and laboratories. Standardized case reports are used; these forms are used to collect socio-demographic information, mode of transmission, laboratory and clinical information, vital status and referrals for treatment services.

**Population:** All persons who meet the 1993 CDC AIDS Surveillance Case definition.

**Strengths:** Surveillance data is the only source of AIDS information that is available in all areas (states). These data reflect the impact of AIDS on a community and trends of the epidemic in a community. AIDS surveillance has been determined to be more than 85 percent complete. The data include all demographic groups (age, race/ethnicity, sex).

**Limitations:** Due to the long and variable period from infection to the development of AIDS, trends in AIDS surveillance do not represent recent HIV infections. Asymptomatic HIV-infected persons are also not represented by AIDS case data. In addition, incomplete HIV or CD4+ t cell testing may interfere with the representativeness of reporting. Further, widespread use of HAART complicates the interpretation of AIDS case surveillance data and estimation of the HIV/AIDS epidemic in an area. Newly reported AIDS cases may reflect treatment failures or the failure of the health care system to halt progression of HIV infection to AIDS. AIDS cases represent late-stage HIV infections.

### Behavioral Risk Factor Surveillance System

**Overview:** The Behavioral Risk Factor Surveillance System (BRFSS) is a state-based, random digit-dialed telephone survey that monitors state-level prevalence of the major behavioral risks among adults associated with premature morbidity and mortality. Each month, a sample of households is contacted and one person in the household who is 18 years or older is randomly selected for an interview. Multiple attempts are made to contact the sampled household. A Spanish translation of the interview is available. Respondents to the BRFSS questionnaire are asked a variety of questions about their personal health behaviors and health experiences. Since 1994, the BRFSS questionnaire has asked questions related to HIV/AIDS of respondents aged 18 to 49 years. These questions include: perceived risk of getting an HIV infection; use of HIV testing; reasons for testing; if tested, the type of place where tested; receipt of post-HIV test

counseling; attitudes toward condoms; and attitudes about when to initiate HIV/AIDS education in school. As of 2001, respondents have been asked about their perception of the importance of HIV testing.

**Population:** All non-institutionalized adults, 18 years and older who reside in a household with a telephone.

**Strengths:** Data from the BRFSS survey are population-based; thus, estimates about testing attitudes and practices can be generalized to the adult population of a state. Information collected from the BRFSS survey may be useful for planning community-wide education programs.

**Limitations:** BRFSS data are self-reported; thus, the information may be subject to recall bias. BRFSS respondents are contacted by telephone; thus, the data are not representative of households without a telephone. In addition, BRFSS data are representative of the general, non-institutionalized adult population in an area, not just persons at highest risk for HIV/AIDS. The extent of HIV behavioral risk information collected by the BRFSS questionnaire is limited and inferences can be made only at the state level.

## HIV Counseling, Testing and Referral Services

**Overview:** All states, territories and select cities receive funding to support HIV counseling, testing and referral programs as part of the HIV prevention cooperative agreements they have entered into with CDC. To monitor these programs, the CTR collects information to quantify and characterize counseling and testing services delivered at CDC-funded testing sites. Data captured include demographic, insurance, risk information, testing information (testing history, test result). Personal identifying information is not collected.

**Population:** All clients who receive confidential or anonymous HIV counseling and testing services at a counseling and testing site funded through a CDC cooperative agreement.

**Strengths:** Standardized data on clients who are tested for HIV are available at the local level. Data may offer insights into HIV infection rates in an area's high-risk population. CTR testing data may highlight the impact of a prevention program upon the populations being targeted.

**Limitations:** In most areas, the CTR collects test-based, rather than person-based, data and collects information only from persons who seek counseling and testing services at a CDC-funded site. Population estimation of HIV seroprevalence is not possible with CTR data because data are test-based. In test-based systems, it is not possible to distinguish individuals who have tested multiple times; however, a 'previous HIV test' variable is available on the client abstract form to quantify prior testing. Because the CTR system gathers data on HIV testing or program activities, changing testing patterns may reflect changing program priorities rather than testing patterns of individuals.

## HIV Surveillance

**Overview:** CDC and other professional organizations have recommended reporting of HIV infections to local health authorities as an integral part of AIDS surveillance since HIV was identified and a test for HIV was licensed. As part of ongoing active HIV surveillance, health departments educate providers on their reporting responsibilities, establish liaisons with laboratories conducting CD4+ lymphocyte cell analysis and EIA and Western Blot testing and follow up upon HIV cases of epidemiologic importance.

Ohio law requires physicians to report diagnoses of HIV infection, perinatal transmission to HIV and subsequent seroreversion. Laboratories are required to report lab finding indicating HIV infection. In addition, laboratories are required to report a CD4+ T lymphocyte count below 200 cells per microliter or a CD4+ T lymphocyte percentage of less than 14 when HIV infection has not been ruled out as the cause.

