

# **FY 2005- 2010 RYAN WHITE COMPREHENSIVE PLAN**

Prepared by

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## **WEST CENTRAL FLORIDA RYAN WHITE CARE COUNCIL**

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We are a planning body that assesses needs, plans, allocates resources, and evaluates HIV/AIDS services to improve the lives of those infected and affected.

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## TABLE OF CONTENTS

Introduction	1
A. Care Act Overview	1
B. Overview of Title I Program	2
C. Title II Overview	3
D. Care Council Background	3
E. Care Council Coordination	4
F. Needs Assessment	4
G. Comprehensive Plan	5
H. Allocations	5
 Section 1: Where Are We Now?	 6
A. Overview of the Service Area	6
1. Geographic and Economic Indicators	6
a. Population Characteristics	8
b. Poverty and Economic Indicators	9
c. Causes of Death	12
2. AIDS/HIV Proportions by County	14
3. Epidemiological Profile	15
a. Cumulative Living HIV and AIDS Cases-TSA	15
b. Cumulative Living AIDS and HIV Cases-EMA	17
c. Cumulative Living AIDS and HIV cases –Non-EMA	18
d. AIDS Incidence and Trends 2000-2004	19
1. Gender	19
2. Race and Ethnicity	21
3. Mode of Transmission	22
4. Age	24
4. Unmet Need	30
a. Estimates of Unmet Need	30
b. Undiagnosed Cases	35
c. In-Migration	35
d. Reasons for not Accessing Care	36
5. Prevention Needs	36
a. Prioritization of Target Populations	36
6. Service Gaps	38
7. Barriers to Care	41

8. History of response to the Epidemic	43
9. Continuum of Care	46
a. Ambulatory/Outpatient Care	48
b. Case Management	49
c. Drug Reimbursement	50
d. Health Insurance	52
e. Mental Health	53
f. Oral Health	56
g. Substance Abuse Services	57
h. Other Support Services	59
10. Profile of Providers	61
a. Hardee County	61
b. Highlands County	61
c. Hernando County	61
d. Hillsborough County	62
e. Manatee County	63
f. Pasco County	63
g. Pinellas County	64
h. Polk County	65
11. Resource Analysis	67
12. HIV/AIDS Services Funding	96
Section 2: Where Do We Want To Go?	98
Section 3: How Will We Get There?	107
Section 4: How Will We Monitor Progress?	117
A. Comprehensive Plan Monitoring	117
B. Quality Management	118
C. Fiscal and Program Monitoring	118
Glossary	120

## LIST OF TABLES, GRAPHS AND FIGURES

Table 1: Geographic Description by County, EMA and Non-EMA	6
Figure 1: Map of Total Service Area	7
Table 2: General Population Characteristics	8
Table 3 Economic Indicators by County	9
Table 4: Migrant and Seasonal Farm Worker Population Estimates	10
Table 5: Estimated Uninsured Residents and Medicaid Eligible by County	11
Table 6: Public Assistance and Social Security Recipients by County	11
Table 7: TSA Leading Causes of Death, All Races, By Age Group	12
Table 8: AIDS/HIV Proportions by County	14
Graph 1: TSA AIDS Incidence by Gender	20
Graph 2: EMA AIDS Incidence by Gender	20
Graph 3: Non-EMA AIDS Incidence by Gender	20
Graph 4: TSA AIDS Incidence by Race/Ethnicity	21
Graph 5: EMA AIDS Incidence by Race/Ethnicity	22
Graph 6: Non-EMA AIDS Incidence by Race/Ethnicity	22
Graph 7: TSA AIDS Incidence by Mode of Transmission	23
Graph 8: EMA AIDS Incidence by Mode of transmission	23
Graph 9: Non-EMA AIDS Incidence by Mode of Transmission	24
Graph 10: TSA AIDS Incidence by Age	25
Graph 11: EMA AIDS Incidence by Age	25
Graph 12: Non-EMA AIDS Incidence by Age	26
Table 9: TSA AIDS Incidence, AIDS Prevalence, and HIV Prevalence by Gender, Race and Ethnicity, Exposure Category and Age at Diagnosis	27
Table 10: EMA AIDS Incidence, AIDS Prevalence, and HIV Prevalence by Gender, Race and Ethnicity, Exposure Category and Age at Diagnosis	28
Table 11: Non-EMA AIDS Incidence, AIDS Prevalence, and HIV Prevalence by Gender, Race and Ethnicity, Exposure Category and Age at Diagnosis	29
Table 12: Unmet Need Estimates	32
Table 13: Area 5 Target Populations	37
Table 14: Area 6 Target Populations	38
Table 15: Area 14 target populations	38
Table 16: Service Gaps by TSA, EMA and Non-EMA	39
Table 17: Service Gaps by Blacks, Hispanics and Women	40
Table 18: Barriers to Care, Case Managers and Experts	41
Table 19: Barriers to Care, Client Survey, By TSA, EMA and Non-EMA	42
Table 20: Milestones related to HIV/AIDS	43
Table 21: Adult Mental Health Services	54
Figure 2: Map of Ryan White Funded Service Providers	66
Table 22: Service Providers-Hardee County	68
Table 23: Service Providers – Hernando County	70
Table 24: Service Providers- Highlands County	72
Table 25: Service Providers- Hillsborough County	75
Table 26: Service Providers-Manatee County	81
Table 27: Service Providers-Pasco County	84

Table 28: Service Providers-Pinellas County	86
Table 29: Service Providers-Polk County	93
Figure 3: TSA Funding Sources 2003/04	97
Table 30: Trends and Emerging Issues by Service Category and Population	99

## INTRODUCTION

### A. Care Act Overview

On August 18, 1990, Congress enacted Public Law 101-381, The Ryan White Comprehensive AIDS Resource Emergency (CARE) Act. This legislation was re-authorized and amended in May of 1996, again in November 2000, and is scheduled for re-authorization in 2005. The CARE Act represents the largest dollar investment by the Federal government to date, specifically for the provision of services for people living with HIV/AIDS (PLWH). The CARE Act is intended to help communities and states increase the availability of primary health care and support services, in order to reduce the more costly inpatient care, increase access to care for underserved populations, and improve the quality of life of those affected by the epidemic. Briefly, the Act directs assistance through the following channels.

- Title I** Funding to Eligible Metropolitan Areas (EMAs) hardest hit by the HIV/AIDS epidemic.
- Title II** Formula funding to all states, and territories to improve the quality, availability, and the organization of health care and support services for individuals living with HIV/AIDS and their families.
- Title III** Funding to public and private not for profit entities to support outpatient early intervention HIV services for PLWH.
- Title IV** Funding to public and not for profit entities for projects to coordinate services to, and provide enhanced access to research for children, youth, women, and families with HIV/AIDS.
- Part F** Special Projects of National Significance (SPNS) provides support for the development of innovative models of HIV/AIDS care that are designed to be replicable and have a strong evaluation component.  
  
Funding for AIDS Education and Training Centers (AETC) to conduct training and education for health care providers.

The Dental Reimbursement Program assists accredited dental schools and postdoctoral programs with uncompensated costs incurred in providing oral health treatment to HIV positive patients.

The Health Resources and Services Administration (HRSA) HIV/AIDS Bureau has lead responsibility for the implementation of the CARE Act. Within the HIV/AIDS Bureau, the Division of Service Systems (DSS) administers Titles I and II, and the AIDS Drug Assistance Program (ADAP). The Division of Community Based Programs administers Titles III, IV and the Dental Reimbursement Program. The Division of Training and Technical Assistance (DTTA) administers the AIDS Education Training Centers (AETC). The Bureau's Office of Science and Epidemiology administers the Special Projects of National Significance (SPNS) Program.

## **B. Overview of Title I Program**

Title I funding provides formula and supplemental grants to Eligible Metropolitan Areas (EMAs) that are disproportionately affected by the HIV epidemic. These areas are eligible for Title I formula grants if they have reported more than 2,000 AIDS cases in the preceding five years, and they have a population of at least 500,000. Supplemental grants are awarded based upon competitive applications from EMAs demonstrating additional need for financial assistance are awarded to the chief elected official (CEO) of the city or county that administers the health agency providing services to the greatest number of PLWH in the EMA. The CEO must establish an HIV health services planning council that is representative of the local epidemic and includes representatives from specific groups such as health care agencies and community based organizations serving the HIV populations, social service providers, mental health and substance abuse treatment providers, local public health agencies, affected and under served populations. At least 33% of voting members must be non-conflicted PLWH who are recipients of a Title I service. Non-elected community leaders, other CARE Act Title grantees and other funders of HIV services are also required. The planning council conducts a needs assessment, sets the priorities for the allocation of funds within the EMA, develops a comprehensive plan, and assesses the Grantee's administrative mechanism in allocating funds.

The Grantee must distribute grant funds according to the priorities established by the planning council. Funds are to be used for delivering or enhancing HIV related services. No more than five percent of the award can be used for administrative costs. Grant funds may not support services which are reimbursable under any other program.

## **C. Title II Overview**

Title II grants are awarded on a formula basis to states, the District of Columbia, Puerto Rico and eligible U.S. territories to provide health care and support services for people living with HIV disease. Title II funds may be used to support a wide range of services, i.e. home and community-based health care and support services, continuation of health insurance coverage, pharmaceutical treatments, and direct health care services.

Most states provide some services directly and others through subcontracts with local Title II HIV care consortium. A consortium is an association of public and not-for-profit health care and support services providers and community-based organizations that plans, develops, and delivers services for people living with HIV disease. A consortium must conduct a needs assessment, develop a plan for delivery of services, set service priorities, promote coordination and integration of community resources, and evaluate the success of the consortium.

## **D. Care Council Background**

In September of 1999, the Title II Consortium along with the Title I Planning Council combined efforts and became the West Central Florida Ryan White Care Council, a.k.a. The Care Council. This merger was undertaken to prevent duplication of effort and to insure coordination between the Titles.

The Care Council has incorporated the structure of the planning council, which is required by HRSA, with the critical role of the consortium in networking and planning for actual service delivery. Care Council by-laws allow for a maximum of 40 voting members.

The goal to streamline coordination while maintaining effective and efficient quality services is an ongoing process. The utilization of funds in a manner that will best meet the real needs of the HIV/AIDS affected in our Total Service Area (TSA) is the greatest challenge. The Care Council's committee structure was designed to meet the challenge.

Nine committees address specific issues and provide an opportunity for input from consumers, providers and interested individuals. Committees include:

- Client Services
- Health Services Advisory
- Membership, Nominations, Recruitment and Training
- Minority Advocacy
- Planning and Evaluation

Resource Prioritization and Allocation Recommendations (RPARC)  
Rural Issues  
Standards, Issues and Operations (SIOC)  
Women, Infants, Children, Youth and Families (WICYF)

Committees are open to any interested person and are co-chaired by a member of the Care Council. Each member of the Care Council must be an active member of at least one committee. Each committee is also encouraged to have a consumer as one of the co-chairs.

The four mandated duties, conducting a needs assessment, prioritizing the needs identified, developing a comprehensive plan for the delivery of services and assessing the administrative efficiency, are each assigned to a designated committee. Supporting committees including Client Services, Minority Advocacy, Rural Issues, and Women, Infants, Children, Youth and Families are intended to bring the issues and ideas of the disproportionately affected and hard to reach communities and populations into the planning and decision-making process. The Health Services Advisory Committee provides expertise on issues related to primary care, dental, medications, new treatments, adherence, and other clinical issues related to the maintenance and improvement of health.

In order for the Care Council to be successful in accomplishing its goals, there must be coordination between the committees. Adequate representation of all committees in all aspects of the planning and decision making process is imperative. The Care Council continues to strive for excellence in its pursuit of community involvement, meeting the needs of People Living with HIV (PLWH), and in the provision of quality service.

#### **E. Care Council Coordination**

Title I, Title II, Title III, Title IV and the AETC are represented on the Care Council and its nine committees ensuring coordination of efforts and sharing of information. The Grantee/Lead Agency for Titles I and II also administers some HOPWA funds and state general revenue funds dedicated to HIV care and treatment. A representative of the Grantee/Lead Agency attends Care Council and committee meetings. The Care Council also has a designated representative for statewide advisory group on patient care and several members participate in the Community Prevention Planning (CPP) process, in order to facilitate coordination and integration of HIV prevention and early intervention efforts in the local continuum of care.

#### **F. Needs Assessment**

The needs assessment includes a variety of elements that are updated over a multi-year period including an assessment of the service continuum in each county, client surveys, provider and expert surveys, and focus groups, as well as a funding system analysis which includes non-Ryan White funded services for PLWH.

While the epidemiology element is updated on an annual basis, the Planning and Evaluation Committee determines the elements for update and methodology for accomplishing the data collection annually. A prioritization of the HRSA funded service categories is determined based upon an analysis of the needs assessment data and the priorities are shared with the RPARC to assist in the accomplishment of their prescribed duties. A section devoted to the needs assessment is contained in this plan.

## **G. Comprehensive Plan**

Planning has always been a central focus of the CARE Act legislation, and a critical part of Title I and II programs. Since the inception of the Act, planning councils have been establishing service and resource allocation priorities, and goals and objectives for each grant year. However, comprehensive HIV services planning goes beyond annual service or resource allocation. Comprehensive planning should result in a road map for incremental development of a system of care over the longer term.

The purpose of comprehensive planning is to help the Care Council and its committees make better decisions about services for PLWH and how to develop and maintain a continuum of care. A comprehensive plan examines HIV care needs for the entire community and assesses all available resources and barriers. Comprehensive planning builds upon epidemiologic and needs assessment information. Most important, the comprehensive plan sets out long-term goals by outlining the values and vision that will guide the community's system of care. Comprehensive planning helps to answer four basic questions.

- 1) Where are we now?
- 2) Where are we going?
- 3) How will we get there?
- 4) How will we monitor our progress?

## **H. Allocations**

The allocations process is the responsibility of the RPARC. Information from the needs assessment and the comprehensive plan, along with historical information regarding expenditures is used to develop allocations of funds by HRSA service category. Allocation recommendations must be approved by the Care Council before the Grantee/Lead Agency can issue Requests for Applications (RFAs) to perspective contractors. Although the needs assessment and comprehensive plan process are a joint effort for Titles I and II, allocations occur separately for each title.

## SECTION 1: WHERE ARE WE NOW?

### A. OVERVIEW OF THE SERVICE AREA

#### 1. Geographic and Economic Indicators

The total service area (TSA) of the West Central Florida Ryan White Care Council includes eight counties, that can be divided into the Eligible Metropolitan Area (EMA) and the non-eligible metropolitan area counties (non-EMA). The EMA receives funds under Title I and the non-EMA does not. All counties in the TSA can access Title II funds.

Geographically, the area served is the central west coast of Florida (see Figure 1). The service area includes highly diverse geographic, demographic, and economic factors.

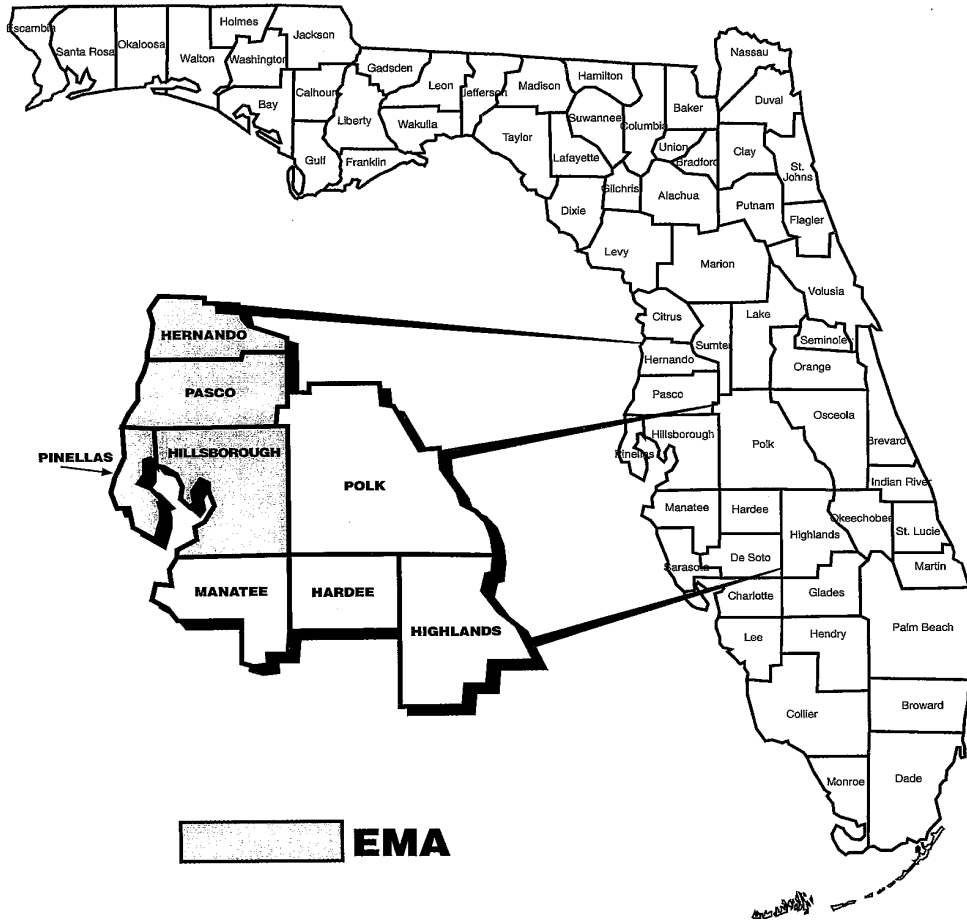
The total service area comprises 6,836 square miles with individual county size ranging from 280 square miles to 1,875 square miles. Population densities in the area range from a low of 43 persons per square mile to 3,355 persons per square mile (see Table 1).

**Table 1**  
**Geographic Description by County, EMA, Non-EMA, and TSA**

County	Square Miles	Total Population	Population Density (persons per square mile)
Hardee	637	27,400	43
Hernando	478	140,670	294
Highlands	1,028	90,393	88
Hillsborough	1,051	1,079,587	1,051
Manatee	741	286,884	387
Pasco	745	375,318	504
Pinellas	280	939,864	3,355
Polk	1,875	511,929	273
Total EMA	2,554	2,535,439	993
Total Non-EMA	4,282	916,606	214
Total Service Area	6,836	3,452,045	505

Source: Florida Statistical Abstract, 2004

**FIGURE 1**  
**Map of Total Service Area**



**a. Population Characteristics**

Table 2 describes age, gender and race characteristics of the general population of each county in the TSA. Highlands County has the highest percentage of individuals 65 years and older, and Hillsborough County has the lowest percent in the same age group. Hardee County has the highest percent of individuals less than 18 years of age, and Hernando County has the lowest.

Females average 51.4% of the population throughout the TSA, with a low of 50.6% in Hardee County and a high of 52.5% in Hernando County.

Blacks range from a low of 2.2% in Pasco County to a high of 15.3% in Hillsborough County. The overall average percent of Blacks in the TSA is 8.8%. Hispanics, who can be of any race, range from a low of 5.0% in Pinellas County to a high of 36.6% in Hardee County. Hispanics average 13.2% throughout the TSA.

**Table 2  
General Population Characteristics**

<b>County</b>	<b>% under 18 years old</b>	<b>% 65 years old and over</b>	<b>% Female</b>	<b>% White</b>	<b>% Black</b>	<b>% Hispanic</b>
Hardee	26.9	13.8	50.6	54.3	8.3	36.6
Hernando	18.5	21.8	52.5	89.5	4.1	5.3
Highlands	18.8	32.0	51.2	76.4	9.2	12.8
Hillsborough	25.6	11.8	50.9	62.5	15.3	19.2
Manatee	51.5	23.4	51.5	80.1	8.3	10.3
Pasco	20.2	24.5	51.8	90.1	2.2	6.1
Pinellas	19.1	21.9	52.1	82.9	9.3	5.0
Polk	24.1	17.9	50.8	74.3	13.7	10.5

Source: University of Florida, Bureau of Economic and Business Research, 2004

## b. Poverty and Economic Indicators

Table 3 illustrates economic indicators which show the average cost of a single family home ranges from \$127,585 (Highlands) to \$181,026 (Pinellas) and median household income ranges from \$28,004 (Hardee) to \$42,407 (Hillsborough). The percentage of people in poverty ranges from a low of 10.7% in Manatee County to a high of 23.2% in Hardee County. Unemployment figures range from 3.9% in Manatee County to 9.3% in Hardee County.

**Table 3**  
**Economic Indicators by County**

County	Average cost of a single family home 2003 in \$	Median Household Income 2002 in \$	Percent of people below poverty level 2002	Unemployment rate 2003
Hardee	128,255	28,004	23.2	9.3
Hernando	135,798	32,247	12.3	5.4
Highlands	127,585	28,718	14.7	5.9
Hillsborough	153,488	42,407	12.5	4.3
Manatee	154,961	38,647	10.7	3.9
Pasco	141,876	33,433	12.1	5.0
Pinellas	181,026	35,690	11.4	4.7
Polk	137,508	34,620	13.6	6.1

Poverty level is equal to \$16,954 for a family of four plus \$2,928 for each additional person in the household. Source: Florida Statistical Abstract, 2004

The more rural counties in the service area including Hardee, Highlands, Manatee, and Polk counties rely heavily on agriculture for employment. While both Hernando and Pasco counties are also rural in nature, their dependence on agriculture for economic growth is considerably less. Hernando and Pasco counties have become bedroom communities for the Tampa-St. Petersburg area. The remaining counties have more diverse economies including tourism, manufacturing, service, retail, technologies, education, and health care industries.

Directly related to economic base is the impact of migrant and seasonal farm workers in the rural counties. Florida provides work for

both residents of the state as well as attracting out-of-state migrants, since Florida's climate has jobs available during the winter season for farm workers from other parts of the country. An estimate of the impact of migrant workers and their families is provided in Table 4.

The more rural and less populated counties face limitations in accessibility to services due to the lack of qualified providers for some services and the great distances that must be traveled in order to receive services. Insufficient or non-existent public transportation further complicates access even to services that may be available locally. Limited transportation funds can be expended quickly when great distances must be traveled. More discussion of this issue appears in the Transportation Section of the plan. The lack of diversity in the economic base in the rural counties limits options for employment, especially for individuals who may require adjustments or accommodations to work schedule and/or environment due to HIV.

**Table 4**  
**Migrant and Seasonal Farm Worker Population Estimates by County, EMA, Non-EMA, and TSA**

County	Adjusted Migrant and Seasonal Farm worker (MSFW) Population Estimate	MSFW and non-farm workers in households
Hardee	5,817	8,459
Hernando	142	206
Highlands	7,173	10,431
Hillsborough	17,202	25,013
Manatee	12,504	18,183
Pasco	3,704	5,386
Pinellas	823	1,197
Polk	16,525	24,030
Total EMA	21,871	31,802
Total Non-EMA	42,019	61,103
Total Service Area	63,890	92,905

Source: Migrant and Seasonal Farm worker Enumeration Profiles Study: Florida; Migrant Health Program, Bureau of Primary Health Care, Health Resources and Services Administration. September, 2000.

Overall health status is affected by access to medical care. Estimates of the percentage of the population that are uninsured or eligible for Medicaid for each county are presented in Table 5.

**Table 5  
Estimated Uninsured Residents and Medicaid Eligible by County**

<b>County</b>	<b>% Uninsured</b>	<b>% Medicaid Eligible</b>
Hardee	19.9	23.1
Hernando	16.5	9.9
Highlands	15.8	13.1
Hillsborough	14.1	12.4
Manatee	16.9	8.6
Pasco	15.6	10.7
Pinellas	19.0	11.2
Polk	19.1	14.8

Source: Florida Agency on Healthcare Administration, 2003. Hillsborough and Pinellas County data, Florida Health Insurance Study, 2004.

Table 6 describes the number of recipients of public assistance and social security by county. Recipients of Supplemental Security Income (SSI) range from 1.3% (Manatee) to 3.3% (Hardee). Aid to Families with Dependent Children (AFDC) had less variability with a range of 0.3% to 0.5%. Recipients of all types of social security ranged from a low of 3.7% (Hernando) to a high of 32.9% in Highlands County. (Highlands County also has the greatest percentage in individuals age 65 and older which likely accounts for this.)

**Table 6  
Public Assistance and Social Security Recipients by County**

<b>County</b>	<b>Recipients of Supplemental Security Income</b>		<b>Recipients (# of families) of Aid to Families with Dependent Children</b>		<b>Social Security Recipients-All Types <sup>1</sup></b>	
	<b>#</b>	<b>%</b>	<b>#</b>	<b>%</b>	<b>#</b>	<b>%</b>
Hardee	580	2.1	185	0.7	4,035	14.7

	Recipients of Supplemental Security Income		Recipients (# of families) of Aid to Families with Dependent Children		Social Security Recipients-All Types <sup>1</sup>	
Hernando	5,360	3.8	361	0.2	49,120	34.9
Highlands	2,450	2.7	339	0.4	29,620	32.8
Hillsborough	23,745	2.2	3,866	0.4	165,370	15.3
Manatee	5,830	2.0	765	0.2	69,435	24.2
Pasco	13,020	3.5	1,076	0.3	105,380	28.1
Pinellas	24,610	2.6	3,489	0.4	217,170	23.1
Polk	14,720	2.9	2,258	0.4	112,470	21.9

Source: Florida Statistical Abstract, 2004

<sup>1</sup> Social Security includes retired and disabled workers, spouses, children and widows/widowers.

### c. Causes of Death

Table 7 provides the information on the rank of leading causes of death for all races, by age group for the TSA in 2004.

**Table 7**  
**TSA Leading Causes of Death, All Races, by Age Group**

Age Group	Cause of Death	Rank
<1	Perinatal Conditions	1
	Congenital Abnormalities	2
	Sudden Infant Death Syndrome	3
		4
	Accident	5
	Heart Disease	
1-4	Accident	1
	Congenital Abnormalities	2
	Cancer	3
	Homicide	4
	Heart Disease	5

<b>Age Group</b>	<b>Cause of Death</b>	<b>Rank</b>
5-14	Accident	1
	Cancer	2
	Congenital Abnormalities	3
	Homicide	4
	Suicide	5
15-24	Accident	1
	Homicide	2
	Suicide	3
	Cancer	4
	Heart Disease	5
23-34	Accident	1
	Suicide	2
	HIV	3
	Homicide	4
	Cancer	5
35-44	Accident	1
	Cancer	2
	Heart Disease	3
	HIV	4
	Suicide	5
45-54	Cancer	1
	Heart Disease	2
	Accident	3
	Chronic Liver Disease	4
	Suicide	5
55-64	Cancer	1
	Heart Disease	2
	Chronic Lower Respiratory Disease	3
	Stroke	4
	Diabetes	5
65-74	Cancer	1
	Heart Disease	2
	Chronic Lower Respiratory Disease	3
	Stroke	4
	Diabetes	5

Age Group	Cause of Death	Rank
75-84	Heart Disease	1
	Cancer	2
	Chronic Lower Respiratory Disease	3
	Stroke	4
	Diabetes	5
85+	Heart Disease	1
	Cancer	2
	Stroke	3
	Alzheimer's Disease	4
	Chronic Lower Respiratory Disease	5

Source: Florida Department of Health, 2005

As indicated in Table 8 above, HIV is the third leading cause of death in the 23 to 34 age group across all races. It ranks fourth in the 35 to 44 age group. Across all ages and races, HIV ranks 13 in cause of death.

There are racial disparities between whites and non-whites. While whites tend to mirror the overall rankings for leading causes of death, mortality rates among non-whites are higher for two-thirds of the major causes of death. Overall, the leading cause of death for whites is cancer followed by heart disease. For non-whites, the order is reversed. The greatest difference occurs in the third ranking. For whites across all ages, accidents rank third compared with HIV for non-whites. However, whites are more likely to die of lung disease or suicide than non-whites.

## 2. AIDS/HIV Proportions by County

County population proportion estimates of people living with AIDS and HIV are as follows:

**Table 8**  
**Proportions of TSA's PLWA/PLWH Population by County**

County	% PLWA Population	% of PLWH Population	% of TSA Total Population
Hardee	1	1	.8
Hernando	2	1	4.0

Highlands	1	2	2.6
Hillsborough	43	47	31.4
Manatee	8	7	8.3
Pasco	5	4	10.9
Pinellas	28	26	27.2
Polk	12	11	14.8
Total	100	100	100

Source: Florida Department of Health, March 2005

### 3. Epidemiological profile

Florida has had HIV reporting since July 1, 1997. The Florida HARS (HIV/AIDS Reporting System) data provides exposure data for adults by sex and with risks redistributed according to the history of the local area. This is more precise than the CDC's protocol which uses history of risk reclassification for the entire southeast quadrant of the United States. In addition, Florida provides a more comprehensive breakdown of HIV and AIDS cases by current age group. Using local historical reclassified data takes into account the different risk profiles for each EMA and Consortia area. There are limitations to the HARS system. Reports are limited to confirmatory tests performed in confidential settings since July 1, 1997. Reporting of cases identified prior to 1997 and anonymous test sites are not included in HARS. In addition, in-migration of individuals diagnosed in another state is not accounted for in HARS leading to what is suspected to be an underreporting of living cases in the TSA.

Epidemiological data is updated each year and is provided by the State Department of Health to the local areas for analysis. Data from areas which included one or two cases of HIV/AIDS have been suppressed and reported as "<3" so that the exact number of cases cannot be determined thereby protecting the confidentiality of those infected. The State has made attempts to reclassify "no specified risk" transmissions to other categories so comparisons between years for mode of transmission should be made with caution. Finally, age data used to be reported as age at diagnosis, but in 2003 reports were adjusted to reflect current age therefore caution should be used in interpreting trends with this factor as well.

#### a. Cumulative Living AIDS and HIV Cases-TSA

As of December 31, 2004, a total of 5,849 living AIDS cases and 4,026 living HIV cases had been reported for the TSA.

- Overall, White males accounted for the highest number of reported living AIDS cases (43%) followed by Black males (22%) and Black Females (14%). This proportional breakdown was also seen among the living HIV cases: White males 32%, Black males 23%, and Black females 22%.
- Among males, Whites accounted for the highest number of reported living AIDS cases (58%) and living HIV cases (50%) followed by Blacks (30% and 36%) and Hispanics (11% and 12%). These numbers represent an increase of 4% in the proportion of whites represented among males living with AIDS, with a corresponding 4% decrease in Black males.
- Among females, Blacks accounted for 56% of reported living AIDS cases and 61% of living HIV cases. Whites accounted for 30% of AIDS cases and 27% of HIV cases followed by Hispanics (13% and 11%).
- Overall, MSM (men who have sex with men) transmission accounted for the highest percentage of reported living AIDS and HIV cases (43% and 33%), followed by heterosexual transmission (24% and 28%), and intravenous drug use (IDU) at 13% and 10 percent.
- Among males, MSM transmission accounted for the largest number of reported AIDS and HIV cases (58% and 52%). Risk Not Specified (RNS) ranked second (12% and 20%), with Heterosexual transmission in AIDS cases also at 12%. Heterosexual transmission ranked third in HIV cases with 14%.
- Among females, in both reported living AIDS cases and HIV cases, heterosexual transmission ranked highest (58% and 51%). Risk Not Specified ranked second (19% and 33%), with IDU transmission in AIDS cases also reported at 19%. IDU transmission ranked third in HIV cases with 15%.
- Overall 44% of all persons reported as receiving an AIDS diagnosis in the 40-49 age group, followed by 23% in the 30-39 age group. In terms of HIV cases, 33% occurred in the 40-49 age group followed by 31% in the 30-39 age group.
- In the 20-29 age group, females represented a greater proportion of cases than males for HIV (13% versus 33%); representing a 7% increase for females in that age group from the 2003 reported cases data. Women also had slightly higher percentages of HIV in the 30-39 cohort (33% vs. 31%)

## **b. Cumulative Living AIDS and HIV Cases-EMA**

Through December 31, 2004, 4,589 living AIDS cases and 3,196 living HIV cases have been reported for the four counties (Hernando, Hillsborough, Pasco and Pinellas) that comprise the Eligible Metropolitan Area (EMA).

- Overall, among AIDS and HIV cases, White males ranked highest (47% and 34%) followed by Black males (21% and 23%) and Black females (13% and 21%).
- Among males, Whites accounted for the highest number of reported living AIDS cases (61%) and living HIV cases (53%). Blacks ranked second (27% and 34%) followed by Hispanics (10% and 11%).
- Among females, Blacks accounted for 54% of reported living AIDS cases and 60% of living HIV cases. Whites accounted for 32% of reported living AIDS cases and 27% of living HIV cases followed by Hispanics (14% and 12%).
- Overall, MSM transmission cases accounted for the highest percentage of reported living AIDS and HIV cases (48% and 36%) followed by heterosexual transmission (22% and 26%) and intravenous drug use (IDU) (13% and 10%).
- In terms of male AIDS and HIV cases, MSM transmission accounted for the highest total percentage of AIDS and HIV cases (62% and 55%). Heterosexual transmission ranked second for both AIDS and HIV cases (10% and 13%) followed by IDU transmission (10% and 8%).
- For female AIDS and HIV cases, heterosexual transmission ranked highest (59% and 52%) followed by cases reported as IDUs for AIDS (20%) and risk not specified for HIV (31%). Risk not specified ranked third for AIDS cases (17%) and IDUs ranked third for HIV (15%).
- In the EMA, AIDS cases among 40-49 year olds represented 46% of the total PLWA population. In terms of HIV cases, the highest percentage of cases was found equally among both the 30-39 and the 40-49 year olds (33%).
- For males, 47% of all reported living AIDS cases were found among the 40-49 age category followed by 30-39 and 50-59 year old males (21%). Of the male HIV cases, 37% were among the 40-49, and 31% among the 30-39 age category.
- For females, 41% of all reported living AIDS cases were found in the 40-49 year old category followed by the 30-39 year old category (27%) and

50-59 year old category (18%). In terms of HIV, the highest percentage was found among 30-39 year olds (33%) followed by 40-49 year olds (27%) and 20-29 year olds (22%).

### **c. Cumulative Living AIDS and HIV Cases- Non-EMA area**

Through December 31, 2004, 1,263 living AIDS cases and 830 living HIV cases were reported for the non-EMA counties (Hardee, Highlands, Manatee and Polk).

- Overall in terms of living AIDS cases, White males ranked highest (31% followed by Black males (28%) and Black females (20%). In terms of HIV cases, Black females ranked highest (27%) followed by Black males (24%) and White males (23%).
- Among males, Whites accounted for the highest number of reported living AIDS cases (46%) followed by Blacks (41%) and Hispanics (12%). Among living HIV cases, Blacks ranked first (43%) followed by Whites (41%) and Hispanics (16%).
- Among females, Blacks accounted for the highest number of reported living AIDS cases (62%) and living HIV cases (62%). Whites ranked second (27% and 29%) followed by Hispanics (10% and 8%).
- Among AIDS cases, males accounted for 67% of the total compared to females (33%). The gender difference was smaller in HIV cases where males accounted for 56% and females accounted for 44%.
- Overall, 31% of all AIDS cases were reported as Heterosexual transmission, followed by 26% reported as MSM transmission, and 25% as risk not specified. IDU transmission ranked last at 12%. Of the HIV cases, 33% were reported as risk not specified followed by heterosexual transmission and MSM transmission (21%). Similar to the AIDS cases, IDU transmission ranked last at 11% of all living HIV cases.
- Among male AIDS cases MSM transmission accounted for the highest proportion with 39% of the case followed by 25% reported as risk not specified and 19% as heterosexual transmission. Of the HIV cases, 55% were reported as MSM transmission followed by 18% risk not specified and 13% as heterosexual transmission. IDU transmission accounted for 7% and 8% of the AIDS and HIV living cases, respectively.
- Among females AIDS and HIV cases, heterosexual transmission ranked highest (59% and 47%) followed by those reported as risk not specified (17% and 37%) and IDU transmission (16% and 13%).

- Overall, AIDS diagnoses occurred most frequently among 40-49 year olds (39%) followed by 30-39 year olds (25%) and 50-59 year olds (21%).
- Overall, 32% of the HIV cases were in the 40-49 age group followed by 29% in the 30-39 age group, and 20% among 20-29 year olds.
- For male AIDS cases, 42% of AIDS occurred among 40-49 year olds, followed by 50-59 year olds (23%) and 30-39 year olds (21%). In terms of HIV male cases, 37% occurred among 40-49 year olds, followed by the 30-39 year old age group (27%) and the 20-29 and 50-59 year olds at 15%.
- For females, 41% of AIDS cases occurred among 40-49 year olds, followed by 30-39 year olds (27%) and 50-59 year olds (18%). In terms of HIV cases, 32% occurred among 30-39 year olds followed by 20-29 year olds (27%) and 40-49 year olds (26%).
- There was one-third more 20-29 year old females reported as living with HIV (12%) than males (8%) in the same age group.

#### **d. AIDS Incidence and Trends 2000 to 2004**

The AIDS incidence for the TSA, EMA and non-EMA areas are presented from January 2000 through December 2004. Incidence refers to the number of new diagnosed AIDS cases reported each year. The value of incidence data is its capacity to report demographic and epidemiologic trends in the TSA over time.

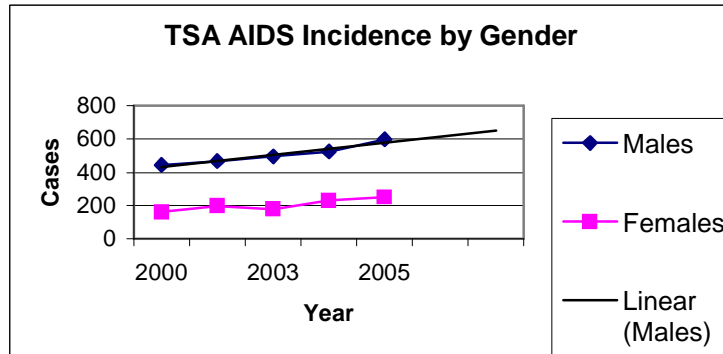
Data in this section includes tables, graphs and highlights. Graphs include trend lines that represent changes in number, not percentage. Trend line projections were analyzed through 2006 by linear regression analysis to aid in interpretation. This type of analysis yields conservative projections and should be used for estimation purposes only. If the number of HIV or AIDS cases declines from year to year, the lines on the graph will go down in proportion to this decline even though the percentages may be increasing. This is because the percentages show how each category of a particular characteristic such as race compares to the other categories for each year.

##### **1. Gender**

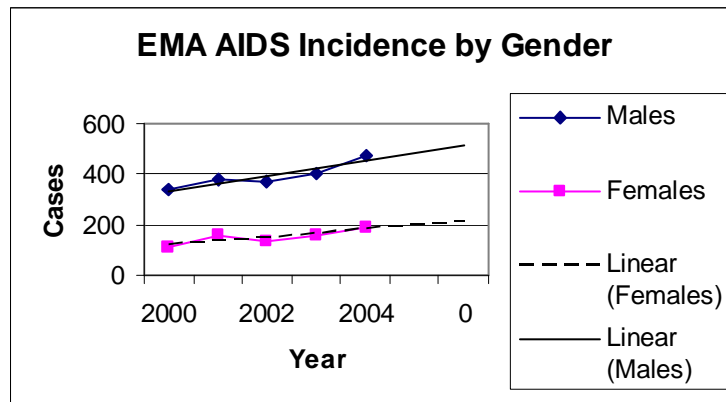
- In the TSA Males accounted for an average of 73% of all AIDS cases from 2000 through March 2005. From 2000 to 2005 there was a 3% decrease in the AIDS incidence among males.
- In the TSA Females accounted for an average of 26% of all AIDS cases during the past five years. From 2000 to 2005, there was an increase of 3% in the AIDS incidence among females.

- In the non-EMA, males accounted for 68% of all AIDS cases from 2000 through 2004. In the EMA, males accounted for an average of 73% of all AIDS cases from 2000 through December 2004 indicating a 4% decrease during the reviewed period.

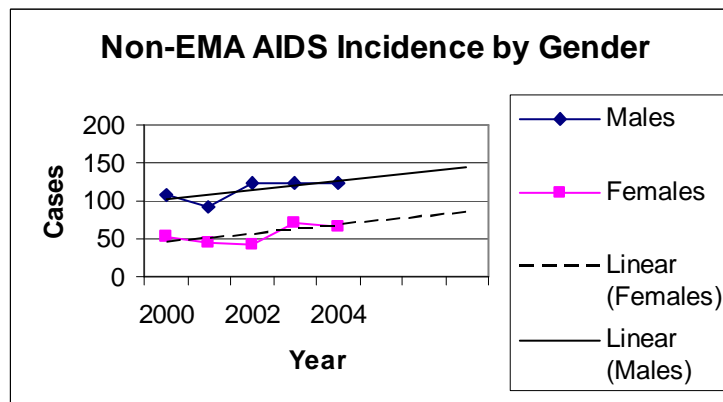
**Graph 1: TSA AIDS incidence by Gender**



**Graph 2: EMA AIDS Incidence by Gender**



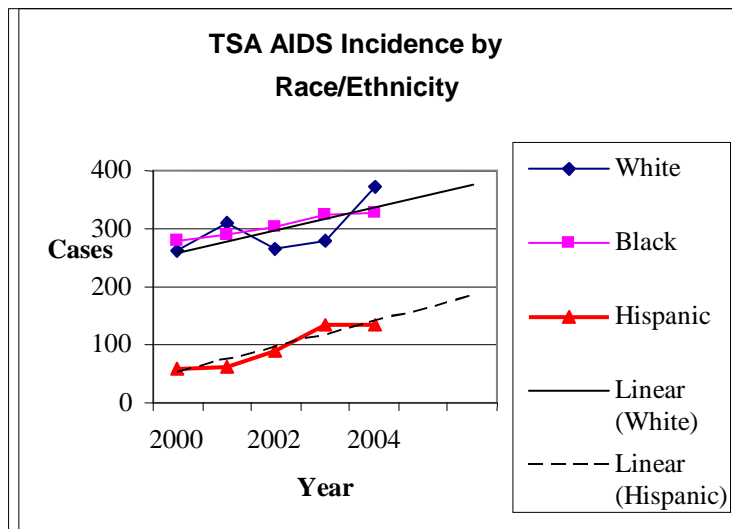
**Graph 3: Non-EMA AIDS Incidence by Gender**



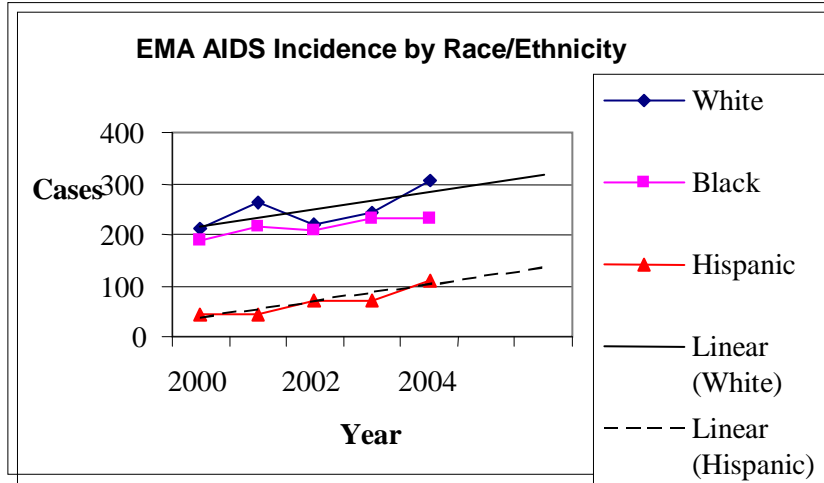
## 2. Race and Ethnicity

- In the TSA Blacks accounted for an average of 44% of all AIDS cases followed by Whites (39%) and Hispanics (16%).
- In the TSA the AIDS incidence among Whites remained similar from 43% in 2000 to 44% in 2005. The incidence among Blacks showed a 7% increase in the same time period. For Hispanics the incidence in 2005 was 6% higher than reported in 2000.
- In the non-EMA between 2000 and March 2005, Blacks accounted for an average of 54% of all AIDS cases followed by Whites (33%) and Hispanics (13%).
- In the non-EMA in 2005, there were 3% more Hispanics cases than in 2000.

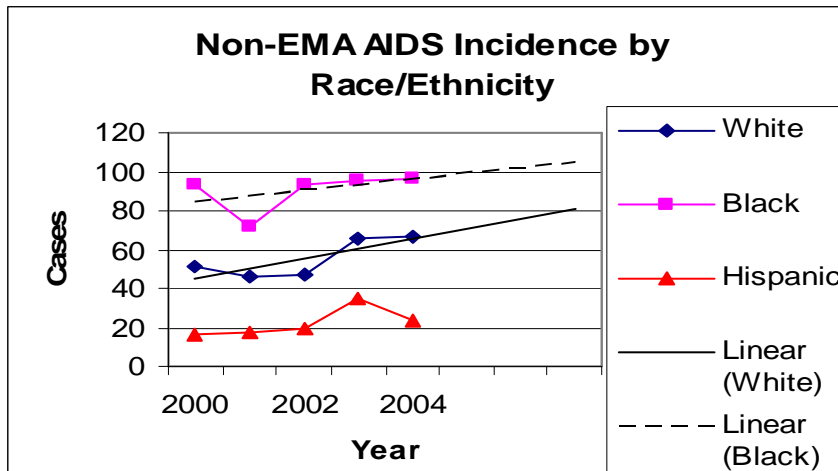
**Graph 4: TSA AIDS Incidence by Race/Ethnicity**



**Graph 5: EMA AIDS Incidence by Race/Ethnicity**



**Graph 6: Non-EMA AIDS Incidence by Race/Ethnicity**

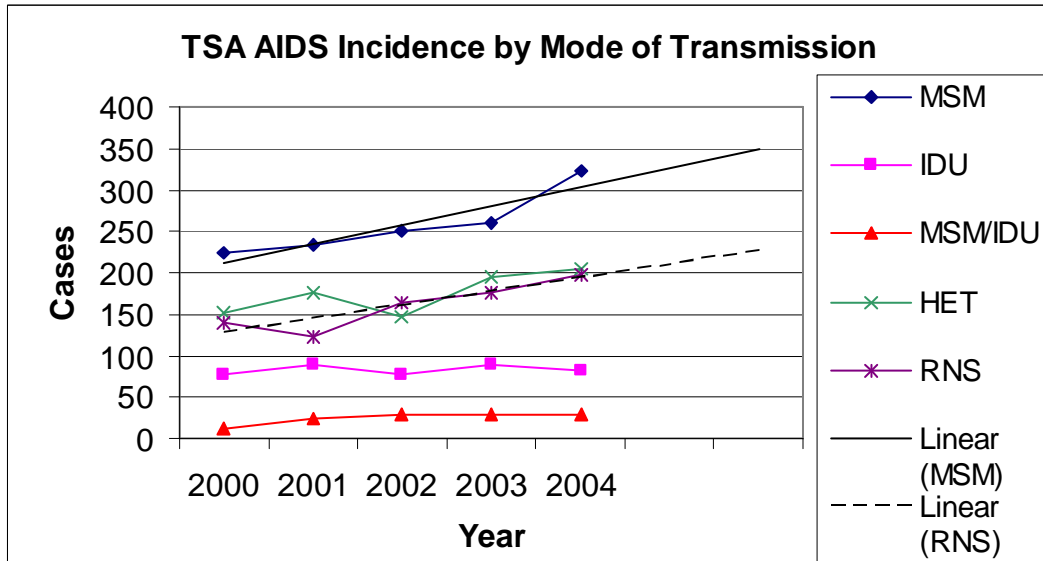


### 3. Mode of Transmission

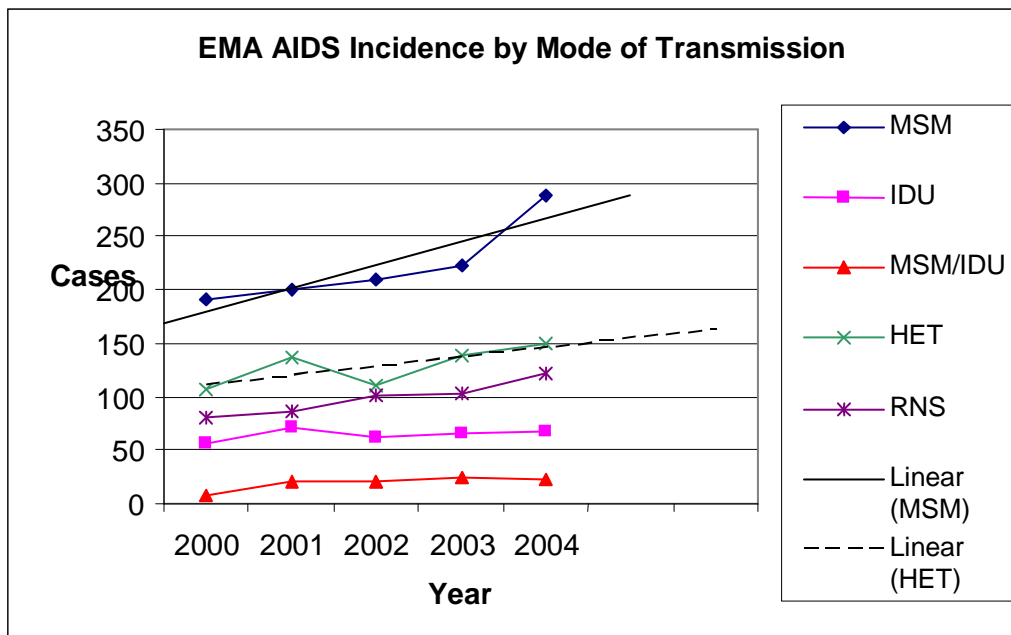
- In the TSA MSM transmission accounted for an average of 37% of all AIDS cases from 1999-2005 followed by heterosexual transmission (25%) and IDU (12%).
- On average, between 2000 and March 2005, 28% of new AIDS (incidence) cases in the non-EMA were reported as heterosexual transmission followed by MSM transmission (22%).
- In the EMA, between 2000 and 2004, MSM transmission accounted for the largest percentage of cases (41%). Heterosexual transmission

represented an average of 24% of the cases.