**Population:** All persons who test positive for HIV.

**Strengths:** HIV surveillance data represent more recent infection, compared with AIDS surveillance data. Based upon state evaluations, HIV infection reporting is estimated to be more than 85 percent complete for persons who have tested positive for HIV. HIV surveillance provides a minimum estimate of the number of persons known to be HIV infected and reported to the health department, may identify emerging patterns of transmission and can be used to detect trends in HIV infections among populations of particular interest (e.g. children, adolescents, and women) that may not be evident from AIDS surveillance. HIV surveillance provides the basis for establishing and evaluating linkages to prevention and early intervention services and can be used to anticipate unmet needs for HIV care.

**Limitations:** HIV surveillance data may underestimate the level of recently infected persons because some infected persons either do not know they are infected or have not sought testing. Persons who have tested positive in an anonymous test site and have not sought medical care, where they would be confidentially tested, are not eligible to be reported to the surveillance system. HIV surveillance data represent infections in jurisdictions where reporting laws for HIV are in place. Reporting of behavioral risk information may not be complete.

## National Household Survey of Drug Abuse

**Overview:** The National Household Survey of Drug Abuse (NHSDA) is an ongoing source of statistical information on the use of illicit drugs by the U.S. civilian population aged 12 or older. The survey collects data by administering questionnaires to a representative sample of the population through face-to-face, computer-assisted interviewing (CAI) method at their place of residence. Information captured by the NHSDA questionnaire includes use of cocaine; receipt of treatment for illicit drugs and need of treatment for illicit drugs during the past year; use of alcohol, tobacco or marijuana during the past month; and past month perceived risk of binge drinking, marijuana use or smoking during the past month.

The NHSDA employed a 50-state sampling design; for the eight states with the largest populations, the sampling design provides the sample large enough to support direct state estimates. Youths and young adults were over-sampled so that each state's sample was

approximately equally distributed among three major age groups: 12-17 years, 18-25 years and 26 years or older.

**Population:** Noninstitutionalized, civilian U.S. population ages 12 years or older.

**Strengths:** National standardized survey of drug use behaviors among the general population. To increase the level of honest reporting, since 1999 information has been collected using a combination of CAI methods to provide respondents with highly private and confidential means of responding to questions about substance use and other sensitive behaviors.

**Limitations:** NHSDA estimates represent behaviors in the general population; thus, the survey may underestimate the level of substance use in the population at highest risk for HIV. Further, data from the NHSDA are self-reported, are subject to recall bias, and may under-report the level of a sensitive behavior.

## Ohio HIV/STD Surveillance Study

**Overview:** In 2011, The Ohio Department of Health (ODH) HIV/AIDS Surveillance Program retrospectively assessed all Ohio reports of syphilis, gonorrhea and HIV infections reported among persons 13 years of age and older during the 10 years between January 1, 2001 and December 31, 2010. All syphilis and gonococcal infections reported during the study period were exported out of the Ohio Disease Reporting System (ODRS) into a data set. Persons reported living with a diagnosis of HIV infection (PLWHA) as of June 30, 2011 during the 10-year study period were exported out of the Enhanced HIV/AIDS Reporting System (eHARS) into a separate data set. Each data set was standardized and de-duplicated, and probabilistic matching determined which individuals had multiple disease reports amongst the two data sets.

**Population:** All reported persons who test positive for HIV/AIDS, syphilis and/or gonorrhea.

**Strengths:** HIV infection reporting is estimated to be more than 85 percent complete for persons who have tested positive for HIV. HIV/AIDS surveillance provides a minimum estimate of the number of persons known to be HIV infected and reported to the health department, may identify emerging patterns of transmission and can be used to detect trends in HIV infections among populations of particular interest. HIV/AIDS surveillance provides the basis for establishing and evaluating linkages to prevention and early intervention services and can be used to anticipate unmet needs for HIV care.

STD data are widely available at the state and local level and because of shorter incubation time period between transmission and infection; STDs can serve as a marker for recent unsafe sexual behavior. In addition, certain STDs (i.e., ulcerative STDs) can facilitate transmission or acquisition of HIV infection.

**Limitations:** HIV/AIDS surveillance data may underestimate the level of recently infected persons because some infected persons either do not know they are infected or have not sought testing. Persons who have tested positive in an anonymous test site and have not sought medical care, where they would be confidentially tested, are not eligible to be reported to the surveillance system. HIV/AIDS surveillance data represent infections in jurisdictions where reporting laws for HIV infection are in place. Reporting of behavioral risk information may not be complete.

Reporting of STDs from private-sector providers may be less complete. Although STD risk behaviors result from unsafe sexual behavior, they do not necessarily correlate with HIV risk.

**Population:** MSM who attend bars that serve gay and bisexual men, have access to the internet or are networked to agency representatives, clients, programs or services.

**Strengths:** In most regions, some degree of homogeneous sampling was possible by convening groups with similar demographic characteristics such as race, age range, or HIV status within the local MSM community. Purposive sampling can be more efficient than random sampling in practical field circumstances because the random member of a community may not be as knowledgeable and observant as an expert informant. The use of purposive sampling supports rapid data collection. Results from the data collection will help to guide future strategic directions and provide valuable information on risk behaviors in a subpopulation of MSM at high risk for HIV infection.