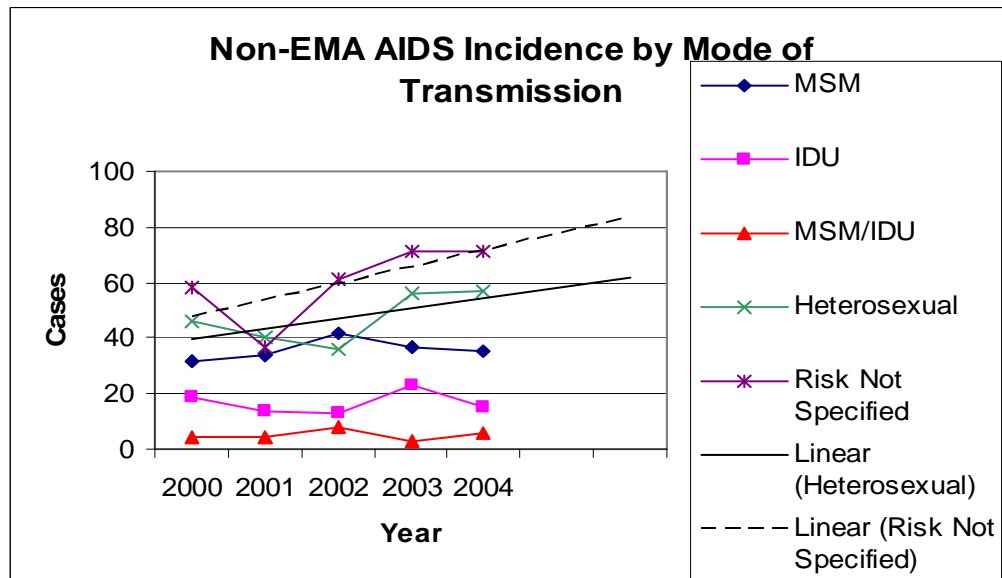
**Graph 7: TSA AIDS Incidence by Mode of Transmission**



**Graph 8: EMA AIDS Incidence by Mode of Transmission**



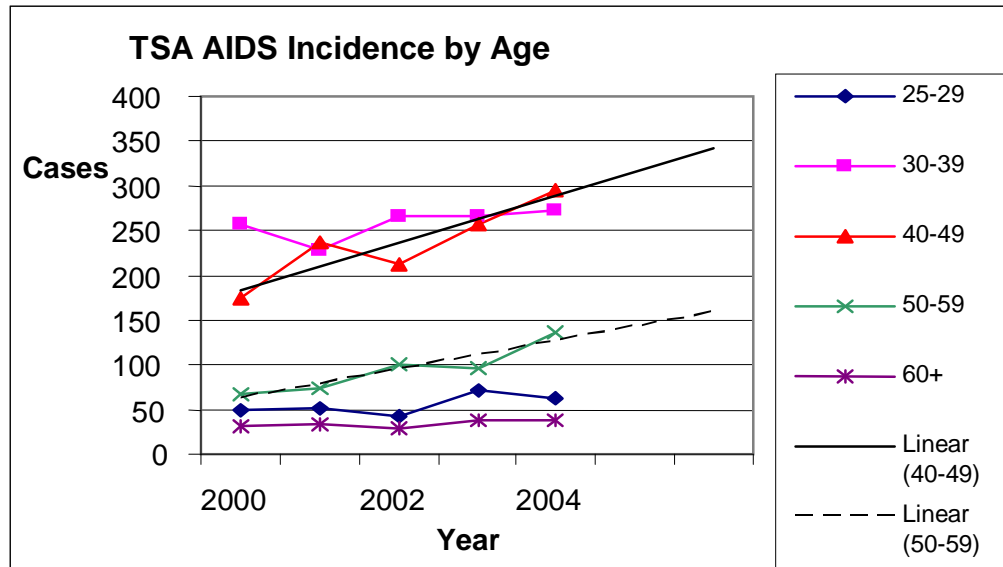
**Graph 9: Non- EMA AIDS Incidence by Mode of Transmission**



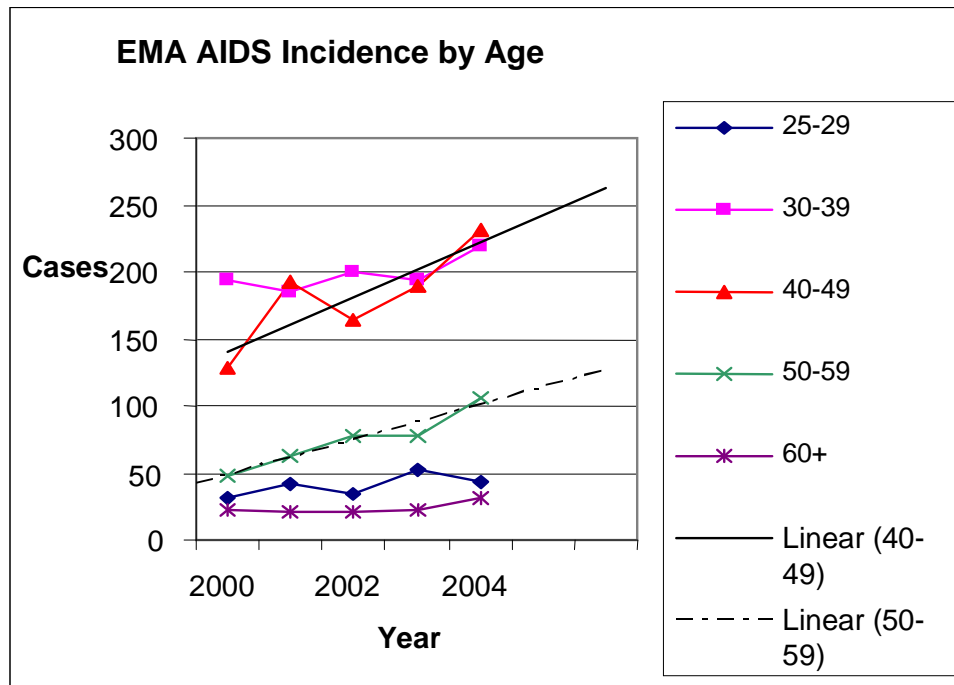
**4. Age**

- On average in the TSA, over the five-year period, AIDS in the TSA occurred most frequently in the 30-39 year old category (n=258, 37%) followed by the 40-49 year olds (n=235, 33%) and the 50-59 year olds (n=95, 13%). Trends were similar in the EMA and non-EMA
- TSA projections indicate that AIDS in the 40-49 and 50-59 year old age groups will slowly increase. Similar trends are seen in the non-EMA area.
- In the EMA there were 11% fewer cases reported among the 30-39 age group in 2005 than in 2000. The 50-59 age group had more than twice as many cases in 2005 than in 2000.
- In the EMA projections indicate a sharp increase in the AIDS cases among the 40-49 age group and the 50-59 age group.

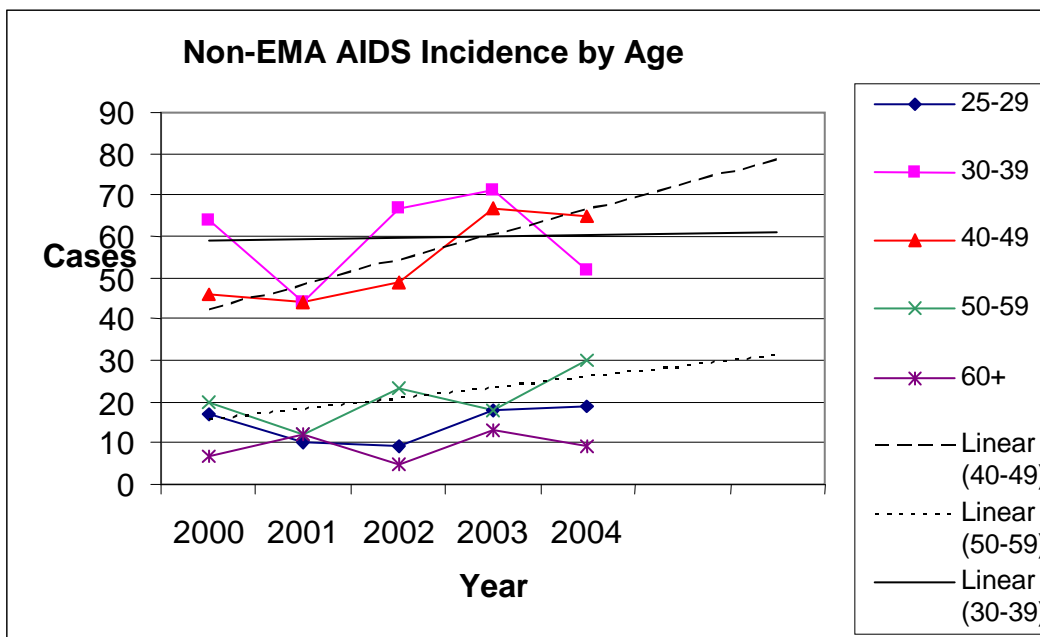
**Graph 10: TSA AIDS Incidence by Age**



**Graph 11: EMA AIDS Incidence by Age**



**Graph 12: Non-EMA AIDS Incidence by Age**



**Table 9: TSA AIDS Incidence, AIDS Prevalence, and HIV Prevalence by Gender, Race and Ethnicity, Exposure Category and Age at Diagnosis**

Demographic Group/ Exposure Category	AIDS Incidence 1/1/2000-12/31/04		As of 12/31/04		HIV Prevalence As of 12/31/04	
	# of cases	% of Total	# of Cases	% of Total	# of Cases	% of Total
	<i>AIDS Incidence is defined as the number of new AIDS cases reported to the CDC for the period specified.</i>					
	<i>AIDS Prevalence is defined as the number of people with AIDS as of the date specified</i>					
	<i>HIV Prevalence is defined as the estimated number of people living with HIV, not AIDS, as of the date specified.</i>					
<b>Gender</b>						
Male	2533	71%	4344	74%	2559	64%
Female	1019	29%	1505	26%	1467	36%
TOTAL	3552	100%	5849	100%	4026	100%
<b>Race/Ethnicity</b>						
White	1492	42%	2991	51%	1689	42%
Black	1526	43%	2142	37%	1810	45%
Hispanic	478	13%	659	11%	478	12%
Other/Unknown	56	2%	57	1%	49	1%
TOTAL	3552	100%	5849	100%	4026	100%
<b>Exposure Category</b>						
MSM	1291	37%	2516	43%	1331	33%
IDU	410	12%	732	13%	413	10%
MSM/IDU	123	3%	290	5%	129	3%
Heterosexual	880	25%	1396	24%	1100	27%
Pediatric		0%		0%	2	0%
Risk Not Specified	800	23%	792	14%	44	1%
Other Identified Risk	32	1%	123	2%	1001	25%
TOTAL	3536	100%	5849	100%	4020	100%
<b>Age</b>						
<12 years	19	1%	39	1%	25	1%
13-19 years	29	1%	49	1%	43	1%
20-29 years	372	11%	218	4%	674	17%
30-39 years	1291	37%	1376	24%	1269	32%
40-49 years	1178	33%	2581	44%	1336	33%
50-59 years	475	13%	1199	20%	514	13%
60+ years	168	5%	387	7%	165	4%
TOTAL	3532	100%	5849	100%	4026	100%

**Table 10: EMA AIDS Incidence, AIDS Prevalence, and HIV Prevalence for EMA Counties by Gender, Race and Ethnicity, Exposure Category  
An Age at Diagnosis**

Demographic Group/ Exposure Category	AIDS Incidence 1/1/2000-12/31/04		AIDS Prevalence As of 12/31/04		HIV Prevalence As of 12/31/04	
	# of Cases	% of Total	# of Cases	% of Total	# of Cases	% of Total
<b>Gender</b>						
Male	1961	73%	3496	76%	2097	66%
Female	743	27%	1090	24%	1099	34%
TOTAL	2704	100%	4586	100%	3196	100%
<b>Race/Ethnicity</b>						
White	1242	46%	2493	54%	1397	44%
Black	1081	40%	1536	33%	1384	43%
Hispanic	338	13%	511	11%	372	12%
Other/Unknown	42	2%	46	1%	43	1%
TOTAL	2703	100%	4586	100%	3196	100%
<b>Exposure Category</b>						
MSM	1111	41%	2182	48%	1157	36%
IDU	323	12%	579	13%	324	10%
MSM/IDU	96	4%	243	5%	113	4%
Heterosexual	642	24%	1008	22%	841	26%
Pediatric	0	0%	0	0%	1	0%
Risk Not Specified	493	18%	476	10%	721	23%
Other Identified Risk	28	1%	98	2%	39	1%
TOTAL	2693	100%	4586	100%	3196	100%
<b>Age</b>						
<12 years	13	0%	30	1%	18	1%
13-19 years	23	1%	36	1%	36	1%
20-29 years	273	10%	158	4%	508	16%
30-39 years	993	37%	1054	24%	1026	32%
40-49 years	906	34%	2086	44%	1070	33%
50-59 years	372	14%	935	20%	413	13%
60+ years	118	4%	287	7%	125	4%
TOTAL	2698	100%	4586	100%	3196	100%

**Table 11: Non-EMA AIDS Incidence, AIDS Prevalence, and HIV Prevalence by Gender, Race and Ethnicity, Exposure Category, and Age at Diagnosis**

Demographic Group/ Exposure Category	AIDS Incidence 1/1/2000-12/31/04		AIDS Prevalence As of 12/31/04		HIV Prevalence As of 12/31/04	
	# of Cases	% of Total	# of Cases	% of Total	# of Cases	% of Total
<i>AIDS Incidence is defined as the number of new AIDS cases reported to the CDC for the period specified.</i>						
<i>AIDS Prevalence is defined as the number of people with AIDS as of the date specified</i>						
<i>HIV Prevalence is defined as the estimated number of people living with HIV, not AIDS, as of the date specified.</i>						
<b>Gender</b>						
Male	572	67%	848	67%	462	56%
Female	276	33%	415	33%	368	44%
TOTAL	848	100%	1263	100%	830	100%
<b>Race/Ethnicity</b>						
White	277	33%	498	39%	292	35%
Black	449	53%	606	48%	426	51%
Hispanic	111	13%	148	12%	106	13%
Other/Unknown	7	1%	11	1%	6	1%
TOTAL	844	100%	1263	100%	830	100%
<b>Exposure Category</b>						
MSM	180	22%	334	26%	174	21%
IDU	84	10%	153	12%	89	11%
MSM/IDU	25	3%	47	4%	16	2%
Heterosexual	235	28%	388	31%	259	31%
Pediatric	0	0%	0	0%	1	0%
Risk Not Specified	298	36%	316	25%	280	34%
Other Identified Risk	12	1%	25	2%	11	1%
TOTAL	834	100%	1263	100%	830	100%
<b>Age</b>						
<12 years	5	1%	9	1%	7	1%
13-19 years	7	1%	13	1%	7	1%
20-29 years	98	12%	60	5%	166	20%
30-39 years	298	36%	322	25%	243	29%
40-49 years	271	33%	495	39%	266	32%
50-59 years	103	12%	264	21%	101	12%
60+ years	46	6%	100	8%	40	5%
TOTAL	828	100%	1263	100%	830	100%

#### **4. Unmet Need**

HRSA has placed an emphasis on the need to determine the number and demographics of HIV+ individuals who are aware of their status but are not in care. In addition, HRSA further directs that the needs of such populations and disparities in access and services among affected subpopulations and underserved communities be determined.

By HRSA definition, an individual is determined to be in care if he/she is receiving regular primary HIV-related medical care. Regular care is defined by having at least one of the following in a specified 12-month period:

- Viral load testing
- CD4 count
- Provision of anti-retroviral therapy.

The term “service gap” applies to all service needs of all PLWH *except* primary health care services for those who know their status but are not in care.

HRSA provided a framework developed in conjunction with the University of California San Francisco (UCSF) to estimate the number of individuals not in care. The framework encouraged the matching of data bases from a variety of sources including Medicaid, Ryan White, private insurance, Medicare, local indigent health plans and the Veteran’s Administration.

The six EMAs of Florida decided to ask the Florida Department of Health for assistance in determining the inputs for the framework, so that to the extent possible, unmet need estimates in Florida could be compared with each other.

##### **a. Estimates of Unmet Need**

Although the HIV/AIDS Reporting System (HARS) data was utilized as one of the primary tools for estimating unmet need, it must be noted that there are limitations to the data in HARS. HIV (not AIDS) cases were not reportable in Florida until July 1, 1997. Furthermore, the report is limited to HIV confirmatory tests performed in a confidential setting since that time. Reporting of retroactive cases, HIV tests from an anonymous test sites and Viral Load HIV tests are not reportable. In addition, in-and out migration is not accounted for in HARS. Florida is one of the fastest growing states and the impact of PLWHAs arriving from other states, but not accounted for in HARS may be significant.

Concerted efforts are made to update HARS with at least one CD4 and/or Viral Load test result per calendar year on persons already reported in HARS. However, this is limited to staff time, as entering new cases takes priority. Furthermore, a bill was passed in 2005, to allow for the reporting of Viral Load Tests for HIV. Once implemented, the reporting of HIV cases aware and in care will become more complete.

Since the HIV reporting database is not complete at the present time, it is impossible to perform a profitable match with databases such as Medicaid, ADAP, Medicare, VA or other databases as suggested in the UCSF framework. Other logistics, such as access to these databases with names of HIV-infected persons receiving HIV care at the county level have proved prohibitive.

As a result of these limitations, Florida has chosen to develop its own methodology for calculating and quantifying the estimated care patterns of persons living and aware with HIV (not AIDS), Persons Living and aware with HIV or AIDS (PLWHA), and People Living and aware with AIDS (PLWA). Furthermore, Florida's methodology identifies different care pattern estimates by county. This was accomplished by utilizing data from HARS, Medicaid and ADAP databases as well as local data resources. One limitation of these methodologies is that they assume the same care patterns across all sub populations within a given area. In the upcoming year, Florida will explore ways to improve this methodology to identify different care patterns for each sub population within each TSA.

2004 HARS data was used to determine the number of people living with HIV (not AIDS) and aware of their status and the number of people with AIDS and aware. The estimates are adjusted by 5% for underreporting (for example, HIV cases diagnosed prior to 1997 and cases that were diagnosed through anonymous testing which are not included in HARS). Further adjustments for awareness were made separately for HIV and AIDS based on return rates for test results and a variety of sample studies conducted throughout Florida. AIDS cases are estimated at 100% aware and HIV cases are estimated at 80% aware in the TSA.

Utilizing this method, it is estimated that 6,157 people are living with AIDS and 4,113 people are living with HIV in the TSA (See Table 12).

**Table 12  
Unmet Need Estimates**

<b>Population size</b>	<b>TSA</b>	<b>EMA</b>	<b>Non-EMA</b>
A. Number of persons living with AIDS (PLWA)	6,157	4,827	1,690
B. Number of Persons living with HIV (PLWH)	4,113	3,266	847
<b>Care Patterns</b>			
C. Number of PLWA who received the specified primary care in the previous 12 month period	4,735	3,994	741
D. Number of PLWH (Aware, non-AIDS) who received the specified primary care in the previous 12 month period	1,782	1,656	126
<b>Results</b>			
E. # PLWA <b>not</b> in Care	1,422	834	588
F. Number PLWH <b>not</b> in care	2,331	1,610	721
G. Total HIV+ aware and <b>not</b> in care	3,754	2,444	1,310

Estimates of the number and percent of people in care according to the HRSA definition are determined as follows:

In 2003, ADAP, HARS and Medicaid data were cross-referenced and unduplicated giving an initial percent of PLWHA in care (there was less than 2% duplication). HARS was utilized to separate HIV (not AIDS) and AIDS cases by reviewing all cases with viral load or CD4 test result from 2004. These percentages were applied to other funding sources to delineate HIV and AIDS where it was unavailable.

Local estimates for other funding sources were gathered in the following manner:

- Title I and Title II recipients were unduplicated by the Grantee.
- Veterans Administration data was extrapolated for the EMA, since the EMA is served by two major VA facilities and data was not available by county of residence from the VA. These estimates were then compared with the percent of individuals responding to the client survey (n=901) indicating the VA as their provider of primary care services. Estimates were within 3 percent of each other and the lower estimate was used.
- Medicare coverage information was sought but was unavailable in any useable form, outside of client survey responses. The percent

indicated in the client survey was used as an average in the calculation.

- Data for estimating the number/percent of privately insured was collected from the following sources: Florida Department of Financial Services data on health insurance enrollment in the general population, unduplicated AIDS Insurance Continuation Program and Ryan White funded health insurance services recipients, survey of major HIV physicians in the EMA regarding private insurance status of client base and client survey data regarding primary care. The percentages were graphed and compared to develop a range of percent privately insured by county, and the mid-point of the range was selected for inclusion in the calculations.

One of the biggest challenges faced in the TSA has been determining the demographics, location and needs of persons not in care. Many attempts to collect information from this population have been attempted with very limited results.