**Limitations:** Interpretation of results is limited to the population under study. Subsets of MSM that may be under represented in the data include those without home computers, MSM who are not bar patrons, and MSM who do not identify with the MSM subgroup of gay men networked to agency representatives, clients, programs or services.

## **Pregnancy Risk Assessment Monitoring System**

**Overview:** The Pregnancy Risk Assessment Monitoring System (PRAMS) is a population-based survey designed to examine maternal behaviors and experiences before, during and after a woman's pregnancy, and during the early infancy of her child. The Centers for Disease Control and Prevention initiated PRAMS in 1987 in an effort to reduce infant mortality and the incidence of low birth weight. PRAMS was implemented in Ohio in April of 1999.

**Population:** Women who have given birth to a live infant.

**Strengths:** PRAMS data are population-based, findings from data analyses can be generalized to the entire state's population of women having live births. Health planners have used PRAMS data to help understand maternal behaviors and experiences and their relationship with adverse pregnancy outcomes. These findings can be used to develop and assess public health programs and policies to improve maternal and infant health.

**Limitations:** PRAMS does not capture information about all women who become pregnant. Important differences may exist between women having live births and those whose pregnancies resulted in other outcomes. Furthermore, it is important to remember that most of the information from PRAMS is self-reported by the mother. Mothers are surveyed two to six months postpartum about events occurring several months earlier and may inaccurately recall events.

## **Sexually Transmitted Diseases (STD) Surveillance**

**Overview:** STD surveillance activities are conducted to monitor the levels of syphilis, gonorrhea and chlamydia to establish prevention programs, develop and revise treatment guidelines and identify populations at risk for STDs. Case report forms include information on patient demographics, type of infection and source of report (private or public sector).

**Population:** All persons who are diagnosed with an infection that meets the CDC surveillance case definition for the infection and are reported to local health departments.

**Strengths:** STD surveillance data can serve as a surrogate marker for unsafe sexual practices and/or demonstrate the prevalence of changes in a specific behavior. STD data are widely available at the state and local level and because of shorter incubation time period between transmission and infection; STDs can serve as a marker for recent unsafe sexual behavior. In addition, certain STDs (i.e., ulcerative STDs) can facilitate transmission or acquisition of HIV infection. Finally, changes in trends of STDs may indicate changes in community sexual norms (i.e., unprotected sex).

**Limitations:** STDs are reportable, but requirements for reporting vary across states. Reporting of STDs from private-sector providers may be less complete. Although STD risk behaviors result from unsafe sexual behavior, they do not necessarily correlate with HIV risk. Trends in chlamydia infections may reflect changes in reporting and screening practices rather than actual trends in disease.

## **U.S. Bureau of the Census**

**Overview:** The Census Bureau collects and provides timely information about the people and economy of the United States. The Web site for the Census Bureau includes data on the demographic characteristics (e.g., age, race, Hispanic ethnicity, sex) of the population, family structure, educational attainment, income level, housing status and the percentage of persons living at or below the poverty level. Tables and maps of census data are available for all geographic areas to the block level. Summaries of the most requested data for states and counties are provided, as well as analytical reports on population change, race, age, family structure and apportionment. Links to other census-related sites are included.

**Population:** U.S. population.

**Strengths:** A wide range of online statistical data on the U.S. population are available in different formats (e.g., tables, maps). State- and county-specific information is easily accessible and links to other census Web sites are provided.

**Limitations:** Some files take longer to download.

## **Vital Statistics – Death Data**

**Overview:** In the United States, state laws require death certificates to be completed for all deaths and federal law mandates national collection and publication of deaths. A standard certificate of death is used to record death information on each decedent.

**Population:** All deaths occurring within Ohio.

**Strengths:** Reporting of deaths is 100 percent complete. The data are widely available and can be used to determine the impact of deaths related to HIV infection in a service area. Standardized procedures are used throughout the nation to collect death certificate data.

**Limitations:** Deaths resulting from, or whose underlying cause was, HIV infection may be under reported on the death certificate. Clinical information related to HIV or AIDS may be missing. Death records are less timely than AIDS case reports.

## Youth Risk Behavior Surveillance System

**Overview:** The Youth Risk Behavior Surveillance System (YRBSS) was established to monitor six priority high-risk behaviors that contribute to leading causes of mortality, morbidity and social problems among youth and adults in the United States. YRBSS was developed to collect data that are comparable among national, state and local samples of youth. Using a self-administered questionnaire, YRBSS collects information on six categories of behaviors, which includes sexual behaviors that contribute to unintended pregnancy, STDs and HIV. Questions are also asked about transmission to HIV prevention education materials, sexual activity (age of onset, number of partners, condom use, preceding drug or alcohol use), contraceptive use and pregnancy history.

**Population:** YRBSS is a representative sample of ninth through 12<sup>th</sup> grade students.

**Strengths:** YRBSS is a population-based survey that samples adolescents in public and private high schools. The YRBSS questionnaires are self-administered and anonymous inferences from YRBSS estimates can be drawn about behaviors and attitudes of young people in high school making the information useful for developing community-wide prevention programs aimed at adolescents. YRBSS uses a standardized questionnaire so comparisons can be made across participating states and the questionnaire is flexible so states can ask specific questions to meet their needs.

**Limitations:** The YRBSS projections rely on upon self-reported information; reporting of sensitive behavioral information may not be accurate (under-or over-reporting may occur). Because the YRBSS questionnaires are administered in high schools, the data are representative only of adolescents who are enrolled in school and cannot be generalized to all young people. Questions that ask about behaviors during the past year may be subject to recall bias; however, this bias may be minimal because of the young age of the respondents. In addition, the questionnaire does not ask about homosexual or bisexual behavior or experiences.

## Appendix B: Glossary of Terms

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**Adjustments:** Statistical calculations that allow the comparison of different groups (when the difference may affect what is being studied) as though they are alike. Differences in populations or subgroups make it difficult to make comparisons; adjustments remove the influence of a specific factor (e.g., age, sex, race or disease status) from the analysis.

**AIDS (Acquired Immune Deficiency Syndrome):** The condition that results from HIV infection and is marked by CD4 count below 200 cells/ $\mu$ L (or 14 percent) and/or the presence of opportunistic infections that do not affect persons with healthy immune systems.

**Behavioral data:** Data collected from studies of human behavior that are relevant to disease risk. Relevant behaviors for HIV risk may include sexual activity, substance use, sharing of drug paraphernalia, condom use or responses to primary and secondary prevention messages.

**CARE Act (Ryan White Comprehensive AIDS Resources Emergency Act):** Now known as the Ryan White Treatment Modernization Act. The primary federal legislation created to address the needs for health and support services among persons living with HIV/AIDS and their families in the United States; enacted in 1990.

**Case:** A condition such as HIV infection (e.g., an HIV case) or AIDS (e.g., an AIDS case) diagnosed according to a standard case definition.

**CDC:** The Centers for Disease Control and Prevention (CDC), within the U.S. Department of Health and Human Services, is the lead federal agency for protecting the health and safety of the people of the United States. CDC accomplishes its mission through developing and applying disease prevention and control, environmental health and health promotion, and education activities designed to improve public health in the United States. The CDC provides majority of funding for HIV prevention and HIV surveillance activities in Ohio.

**Community Planning Group:** A group of persons who represent or have interests in a given community and who work in partnership with health departments to design local prevention plans to meet the needs of persons at risk for, or infected with, HIV.

**Co-morbidity:** The co-existence of a disease or illness and HIV infection in one person (e.g., an HIV-infected person who also has TB).

**Confidentiality:** The treatment of information that an individual or institution has disclosed in a relationship of trust, with the expectation that the information will not be divulged to others in ways that are inconsistent with the individual's or institution's understanding when the individual or institution provided the information. It encompasses access to and disclosure of information in accordance with requirements of state law or official policy. For HIV/AIDS surveillance data, confidentiality refers to the protection of private information collected by the HIV/AIDS surveillance system.

**Eligible Metropolitan Area (EMA):** A metropolitan statistical area that qualifies for Part A funding by reaching a certain threshold of AIDS cases. EMAs may cover one city, several cities or counties or more than one state.

**Epidemiology:** The study of the distribution and the determinants of health-related states or events in specified populations and the application of this study to the control of health problems.

**Estimate:** In situations in which precise data are not available, an estimate may be made based on available data and an understanding of how the data can be generalized to larger populations. In some instances, national or state data may be statistically adjusted to estimate local conditions. Good estimates are accompanied by statistical estimates of error (a confidence interval), which describes the limitations of the estimate.

**Federal Poverty Level (FPL):** Families and persons are classified as below poverty if their total family income or unrelated individual income was less than the poverty threshold specified for the applicable family size, age of householder and number of related children under 18 present.

**HIV (Human Immunodeficiency Virus):** The virus that causes AIDS. Persons with HIV in their immune system are referred to as HIV infected.

**HIV Care Consortia:** An association of public and private, nonprofit providers of health support services and community-based organizations that plans, develops and delivers services for people living with HIV. The CARE Act authorizes states to use Part B funds to establish consortia in “areas most affected by HIV disease.”

**HIV primary medical care:** Medical evaluation and clinical care that is consistent with U.S. Public Health Service guidelines for the treatment of HIV/AIDS.

**HIV/AIDS surveillance:** The systematic collection, analysis, interpretation, dissemination and evaluation of population-based information about persons with a diagnosis of HIV infection and persons with a diagnosis of AIDS.

**Incidence:** The number of new cases in a defined population during a specific period, often a year, which can be used to measure disease frequency. It is important to understand the difference between HIV incidence and reported HIV diagnoses. Because the results of anonymous tests are not included and therefore not all diagnoses of HIV infection are included, HIV surveillance data do not represent incident cases.