Zip code information from HARS was provided to help identify those areas with the highest number of cases. Most cases were concentrated in the metropolitan areas of Hillsborough and Pinellas Counties. However, limitations in data on those in care have made it difficult to determine the location of individuals not in care. HARS only indicates zip code at time of diagnosis and may not necessarily reflect the current residence. There are pockets of PLWHA in the rural areas of Hillsborough County, including migrant laborers and other minority groups which we strongly suspect are not in care but we do not have data to indicate the number. A special study has been commissioned by the Grantee that will provide additional information to answer this question in the next year.

Several attempts to determine the reasons why people who are aware of their status have decided not to access care and their needs in order to access care have been made. The first attempt included the development of a questionnaire for one-on-one interviews. Incentives for participation were available through a local hospital. Primary care providers and case management agencies asked clients to assist in locating positive individuals that have not accessed care. Several individuals were identified, however all declined to participate in the interview in spite of the incentives. Ongoing efforts will be made in this area in an attempt to gather information.

The second attempt to reach this population involved a plan to utilize Sexually Transmitted Disease (STD) workers in County Health Departments to conduct a six month follow-up with newly diagnosed individuals to determine the reasons why they had or hadn't accessed care. These workers were identified as the best source for access to the newly diagnosed due to

confidentiality laws. A representative of the Care Council approached the Florida Department of Health for assistance in implementing this effort statewide, but was unsuccessful. Additional attempts were made to secure agreement from local health departments to participate in a time-limited study were also unsuccessful due to heavy workloads among STD workers and limited budget.

A third attempt involved one of the minority AIDS initiatives programs. The program identified minority individuals who had dropped out of care and worked to get them back into care. A survey was developed for these program participants that asked about seeking treatment and remaining in care. The sample size was small (n=18) so caution must be used in making assumptions over a larger population.

Additional information was also gathered under the Ryan White funded Minority Outreach Pilot Project (MOPP), which included interviews with six (five men, one woman) individuals who had dropped out of care. This study had the same difficulty identifying and recruiting participants as other attempts made by the Care Council.

In addition, 24 respondents to the client survey also reported themselves as never being in care. Their reasons for not receiving care and barriers to care have been identified as follows:

Reasons for not receiving care (from most common to least common:

- Afraid people would find out
- Don't need help, not sick
- In denial
- Actively using drugs
- Don't know where to go for help
- Can't afford to pay for care
- Don't want care
- Had to wait too long for an appointment
- Clinic hours not convenient
- Don't trust doctors/clinics
- Homeless
- Too much paperwork

Barriers to care include:

- Lack of transportation
- Don't know where to go
- Need for caring /respectful staff and doctors
- Payment source needed/don't qualify
- Waiting lists

- Mental health issues
- Confidentiality concerns
- Need more convenient hours for service
- Child care needs

Plans to find people not in care and encourage them to get into care will also be part of the focus of the special study underway in the EMA at this time. Additional work is also being done with the Care Council to better define how the Council should balance the needs of underserved populations not currently in care with those that are currently in care given the limitations of available funding and HRSA focus on core services. A consultant will be working with the Council in the winter of 2006 to help clarify the direction and methods to address these concerns and incorporate the policies into the comprehensive plan, priority setting and allocation processes.

### **b. Undiagnosed Cases**

In addition, there are those individuals who are positive but are not yet aware of their status. This population represents an additional potential demand on the system of care, and is not accounted for in the calculations for determining unmet need. With increased emphasis on HIV testing in both pregnant women and the general population as a standard practice in health care, this number may decrease over time. Currently the State of Florida and the Centers for Disease Control and Prevention estimate that the number of undiagnosed cases is approximately 25% of the existing HIV/AIDS cases. Using this estimate, there is a potential for additional cases as follows:

- TSA -2,468
- EMA - 1,945
- Non-EMA – 523

### **c. In-Migration**

Florida is also experiencing in-migration of individuals already infected, both aware and unaware, as well as migration throughout the state between service areas. Unless an individual has their initial HIV test while residing in Florida, they are not reflected in surveillance data. The state is working on a methodology to estimate the numbers and impact of in-migration but figures are not currently available.

The 2004 client survey (n=901) revealed that 28% of respondents were initially diagnosed somewhere other than Florida. The Department of Health also conducted a limited study which estimated 26% of Hillsborough County service recipients and 25% of Pinellas County were originally from other states

#### **d. Reasons for not Accessing Care**

The Care Council has made several attempts to determine why individuals do not enter care once they are aware of their status. The top seven reasons cited in the 2004 Client Survey for not getting care (n = 901, multiple answers were permitted) were as follows:

I was afraid people would find out I was HIV+	29.2%
I was in denial	27.8%
I could not afford care	23.8%
I did not need help/I wasn't sick	21.2%
I did not understand the risks of waiting to get care	19.5%
I didn't know where to go	17.8%
I was actively using drugs or alcohol	17.2%

Additional attempts were made to determine the reasons for not accessing care during the past few years. Similar themes developed in other surveys and focus groups regarding reasons for not accessing care. The challenges of educating individuals about the need to get into care even if medications aren't needed is an issue with which testing and early intervention providers continue to struggle. In addition, when cultural norms stigmatize individuals, all barriers to accessing care become intensified.

#### **5. Prevention Needs**

Prevention planning occurs through a mechanism of local planning bodies called AIDS Community Planning Partnership (CPP) and the statewide initiative known as the Florida Community Planning Network (FCPN). The priority setting methodology designed and implemented by the FCPN attempted to ensure the selection of target populations and the allocation of resources in a fair and uniform manner across the state.

##### **a. Prioritization of Target Populations**

An instrument was applied to each of eighteen possible target populations as identified by the Florida Bureau of HIV/AIDS. The target populations were comprised of the following indicators:

- HIV Case Data
- The Disproportionate Impact of HIV upon the Target Population
- The Prevalence of Risk Behaviors and Increased Susceptibility of Infection of Target Population - Gonorrhea
- Community Input: Barriers/Issues
- Barriers of Provider

- Barriers to Target Population
- Community Input Process Points (CIPPS)
- AIDS Case Data
- Riskiness of Behavior
- Size of the Population
- Other Behavioral Data

Each item was assigned a weight in terms of its bearing on the overall impact of HIV/AIDS on a target population. The maximum score a target population could receive was 100 points. Those target populations with the highest scores were then selected as priority target populations for prevention efforts.

Representatives of Area 5 (Pasco and Pinellas), 6 (Hernando, Hillsborough, and Manatee) and 14 (Hardee, Highlands and Polk) and other interested parties met to implement the revised methodology. The data used to analyze the eighteen different target populations included: summary epidemiological profile data for by race, sex, and age group, 2000 census population data, HIV and AIDS cases, HIV/AIDS case deaths, HIV/AIDS presumed living cases, with No Identified Risk (NIR) redistributed and current age groups, Sexually Transmitted Disease (STD) cases (syphilis, gonorrhea and chlamydia), Tuberculosis (TB) cases, HIV counseling and testing data, estimates for the number of injecting drug users (IDU) in the areas and estimates for the number of men who have sex with men in the area. With this data and their expertise in the field of HIV, representatives from each area completed a worksheet with the eighteen populations approved by the Centers for Disease Control and Prevention and answered ten questions. Using the formulas provided on the worksheet, area representative arrived at final scores and thus prioritized their area's target populations. Tables 13, 14, and 15 provide the results. Prevention with positives was added to each area as the CDC shifted focus to this population.

**Table 13**  
**Area 5 Target Populations**

<b>RANK</b>	<b>2004-2006 TARGET POPULATIONS</b>	<b>SCORE</b>
	Prevention with Positives	
1	Black Heterosexual Female	81.4
2	Black Men Who Have Sex With Men (MSM)	76.0
3	Black Heterosexual Male	72.9
4	White Male Injection Drug User (IDU)	67.6
5	White Men Who Have Sex With Men (MSM)	61.6

**Table 14  
Area 6 Target Populations**

<b>RANK</b>	<b>2004-2006 TARGET POPULATIONS</b>	<b>SCORE</b>
	Prevention with Positives	
1	Hispanic Men Who Have Sex With Men (MSM)	81.8
2	Black Men Who Have Sex With Men (MSM)	75.6
3	White Men Who Have Sex With Men (MSM)	69.0
4	Black Heterosexual Female	68.5
5	Black Heterosexual Male	63.6

**Table 15  
Area 14 Target Populations**

<b>RANK</b>	<b>2004-2006 TARGET POPULATIONS</b>	<b>SCORE</b>
	Prevention with Positives	
1	Black Heterosexual Female	69.4
2	Black Heterosexual Male	68.1
3	White Men Who Have Sex with Men (MSM)	65.9
4	White Heterosexual Female	61.6
5	Black Men Who Have Sex with Men (MSM)	56.9

**6. Service Gaps**

Service gaps are assessed in part by the client survey which is conducted as part of the needs assessment. The needs assessment is a three year process, which incorporates a variety of techniques and target populations to assess overall service needs. Gaps were assessed by TSA, EMA and non-EMA as well as by Black, Hispanic and Women. Gaps are determined by respondents indicating which services they needed in a specified twelve-month period, but did not receive. Percentages indicate the respondents that did not receive the service. Overall need for some services may actually be low, such as respite care, but the gap may appear high if there is no (or limited) provider for the service. Tables 16 and 17 provide service gap information:

**Table 16  
Service Gaps by TSA, EMA and Non-EMA**

<b>Service</b>	<b>TSA % Gap</b>	<b>EMA % Gap</b>	<b>Non-EMA % Gap</b>
Ambulatory/outpatient care	19.8	19.1	24.4
Buddy/companion services	56.5	57.5	46.7

<b>Service</b>	<b>TSA % Gap</b>	<b>EMA % Gap</b>	<b>Non-EMA % Gap</b>
Case management	9.6	7.9	20.2
Child welfare services	39.6	41.3	28.6
Client advocacy	29.8	28.3	40.0
Drug reimbursement	6.1	6.8	9.1
Emergency assistance	53.7	52.3	61.9
Food bank, home delivered meals, nutritional supplements	31.2	29.6	42.5
Health insurance	47.2	47.0	47.0
Early intervention services	12.4	11.5	10.7
HIV prevention	10.5	10.4	19.0
Home health care	59.3	57.2	77.8
Hospice	37.8	34.1	25.0
Housing related services	57.1	55.6	50.0
Housing assistance	52.1	52.4	67.9
Legal	56.6	52.9	86.2
Mental health	28.0	27.1	35.4
Nursing home	47.5	45.7	60.0
Nutrition counseling	21.8	20.6	29.7
Oral health	41.5	40.2	50.0
Other support	43.8	38.1	16.7
Permanency planning	69.6	67.7	14.3
Psychosocial support	26.7	19.7	64.5
Referral	37.6	37.8	36.4
Rehabilitation services	58.3	56.6	69.7
Day or respite care	62.2	57.6	100
Substance abuse services	22.5	19.7	50
Treatment adherence	28.7	28.3	31.3

**Table 17**  
**Service Gaps by Blacks, Hispanics and Women**

<b>Service</b>	<b>Black % Gap (n=329)</b>	<b>Hispanic % Gap (n=142)</b>	<b>Women % Gap (n=334)</b>
Ambulatory/outpatient care	19.4	24.2	18.4
Buddy/companion services	53.6	55.2	55.0
Case management	15.0	11.8	11.1
Child welfare services	50.0	27.3	29.0
Client advocacy	26.0	27.3	28.6
Drug reimbursement	4.7	11.5	5.7
Emergency assistance	52.9	60.6	52.6
Food bank, home delivered meals, nutritional supplements	24.9	35.5	23.8
Health insurance	56.1	55.8	40.8
Early intervention services	13.8	3.6	7.8
HIV prevention	16.9	5.1	11.3
Home health care	48.3	78.1	62.9
Hospice	35.0	37.5	26.7
Housing related services	56.4	55.6	49.6
Housing assistance	50.0	53.7	54.4
Legal	51.0	65.8	53.3
Mental health services	28.6	20.8	26.9
Nursing home	33.3	50.0	38.5
Nutrition counseling	18.7	34.1	17.0
Oral health	44.1	36.6	37.4
Other support	35.3	64.3	36.4
Permanency planning	58.8	76.9	67.4
Psychosocial support	22.4	36.7	23.4

<b>Service</b>	<b>Black % Gap (n=329)</b>	<b>Hispanic % Gap (n=142)</b>	<b>Women % Gap (n=334)</b>
Referral	28.4	46.2	40.5
Rehabilitation services	58.8	70.6	67.7
Day or respite care	43.8	77.8	66.7
Substance abuse services	17.6	36.0	15.3
Treatment adherence	16.7	42.9	25.7

## 7. Barriers to Care

Barriers to care were identified by case managers, local “experts”, and clients responding to a survey (n=901). Barriers cited by case managers and experts are as follows:

**Table 18: Barriers to Care, Case Managers and Experts**

<b>Barriers - Case Managers</b>	<b>Barriers- Experts</b>
Lack of on-going assistance for utilities	Lack of on-going assistance for utilities
Lack of providers of services	Lack of specialty medical care
Lack of specialty medical care	Waiting lists
Waiting lists	Need for job training and placement assistance
Need for job training and placement assistance	Complacency
PLWHA not involved in advocacy	Compliance/adherence among PLWHA
Compliance/adherence among PLWHA	Poor coordination of services
Poor coordination of services	Cultural barriers
Cultural barriers	Inconvenient service hours
Motivating PLWHA to get into care	Motivating PLWHA to get into care
Lack of staff training	Poor communication on available services
Clients not legal residents	Substance use and mental illness
Language barriers	Language barriers
Service locations inconvenient	Service locations inconvenient
Poverty	Lack of opportunities for PLWHA to socialize
No case management agency with outreach	Spending on support services diverts funds from core services
Lack of client/administration relationships	
Lack of education about HIV prevention	

**Table 19: Barriers to Care- Client Survey, by TSA, EMA and Non-EMA**

<b>Reason</b>	<b>TSA % (n=395)</b>	<b>EMA% (n=310)</b>	<b>Non-EMA% (n=65)</b>
I can't afford to pay for service	44.6	41.5	60.0
I don't know where to go	38.2	40.2	29.2
I have bad credit/poor rental history	26.1	26.5	24.6
Lack of transportation	25.6	26.5	21.5
I have a criminal record	16.2	17.1	12.3
I'm afraid people will find out I'm HIV+	15.4	14.6	20.0
I'm not sick enough to qualify (No AIDS diagnosis)	14.2	14.3	13.8
There are no openings for service	12.9	14.0	7.7
I earn too much money	11.9	10.4	16.9
I worry I'll take the service away from someone who needs it more	10.6	10.4	12.3
I'm on a waiting list	10.4	12.2	0.0
I need help filling out forms	7.8	7.9	7.7
I don't have a case manager	7.8	6.7	13.8
Services don't meet my needs	6.6	6.4	7.7
My legal status	5.8	6.1	4.6
Lack of child care	3.5	3.7	3.1
My family size	3.8	4.6	0.0
Language barrier	2.3	2.1	3.1
I don't have ID	1.3	1.2	0.0
I don't have proof of HIV	2.0	2.4	0.0
I've used up my eligibility this year	5.1	5.5	3.1
Other	5.3	5.2	9.2

“Other” reasons cited included “case manager hasn’t helped me yet”, “case manager continually rejects my requests”, “mental illness”, “location is far away”, “limited

services at VA or jail”, “They want your life history when you ask for help”, “waiting on next month’s funding” and “dental work needed is not emergency service”.

Additional barriers to care include changing service delivery systems in Medicaid, which is moving toward an HMO model, and Medicare Part D Share of cost requirements including which funding sources will be allowed to fill the gap. In addition, standardized eligibility criteria for services (including income limitations) is being proposed for Title II which may be adopted by Title I services in the TSA. This may mean some individuals currently receiving services may no longer be eligible. At this time it is too early to tell the impact of these policy issues as details are as yet unknown. The Care Council will monitor these items as well as other issues that may occur in order to formulate effective responses.

## 8. History of Response to the Epidemic

The history of the area’s response is tied directly to events at the state and national level as most funding sources and regulatory authority occurs at these levels of government. A general time line of milestones appears in Table 20.

**Table 20: Milestones Related to HIV/AIDS**

<b>Year</b>	<b>Milestones</b>
1981	First AIDS case in Florida AIDS Case Surveillance established
1983	CDC declares AIDS a reportable disease Florida requires physicians to report diagnosed AIDS cases to State USPHS issues recommendations for prevention of transmission through sexual contact and transfusions
1984	Active surveillance begins in Florida
1985	Anonymous Testing begins in Florida Statewide hotline established FDA approves first HIV anti-body test and national screening of blood supply USPHS recommends guidelines for prevention of transmission from mother to child Ryan White barred from attending school in Indiana
1986	Statewide public information program initiated Ricky Ray barred from attending school in Florida CDC adds female partners of men with AIDS as a risk group Five regional AIDS coordinators hired (Includes Tampa area)
1987	Florida is first state to establish voluntary, confidential HIV counseling and testing at all county public health units Specific funding obtained by the state to expand HIV prevention education to minorities and community-based groups

	<p>AZT approved by FDA</p> <p>First human tests of vaccine</p> <p>FDA accelerates drug approval process by two to three years</p>
1988	<p>Florida passes comprehensive AIDS bill that prohibits discrimination against PLWHA</p> <p>Partner notification included into services provided by STD staff</p> <p>Supplemental AZT funding received</p> <p>Testing and counseling sites expanded to include substance abuse treatment facilities</p> <p>First World AIDS Day (December 1<sup>st</sup>)</p> <p>FDA allows importation of unapproved drugs for life threatening illnesses</p>
1989	<p>Project AIDS Care (PAC) Medicaid waiver program established</p>
1990	<p>Ryan White dies at 18 years of age</p> <p>Ryan White Care Act passed –funded at 220.5 million dollars</p> <p>Americans with Disabilities Act (ADA) passed</p> <p>AZT approved for pediatric cases</p>
1991	<p>First Ryan White Title II consortium in Florida</p> <p>FDA approves 2<sup>nd</sup> antiviral (Videx)</p> <p>HOPWA enacted</p> <p>Ricky Ray dies from AIDS</p>
1992	<p>Governor commissions Red Ribbon Panel on AIDS to address prevention and treatment issues</p> <p>FDA approves combination therapy</p> <p>Tampa-St. Petersburg EMA designation</p> <p>AIDS becomes #1 cause of death in US for men 25-44 years old</p>
1993	<p>AIDS definition expanded (CD4 &lt;200)</p> <p>AZT resistance detected</p> <p>Florida Community Planning Group (Prevention) created</p> <p>AIDS Insurance Continuation Program (AICP) implemented and became largest of its kind in the nation</p> <p>Florida begins Department of Corrections projects</p> <p>First “All Titles” meeting of Ryan White Care Act grantees in Florida</p> <p>Female condom approved</p>
1994	<p>First HIV Prevention Plan for Florida is completed</p> <p>Florida AIDS Health Fraud Task Force formed</p> <p>OraSure approved by FDA</p> <p>AIDS becomes leading cause of death for all persons 25-44 in US</p>
1995	<p>First detailed statewide EPI profiles developed</p> <p>ADAP receives additional allocations</p> <p>Protease inhibitors approved</p>
1996	<p>Ryan White Care Act Amendments</p> <p>Annual number of HIV/AIDS deaths declines for the first time in the state</p> <p>Florida mandates counseling and offering of HIV tests to pregnant</p>

	<p>women</p> <p>FDA approves viral load test</p> <p>FDA approves non-nucleoside reverse transcriptase inhibitor (NNRTI)</p> <p>Number of new AIDS cases declines for the first time in US</p> <p>AIFDS no longer leading cause of death</p>
1997	<p>HIV reporting begins in Florida</p> <p>Florida Bureau of HIV/AIDS holds first Black Leadership Conference on HIV/AIDS</p>
1998	<p>AIDS Omnibus Act revised to streamline HIV testing in private sector</p> <p>Supplemental funds received for Florida to use for minority projects</p> <p>TOPWA (Targeted Outreach for Pregnant Women Act) passed</p> <p>HHS issues first national guidelines for use of anti-retroviral therapies in adults</p> <p>Ricky Ray Hemophilia Relief Act funded</p>
1999	<p>Florida HIV/AIDS Minority Network established</p> <p>Creation of 8 Regional Minority AIDS Coordinators and one statewide coordinator</p> <p>Florida receives funding to enhance perinatal HIV prevention</p> <p>Formation of West Central Florida Ryan White Care Council (combined Titles I and II)</p> <p>Protease inhibitor approved</p>
2000	<p>Statewide Minority Media Campaign</p> <p>Case Manager Training Program offered locally</p> <p>Local MAI programs addressing adherence, education and substance abuse outreach begin</p> <p>Ryan White Care Act Amendments (includes requirement for estimating number and needs of individuals aware of their status but not in care)</p> <p>State approves testing of inmates at Department of Corrections facilities prior to release</p>
2001	<p>Minority Outreach Pilot Project undertaken locally</p> <p>Medication Adherence Study conducted locally</p> <p>One-on-one capacity building activities offered by the State</p> <p>Initial Prevention for Positives programs funded</p> <p>Resources for ex-offenders formed</p>
2002	<p>Ora-quick rapid test approved by FDA</p> <p>Case Management Standards and Guidelines implemented Statewide</p> <p>First patient care comprehensive plan developed by the State</p> <p>Implemented rapid testing pilot projects throughout the state</p> <p>Insurance Services Program (ISP) becomes contracted service for Titles I and II in TSA</p>
2003	<p>Quality Management Initiatives undertaken locally</p>

	Entry inhibitors approved by FDA
2004	Rapid testing for pregnant women initiated at hospitals Rapid testing availability expands to 24 sites in Florida Behavioral surveillance begins in Florida
2005	Mandatory lab test reporting passed in Florida

## 9. Continuum of Care

The continuum of care is a coordinated delivery system encompassing a comprehensive range of health and social services that meet the needs of People Living with HIV/AIDS (PLWHA) in all stages of illness. Within services there are also continua, which reflect the range of options for care depending on the severity of need. There are to some degree, separate continuums for children/adolescents and adults. Some providers may serve both populations but many specialize in one or the other.

Ideally, entry into the continuum begins with HIV testing. This can occur at licensed testing sites, hospital emergency rooms, private physician's offices, and outreach programs.

Florida offers both confidential and anonymous testing and requires pre- and post-test counseling. The TSA has an extensive array of testing sites with more being added each year. When a positive test is received, counselors inform clients of the need for a confirmatory test and provide information on HIV and available services. When the client returns for the confirmatory test, the opportunity for additional information and referrals for services occurs. This scenario is less likely to occur from emergency room diagnoses as staff may not have adequate time to provide support.

The continuum of care for children and adolescents is operated by the University of South Florida (USF) and All Children's Hospital (ACH) Pediatric HIV Program. Begun in 1990, it provides an accessible, comprehensive, family centered, culturally competent, community-based, coordinated system of care for infants, children, adolescents and pregnant women infected with or exposed to HIV. This program is the sole provider of comprehensive HIV care to children and youth in a geographic area of ten counties encompassing West Central Florida.

The program provides a "medical home" with 24-hour on-call services and intensive medical case management services that are provided by doctors, nurses, nutritionists, pharmacists, and social workers. The primary goal is to improve the health and lives of children and their families through medical care, access to clinical trials, psychosocial support, and education. A second goal is to continue to decrease the transmission of HIV from mother to infant, and prevent HIV infection in adolescents through early intervention and community out-reach and education. This program is funded through a variety of sources and the network of the

university; local, state and federal support has allowed for continued growth of the program.

Over the past four years, the division of Adolescent Medicine and Pediatric Infectious Disease has expanded clinical services for both HIV negative and HIV positive youth. Both primary and specialty care are provided concomitantly. A general adolescent clinic is offered at the same time as the HIV clinic so that there is continued support for gynecologic services and other adolescent issues that may arise. The Tampa clinic provides six day per week acute care appointments. Access to mental health services, both on site and through referral, has been expanded.

A multidisciplinary team is composed of a nurse case manager, social workers, nutritionists and an adherence coordinator. Access to medication consults and psychology and psychiatry exist. Weekly team conferences and daily team contacts occur. Continuity of care coordination, including hospitalization, is provided to each patient.

In addition, a monthly comprehensive clinic occurs at USF Main Campus, with the Adult HIV clinic. A gynecologist attends and provides on site colposcopies and sub-specialty GYN care.

The Mother-Baby Care program follows youth through pregnancies providing the ID care and a perinatal nurse case manager. Infants are evaluated in the same clinic setting to decrease appointments and provide consistency of providers. A transition program assists youth in effectively accessing services as an adult. Medication and treatment adherence education and counseling are provided by an adherence nurse, and education about, and access to, a variety of therapeutic and prevention trials are provided.

Primary and subspecialty care for youth enrolled in the AMTU are provided in three USF clinics located in Hillsborough and Pinellas counties that are conveniently located for patients in the most populated sections of the TSA (17 Davis Pediatric Clinic, All Children's Hospital (ACH) Pediatric Clinic and USF Main Campus clinic).

In order to prevent mother-to-child transmission, the perinatal HIV prevention program was developed as a collaborative community program funded by Ryan White Titles I, II, IV and Children's Medical Services (CMS). The purpose is to identify pregnant HIV+ women and educate them on how to reduce the risk of transmitting HIV to their child. The client and her family are involved in activities that include confidential care coordination, counseling and support services. Hospital, medications and OB visits are included as is a comprehensive education component. Florida perinatal transmission rates have dropped significantly with only seven cases reported statewide in 2004.

The continuum of care for adults is somewhat more fragmented, although several providers offer a range of services for HIV+ clients as noted in the provider description section. Accessing the continuum of care for adults in the TSA is generally achieved through the case management system. Case managers assess the client's acuity level, develop a case plan, provide information and referrals for accomplishing the goals of the plan and monitor the progress of the client through the continuum. Most services may be accessed without the referral of a case manager (health insurance and co-pays is one exception) and an experienced client with limited needs may navigate the system of care without assistance at any point on the continuum. The Care Council adopted a policy that anyone presenting for Ryan White funded services must show proof of primary care in the past year (as per the HRSA definition).

**a. Ambulatory/Outpatient Care**

Ambulatory or outpatient medical care is the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist or nurse practitioner in an outpatient, community-based and /or office setting. This includes diagnostic testing, early interventions and risk assessment, preventive care and screening practitioner examination, medical history taking and diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, care of minor injuries, education and counseling on health and nutritional issues, minor surgery and assisting at surgery, well-baby care, continuing care and management of chronic conditions and referral to and provision of specialty care. This type of care is commonly known as primary care.

Early entry into primary care can have a positive impact on the overall length and quality of life of an HIV infected individual. A major barrier for entry into primary care is having a payer source. HIV-related primary care is available in all of the counties of the TSA with the exception of Hardee County. Due to the small number of cases in the county and limited resources, Hardee is provided service by the Polk County Health Department through Title II and Title III programs. Each year the Health Services Advisory Committee conducts a survey to determine that at least one qualified public provider is serving each county.

Medicaid is a major funding source for primary care services for HIV infected individuals. The state enacted a disease management initiative for Medicaid eligible HIV infected individuals designed to improve medical outcomes. This program provides nurse case managers and access to a wide range of medical services. Medicaid is more likely to serve women with children than single males due to eligibility criteria and generally lower incomes of women.

The Medicaid Project AIDS Care (PAC) Waiver program provides services for Medicaid eligible PLWH in their homes or in the community. An individual must have a diagnosis of AIDS and meet income and disability criteria.

Medicare is available for those individuals who meet the Social Security Administration's definition of "disabled" through the SSI and SSDI programs.

The Veteran's Administration (VA) also provides care for HIV. Major VA health care facilities are located in both Hillsborough and Pinellas counties, as well as several satellite clinics.

Other resources for the medically needy in the TSA include Hillsborough County Health Care Plan which pays for inpatient care and a portion of outpatient services. Pinellas County Social Services supports a limited number of outpatient services. Polk County also offers limited health care coverage for eligible residents.

Private insurance also funds care for those individuals that are covered, frequently through employers. The AIDS Insurance Continuation Program (AICP) helps individuals pay for premiums, deductibles and co-pays, as do Titles I and II of Ryan White.

#### **b. Case Management**

The Ryan White Care Act defines case management as, " A range of client-centered services that link clients with health care, psychosocial and other services to insure timely, coordinated access to medically appropriate levels of health and support services, continuity of care, on-going assessment of the client's and other family members' needs and personal support systems, and inpatient case management services that prevent unnecessary hospitalization or that expedite discharge, as medically appropriate, from inpatient facilities."

Case management is a collaborative process that assesses plans, implements, coordinates, monitors and evaluates options and services to meet an individual's health care needs using available community resources. It is a client-centered service delivery system that works to empower individuals to make choices that enhance the quality of their lives in the least restrictive setting and in the most cost effective manner. Because of its complexity, the health care and social service delivery systems can be difficult to unravel to the client's advantage. Case management helps clients and their families make informed decisions based on the client's needs, abilities, resources and personal preferences. Case management can also personalize care in an otherwise impersonal system.

The role of the case manager is to work in partnership with the service recipient and other caregivers. Case management is necessary when the client with multiple needs is unable to define, locate or retain the resources and services necessary to ensure their continuum of care. Case management is the 'hub of the wheel" of the coordinated service delivery system. The client and the case manager work together to build relationships that add to the matrix of support services. These

relationships may include services already being used by the client as well as newly identified resources. By monitoring the quantity and status of these relationships, case management is able to maintain the integrity of a coordinated service delivery system.

Successful case management requires more than just the development and implementation of a process for coordinating services. It requires that staff, both administrative and direct care, adopt a philosophy about the process. The philosophy or mission statement could include the following:

- ▶ The needs of individual clients are unique, wide-ranging and will vary over time; therefore, the system must be flexible enough to be responsive to the client and structured enough to provide support and guidance to the case manager.
- ▶ Clients can function in the community when provided with varying degrees of support and should be encouraged to function as independently as possible.
- ▶ Clients should be encouraged to assume an active, rather than a passive, role in the case management process.
- ▶ Case management is not a time-limited service, but rather an ongoing one.

There are six phases of case management:

1. Initial Intake
2. Initial Assessment
3. Initial Plan of Care Development
4. Coordination of Services
5. Monitoring and Care Plan Revisions
6. Documentation and Reporting

In the TSA, there is a standardized acuity assessment tool which is used for agencies to determine the amount of contact a case manager needs to have with a client.

### **c. Drug Reimbursement**

Notable advances have been made in the treatment of HIV and associated opportunistic infections. Medications play a significant role in maintaining health and quality of life of HIV infected persons.

Medications, or more frequently, a combination of medications commonly referred to as Highly Active Antiretroviral Therapy (HAART) may be prescribed when an individual develops symptoms such as wasting, thrush, unexplained fever for more than two weeks, or when their CD4 count is less than 500 cells/mm. However, this is a general guideline and the decision to begin medications must be made by the client and their physician, with a full understanding of the benefits and risks involved. Pregnant women may be advised to utilize medications to help prevent the

transmission of the virus to the fetus, even if they do not currently meet the guidelines for beginning drug therapy.

Most medications have side effects that can range from mild to severe. In some cases, side effects can be managed; in other cases a different or additional medication must be prescribed. Beginning treatment in asymptomatic individuals creates the potential for developing drug resistance early on in the disease process, thereby limiting future treatment options. Many drug regimens are also inconvenient, and the long term toxicity of some drugs is not yet known.

Resistance can also occur when medications are not taken correctly, allowing the virus to reproduce and mutate. Genotypic and phenotypic tests are available to determine if someone is resistant to medications. Genotypic tests look for markers of resistance, or mutations in the HIV gene. Phenotypic testing inserts a medication directly into the virus to see how much is required to prevent the virus from growing. While these tests may be helpful in determining what medications may be helpful to an individual, both tests have to be conducted in very specific ways and must be interpreted by someone well versed in the tests. In addition, these tests are expensive, and may not be available everywhere.

Prophylaxis is the observance of a regimen for the sake of disease prevention. Drugs are taken before a disease develops with the intention of preventing the disease from occurring. By keeping small doses of drugs in the bloodstream, opportunistic germs can be killed when they enter the body. Prevention of opportunistic infections is important for improving the over-all well being of an infected individual, and ideally enhancing their life span.

Medications make up the single largest expenditure in the treatment of HIV. In the TSA, medications represented 46% of the budgeted figures for all identified funding streams in 2004. This does not include payments for co-pays under the health insurance or AICP programs.

HIV-related medications are provided through a variety of sources but are most frequently accessed through the AIDS Drug Assistance Program (ADAP) and Medicaid. Ryan White also funds medication assistance, as do private insurance, the Veteran's Administration and compassionate use programs provided by drug manufacturers. Policy changes, including the roll-out of Medicare Part D, increased co-pays and formulary restrictions/revisions makes medications a service category with the potential for dramatic change and negative financial impact for the Ryan White programs.

#### **d. Health Insurance**

Health insurance services are defined by HRSA as: "A program of financial assistance for eligible individuals with HIV disease to maintain continuity of health

insurance or to receive medical benefits under a health insurance program including risk pools.”

Private health insurance coverage assists in spreading the cost of managing HIV disease over both the public and private sectors. As clients remain healthier for longer periods of time due to the use of medications and lifestyle changes, the possibility to continue working, and thereby continue private health insurance, dramatically increases. For this reason, Health Insurance Services is considered a core service by the Care Council.

Clients may still require assistance with meeting deductibles and co-payments for services and medications. In the event that an individual becomes too ill to work, or otherwise loses employment, the Consolidated Omnibus Budget Reconciliation Act (COBRA) allows for the continuation of health insurance at the individual's expense for a period of up to 18 months and for conversion to private policies.

A primary source of health insurance coverage is the AIDS Insurance Continuation Program (AICP). AICP operates statewide by providing payment for premiums and in some cases, co-payments and deductibles to allow symptomatic HIV+ individuals to continue their health insurance under COBRA, or to maintain other private insurance. In addition the program also can provide family coverage up to the limits of monthly premiums (currently \$650.00), policy conversion after COBRA eligibility expires, and policy upgrades for expanded drug formulary coverage.

During 2001-2002, AICP began to experience a shortfall of funds. Waiting lists were instituted that were at times 6 months long. While there have been temporary improvements in funding for AICP, in 2005 wait lists have returned. New enrollments statewide are limited to approximately 10 persons per month, down from nearly 30 per month. Many of those wait-listed are not expected to be enrolled for at least 10 months and may lose coverage and need to access other payer sources including Ryan White for their care and medications.

Ryan White has been assisting with health insurance through the Direct Client Services Fund (DCSF) until March 1, 2002 when this service was directly contracted. Services are funded by Titles I and II and State General Revenue funds. Up to 140 individuals are enrolled in the program where they can receive up to \$175.00 per month for co-pay and deductible assistance. In addition, 19 individuals received premium assistance (as of October, 2005) while waiting for AICP coverage. In October 2005, an additional 196 individuals began receiving assistance with medication co-payments on a funds-available basis.

There are also county operated health plans in Hillsborough and Polk counties that serve medically indigent, low income people. The high cost of operating these plans has led to limitations of coverage, exclusion of HIV medications from formularies and tighter eligibility criteria, making their role in HIV care a diminishing one.

## **e. Mental Health Services**

Following a diagnosis of HIV or AIDS, the need for mental health services is often intensified. Feelings of anger, fear, guilt, denial, and sadness can overwhelm a newly diagnosed person. Individuals who have lived with an HIV diagnosis for a long time also have to face additional stressors in coping with the disease, and may have frequent episodes of bereavement following the loss of friends and family members. Pressure regarding who to disclose one's HIV status to, as well as the impact of HIV on establishing or maintaining close relationships can contribute to mental health conditions needing treatment.

The assessment of psychiatric conditions in HIV+ individuals can be further complicated by many factors including the direct and indirect impact of HIV on the central nervous system, the impact of medical illness as well as pre-existing psychiatric conditions, impact of medications, and the psychological distress and adjustment difficulties mentioned above.

Types of disorders include generalized anxiety disorder, phobias, post-traumatic stress disorder, panic disorder, obsessive-compulsive disorder, bi-polar disorder, and depressive disorders. While there is mixed evidence regarding the frequency of depression and other disorders among HIV+ individuals when compared against the population at large, there does seem to be a greater likelihood of minor depressive symptoms among HIV+ individuals.

Drug interactions and/or the progression of the disease may lead to the above mentioned conditions as well as other conditions including delirium, cognitive impairment and dementia, and manic syndrome. In addition, special considerations must be made when using psychotropic drugs in conjunction with protease inhibitors. Lower dosing may be necessary, and certain medications should be avoided.

Psychiatric disorders may involve physical, genetic or medical origins, or may be in response to acute or chronic life stressors. Most disorders involve more than one factor. Treatment may involve the use of medication, psychotherapy, or a combination of both.

Support groups can be particularly helpful for an HIV+ person to develop knowledge of the disease, ease tensions relating to the disease, and provide an opportunity to remain engaged in the community. These groups are generally led by a trained facilitator, but not necessarily a licensed practitioner. However, support groups may be difficult to coordinate in rural areas due to transportation and confidentiality issues.

Publicly-funded mental health services in Florida have identified target populations among adults with serious mental illnesses including adults with severe and persistent psychiatric disabilities, adults in mental health crisis, and adults with court involvement. Services for children are also provided for, but will not be discussed in depth in this document.

Three principles of the mental health system are:

- ▶ The system is person centered
- ▶ The system is community based
- ▶ The system is results oriented

All citizens in Florida have the right to certain publicly-funded mental health services regardless of their ability to pay. However, some services may be limited when funds are not available, and not all services are available in all communities. The types of services available include:

**Table 21  
Adult Mental Health Services**

<b>Type of Service</b>	<b>Description</b>
Assessment	Assess and evaluate need for care and level of care needed.
Case Management	Activities aimed at identifying needs, planning services, linking and coordinating system components, monitoring delivery of services and evaluating effectiveness of services received.
Crisis Stabilization	Residential acute care services provided 24 hours a day/7 days a week, for individuals experiencing acute crisis that would otherwise need hospitalization.
Crisis Support/Emergency	Non-residential 24 hour/7 days a week service to intervene in crisis not requiring hospitalization. Includes walk-in centers, mobile crisis response, telephone support, etc.
Day/Night	A structured array of non-residential services for four or more consecutive hours per day. Activities are designed to help develop skills of daily living.

Drop In/Self Help	A range of activities for the mentally ill to independently develop, operate and participate in social, recreational and networking activities.
In Home/On-site	Therapeutic support services which are provided in homes, nursing home, assisted living facilities, schools, foster homes and other community settings.
Intensive Case Management	Case management services typically offered to someone being discharged from an inpatient setting who are still in need of professional care in a less restrictive setting.
Outpatient Individual	Designed to improve functioning or to prevent further deterioration. Generally provided through scheduled appointments.
Professional/Respite Services	Designed to sustain family or other primary care giver by providing time-limited, temporary relief from care-giving responsibilities.
Residential Level 1	Structured non-hospital environment with 24 hour supervision. Includes short term residential treatment (average of 90 days) and group homes.
Residential Level II	Structured rehabilitation oriented environment with 24 hour supervision for individuals with significant deficits in independent living, and who need extensive supervision.
Residential Level III	24 hour supervised residential facility for persons with moderate functional capacity for independent living. Includes supervised apartments.
Residential Level IV	Least intensive level. Includes satellite group homes and apartments with less than 24 hour on-site supervision.
Sheltered Employment	Non-competitive employment within a work-based facility.

Supported Employment	Community-based employment in an integrated work setting providing regular contact with non-disabled co-workers or the public. Job coach provides ongoing support.
Supported Housing	Assists persons with psychiatric disabilities in selection of housing of their choice and provides support services to assure continued success in transition to community living.

Source: Florida Department of Children and Families

Funding for mental health services for HIV+ individuals includes sliding fee scales, Medicaid, pro-bono assistance from private providers, State of Florida, private insurance and the Ryan White Care Act. Many providers are multi-service agencies offering a comprehensive range of services, or providing linkages to other providers in the community. The tables in the resource analysis section provide a snapshot of the providers available in each county, but do not include the large number of private practitioners available.

#### **f. Oral Health**

Oral health services have the primary focus of alleviating discomfort, keeping teeth and gums healthy, preventing infection and maintaining the ability to eat nutritional foods with the goal of optimizing overall health.

HRSA defines oral health services as “Diagnostic and therapeutic services rendered by dentists, dental hygienists, and similar professional practitioners to HIV-infected individuals. Services include, but are not limited to, prophylactic treatment such as minor fillings and extractions, exams, x-rays, cleaning, gross scaling, root cleaning and polishing.

Oral signs and symptoms common in HIV infection include:

- ▶ Oral Kaposi’s Sarcoma
- ▶ Candidiasis
- ▶ Hairy leukoplakia
- ▶ Premature and advanced periodontal disease
- ▶ Herpes simplex or herpes zoster infection
- ▶ Papillomavirus (HPV) lesions
- ▶ Ulcerations

When dental treatment is indicated, decisions regarding the appropriateness of ongoing and long-term dental care of individuals with HIV should take into account the patient's general medical status.

While an asymptomatic individual usually does not require any special consideration in the provision of dental care; as the disease advances to AIDS, lab tests (CD+4, viral loads, sensitivity tests, platelet counts) may be valuable in determining an appropriate treatment plan.

Daily brushing and flossing as well as bi-annual exams are recommended for asymptomatic individuals. Certain medications may decrease salivary flow, which may increase the incidence of cavities. Oral lesions may also require more frequent visits.

Specific considerations need to be given to interaction of HIV medications and agents prescribed by the dentist. Patients in advanced stage of the disease may already be taking antibiotics to prevent opportunistic infections, so additional agents should be used with caution. Antibiotic mouth rinses prior to, and immediately after certain procedures may be appropriate in patients with poor oral hygiene. A thorough medical history as well as knowledge of potential interactions is essential for the clinician.

Scaling and irrigation prior to tooth extraction is helpful in reducing the risk of post-procedural complications. The use of anesthesia other than locals may not be appropriate for all patients.

Payment sources for oral health are Ryan White, County Health or Social Services Departments, and Medicaid. There continues to be a need for specialty dental care for those with HIV.

#### **g. Substance Abuse Services**

Injecting drug use (IDU) is the third ranked mode of transmission in the Total Service Area. While research results have been conflicting regarding the effects of alcohol or drug abuse on accelerating the progression of HIV to AIDS, it does appear that addicts who are HIV+ are generally less compliant with medical treatment as a result of their substance abuse. Substance abusers may also be less likely to be aware of their HIV status. HIV infection is often diagnosed later in the course of the disease among drug users than in other groups, frequently after the onset of AIDS. HIV+ clients who are drug users are more likely to be without a source of primary care and more likely to use emergency medical services than HIV+ clients who are not drug users.

Alcohol and drug abuse have also been associated with high-risk sexual behavior, increasing the possibility of transmitting the virus to others, as well as increasing the risk of re-infection.

Substance abuse treatment often begins with an assessment of the level of intensity required to meet an individual client's need, which may or may not include hospitalization. Clients progress to less intensive levels of care as treatment goals are met. Increasingly, insurers and managed care providers pay for mental health and substance abuse treatment on a day-by-day basis, with an emphasis on minimizing both the duration and intensity of treatment.

There are generally three levels of care: inpatient, intensive outpatient, and outpatient treatment. The continuum of care from most intense to least intense would generally follow the progression identified below:

- ▶ Detoxification Services
- ▶ Residential Treatment
- ▶ Day/Night Treatment
- ▶ Outpatient/Methadone Maintenance/Aftercare

Detoxification services are generally short-term in nature, and while usually provided in an inpatient setting, they can also be provided on an outpatient basis. Depending upon the substance used and the individual client's need, the goal of detoxification is to offer assistance dealing with the physical symptoms of withdrawal, and referring the client on to the next appropriate level of care.

Residential treatment programs are long-term treatment, generally lasting from six to 18 months. Often these programs are based on the therapeutic community model which provides intense peer support designed to produce behavioral changes in the substance abuser. Principles of treatment include the use of peer support, confrontation, and behavior shaping using a system of rewards and punishments. There are a number of other levels of residential treatment, including programs where day or night treatment is utilized and a client resides with a host family, and supported housing or half-way house which provides a supportive environment for a client completing treatment.

Intensive outpatient services include day or night treatment, which provide a schedule of services and activities for several hours each day. Services may be offered in the evening or on weekends to allow clients to continue working while participating in treatment.

Outpatient services traditionally involve a few hours of treatment per week and include individual and/or group counseling. This level of treatment is often the most appropriate for people who are employed and have a stable support network. Outpatient programs provide no living facilities and usually have little medical

supervision. However it should be noted that methadone maintenance programs are medically supervised, to assure that the client maintains an optimal dosage level to prevent withdrawal symptoms.

Outpatient/aftercare services may also include self-help programs. The general goal is to prevent relapse. Self-help are the most widely accessible programs, they are free, and generally based on the “twelve-step” model. Programs such as Alcoholics Anonymous (AA), Narcotics Anonymous (NA), and Cocaine Anonymous (CA) have a strong abstinence orientation, and a philosophy that emphasizes medication-free treatment, which can be problematic for HIV+ individuals who must take medications in order to live.

Substance abuse treatment is funded through the State, SAMHSA and Ryan White funds. The need for these services is great; however research has shown repeatedly that successful treatment depends on an individual’s readiness to enter treatment. Multiple attempts at rehabilitation must often be made, and supportive living arrangements in the community must be in place for long term success.

#### **h. Other Support Services**

In addition to the core services, support services such as transportation, housing assistance, legal assistance and food bank/nutritional supplements are also funded under Title I. These services are necessary in order to get people into care and maintain them in care.

Transportation assistance is limited to medical and social service appointments. Recent changes in transportation services discontinued monthly bus passes in favor of single-day passes making it more difficult for individuals to take care of other aspects of living such as grocery shopping and attending support groups. Mass transportation is very limited in the TSA. Pinellas and Hillsborough Counties have extensive but somewhat inefficient bus systems, which can result in several hours of travel to and from an appointment. While there is limited service between the two counties, it occurs mostly during “rush hours” which makes it difficult for people who need to cross county lines for appointments later in the day.

Transportation issues in the more rural counties are even more serious. While there are some limited bus routes in some of the counties, frequency and area of service are severely limited. Geographic distance is often a barrier to accessing care, and there has been little progress made in addressing this issue in rural areas.

The State’s Transportation Disadvantaged program coordinates travel for medical care in most counties. However, recent changes in Medicaid removed members of Medicaid HMOs from that system and provided funds directly to the HMOs to arrange for eligible travel. This creates an additional “system” that needs to be navigated by clients.

Housing is a serious issue facing all low and moderate income people in the TSA regardless of HIV status. The cost of housing has increased significantly in the Tampa Bay area, and many lower cost alternatives are being demolished and redeveloped with more expensive housing. Accessing what little affordable housing there is can become impossible for individuals with a criminal record, poor credit and substance abuse issues. There are also shortages of housing for single males and large families. Public housing programs have waiting lists in excess of three years in some areas.

There are active Homeless Coalitions in the TSA as well as several affordable housing task forces working to improve the availability of affordable housing. The EMA's HOPWA program is convening a coalition to conduct an in-depth analysis of housing needs beginning in October 2005. Findings from this effort will be used to better allocate HOPWA funds based on needs in each county.

In general the housing continuum includes the following elements:

- Emergency/Homeless Shelters
- Transitional Living
- Service Enriched Housing
- Permanent Housing
- Assisted Living
- Skilled Nursing/Hospice Care

Legal assistance is contracted with local non-profit legal service providers. Services are used to assist with permanency planning for minor children, final directives, wills, and most frequently disability applications. This service is important as individuals receiving disability payments are eligible for medical care through Medicare. Without this coverage, many would be turning to Ryan White for medical care and medications.