**Incidence rate:** The number of new cases in a specific area during a specific period among persons at risk in the same area and during the same period. Incidence rate provides a measure of the effect of illness relative to the size of the population. Incidence rate is calculated by dividing in the specified period by the population in which cases occurred. A multiplier is used to convert the resulting fraction to a number over a common denominator (often 100,000).

**Interpretation:** The explanation of the meaning of the data. For example, interpreting a trend in the number of HIV cases diagnosed during a five-year period enables a planning group to assess whether the number of cases has increased or decreased. However, groups should use caution in interpreting trends that are based upon small increases or decreases.

**Line graph:** A type of figure used to display the changes in a particular variable over time. Values are recorded periodically as points on the graph and then connected as a line to show a trend.

**Mean:** The sum of individual values in a data set divided by the total number of values. The mean is what many people refer to as an average.

**Median:** The middle value in a data set. Typically, approximately half the values will be higher and half will be lower. The median is useful when a data set has unusually high or unusually low values, which can affect the mean. It is also useful where data are skewed; meaning most of the values are at one extreme or the other.

**Men who have sex with men (MSM):** Men who acknowledge having had sexual contact with another male regardless of how he identifies in terms of sexual orientation and regardless of any reported sexual contact with a female.

**Morbidity:** The presence of illness in the population.

**Mortality:** The total number of persons who have died from the disease of interest. Usually expressed as a rate, mortality (total number of deaths over the total population) measures the effect of the disease on the population as a whole.

**Needs assessment:** The process of gathering and analyzing information from a variety of sources to determine the status and the unmet needs for HIV prevention or care among a defined population or in a geographic area.

**No identified risk (NIR):** Cases in which epidemiologic follow up has been conducted, sources of data have been reviewed – which may include an interview with the patient or provider – and no mode of transmission has been identified. Any case that continues to have no reported risk 12 or more months after the report date is considered NIR.

**No reported risk (NRR):** Cases in which risk information is absent from the initial case report because the information had not been reported by the reporting source, had not been sought or had not been found by the time the case was reported. Cases may remain NRR until epidemiologic follow up has been completed and potential risks (transmissions) have been identified. If risk has not been identified within one year of being reported as NRR, the case may be considered NIR.

**Odds Ratio:** The probability that an event will happen to the probability that it will not happen.

**Percentage:** A proportion of the whole, in which the whole is 100.

**Prevalence:** The total number of cases of a disease in persons not known to have died in a given population at a specific point in time. Prevalence does not indicate how long a person has had a disease and cannot be used to calculate rates of disease. It can provide an estimate of risk for a disease at a point in time. For HIV/AIDS surveillance, prevalence refers to living persons with HIV disease, regardless of time of infection or date of diagnosis. Note the difference between prevalence of a condition in the population and the prevalence of cases, namely, that a case must be diagnosed according to a definition.

**Proportion:** A portion of a complete population or data set, usually expressed as a fraction or percentage of the population or data set.

**Range:** The largest and smallest values in a data set.

**Rate:** A measure of the frequency of an event or disease compared with the number or persons at risk for the event or disease.

**Ratio:** A way of showing the relative size of two numbers. The first number is divided by the other number to derive the ratio. The ratio may be expressed as a fraction (e.g. 2/3), or a colon may separate the two numbers (X:Y).

**Reporting delay:** The time between when a diagnosis of HIV infection or AIDS and the time the report is received by the health department.

**Representative:** A sample that is similar to the population from which it is drawn and thus can be used to draw conclusions about the population.

**Sample:** A group of people selected from a total population with the expectation that studying this group will provide important information about the total population.

**Sociodemographic factors:** Background information about the population of interest (e.g., age, sex, race, educational status, income, geographic location). These factors are often thought of as explanatory because they help make sense of the results of the analyses.

**Socioeconomic status (SES):** A measure of social and economic factors that helps to describe a person's standing in society (e.g. income levels, relationship to national poverty line, educational achievement, neighborhood of residence, home ownership).

**Part A (CARE Act):** Provides formula and supplemental grants to EMAs that are disproportionately affected by the HIV epidemic.

**Part B (CARE Act):** Provides formula grants to states, the District of Columbia, Puerto Rico and eligible U.S. territories to improve the quality, availability and organization of health care and support services for people living with HIV and their families.

**Trend:** A long-term movement or change in frequency, usually upward or downward; may be presented as a line graph.

**Year of diagnosis:** The year in which the diagnosis of HIV infection or AIDS was made.

**Year of report:** The year in which a person with a diagnosis of HIV infection or AIDS was reported to the health department.