Food bank and nutritional supplements are provided in the EMA through Titles I and II. Proper nutrition is essential for maintaining good health. Nutritional supplements can assist individuals with wasting syndrome or other problems that make them unable to eat solid food.

## **10. Profile of Providers**

Profiles of ambulatory/outpatient care and case management providers funded by Ryan White Titles I and II have been included to provide a snapshot of how services are delivered. A map of provider locations appears in Figure 2.

#### a. Hardee County

The most rural county in the TSA also has the fewest number of HIV/AIDS cases. While there is a county health department which provides limited services, HIV-related medical care is coordinated by neighboring Polk County Health Department through Title II and as part of a Title III grant. Case managers travel to Hardee County and clients are transported to the Polk County Specialty Care Clinic in Bartow. A comprehensive range of services is available through the Polk County Health Department as described below.

Central Florida Health Care, a federal Community Health Center, also provides primary care, limited dental services and case management in Wachula, but does not receive funding from Ryan White.

Hardee County is a healthcare manpower shortage area and therefore referrals for specialists can be problematic even if a payer source is available.

#### b. Highlands County

Also a rural county, Highlands County is also served by the Polk County Title III program. The Highlands Health Department provides HIV-related primary care, treatment adherence education, lab tests, ADAP, case management, limited nutrition and dental services, and manages HOPWA funds for Hardee and Highlands counties. Clinical services are available at two locations, Sebring and Lake Placid. Mental health services are coordinated with the Marge Brewster Center and substance abuse services are coordinated with Tri-County Human Services.

Central Florida Health Care also provides services in Avon Park including primary care, case management and limited dental services. Highlands County is also a healthcare manpower shortage area and faces the same issues with regard to specialty referral as Hardee County.

#### c. Hernando County

The Hernando County Health Department provides HIV related primary care five days per month at the Brooksville site. Other services include treatment adherence education, labs, dental, nutrition and ADAP. Mental health services are coordinated through the community mental health system, and a psychiatrist is available one day per week. Substance abuse treatment is coordinated with a community treatment provider. Referrals for specialty care, particularly dermatology, gastroenterology and immunology/rheumatology are limited.

Case management services are provided by Gulf Coast Community Care's Tampa Bay AIDS Network (TBAN). The agency also provides transportation, limited food bank and food vouchers for Ryan White clients in the county.

#### d. Hillsborough County

Hillsborough County is the largest county in the TSA and has the highest number of HIV/AIDS cases. There are several providers of ambulatory outpatient care and case management in the county.

A collaborative effort between Tampa General Hospital, the University of South Florida's College of Medicine and the Hillsborough County Health Department provides a comprehensive range of services to HIV+ individuals. ARNPs and Infectious Disease specialists provide primary medical care through an outpatient clinic in Tampa. Nutritional counseling, pharmacy (including ADAP), labs, dental services and treatment adherence education are provided. In addition, clinical research trials are available for clients that expand care options for many who have exhausted other treatment protocols. The Health Department conducts rapid HIV testing, and the Specialty Care Center is one of the pilot sites for the ADAP Hepatitis C treatment program. Early morning appointments are available and translation services for most languages are available given advance notice. The Specialty Care Center works closely with the USF Department of Pediatrics to transition HIV+ adolescents into the adult system of care. The Center also refers pregnant women to USF's perinatal program. The Health Department also provides an HIV/TB co-morbidity project which provides therapy for identified HIV/TB cases in the facility or at the client's home. Cases are monitored until treatment is completed.

Metropolitan Charities provides one general HIV case manager on site as well as two specialty case managers related to the Hillsborough County Health Plan. Bay Area Legal Services holds sessions at the center twice each month. This coordination allows clients to experience "one-stop-shopping".

The Specialty Care Center coordinates with Tampa General's Emergency Room, and local homeless and domestic violence shelters which help to link HIV+ people into care. Substance abuse treatment is referred to a local treatment provider, DACCO, and a health department staff member meets with all incarcerated individuals who test positive for HIV to provide in-depth counseling and referral for appropriate medical care. Referrals for specialty care and high-risk ob/gyn services are available.

Comprehensive medical services are also provided by Tampa Care Clinic which is affiliated with the Comprehensive Research Institute of St. Joseph's Hospital in Tampa. Evening appointments are available one day per week. Services include HIV related primary care, treatment adherence education, health education, labs, dietician, and mental health social work. In addition, clinical trials are available as is acupuncture and massage (on a limited basis). Care is coordinated by ARNPs with physician oversight. Transportation is provided and coordinated for clients. Referrals to all specialties are available as needed.

Case management services are provided by Metropolitan Charities and TBAN. Metropolitan Charities offers case management services for Medicaid PAC waiver clients, and works in the county jail to assist HIV+ inmates in planning their release by linking them to care. Offices are located in Tampa and evening hours are available, as are in-home visits and occasional Saturday appointments.

TBAN is located in Tampa, and provides Ryan White and PAC Waiver case management, food pantry, and emergency financial assistance for rent and utilities. In addition, a medical education, advocacy and treatment adherence services under the Minority AIDS Initiative program is provided. Services are available after hours as needed or in the client's home.

#### e. Manatee County

Manatee County is a rural area with one major city. In many ways Manatee County is more closely related to the Sarasota area as opposed to the Tampa Bay area, and crossing county lines for medical services is not uncommon.

Manatee Rural Health Services provides an array of services through a clinic in Bradenton. A Title III program provides funding for services along with Title II. Services include HIV-related primary care, dental, case management, nutrition counseling, treatment adherence, mental health counseling, housing assistance, medications, specialty referrals, food pantry and transportation assistance. The Manatee County Health Department provides ADAP assistance. Substance abuse treatment is coordinated with community providers.

#### f. Pasco County

Pasco County is a part of the EMA, and although it is a fast-growing bedroom community for Hillsborough County, it remains largely rural, particularly in the eastern portion of the county. As in many other counties, the Pasco Health Department is the provider of HIV-related primary care, treatment adherence, ADAP and lab tests. There are two service locations, New Port Richey and Dade City. The Dade City location has limited service hours, with clinic held once per month and case management services two days per week. Limited nutrition and dental services are available and specialty care is provided through referrals. As with other rural counties, access to some specialists is problematic, but nearby urban centers can be accessed if payment source and transportation are available. Mental health and substance abuse treatment are referred to local community-based providers.

Case management services are provided by Gulf Coast Community Care's Tampa Bay AIDS Network (TBAN). The agency also provides transportation, limited food bank and food vouchers for Ryan White clients in the county.

#### g. Pinellas County

Pinellas County is the most densely populated county in the TSA and the state. With over 20 municipalities and two large cities (St. Petersburg and Clearwater) the county, as a whole, is urban.

The Pinellas Care Clinic, located in St. Petersburg is the largest provider of HIV-related medical care in the county. The clinic is affiliated with the BayCare Health System and the Comprehensive Research Institute at St. Joseph's Hospital in Tampa. Patient care is managed by ARNPs specializing in HIV, supervised by a physician. Evening appointments are available one day each week.

Services include HIV related primary care, treatment adherence education, health education, labs, dietician, and mental health social work. In addition, clinical trials are available as are referrals to specialty care. Transportation is coordinated for clients in need of the service, and admission to St. Anthony's Hospital can be accessed as needed.

Ryan White funds also support primary care and treatment adherence services at the Bay Pines VA hospital.

Case management services and emergency financial assistance are provided by Gulf Coast Community Care's Tampa Bay AIDS Network (TBAN).

AIDS Services Association of Pinellas (ASAP) provides case management, mental health counseling, client and community education and limited emergency financial assistance. There are two offices, one serving the southern portion of the county in St. Petersburg, and one in northern portion in Clearwater. An additional site for prevention and HIV testing is located at the primarily gay Suncoast Resort in St. Petersburg. Services are available after hours and early mornings.

Metropolitan Charities provides case management services, inmate discharge planning in conjunction with Pinellas County jail, and a women's personal care pantry and thrift store. Evening hours are available one day per week.

The Pinellas County Health Department provides ADAP services and an HIV/TB co-morbidity project which provides therapy for identified HIV/TB cases in the facility or at the client's home. Cases are monitored until treatment is completed. The Health Department also coordinates HIV medical care within the Pinellas County jail.

The Minority AIDS Initiative (MAI) program which focuses on substance abuse outreach counseling and medical educators is provided by Operation Hope. Operation Hope also provides a food pantry.

Substance abuse treatment referrals are made to WestCare Foundation in St. Petersburg.

#### h. Polk County

The Polk County Health Department provides an array of service to residents of Hardee, Highlands and Polk counties. While rural, there are several small cities in Polk County, and Polk County has the third highest number of HIV cases in the TSA. Both Title II and Title III provide funding for HIV services.

The Specialty Care Clinic is located in Bartow. Services are available five days a week. Early morning appointments are available and evening appointments will be available in the near future. Services include case management, HIV-related primary care, treatment adherence, labs, ADAP, nutrition counseling, mental health counseling and support groups. Transportation is provided, though funding is limited for this service. Substance abuse treatment is coordinated with local provider (Tri-County Human Services).

**Figure 2: Map of Ryan White Funded Service Providers**

## 11. Resource Analysis

Resource analysis is conducted as part of the needs assessment process. A specific set of services were identified for inclusion, which considered HRSA and Florida SCSN core services as well as several support services including transportation, housing and food.

Hernando, Hillsborough and Pinellas counties have extensive information and referral systems known as “211”. 211 can be accessed by phone (by dialing 2-1-1) or on-line. Websites also offer information in Spanish. As the listings are quite extensive and updated more regularly than would be feasible for any other form of directory, this resource is highly valuable to clients and services providers wishing to link clients with services.

To gain information not provided by internet resource site, contact were made with provider agencies by telephone, fax and e-mail communication. In addition, input from County Health Department staff particularly in rural areas.

Tables 22-29 include a summary of key providers by county and where available, information on accessibility, wait lists and other languages spoken. It is important to note the just because information is not included does not mean that the service provider doesn't offer it, but may mean that they did not respond to the inquiry. Wait list and capacity information was extremely difficult to gather, as there may be cyclical variations in availability, and service access may be dependent on funding or cumulative utilization which fluctuates.

The rural counties in general do not offer public transportation. Large land areas and low population densities make travel to service providers problematic for some clients. The urban counties do have bus systems but depending on where a client needs to travel it can take several hours to reach a destination.

All counties had at least some service providers that provided services in Spanish. All providers can access the statewide TDD assistance for the speaking and hearing impaired. Creole is available to a limited extent in area with concentrations of Haitian populations. Most areas had some services (primary care, case management, counseling, support groups, substance abuse treatment, emergency shelters and food banks) that were provided outside of traditional hours.

**Table 22: Service Providers- Hardee County**

<b>Service Category</b>	<b>On Bus line</b>	<b>Languages (other than English)</b>	<b>Waiting list</b>	<b>Non-traditional Hours</b>
<b>Ambulatory/Outpatient</b>				
Polk County Health Department 1255 Brice Boulevard Bartow, FL 33830 (863) 519-8237	Yes	Spanish Creole	No	Flexible per client's need
U.S. Veterans Administration James A. Haley VA Medical Center 13000 Bruce B. Downs Blvd. Tampa, FL 33612 (813) 972-2000 <a href="http://www1.va.gov/visn8/tampa">http://www1.va.gov/visn8/tampa</a>			No	24/7
<b>Case Management</b>				
Polk County Health Department 1255 Brice Boulevard Bartow, FL 33830 (863) 519-8237	Yes	Spanish Creole	No	Flexible per client's need
<b>Mental Health</b>				
Good Shepard Hospice Grace Health Care 105 Arneson Ave. Auburndale, FL 33823 (863) 802-0313 <a href="http://www.goodshepherdhospice.org">http://www.goodshepherdhospice.org</a>			No	No
<b>Substance Abuse Treatment</b>				
Tri- County Human Services Florida Addiction and Dual Disorders 100 College Park Drive W. Avon Park, FL 33825 (941) 452-3858 <a href="http://www.tchsonline.com">http://www.tchsonline.com</a>				
<b>Substance Abuse Prevention</b>				
Bridges of America- Hardee Correctional Institute				
Tri-County Human Services-Wauchula Outpatient Clinic				
<b>Drug Reimbursement</b>				
Hardee County Health Department 115 KD Revell Rd. Wauchula, FL 33873 (863) 773-4161		Spanish	No	No
Hardee Health Center P.O. Box 422 131 N. 8 <sup>th</sup> Avenue Wauchula, FL 33873 (863) 773-0034		Spanish	No	No
Hillsborough County Health Department (Mail order HIV+) 1105 E. Kennedy Blvd. Tampa, FL 33602		Spanish		

<b>Service Category</b>	<b>On Bus line</b>	<b>Languages (other than English)</b>	<b>Waiting list</b>	<b>Non-traditional Hours</b>
(813) 307-8000 <a href="http://www.hillscountyhealth.org">http://www.hillscountyhealth.org</a>				
Lincourt Pharmacy, Inc (Controlled substance mail order) 501 S. Lincoln Avenue Clearwater, FL 33756 (727) 446-0302				
Polk County Health Department 1255 Brice Boulevard Bartow, FL 33830 (863) 519-8237	Yes	Spanish Creole	No	Flexible per client's needs
<b>Oral Health</b>				
Polk County Health Department	Yes	Spanish Creole	No	8am- 5pm M-F
<b>Health Insurance/Co-pay Assistance</b>				
The Health Councils, Inc 9455 Koger Boulevard, Suite 104 St. Petersburg, FL 33702 (727) 217-7070 <a href="http://www.healthcouncils.org">http://www.healthcouncils.org</a>	N/A			No
<b>HIV Prevention/Early Intervention</b>				
Hardee County Health Department (Advocacy, Testing, Outreach, Prevention)		Spanish	No	No
<b>Housing Assistance/ Referral/ Provision</b>				
Hardee Health Center (Housing/Rent assistance)		Spanish	No	No
Polk County Health Department (Housing/Rent assistance) Polk County Health Department- HOPWA (Housing Provision)	Yes	Spanish Creole	No	No
<b>Legal Services/ Permanency Planning</b>				
Heart of Florida Legal Aid Society (Legal Services)				
Department of Children and Families (Permanency Planning for Children)			No	No
<b>Transportation</b>				
No contracted provider				
<b>Food Bank/ Home delivered meals/Nutritional Supplements</b>				
Hardee Health Center (Food Bank)		Spanish	No	No
Food with Care (Home delivered meals)			No	No
Health Councils, Inc (Nutritional supplements)	N/A			No
<b>Psycho-social Support Services</b>				
Alcohol Abuse 24 Hour Action Line (Support Groups Alcohol/Drugs)	N/A		N/A	24/7
Alcoholics Anonymous 24 Hour Helpline	N/A		N/A	24/7

**Table 23: Service Providers- Hernando County**

<b>Service Category</b>	<b>On Bus line</b>	<b>Languages (other than English)</b>	<b>Waiting list</b>	<b>Non-traditional Hours</b>
<b>Ambulatory/Outpatient</b>				
Hernando County Health Department 300 South Main Street Brooksville, FL 34601 (352) 754-4067 <a href="http://www.health.co.hernando.fl.us">http://www.health.co.hernando.fl.us</a>	No			No
James A. Haley VA Medical Center (Veteran's Only) 13000 Bruce B. Downs Blvd. Tampa, FL 33612 (813) 972-2000 <a href="http://www1.va.gov/visn8/tampa">http://www1.va.gov/visn8/tampa</a>	No		No	24/7
<b>Case Management</b>				
Gulf Coast Community Care Tampa Bay AIDS Network Program (TBAN) 5744 Missouri Avenue New Port Richey, FL 34652 (727) 816-1235 <a href="http://www.gcjfs.org/svc-aidsnetwork.htm">http://www.gcjfs.org/svc-aidsnetwork.htm</a>	No	Spanish	No	By Appointment
Hernando County Health Department 300 South Main Street Brooksville, FL 34601 (352) 754-4067 <a href="http://www.health.co.hernando.fl.us">http://www.health.co.hernando.fl.us</a>	No			No
<b>Mental Health</b>				
The Harbor Behavioral Health Care Inst.- Brooksville P.O. Box 428 New Port Richey, FL 34656 (352) 796-9496 <a href="http://www.theharbor-bhci.org">http://www.theharbor-bhci.org</a>				
The Harbor Behavioral Health Care Inst.-Spring Hill 7074 Grove Road Spring Hill, FL 34609 (352) 540-9335 <a href="http://www.theharbor-bhci.org">http://www.theharbor-bhci.org</a>				
The Harbor Behavioral Health Care Inst.- TASC Hernando County 7537 Forest Oaks Blvd. Spring Hill, FL 34606 (813) 841-4430 <a href="http://www.theharbor-bhci.org">http://www.theharbor-bhci.org</a>				

<b>Service Category</b>	<b>On Bus line</b>	<b>Languages (other than English)</b>	<b>Waiting list</b>	<b>Non-traditional Hours</b>
<b>Substance Abuse Treatment</b>				
<b>Substance Abuse Prevention</b>				
Creative Change-Spring Hill				
Act II Counseling- Hernando Site				
Eckerd Youth Alternatives- Camp E-How Kee & Mary Giella Elementary School				
Life Management Services, Inc - Brooksville				
The Harbor Behavioral Health Care Inst.- Brooksville				
The Harbor Behavioral Health Care Inst.-Spring Hill				
The Harbor Behavioral Health Care Inst.- TASC Hernando County				
<b>Drug Reimbursement</b>				
Hillsborough County Health Department (Medications HIV+ Mail order) 1105 E. Kennedy Blvd. Tampa, FL 33602 (813) 307-8000 <a href="http://www.hillscountyhealth.org">http://www.hillscountyhealth.org</a>				
Lincourt Pharmacy, Inc (Medications- Controlled substance mail order) 501 S. Lincoln Avenue Clearwater, FL 33756 (727) 446-0302				
The Salvation Army 15464 Cortez Blvd. Brooksville, FL 34613 (352) 544-1288	No	Spanish	No	No
<b>Oral Health</b>				
Hernando County Health Department	No			
<b>Health Insurance/Co-pay Assistance</b>				
The Health Councils, Inc 9455 Koger Blvd, Suite 104 St. Petersburg, FL 33702 (727) 217-7070 <a href="http://www.healthcouncils.org">http://www.healthcouncils.org</a>	N/A			No
<b>HIV Prevention/Early Intervention</b>				
Hernando County Health Department (Advocacy, Testing, Information, Outreach)	No			No
<b>Housing Assistance/ Referral/ Provision</b>				
Catholic Charities ( Housing/Rent Assistance)				No

<b>Service Category</b>	<b>On Bus line</b>	<b>Languages (other than English)</b>	<b>Waiting list</b>	<b>Non-traditional Hours</b>
Public Housing Authority (HUD) (Housing Provision)			Yes	
<b>Legal Services/ Permanency Planning</b>				
Withlacoochee Area Legal Services (Legal Services)				No
Department of Children and Families			No	No
<b>Transportation</b>				
Gulf Coast Community Care				
<b>Food Bank/ Home delivered meals/Nutritional Supplements</b>				
Cavalry Church of the Nazarene (Food Bank)		Spanish	No	T-F 10 am
Church of God Prophecy Food Pantry (Food Bank)			No	No
Daystar Life Center (Food Bank)			No	No
Dayspring Presbyterian Church (Food Bank)			No	M, F 11 am- 1 pm
First Baptist Church of Brooksville (Food Bank)	No		No	No
Gulf Coast Community Care Tampa Bay AIDS Network Program (Food Bank)	No	Spanish	No	
Mid Florida Community Services (Food Bank)			No	No
New Jerusalem Church of God (Food Bank)			No	
SHARE (Self Help & Resource Exchange) Food Bank	No		No	No
Spring Hill Seventh-Day Adventist Church (Food Bank)	No		No	No
The Salvation Army (Food Bank)	No	Spanish	No	No
Food with Care, Inc (Home Delivered Meals)			No	No
The Health Councils, Inc (Nutritional Supplements)			No	No
<b>Psycho-social Support Services</b>				
Alcohol Abuse 24 Hour Action Line (Support Groups Alcohol/Drugs)	N/A		N/A	24/7
Alcoholics Anonymous 24 Hour Helpline	N/A		N/A	24/7

**Table 24: Service Providers- Highlands County**

<b>Service Category</b>	<b>On Bus line</b>	<b>Languages (other than English)</b>	<b>Waiting list</b>	<b>Non-traditional Hours</b>
<b>Ambulatory/Outpatient</b>				
Highlands County Health Department 7205 S. George Blvd	No	Spanish	No	Yes

<b>Service Category</b>	<b>On Bus line</b>	<b>Languages (other than English)</b>	<b>Waiting list</b>	<b>Non-traditional Hours</b>
Sebring, FL 33872 (863) 386-6040				
<b>Case Management</b>				
Highlands County Health Department 7205 S. George Blvd Sebring, FL 33872 (863) 386-6040	No	Spanish	No	No
<b>Mental Health</b>				
<a href="#">Florida Health Partners, Inc.</a>				
Tri County Human Services- SPMI Mental Health Project 1815 Crystal Lake Drive Lakeland, FL 33871 (863) 709-9392 <a href="http://www.tchsonline.com">http://www.tchsonline.com</a>	Yes		No	24 hour helpline
Volunteers of America of Florida- Lakeshore Assisted Living Program P.O. Box 1235 Sebring, FL 33871 (863) 282-1525 <a href="http://www.voa-fla.org">http://www.voa-fla.org</a>				
<b>Substance Abuse Treatment</b>				
Tri County Human Services – Five Bed Project, Florida Addiction and Dual Disorders, Sebring Outpatient 100 College Park Drive W. Avon Park, FL 33825 (863) 709-9392 <a href="http://www.tchsonline.com">http://www.tchsonline.com</a>				
Florida Center for Addictions and Dual Disorders 100 West College Drive Avon Park, FL (863) 452-3858 <a href="http://www.tchsonline.com">www.tchsonline.com</a>				
<b>Substance Abuse Prevention</b>				
Bridges of America- Avon Park Correctional				
South Florida Community College- Avon Park				
Tri County Human Services- Alpha Intervention/Prevention				
Tri County Human Services- Woodlawn Elementary School				
<b>Drug Reimbursement</b>				
Highlands County Health Department- ADAP 7205 S. George Blvd Sebring, FL 33875 (863) 386-6040	No	Spanish	No	No
Hillsborough County Health Dept.			No	

<b>Service Category</b>	<b>On Bus line</b>	<b>Languages (other than English)</b>	<b>Waiting list</b>	<b>Non-traditional Hours</b>
(Mail order) 1105 E. Kennedy Blvd. Tampa, FL 33602 (813) 307-8000 <a href="http://www.hillscountyhealth.org">http://www.hillscountyhealth.org</a>				
Lincourt Pharmacy, Inc (Controlled substance mail order) 501 S. Lincoln Avenue, Suite 10 Clearwater, FL 33756 (727) 446-0302			No	
<b>Oral Health</b>				
No contracted providers				
<b>Health Insurance/Co-pay Assistance</b>				
The Health Councils, Inc 9455 Koger Blvd, Suite 104 St. Petersburg, FL 33702 (727) 217-7070 <a href="http://www.healthcouncils.org">http://www.healthcouncils.org</a>	N/A			No
<b>HIV Prevention/Early Intervention</b>				
Mid Florida Center for Substance Abuse Svc. Inc (Advocacy, Outreach, Information, Education)				
Highlands County Health Department (Education, Testing, Outreach)	No	Spanish	No	No
<b>Housing Assistance/ Referral/ Provision</b>				
Highlands County Health Department (Housing/rent assistance, Housing provision)	No	Spanish	No	No
Public Housing Authority (Housing Provision)			Yes	No
<b>Legal Services/ Permanency Planning</b>				
Heart of Florida Legal Aid Society (Legal services)				
Department of Children and Families (Permanency planning for children)			No	No
<b>Transportation</b>				
No contracted providers				
<b>Food Bank/ Home delivered meals/Nutritional Supplements</b>				
Bethel Pentecostal Holiness Church (Food Bank)				Last Sunday of the month
Christ Fellowship Church (Food Bank)				
Food with Care, Inc. (Home delivered meals)			No	No
Health Councils, Inc (Nutritional Supplements)			No	No
<b>Psycho-social Support Services</b>				
Alcohol Abuse 24 Hour Action Line (Support Groups Alcohol/Drugs)	N/A		N/A	24/7
Alcoholics Anonymous 24 Hour	N/A		N/A	24/7