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## Appendix C: Data Tables

### Persons living in Ohio, by county, Census 2014 Estimates

County	Persons Living in Ohio		County	Persons Living in Ohio	
	No.	%		No.	%
Adams	28,129	0.2%	Logan	45,507	0.4%
Allen	105,040	0.9%	Lorain	304,216	2.6%
Ashland	53,035	0.5%	Lucas	435,286	3.8%
Ashtabula	99,175	0.9%	Madison	43,918	0.4%
Athens	64,713	0.6%	Mahoning	233,204	2.0%
Auglaize	45,841	0.4%	Marion	65,720	0.6%
Belmont	69,461	0.6%	Medina	176,029	1.5%
Brown	44,116	0.4%	Meigs	23,331	0.2%
Butler	374,158	3.2%	Mercer	40,831	0.4%
Carroll	28,187	0.2%	Miami	103,900	0.9%
Champaign	39,128	0.3%	Monroe	14,465	0.1%
Clark	136,554	1.2%	Montgomery	533,116	4.6%
Clemont	201,560	1.7%	Morgan	14,843	0.1%
Clinton	41,835	0.4%	Morrow	35,152	0.3%
Columbiana	105,686	0.9%	Muskingum	85,818	0.7%
Coshocton	36,516	0.3%	Noble	14,363	0.1%
Crawford	42,480	0.4%	Ottawa	41,154	0.4%
Cuyahoga	1,259,828	10.9%	Paulding	18,989	0.2%
Darke	52,196	0.5%	Perry	35,812	0.3%
Defiance	38,510	0.3%	Pickaway	56,876	0.5%
Delaware	189,113	1.6%	Pike	28,256	0.2%
Erie	75,828	0.7%	Portage	161,882	1.4%
Fairfield	150,381	1.3%	Preble	41,586	0.4%
Fayette	28,800	0.2%	Putnam	34,171	0.3%
Franklin	1,231,393	10.6%	Richland	121,942	1.1%
Fulton	42,580	0.4%	Ross	77,159	0.7%
Gallia	30,397	0.3%	Sandusky	60,179	0.5%
Geauga	94,295	0.8%	Scioto	77,258	0.7%
Greene	163,820	1.4%	Seneca	55,669	0.5%
Guernsey	39,590	0.3%	Shelby	48,951	0.4%
Hamilton	806,631	7.0%	Stark	375,736	3.2%
Hancock	75,337	0.6%	Summit	541,943	4.7%
Hardin	31,796	0.3%	Trumbull	205,175	1.8%
Harrison	15,543	0.1%	Tuscarawas	92,788	0.8%
Henry	27,937	0.2%	Union	53,776	0.5%
Highland	43,045	0.4%	Van Wert	28,462	0.2%
Hocking	28,725	0.2%	Vinton	13,234	0.1%
Holmes	43,898	0.4%	Warren	221,659	1.9%
Huron	58,714	0.5%	Washington	61,213	0.5%
Jackson	32,748	0.3%	Wayne	115,537	1.0%
Jefferson	67,694	0.6%	Williams	37,291	0.3%
Knox	61,167	0.5%	Wood	129,590	1.1%
Lake	229,230	2.0%	Wyandot	22,353	0.2%
Lawrence	61,623	0.5%			
Licking	169,390	1.5%	<b>Ohio</b>	<b>11,594,163</b>	<b>100.0%</b>

Source: U.S. Census Bureau, Census 2014 Estimates.

## Persons living below poverty level in Ohio, by county, Census 2013

County	Population Below 2013 Federal Poverty Level		County	Population Below 2013 Federal Poverty Level	
	No.	%		No.	%
Adams	6,372	22.7%	Logan	7,151	15.9%
Allen	18,850	18.6%	Lorain	42,575	14.6%
Ashland	8,283	16.3%	Lucas	89,289	20.8%
Ashtabula	18,186	18.7%	Madison	4,235	11.0%
Athens	17,499	31.7%	Mahoning	40,290	17.6%
Auglaize	4,001	8.8%	Marion	11,170	18.5%
Belmont	9,609	14.6%	Medina	12,637	7.4%
Brown	6,184	14.1%	Meigs	5,106	21.9%
Butler	48,678	13.6%	Mercer	3,794	9.4%
Carroll	4,403	15.5%	Miami	13,185	13.0%
Champaign	5,214	13.4%	Monroe	2,749	19.0%
Clark	24,958	18.6%	Montgomery	91,424	17.7%
Clermont	20,014	10.2%	Morgan	2,980	20.2%
Clinton	6,725	16.5%	Morrow	4,677	13.6%
Columbiana	17,331	16.9%	Muskingum	15,056	18.1%
Coshocton	6,157	16.9%	Noble	1,833	15.2%
Crawford	7,058	16.6%	Ottawa	4,486	11.0%
Cuyahoga	228,497	18.3%	Paulding	2,628	13.7%
Darke	7,101	13.7%	Perry	6,991	19.6%
Defiance	5,296	13.9%	Pickaway	6,829	13.3%
Delaware	8,570	4.9%	Pike	6,593	23.5%
Erie	10,034	13.3%	Portage	25,196	16.1%
Fairfield	17,096	11.9%	Preble	5,069	12.2%
Fayette	5,686	20.1%	Putnam	2,342	6.9%
Franklin	208,639	18.1%	Richland	18,246	15.7%
Fulton	4,801	11.4%	Ross	14,097	19.7%
Gallia	5,312	17.7%	Sandusky	8,478	14.3%
Geauga	7,494	8.1%	Scioto	17,531	23.3%
Greene	21,277	13.9%	Seneca	8,285	15.5%
Guernsey	7,972	20.3%	Shelby	5,543	11.4%
Hamilton	140,849	18.0%	Stark	54,747	15.0%
Hancock	10,238	14.0%	Summit	81,846	15.4%
Hardin	5,354	18.1%	Trumbull	35,569	17.4%
Harrison	2,833	18.4%	Tuscarawas	13,303	14.6%
Henry	3,728	13.5%	Union	3,844	7.8%
Highland	8,360	19.5%	Van Wert	3,509	12.5%
Hocking	4,537	15.9%	Vinton	2,737	20.6%
Holmes	6,616	15.8%	Warren	13,188	6.3%
Huron	7,916	13.5%	Washington	9,124	15.3%
Jackson	8,028	24.6%	Wayne	13,737	12.4%
Jefferson	11,092	16.6%	Williams	4,994	13.7%
Knox	8,180	14.2%	Wood	17,617	14.7%
Lake	20,874	9.2%	Wyandot	2,455	11.1%
Lawrence	11,249	18.3%			
Licking	19,567	12.0%	<b>Ohio</b>	<b>1,773,853</b>	<b>15.8%</b>