Service Category	On Bus line	Languages (other than English)	Waiting list	Non-traditional Hours
Helpline				

**Table 25: Service Providers- Hillsborough County**

Service Category	On Bus line	Languages (other than English)	Waiting list	Non-traditional Hours
<b>Ambulatory/Outpatient</b>				
FL Health Sciences Center, f/k/a HCHA 1105 E. Kennedy Blvd. Tampa, FL 33675 (813) 307-8064	Yes	Spanish	No	M-F 7am – 5pm
Hillsborough County Health Department 1105 E. Kennedy Blvd. Tampa, FL 33602 (813) 307-8000 <a href="http://www.hillscountyhealth.org">http://www.hillscountyhealth.org</a>	Yes	Spanish Others	No	No
Tampa Care Clinic- St. Joseph's Hospital, Inc 4200 N. Armenia Avenue, Suite 3 Tampa, FL 33607 (813) 870-4760	Yes	Spanish	No	
U.S. Veterans Administration (Veterans only) James A. Haley VA Medical Center 13000 Bruce B. Downs Blvd. Tampa, FL 33612 (813) 972-2000 <a href="http://www1.va.gov/visn8/tampa">http://www1.va.gov/visn8/tampa</a>	Yes		No	24/7
USF Department of Pediatrics (Infants through adolescents) 17 Davis Boulevard, 2 <sup>nd</sup> Floor, Ste 200 Tampa, FL 33606 (813) 259-8705 <a href="http://usfpeds.hsc.usf.edu">http://usfpeds.hsc.usf.edu</a>	Yes	Spanish Creole	No	Yes
<b>Case Management</b>				
Gulf Coast Community Care Tampa Bay AIDS Network Program (TBAN) 7402 N. 56 <sup>th</sup> Street, Suite 101 Bldg 100 Tampa, FL 33617 (813) 769.5180 <a href="http://www.gcjfs.org/svc-aidsnetwork.htm">http://www.gcjfs.org/svc-aidsnetwork.htm</a>	Yes	Spanish	No	By Appointment
Metropolitan Charities, Inc 6421 N. Florida Avenue Tampa, FL 33604 (813) 232-3808 <a href="http://www.metrocharities.org">http://www.metrocharities.org</a>	Yes		No	No
<b>Mental Health</b>				

<b>Service Category</b>	<b>On Bus line</b>	<b>Languages (other than English)</b>	<b>Waiting list</b>	<b>Non-traditional Hours</b>
Bay Area Psychiatric (813) 870-4460	Yes			
Center for Women 305 S. Hyde Park Ave. Tampa, FL 33606 (813) 251-8437	Yes			
Counseling Center of Tampa Bay, Inc. 4534B West Village Drive Tampa, FL 33624 (813) 964-5792 <a href="http://www.cctbinc.com">http://www.cctbinc.com</a>				After 5pm and Saturday
Mental Health Care, Inc 5707 N. 22 <sup>nd</sup> Street Tampa, FL 33610 (813) 272-2244 <a href="http://www.mhcinc.org">http://www.mhcinc.org</a>	Yes			Yes
Northside Mental Health Hospital 12512 Bruce B. Downs Blvd. Tampa, FL 33612 (813) 977-8700 <a href="http://www.northsidemh.org">http://www.northsidemh.org</a>				
Metropolitan Charities, Inc. 6421 N. Florida Avenue Tampa, FL 33604 (813) 232-3808 <a href="http://www.metrocharities.org">http://www.metrocharities.org</a>				
Gulf Coast Jewish Family Services 13542 North Florida Avenue, Ste 111 Tampa, FL 33613 (727) 538-7460 <a href="http://www.gcjfs.org">http://www.gcjfs.org</a>				24/7
Crisis Center of Hillsborough County One Crisis Center Plaza Tampa, FL 33613-1238 (813) 964-1964 <a href="http://www.crisiscenter.com">http://www.crisiscenter.com</a>				
Foster America (Children and Adolescents in Foster Care) 4600 West Cypress Street, # 107 Tampa, FL 33607 (941) 592-9099				
Tampa Bay Alliance for the Mentally Ill 11405 Orilla Del Rio Temple Terrace, FL 33617 (813) 974-1934				
THAP (813) 218-9021	Yes			
<b>Substance Abuse Treatment</b>				
ACTS- Agency for Community Treatment Services 4612 N. 56 <sup>th</sup> Street	Yes			No

<b>Service Category</b>	<b>On Bus line</b>	<b>Languages (other than English)</b>	<b>Waiting list</b>	<b>Non-traditional Hours</b>
Tampa, FL 33610 (813) 246-4899(adults) (813) 354-0664 (children) <a href="http://www.actsfl.org">http://www.actsfl.org</a>				
Tampa Crossroads, Inc 5120 N. Nebraska Avenue Tampa, FL 33603 (813) 238-8557 <a href="http://tampacrossroadsinc.com">http://tampacrossroadsinc.com</a>				
Counseling Center of Tampa Bay, Inc. 4534B West Village Drive Tampa, FL 33624 (813) 964-5742 <a href="http://www.cctbinc.com">http://www.cctbinc.com</a>				Flexible Schedule
DACCO 4422 E. Columbus Drive Tampa, FL 33605 (813) 623-3500 <a href="http://www.dacco.org">http://www.dacco.org</a>	Yes			
Goodwill Industries- Outpatient Drug Treatment 4102 W. Hillsborough Avenue Tampa, FL 33614 (813) 877-3234 <a href="http://goodwill-suncoast.org">http://goodwill-suncoast.org</a>	Yes			Yes
Phoenix House 5620 E. Fowler, Suite 8 Temple Terrace, FL 33617 (813) 989-9170 <a href="http://www.phoenixhouse.org/Florida">http://www.phoenixhouse.org/Florida</a>	Yes			24/7
The Salvation Army- Adult Rehabilitation Center 13815 N. Salvation Army Lane Tampa, FL 33613 (813) 972-0471 <a href="http://www.salvationarmytampa.com">http://www.salvationarmytampa.com</a>				8 am – 12 pm M-F intake
Francis House 4703 N. Florida Avenue Tampa, FL 33603 (813) 237-3066 <a href="http://www.franchishouse.org">http://www.franchishouse.org</a>	Yes			Yes
Hyde Park Counseling Center 207 Verne Street Tampa, FL 33606 (813) 258-4605 <a href="http://www.hydeparkcenter.com">http://www.hydeparkcenter.com</a>				
<b>Substance Abuse Prevention</b>				
The Family Center of Temple Terrace				
C.E. Mendez Foundation, Inc.		Spanish		
Cambridge Foundation				
Families First				

<b>Service Category</b>	<b>On Bus line</b>	<b>Languages (other than English)</b>	<b>Waiting list</b>	<b>Non-traditional Hours</b>
<b>Drug Reimbursement</b>				
All Children's Specialty Care of Tampa (HIV+ Pediatrics) 12220 Bruce B. Downs Blvd. Tampa, FL 33612 813-631-5000 <a href="http://www.allkids.org">http://www.allkids.org</a>	Yes	Spanish	Yes	M-F 7am-6pm
Lincourt Pharmacy, Inc. (Controlled substance mail order) 501 S. Lincoln Avenue, Ste 10 Clearwater, FL 33756 (727) 446-0302	N/A			
St. Joseph's Hospital, Inc. Pinellas Care and Tampa Care Clinic 4200 N. Armenia Avenue, Suite 3 Tampa, FL 33607 (813) 870-4760	Yes	Spanish	No	No
Hillsborough County Health Department 1105 E. Kennedy Blvd. Tampa, FL 33602 (813) 307-8000 <a href="http://www.hillscountyhealth.org">http://www.hillscountyhealth.org</a>	Yes	Spanish Other	No	No
<b>Oral Health</b>				
Dental Research Clinic	Yes			No
Hillsborough County Health Department (HIV+)	Yes			No
Lee Davis Neighborhood Service Center	Yes			No
Ruskin Neighborhood Service Center	Yes			No
<b>Health Insurance/Co-pay Assistance</b>				
Health Councils, Inc 9455 Koger Blvd, Suite 104 St. Petersburg, FL 33702 (727) 217-7070 <a href="http://www.healthcouncils.org">http://www.healthcouncils.org</a>	N/A		No	No
<b>HIV Prevention/Early Intervention</b>				
American Red Cross- Hillsborough County (Education, Referrals)				
DACCO (Education, Testing, Referrals)	Yes			
Hillsborough County Health Department (Education, Testing, Referrals, Outreach)	Yes	Spanish Other	No	No
Hillsborough County School District (Advocacy, Community Mobilization, Education, Referrals, Outreach, Prevention for Positives)		Spanish		No
Metropolitan Charities, Inc (Advocacy, Community Mobilization, Testing, Referrals, Outreach)	Yes			
Planned Parenthood- Tampa	Yes			

<b>Service Category</b>	<b>On Bus line</b>	<b>Languages (other than English)</b>	<b>Waiting list</b>	<b>Non-traditional Hours</b>
(Advocacy, Community Mobilization, Education, Testing, Referrals, Outreach)				
Positive Education, Inc (Advocacy, Community Mobilization, Outreach, Referrals, Education)				
Tampa Hillsborough Action Plan (THAP) (Education, Testing, Referrals, Outreach)	Yes			No
The AIDS Institute (Advocacy, Community Mobilization)	Yes			
Tampa Bay AIDS Network (TBAN) (Advocacy, Community Mobilization, Education, Testing, Referrals, Outreach)	Yes	Spanish		No
USF Student Health Services REACH Peer Education (Education, Testing, Referrals, Outreach)				
<b>Housing Assistance/ Referral/ Provision</b>				
Agency for Community Treatment Services (ACTS)	Yes	Spanish	Yes	No
Catholic Charities- Diocese of St. Petersburg (Housing/ Rent assistance)	Yes			No
Catholic Charities- Mercy House (Housing Provision)	Yes			Yes
Ruskin Neighborhood Service Center (Housing/ Rent assistance)	Yes			No
Tampa Crossroads, Inc. (Housing/ Rent assistance and Housing Provision)	Yes			No
Tampa Hillsborough Action Plan (THAP) (Housing/ Rent assistance and Housing Provision)	Yes			No
The Salvation Army (Housing/Rent assistance)	Yes		No	No
Safe Place- A Homeless Shelter (Housing Provision)	Yes			24/7
Public Housing Authority	Yes		Yes	No
<b>Legal Services/ Permanency Planning</b>				
Bay Area Legal Services				
Camelot- Hillsborough Kids, Inc (Permanency Planning for children)			No	No
<b>Transportation</b>				
Hillsborough Specialized Transport				
<b>Food Bank/ Home delivered meals/Nutritional Supplements</b>				
America's Second Harvest (Food Bank)				No
Beth-El Mission (Migrants/ farm workers) Food Bank				No
Bread of Life (Food Bank)	No			9am -12pm

<b>Service Category</b>	<b>On Bus line</b>	<b>Languages (other than English)</b>	<b>Waiting list</b>	<b>Non-traditional Hours</b>
				Saturdays
Community Food Bank	Yes		No	No
Day Star Life Center ( Food Bank)				No
Emergency Care Help Organization (ECHO) Food Bank				No
Gulf Coast Community Care Tampa Bay AIDS Network Program (TBAN) Food Bank	Yes	Spanish	No	
Lighthouse Gospel Mission, Inc & Faith Home (Food Bank)				24/7
Metropolitan Ministries (Food Bank)	Yes		No	7 days a week
Nativity Catholic Church-Brandon Food Bank				3:15pm -4pm Thursday
Nativity Catholic Church- Dover Food Bank			No	8am- 12 pm M-F
Plant City Neighborhood Service Center (Food Bank)			No	No
St. Anne Catholic Church (Food Bank)				9am -12pm Wed. only
St. Vincent De Paul Society- Dover (Food Bank)				1pm-4 pm M-F
St. Vincent De Paul Thrift Store- North Tampa (Food Bank)	Yes			Call
St. Vincent De Paul Thrift Store- Ruskin (Food Bank)	Yes			Saturdays
Tampa Bay Cream Center (Food Bank)			No	12:45pm Sunday
The Salvation Army (Food Bank)	Yes		No	No
United Food Bank and Services of Plant City			No	No
Food with Care, Inc (Home delivered meals)	N/A		No	
Meals on Wheels- East Hillsborough County (Home delivered meals)	N/A			9am -12pm M-F
Meals on Wheels of Plant City, Inc (Home delivered meals)				8am- 1pm M-F
Meals on Wheels- Riverview (Home delivered meals)	N/A			8:30am – 1pm M-F
Meals on Wheels- Tampa, Inc. (Home delivered meals)	Yes			No
Health Councils, Inc (Nutritional Supplements)	N/A		No	No
<b>Psycho-social Support Services</b>				
Florida Center for Addiction and Dual Disorders (Counseling/Therapy/Support Groups)				24/7
Gulf Coast Community Care Tampa Bay AIDS Network Program (TBAN) (Counseling/Therapy/Support Groups)	Yes	Spanish	No	

<b>Service Category</b>	<b>On Bus line</b>	<b>Languages (other than English)</b>	<b>Waiting list</b>	<b>Non-traditional Hours</b>
Safe Place, A Homeless Shelter	Yes			
Al-Anon/ Ala-teen ( Alcohol Support Group)			No	24/7
Alcoholics Anonymous (Alcohol Support Group)				11am-7pm Tues-Thurs. 9am-1pm Sat.
Family Service Association of Greater Tampa Bay (Support Group)	Yes			Yes
Francis House, Inc. (Support Groups)	Yes			Yes
People With AIDS Coalition (PWAC) (Support Groups)	Yes			
Phoenix House (Support Groups)	Yes			Yes
Project Dove (Domestic Violence Support Groups)	Yes			No
Spring of Tampa Bay (Domestic Violence Support Groups)	Yes			No

**Table 26: Service Providers- Manatee County**

<b>Service Category</b>	<b>On Bus line</b>	<b>Languages (other than English)</b>	<b>Waiting list</b>	<b>Non-traditional Hours</b>
<b>Ambulatory/Outpatient</b>				
Manatee County Rural Health Michael C. Bach Health Center 2703 19 <sup>th</sup> Street Court E. Bradenton, FL 34208 (941) 708-8500 <a href="http://www.mcrhs.org">http://www.mcrhs.org</a>	Yes	Spanish Creole	No	8am-8pm Thurs. 8am-1pm Fri.
U.S. Veterans Administration- Bay Pines (Veterans) 10000 Bay Pines Boulevard Bay Pines, FL 33744 (727) 398-6661 <a href="http://www1.va.gov/visn8/baypines">http://www1.va.gov/visn8/baypines</a>	No- Located in Pinellas County		No	24/7
<b>Case Management</b>				
Manatee County Rural Health Michael C. Bach Health Center 2703 19 <sup>th</sup> Street Court E. Bradenton, FL 34208 (941) 708-8500 <a href="http://www.mcrhs.org">http://www.mcrhs.org</a>	Yes	Spanish Creole	No	8am-8pm Thurs. 8am-1pm Fri.
<b>Mental Health</b>				
Manatee County Rural Health (Counseling/Therapy) Michael C. Bach Health Center 2703 19 <sup>th</sup> Street Court E. Bradenton, FL 34208 (941) 708-8500 <a href="http://www.mcrhs.org">http://www.mcrhs.org</a>	Yes	Spanish Creole	No	8am-8pm Thurs. 8am-1pm Fri

<b>Service Category</b>	<b>On Bus line</b>	<b>Languages (other than English)</b>	<b>Waiting list</b>	<b>Non-traditional Hours</b>
Volunteers of America of Florida Manatee Living Center 4018 20 <sup>th</sup> St. West Bradenton, FL 34207 (941) 751-4168 <a href="http://www.voa-fla.org">http://www.voa-fla.org</a>				
<b>Substance Abuse Treatment</b>				
Manatee Glens Access Center 2020 26 <sup>th</sup> Avenue E. Bradenton, FL 34208 (941) 782-4617 <a href="http://www.manateeglens.com">http://www.manateeglens.com</a>	Yes	Spanish French Korean ASL		24/7
Operation PAR – Bradenton Drug Treatment Community 2104 63rd Avenue East Bradenton, FL 34203 (941) 753-0877 <a href="http://www.operationpar.org">http://www.operationpar.org</a>				
<b>Substance Abuse Prevention</b>				
Anna Maria Island Community Center				
Tallevast Community Center				
<b>Drug Reimbursement</b>				
Hillsborough County Health Department (Mail Order Medications) 1105 E. Kennedy Blvd. Tampa, FL 33602 (813) 307-8000 <a href="http://www.hillscountyhealth.org">http://www.hillscountyhealth.org</a>				
Lincourt Pharmacy, Inc. (Controlled substance mail-order medications) 501 S. Lincoln Avenue, Ste 10 Clearwater, FL 33756 (727) 446-0302				
Manatee County Rural Health Michael C. Bach Health Center 2703 19 <sup>th</sup> Street Court E. Bradenton, FL 34208 (941) 708-8500 <a href="http://www.mcrhs.org/">http://www.mcrhs.org/</a>	Yes	Spanish Creole		
<b>Oral Health</b>				
Manatee County Rural Health	Yes	Spanish Creole	No	8am-8pm Thurs. 8am-1pm Fri.
<b>Health Insurance/Co-pay Assistance</b>				
Health Councils, Inc 9455 Koger Blvd, Suite 104 St. Petersburg, FL 33702 (727) 217-7070 <a href="http://www.healthcouncils.org">http://www.healthcouncils.org</a>	N/A			No
<b>HIV Prevention/Early Intervention</b>				

<b>Service Category</b>	<b>On Bus line</b>	<b>Languages (other than English)</b>	<b>Waiting list</b>	<b>Non-traditional Hours</b>
Manatee County Health Department (Advocacy, Community Mobilization, Education, Referrals, Outreach)				
Manatee County Rural Health (Testing, Outreach)	Yes	Spanish Creole	No	8am-8pm Thurs. 8am-1pm Fri.
Manatee Glens Corporation (Advocacy, Education, Testing, Referrals, Outreach, Case Management, Prevention for Positives)	Yes	Spanish French Korean ASL		24/7
<b>Housing Assistance/ Referral/ Provision</b>				
Public Housing Authority (HUD) (Housing Provision)			Yes	
<b>Legal Services/ Permanency Planning</b>				
Gulfcoast Legal Services				
Legal Aid				
Partnership for Safe Families (Permanency Planning for Children)			No	No
<b>Transportation</b>				
No contracted providers				
<b>Food Bank/ Home delivered meals/Nutritional Supplements</b>				
Trinity Charities (Food Bank)				
Manatee County Rural Health (Food Bank)	Yes	Spanish Creole	No	8am-8pm Thurs. 8am-1pm Fri.
The Salvation Army (Food Bank)	Yes	Spanish	No	No
Food with Care (Home delivered meals)			No	
Health Councils, Inc (Nutritional supplements)			No	No
<b>Psycho-social Support Services</b>				
Alcohol Abuse 24 Hour Action Line (Support Groups Alcohol/Drugs)	N/A		N/A	24/7
Alcoholics Anonymous 24 Hour Helpline	N/A		N/A	24/7
Manatee County Rural Health (Counseling/Therapy/Support Groups)	Yes	Spanish Creole	No	8am-8pm Thurs. 8am-1pm Fri

**Table 27: Service Providers- Pasco County**

<b>Service Category</b>	<b>On Bus line</b>	<b>Languages (other than English)</b>	<b>Waiting list</b>	<b>Non-traditional Hours</b>
<b>Ambulatory/Outpatient</b>				
Pasco County Health Department 10841 Little Road			No	

<b>Service Category</b>	<b>On Bus line</b>	<b>Languages (other than English)</b>	<b>Waiting list</b>	<b>Non-traditional Hours</b>
New Port Richey, FL 34654 (727) 869-3900 <a href="http://www.doh.state.fl.us/chdpasco/default.html">http://www.doh.state.fl.us/chdpasco/default.html</a>				
U.S. Department of Veterans Affairs- Bay Pines (Veterans) 10000 Bay Pines Boulevard Bay Pines, FL 33744 (727) 398-6661 <a href="http://www1.va.gov/visn8/baypines">http://www1.va.gov/visn8/baypines</a>	Yes			24/7
U.S. Department of Veterans Affairs- James A. Haley (Veterans) 13000 Bruce B. Downs Blvd. Tampa, FL 33612 (813) 972-2000 <a href="http://www1.va.gov/visn8/tampa">http://www1.va.gov/visn8/tampa</a>	Yes		No	24/7
USF Department of Pediatrics (Infants through Adolescents) 17 Davis Boulevard, 2 <sup>nd</sup> Floor Tampa, FL 33606 (813) 259-8705 <a href="http://usfpeds.hsc.usf.edu">http://usfpeds.hsc.usf.edu</a>	Yes			
<b>Case Management</b>				
Gulf Coast Community Care Tampa Bay AIDS Network (TBAN) 5744 Missouri Avenue New Port Richey, FL 34652 (727) 816-1235 <a href="http://www.gcjfs.org/svc-aidsnetwork.htm">http://www.gcjfs.org/svc-aidsnetwork.htm</a>	No	Spanish	No	By Appt.
<b>Mental Health</b>				
Gulf Coast Jewish Family Services, Inc 5621 Main Street New Port Richey, FL 34652 (727) 538-7460 <a href="http://www.gcjfs.org">http://www.gcjfs.org</a>				
The Harbor Behavioral Health (Counseling/Therapy) 7809 Massachusetts Avenue New Port Richey, FL 34653 (727) 841-4200 <a href="http://www.theharbor-bhci.org">http://www.theharbor-bhci.org</a>	Yes	Spanish	No	
<b>Substance Abuse Treatment</b>				
Alpha Counseling Services, Inc 6741 Land O'Lakes Blvd. Land O'Lakes, FL 34139 (813) 996-0205				
Gulf Coast Community Care Tampa Bay AIDS Network (TBAN) 5744 Missouri Avenue New Port Richey, FL 34652 (727) 816-1235 <a href="http://www.gcjfs.org/svc-aidsnetwork.htm">http://www.gcjfs.org/svc-aidsnetwork.htm</a>	No	Spanish	No	By Appt.