Note: Population includes all persons except unrelated individuals under age 15 (such as foster children). Since the census survey asks income questions only to people age 15 and over, if a child is not part of a family by birth, marriage, or adoption; their income and whether or not they are poor cannot be determined.

Source: U.S. Census Bureau, Census 2013 Estimates.

**Estimates of uninsured civilian noninstitutionalized population by county of residence,  
Ohio 2013**

<b>County</b>	<b>Number and Percent of Uninsured Persons</b>		<b>County</b>	<b>Number and Percent of Uninsured Persons</b>	
	<b>No.</b>	<b>%</b>		<b>No.</b>	<b>%</b>
Adams	5,223	18.5%	Logan	6,460	14.3%
Allen	12,347	12.0%	Lorain	28,744	9.7%
Ashland	7,826	14.9%	Lucas	54,516	12.6%
Ashtabula	13,607	13.9%	Madison	4,664	12.1%
Athens	6,860	10.7%	Mahoning	25,372	11.0%
Auglaize	3,490	7.7%	Marion	8,171	13.4%
Belmont	7,267	11.0%	Medina	14,181	8.2%
Brown	6,159	14.0%	Meigs	3,635	15.5%
Butler	39,025	10.6%	Mercer	3,178	7.9%
Carroll	4,200	14.8%	Miami	10,932	10.7%
Champaign	4,185	10.6%	Monroe	1,727	11.9%
Clark	16,213	11.9%	Montgomery	65,160	12.3%
Clermont	21,003	10.7%	Morgan	2,013	13.6%
Clinton	4,922	11.8%	Morrow	4,228	12.2%
Columbiana	12,770	12.3%	Muskingum	10,200	12.0%
Coshocton	5,799	15.9%	Noble	1,555	12.9%
Crawford	4,916	11.5%	Ottawa	4,393	10.7%
Cuyahoga	144,984	11.5%	Paulding	1,610	8.3%
Darke	6,469	12.4%	Perry	4,936	13.8%
Defiance	4,307	11.2%	Pickaway	5,033	9.7%
Delaware	9,422	5.3%	Pike	4,065	14.4%
Erie	8,636	11.4%	Portage	16,756	10.3%
Fairfield	13,169	9.1%	Preble	4,964	11.9%
Fayette	4,319	15.2%	Putnam	1,682	4.9%
Franklin	156,132	13.3%	Richland	14,254	12.2%
Fulton	3,319	7.9%	Ross	9,334	13.0%
Gallia	4,488	14.7%	Sandusky	6,625	11.1%
Geauga	11,258	12.1%	Scioto	11,251	14.8%
Greene	13,371	8.4%	Seneca	6,134	11.0%
Guernsey	5,595	14.2%	Shelby	5,105	10.5%
Hamilton	90,005	11.3%	Stark	41,374	11.2%
Hancock	8,002	10.7%	Summit	59,309	11.1%
Hardin	4,617	14.6%	Trumbull	26,373	12.9%
Harrison	1,779	11.5%	Tuscarawas	11,656	12.7%
Henry	2,731	9.8%	Union	4,306	8.7%
Highland	7,023	16.3%	Van Wert	2,649	9.3%
Hocking	3,626	12.7%	Vinton	1,805	13.6%
Holmes	19,219	45.7%	Warren	14,658	7.0%
Huron	6,709	11.4%	Washington	7,036	11.6%
Jackson	4,633	14.2%	Wayne	17,094	15.1%
Jefferson	7,551	11.1%	Williams	4,076	11.2%
Knox	9,005	14.9%	Wood	10,290	8.2%
Lake	22,107	9.7%	Wyandot	2,242	10.1%
Lawrence	7,878	12.8%			
Licking	18,055	10.9%	<b>Ohio</b>	<b>591,786</b>	<b>11.6%</b>

Note: The uninsured include those without health insurance and those who have coverage under the U.S. Indian Health Service only.

Source: U.S. Census Bureau, Census 2013 Estimates.

## Percent of Ohio population on Medicaid, by county, state fiscal year 2013

County	Number and Percent Insured by Medicaid		County	Number and Percent Insured by Medicaid	
	No.	%		No.	%
Adams	7,415	26.3%	Logan	7,180	15.9%
Allen	20,436	19.8%	Lorain	49,037	16.6%
Ashland	7,250	13.8%	Lucas	91,033	21.0%
Ashtabula	19,594	20.0%	Madison	5,042	13.0%
Athens	10,732	16.7%	Mahoning	46,295	20.0%
Auglaize	5,925	13.1%	Marion	13,010	21.4%
Belmont	11,733	17.7%	Medina	15,161	8.8%
Brown	7,944	18.0%	Meigs	5,880	25.1%
Butler	47,199	12.9%	Mercer	4,425	10.9%
Carroll	4,619	16.3%	Miami	13,482	13.2%
Champaign	6,555	16.6%	Monroe	2,496	17.2%
Clark	29,919	22.0%	Montgomery	96,054	18.2%
Clermont	22,768	11.5%	Morgan	3,290	22.2%
Clinton	8,085	19.4%	Morrow	6,389	18.5%
Columbiana	19,829	19.2%	Muskingum	19,381	22.8%
Coshocton	6,714	18.4%	Noble	1,893	15.7%
Crawford	8,615	20.1%	Ottawa	4,941	12.1%
Cuyahoga	245,327	19.5%	Paulding	3,935	20.4%
Darke	8,507	16.3%	Perry	7,715	21.6%
Defiance	6,138	15.9%	Pickaway	8,644	16.7%
Delaware	11,489	6.5%	Pike	8,547	30.3%
Erie	12,052	16.0%	Portage	22,144	13.6%
Fairfield	22,570	15.6%	Preble	6,924	16.6%
Fayette	6,302	22.2%	Putnam	3,288	9.7%
Franklin	194,933	16.6%	Richland	22,997	19.7%
Fulton	5,287	12.5%	Ross	15,634	21.8%
Gallia	7,160	23.5%	Sandusky	9,613	16.1%
Geauga	6,877	7.4%	Scioto	20,239	26.6%
Greene	19,466	12.3%	Seneca	9,638	17.3%
Guernsey	8,802	22.3%	Shelby	6,967	14.3%
Hamilton	129,967	16.4%	Stark	63,824	17.2%
Hancock	9,829	13.2%	Summit	83,435	15.6%
Hardin	5,371	17.0%	Trumbull	37,723	18.4%
Harrison	3,121	20.1%	Tuscarawas	14,638	16.0%
Henry	4,198	15.1%	Union	5,876	11.9%
Highland	10,441	24.3%	Van Wert	4,061	14.3%
Hocking	5,933	20.7%	Vinton	4,202	31.6%
Holmes	4,142	9.9%	Warren	15,977	7.6%
Huron	10,673	18.1%	Washington	10,920	17.9%
Jackson	8,245	25.2%	Wayne	16,331	14.4%
Jefferson	11,785	17.3%	Williams	6,453	17.7%
Knox	9,119	15.1%	Wood	13,381	10.6%
Lake	23,116	10.1%	Wyandot	2,843	12.8%
Lawrence	13,737	22.2%			
Licking	24,419	14.7%	<b>Ohio</b>	<b>1,885,276</b>	<b>16.3%</b>

Source: U.S. Census Bureau, Census 2013 Estimates.

## ODH Programs Contact Information

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### **Ryan White Part B HIV Care Services Program**

(614) 466-6374

Program: <http://www.odh.ohio.gov/odhprograms/hastpac/hivcare/aids1.aspx>

Data: <http://www.odh.ohio.gov/odhprograms/hastpac/hivcare/Data%20Fiscal%20Program.aspx>

### **HIV Counseling, Testing and Referral Services (CTR) Program**

(614) 995-5599

<http://www.odh.ohio.gov/odhprograms/bid/hivstd/hivprev.aspx>

### **HIV/AIDS Surveillance Program**

(614) 995-5599

Program: <http://www.odh.ohio.gov/odhprograms/bid/hivsurv/surv1.aspx>

Data: <http://www.odh.ohio.gov/en/healthstats/disease/hivdata/hivcov.aspx>

### **HIV/STD Prevention Program**

(614) 995-5599

<http://www.odh.ohio.gov/odhprograms/bid/hivstd/hivprev.aspx>

### **STD Surveillance Program**

(614) 995-5599

Program: <http://www.odh.ohio.gov/odhprograms/bid/stdsurv/stdsur1.aspx>

Data: <http://www.odh.ohio.gov/healthstats/disease/std/std1.aspx>