<b>Service Category</b>	<b>On Bus line</b>	<b>Languages (other than English)</b>	<b>Waiting list</b>	<b>Non-traditional Hours</b>
Harbor Behavioral Health Community Recovery Center 6040 Indiana Ave. New Port Richey, FL 34654 (727) 841-4200 <a href="http://www.theharbor-bhci.org">http://www.theharbor-bhci.org</a>				
Operation PAR –Pasco County Narc Addiction Treatment Center 6446 Ridge Road Port Richey, FL 34668 (727) 816-1200 <a href="http://www.operationpar.org">http://www.operationpar.org</a>				
Pathfinder Counseling 37816 SR 54 West Zephyrhills, FL 33542 (813) 417-4359				
Shell of Hope, Inc- Hudson 13805 Old Dixie Highway Hudson, FL 34667 (727) 847-9909				
<b>Substance Abuse Prevention</b>				
Big Brothers/ Big Sisters of Tampa Bay- Land O'Lakes				
Youth and Family Alternatives, Inc- Dade City, New Port Richey, Spring Hill, Land O'Lakes				
<b>Drug Reimbursement</b>				
Hillsborough County Health Department (Mail Order Medications) 1105 E. Kennedy Blvd. Tampa, FL 33602 (813) 307-8000 <a href="http://www.hillscountyhealth.org">http://www.hillscountyhealth.org</a>				
Lincourt Pharmacy, Inc. (Controlled substance mail-order medications) 501 S. Lincoln Avenue, Ste 10 Clearwater, FL 33756 (727) 446-0302				
<b>Oral Health</b>				
Good Samaritan Health Clinic		Spanish	No (By Appt)	Wed. Afternoons
Pasco County Health Department	Yes	Spanish	No	No
<b>Health Insurance/Co-pay Assistance</b>				
Health Councils, Inc 9455 Koger Blvd, Suite 104 St. Petersburg, FL 33702 (727) 217-7070 <a href="http://www.healthcouncils.org">http://www.healthcouncils.org</a>	N/A			No
<b>HIV Prevention/Early Intervention</b>				
Pasco County Health Department (Advocacy, Community Mobilization, Education, Testing, Referrals, Outreach)	Yes	Spanish	No	No

<b>Service Category</b>	<b>On Bus line</b>	<b>Languages (other than English)</b>	<b>Waiting list</b>	<b>Non-traditional Hours</b>
<b>Housing Assistance/ Referral/ Provision</b>				
Mid County Community Services (Housing/Rent assistance)			No	No
Public Housing Authority- HUD (Housing Provision)			Yes	
<b>Legal Services/ Permanency Planning</b>				
Family Continuity Programs, Inc (Permanency Planning for children)			No	No
<b>Transportation</b>				
Gulf Coast Community Care				
<b>Food Bank/ Home delivered meals/Nutritional Supplements</b>				
Gulf Coast Community Care Tampa Bay AIDS Network (TBAN) Food Bank	No	Spanish	No	
Mid Florida Community Services (Food Bank)			No	No
The Salvation Army (Food Bank)			No	No
Food with Care, Inc. (Home delivered meals)			No	No
Health Councils, Inc. (Nutritional supplements)			No	No
<b>Psycho-social Support Services</b>				
Alcohol Abuse 24 Hour Action Line (Support Groups Alcohol/Drugs)	N/A		N/A	24/7
Alcoholics Anonymous 24 Hour Helpline	N/A		N/A	24/7

**Table 28: Service Providers– Pinellas County**

<b>Service Category</b>	<b>On Bus line</b>	<b>Languages (other than English)</b>	<b>Waiting list</b>	<b>Non-traditional Hours</b>
<b>Ambulatory/Outpatient</b>				
Pinellas Care Clinic, St. Josephs Hospital, Inc. (18 or older) 3554 1 <sup>st</sup> Avenue N. St. Petersburg, FL 33713 (727) 321-4846 <a href="http://www.stanthony.com/1133.cfm">http://www.stanthony.com/1133.cfm</a>	Yes	Spanish	No	No
Pinellas County Health Department 205 M.L. King St. N. St. Petersburg, FL 33701 (727) 824-6900 <a href="http://www.pinellashealth.com">http://www.pinellashealth.com</a>	Yes	Spanish Various Asian	No	No
U.S. Department of Veterans Affairs- Bay Pines (Veterans) 10000 Bay Pines Boulevard Bay Pines, FL 33744 (727) 398-6661 <a href="http://www.visn8.med.va.gov/baypines">http://www.visn8.med.va.gov/baypines</a>	Yes			24/7
USF Department of Pediatrics All Children's Hospital (Infants through Adolescents) 801 6 <sup>th</sup> Street S, St. Petersburg, FL 33701	Yes	Spanish Creole		Yes

<b>Service Category</b>	<b>On Bus line</b>	<b>Languages (other than English)</b>	<b>Waiting list</b>	<b>Non-traditional Hours</b>
(727) 892-4150 <a href="http://www.allkids.org">http://www.allkids.org</a>				
<b>Case Management</b>				
AIDS Community Project (ASAP) 1214 Cleveland Street Clearwater, FL 33755 (727) 449-2437	Yes	Spanish	No	No
AIDS Community Project (ASAP) 300 31 <sup>st</sup> Street North, Suite 400 East St. Petersburg, FL 33701 (727) 323-3277				
Di's Imani, Inc (PAC Medicaid Waiver) 3462 5 <sup>th</sup> Avenue N. St. Petersburg, FL 33713 (727) 321-0600	Yes		No	No
EMPACT Resource Service Center, Inc (ASAP) 136 4 <sup>th</sup> Street N., Suite 305 St. Petersburg, FL 33701 (727) 896-8424	Yes	Spanish	No	No
Gulf Coast Community Care Tampa Bay AIDS Network (TBAN) 407 S. Arcturas Avenue Clearwater, FL 33765 (727) 298-1634 <a href="http://www.gcjfs.org/svc-aidsnetwork.htm">http://www.gcjfs.org/svc-aidsnetwork.htm</a>	Yes	Spanish	No	By Appt.
Metropolitan Charities, Inc. 3170 3 <sup>rd</sup> Avenue N. St. Petersburg, FL 33713 (727) 321-3854 <a href="http://www.metrocharities.org">http://www.metrocharities.org</a>				
Operation Hope 861 6 <sup>th</sup> Avenue S. St. Petersburg, FL 33701 (727) 822-2437	Yes		No	No
<b>Mental Health</b>				
AIDS Community Project (ASAP) 1214 Cleveland Street Clearwater, FL 33755 (727) 449-2437	Yes	Spanish		
AIDS Community Project 300 31 <sup>st</sup> Street North, Suite 400 East St. Petersburg, FL 33701 (727) 323-3277				
Boley Centers 445 31 <sup>st</sup> Street North St. Petersburg, FL 33713 (727) 821-4819	Yes			
Camelot Community Care, Inc.	Yes			

<b>Service Category</b>	<b>On Bus line</b>	<b>Languages (other than English)</b>	<b>Waiting list</b>	<b>Non-traditional Hours</b>
4910-D Creekside Drive Clearwater, FL 33760 (727) 593-0003				
Directions for Mental Health, Inc. (Counseling/Therapy) 1437 S. Belcher Road Clearwater, FL 33764 (727) 524-4464	Yes			8am-8pm M-Thurs.
Edward James Reid Counseling Services 2730 Central Avenue St. Petersburg, FL 33712 (727) 327-3767	Yes			
Gift of Life Community Services 4425 Park Blvd. Pinellas Park, FL 33781 (727) 547-0607				
Metropolitan Charities, Inc (Counseling/Therapy) 3150 5 <sup>th</sup> Avenue N. St. Petersburg, FL 33713 (727) 321-3854 <a href="http://www.metrocharities.org">http://www.metrocharities.org</a>	Yes	Spanish		
PEMHS Access Center (Counseling/Therapy) 11254 58 <sup>th</sup> Street N. Pinellas Park, FL 33728 (727) 541-4628				24/7
Pinellas Care Clinic, St. Joseph's Hospital, Inc. (Counseling/Therapy for 18 and older) 3554 1 <sup>st</sup> Avenue N. St. Petersburg, FL 33713 (727) 321-4846	Yes	Spanish	No	No
Suncoast Center for Community Mental Health (Counseling/ Therapy) 4024 Central Avenue St. Petersburg, FL 33711 (727) 327-7656 <a href="http://www.suncoastcenter.com">http://www.suncoastcenter.com</a>	Yes			No
<b>Substance Abuse Treatment</b>				
BayCare Life Management 1128 Central Avenue St. Petersburg, FL 33705 (727) 823-7522	Yes			
Bay Pines Alcoholism Residential Program (Veterans) 10000 Bay Pines Boulevard Bay Pines, FL 33744 (727) 398-6661 <a href="http://www1.va.gov/visn8/baypines">http://www1.va.gov/visn8/baypines</a>	Yes			
Gulf Coast Community Care Tampa Bay AIDS Network (TBAN) 407 S. Acturas Avenue	No	Spanish	No	By Appt.

<b>Service Category</b>	<b>On Bus line</b>	<b>Languages (other than English)</b>	<b>Waiting list</b>	<b>Non-traditional Hours</b>
Clearwater, FL 33765 (727) 298-1634 <a href="http://www.gcjfs.org/svc-aidsnetwork.htm">http://www.gcjfs.org/svc-aidsnetwork.htm</a>				
Metropolitan Charities, Inc. 3150 5 <sup>th</sup> Avenue N. St. Petersburg, FL 33713 (727) 321-3854 <a href="http://www.metrocharities.org">http://www.metrocharities.org</a>				
Operation HOPE 861 6 <sup>th</sup> Avenue S. St. Petersburg, FL 33701 (727) 822-2437	Yes		No	No
Operation PAR 13800 66 <sup>th</sup> Street N. Largo, FL 33771 (727) 538-7244  Operation PAR 6150 150 <sup>th</sup> Avenue N. Clearwater, FL 33760 (727) 538-7280 <a href="http://www.operationpar.org">http://www.operationpar.org</a>	Yes			
Suncoast Center for Community Mental Health 4024 Central Avenue St. Petersburg, FL 33711 (727) 327-7656 <a href="http://www.suncoastcenter.com">http://www.suncoastcenter.com</a>	Yes			No
Turning Point Intervention Center (727) 823-7811				
WestCare Foundation, Inc 1735 ML King Jr. St. S. St. Petersburg, FL 33705 (727) 502-0188	Yes		No	No
<b>Substance Abuse Prevention</b>				
Coalition to Prevent Substance Abuse and Suicide- Clearwater				
Eckerd Youth Alternatives, Inc				
Operation PAR- Community Education				
<b>Drug Reimbursement</b>				
Hillsborough County Health Department (Mail Order Medications) 1105 E. Kennedy Blvd. Tampa, FL 33602 (813) 307-8000 <a href="http://www.hillscountyhealth.org">http://www.hillscountyhealth.org</a>				
Lincourt Pharmacy, Inc. (Controlled substance mail-order medications) 501 S. Lincoln Avenue, Ste 10 Clearwater, FL 33756 (727) 446-0302				

<b>Service Category</b>	<b>On Bus line</b>	<b>Languages (other than English)</b>	<b>Waiting list</b>	<b>Non-traditional Hours</b>
PCHS General and Medical Assistance- Clearwater 2189 Cleveland St., Suites 230 & 266 Clearwater, FL 33765 (727) 464-8400 <a href="http://www.pinellascounty.org/SocialServices">http://www.pinellascounty.org/SocialServices</a>	Yes		No	No
PCHS General and Medical Assistance- Pinellas Park 6350 76th Avenue N. Pinellas Park, FL 33781 (727) 547-7736/(727) 547-7814 <a href="http://www.pinellascounty.org/SocialServices">http://www.pinellascounty.org/SocialServices</a>	Yes		No	8am-4:30 pm M-F
PCHS General and Medical Assistance- St. Petersburg 647 1st Avenue N. St. Petersburg, FL 33701 (727) 582-7781 <a href="http://www.pinellascounty.org/SocialServices">http://www.pinellascounty.org/SocialServices</a>	Yes		No	No
PCHS General and Medical Assistance- South St. Petersburg 2335 22nd Ave. S. St. Petersburg, FL 33712 (727) 893-5007 <a href="http://www.pinellascounty.org/SocialServices">http://www.pinellascounty.org/SocialServices</a>	Yes		No	7:30am-4:30pm M-F
PCHS General and Medical Assistance- Tarpon Springs 301 Disston Ave. South Tarpon Springs, FL 34689 (727) 943-4743 <a href="http://www.pinellascounty.org/SocialServices">http://www.pinellascounty.org/SocialServices</a>	No		No	Tues. and Fri. Only
Pinellas County Health Department 205 M.L. King St. N. St. Petersburg, FL 33701 (727) 824-6900 <a href="http://www.pinellashealth.com">http://www.pinellashealth.com</a>	Yes		No	No
St. Petersburg Free Clinic 863 3 <sup>rd</sup> Avenue N. St. Petersburg, FL 33701 (727) 823-3471 <a href="http://www.stpetersburgfreeclinic.org">http://www.stpetersburgfreeclinic.org</a>	Yes		No	No
St. Vincent De Paul 1015 Cleveland Street Clearwater, FL 33755 (727) 461-9598	Yes		No	9:30am-2:30 pm M-F
The Salvation Army- Clearwater 1521 Druid Rd. E. Clearwater, FL 33756 (727) 446-4177	Yes		No	No
<b>Oral Health</b>				
PCHS General and Medical Assistance- Clearwater	Yes		No	No

<b>Service Category</b>	<b>On Bus line</b>	<b>Languages (other than English)</b>	<b>Waiting list</b>	<b>Non-traditional Hours</b>
PCHS General and Medical Assistance- Pinellas Park	Yes		No	8am-4:30 pm M-F
PCHS General and Medical Assistance- St. Petersburg	Yes		No	No
PCHS General and Medical Assistance- South St. Petersburg	Yes		No	7:30am-4:30pm M-F
PCHS General and Medical Assistance- Tarpon Spring (Extraction only for pain relief)	No		No	Tues. and Fri. Only
Pinellas Opportunity Council (once per year)	Yes		No	8:30am-5pm M,W,F
St. Petersburg Free Clinic	Yes		No	No
St. Vincent De Paul	Yes		No	Call
<b>Health Insurance/Co-pay Assistance</b>				
Health Councils, Inc 9455 Koger Blvd, Suite 104 St. Petersburg, FL 33702 (727) 217-7070 <a href="http://www.healthcouncils.org">http://www.healthcouncils.org</a>	N/A			No
<b>HIV Prevention/Early Intervention</b>				
AIDS Service Association of Pinellas (ASAP)- (Advocacy, Community Mobilization, Education, Testing, Referrals, Outreach, Prevention Case Management, Small Group Support, Prevention for Positives)	Yes	Spanish		
AIDS Community Project- ACP (ASAP) (Advocacy, Community Mobilization, Education, Testing, Referrals, Outreach, Prevention Case Management, Small Group Support, Prevention for Positives)	Yes	Spanish		
Coalition for a Safe and Drug Free Pinellas- St. Petersburg (ASAP) (Advocacy, Community Mobilization, Education, Referrals, Outreach, Small Group Support)	Yes	Spanish		
Di's Imani, Inc- St. Petersburg (Advocacy, Referrals, Prevention for Positives)	Yes			Sat.
For AIDS Care Today (FACT/ASAP)- St. Petersburg (Advocacy, Community Mobilization, Education, Small Group Support)	Yes	Spanish		
Pinellas County Health Department (Education, Testing, Referrals, Outreach, Prevention for Positives)	Yes	Spanish Various Asian	No	No
Pinellas County School District (Education, Testing, Referrals)				No
Pinellas County Sheriff's Office (Jail Linkage Program) (Education, Testing)				
<b>Housing Assistance/ Referral/ Provision</b>				
Community Service Foundation (Housing/Rent assistance)	Yes	Spanish	No	No
PCHS General and Medical Assistance-	Yes		No	No

<b>Service Category</b>	<b>On Bus line</b>	<b>Languages (other than English)</b>	<b>Waiting list</b>	<b>Non-traditional Hours</b>
Clearwater (Housing/Rent assistance)				
PCHS General and Medical Assistance- Pinellas Park (Housing/Rent assistance)	Yes		No	8am-4:30 pm M-F
PCHS General and Medical Assistance- St. Petersburg (Housing/Rent assistance)	Yes		No	No
PCHS General and Medical Assistance- South St. Petersburg (Housing/Rent assistance)	Yes		No	7:30am-4:30pm M-F
PCHS General and Medical Assistance- Tarpon Spring (Housing/Rent assistance)	No		No	Tues. and Fri. Only
Suncoast Center for Community Mental Health (HOST)- Homeless Outreach (Housing/Rent assistance)	Yes			No
Agape House- Salvation Army (Housing Provision)	Yes			No
Boley Center- Affordable Housing Project (Housing Provision)	Yes			No
Christopher Center (Housing Provision)	Yes	Spanish		No
Gulf Coast Community Care Housing (Housing Provision)	Yes	Spanish		No
Public Housing Authority-HUD (Housing Provision)	Yes			Yes
<b>Legal Services/ Permanency Planning</b>				
Community Law Program HIV/AIDS Victims (Legal Services)	Yes		No	No
Gulfcoast Legal Services, Inc				
Family Continuity Services (Permanency Planning for children)	Yes		No	No
<b>Transportation</b>				
Metropolitan Planning Organization (GPTMS)				
<b>Food Bank/ Home delivered meals/Nutritional Supplements</b>				
Abundant Life Ministries (Food Bank)	Yes		No	10am-11am Thursday
C.H.I.P (Food Bank)	Yes			No
FEAST, Inc. (Food Bank)	Yes		No	9am-12pm Tues-Fri.
Good Samaritan Food Pantry (Food Bank)	Yes	ASL	No	Call
Gulfcoast Community Care Tampa Bay AIDS Network (TBAN) Food Bank	Yes	Spanish	No	
"He Cares" Ministry (Food Bank)	Yes		No	10am-12pm W, F
Operation Hope (Food Bank)	Yes		No	No
RCS Food Pantry (Food Bank)	Yes	Spanish		Last Sat. 9am-12pm
St. Petersburg Free Clinic (Food Bank)	Yes		No	No
Tampa Bay Harvest (Food Bank)	Yes			Till 10pm daily
The Salvation Army (Food Bank)	Yes		No	No
Food with Care (Home delivered meals)		Spanish		No

<b>Service Category</b>	<b>On Bus line</b>	<b>Languages (other than English)</b>	<b>Waiting list</b>	<b>Non-traditional Hours</b>
Health Councils, Inc (Nutritional Supplements)			No	No
<b>Psycho-Social Support Services</b>				
Pinellas Care Clinic, St. Joseph's Hospital, Inc. (Counseling/Therapy/Support Groups for 18 and older)	Yes	Spanish	No	No
Suncoast Center for Community Health (Counseling/ Therapy/Support Groups)	Yes			No
12 Step Meeting and Referral Center (Support Groups)				Yes
Alcoholics Anonymous Central Hotline Office of Pinellas County (Support Groups)	Yes			Yes
ASAP- AIDS Service Association of Pinellas (Support Groups)	Yes	Spanish	No	Call
BCW AIDS- PAL Fellowship (Support Groups HIV+ Heterosexual)	No		No	Wed 7pm
Di's Imani, Inc. (Support Groups Ages 4-13)	Yes			Sat
E.J. Reid Counseling Services, Inc. (Support Groups for HIV+ Women)	Yes	Spanish	No	Yes
FACT-For AIDS Care Today (Support Groups)	Yes		No	6:30-8pm Tuesdays
Good Samaritan Church (Social Dinner/Support Groups)	Yes			3 <sup>rd</sup> Wed.
King of Peace Metropolitan Community Church (Support Groups for HIV+ Women)	Yes		No	No
Operation Hope (Support Groups for minority males and substance abuse)	Yes		No	6pm- 7pm Tuesdays
WestCare Foundation, Inc (Support Groups)			No	

**Table 29: Service Providers- Polk County**

<b>Service Category</b>	<b>On Bus line</b>	<b>Languages (other than English)</b>	<b>Waiting list</b>	<b>Non-traditional Hours</b>
<b>Ambulatory/Outpatient</b>				
Good Samaritan Free Clinic 814 N. Kentucky Avenue Lakeland, FL 33801 (863) 687-8475	Yes	Spanish	No	3pm-7pm Thursday
Polk County Health Department 1255 Brice Boulevard Bartow, FL 33830 (863) 519-8237	Yes	Spanish Creole	No	Flexible per client's need
U.S. Veterans Administration- James A. Haley Hospital (Veterans) 13000 Bruce B. Downs Blvd. Tampa, FL 33612 (813) 972-2000 <a href="http://www1.va.gov/visn8/tampa">http://www1.va.gov/visn8/tampa</a>	Yes		No	24/7
<b>Case Management</b>				
Polk County Health Department	Yes	Spanish	No	Flexible per

<b>Service Category</b>	<b>On Bus line</b>	<b>Languages (other than English)</b>	<b>Waiting list</b>	<b>Non-traditional Hours</b>
1255 Brice Boulevard Bartow, FL 33830 (863) 519-8237		Creole		client's need
<b>Mental Health</b>				
<a href="#">Florida Health Partners, Inc (Counseling/Therapy)</a>	Yes		No	No
Peace River Center for Personal Development (Counseling/Therapy) 1239 E. Main St. Bartow, FL 33830 (863) 534-7020 <a href="http://www.peace-river.com">http://www.peace-river.com</a>	Yes			
<b>Substance Abuse Treatment</b>				
<a href="#">TALBOT House</a>	Yes	Spanish	No	
<b>Substance Abuse Prevention</b>				
Pride Partnership of Polk County-Winter Haven				
Human Services Associates, Inc				
<b>Drug Reimbursement</b>				
Hillsborough County Health Department (Mail Order Medications) 1105 E. Kennedy Blvd. Tampa, FL 33602 (813) 307-8000 <a href="http://www.hillscountyhealth.org">http://www.hillscountyhealth.org</a>				
Lincourt Pharmacy, Inc. (Controlled substance mail-order medications) 501 S. Lincoln Avenue, Ste 10 Clearwater, FL 33756 (727) 446-0302				
Polk County Health Department 1255 Brice Boulevard Bartow, FL 33830 (863) 519-8237	Yes	Spanish Creole	No	Flexible per client's need
<b>Oral Health</b>				
Polk County Health Department	Yes	Spanish Creole	No	Flexible per client's need
Good Samaritan Free Clinic	Yes	Spanish	No	No
<b>Health Insurance/Co-pay Assistance</b>				
Health Councils, Inc 9455 Koger Blvd, Suite 104 St. Petersburg, FL 33702 (727) 217-7070 <a href="http://www.healthcouncils.org">http://www.healthcouncils.org</a>	N/A			No
<b>HIV Prevention/Early Intervention</b>				
Friends Together, Inc – Lakeland (Advocacy, Community Mobilization, Education, Referrals, Testing, Outreach, Small Group Support, Prevention for Positives)				

<b>Service Category</b>	<b>On Bus line</b>	<b>Languages (other than English)</b>	<b>Waiting list</b>	<b>Non-traditional Hours</b>
Luster All Pastoral Care & Cultural Center, Inc. - Bartow (Advocacy, Testing)				
Polk County Health Department (Education, Referrals, Outreach, Testing, Small Group Support)	Yes	Spanish Creole	No	No
Parents and Friends of Lesbians and Gays (PFLAG) - Lakeland (Advocacy, Referrals)				
<b>Housing Assistance/ Referral/ Provision</b>				
Polk County Health Department (Housing/Rent Assistance and Housing Provision)	Yes	Spanish Creole	No	No
Public Housing Authority- HUD (Housing Provision)	Yes		Yes	No
<b>Legal Services/ Permanency Planning</b>				
Florida Rural Legal Services				
Heart of Florida Legal Aid Society				
Department of Children and Families (Permanency Planning for children)				
<b>Transportation</b>				
No contracted providers				
<b>Food Bank/ Home delivered meals/Nutritional Supplements</b>				
The Salvation Army (Food Bank)			No	No
Food with Care (Home delivered meals)			No	No
Health Councils, Inc. (Nutritional Supplements)			No	No
<b>Psycho-social Support Services</b>				
Alcohol Abuse 24 Hour Action Line (Support Groups Alcohol/Drugs)	N/A		N/A	24/7
Alcoholics Anonymous 24 Hour Helpline	N/A		N/A	24/7
Crossroads Community Church (Support Groups)			No	Yes

## 12. HIV/AIDS Services Funding

The funding stream analysis is an important component of the planning process. In order to more accurately allocate Ryan White Care Act funds, it is important to have a snapshot of all of the services funded for persons living with HIV.

Services that have multiple funding sources and significant resources committed may be less likely to require Ryan White dollars. Likewise services which have little or no resources may be more likely to need support. However, all decisions relating to allocations must be viewed in the context of overall identified need as well as available resources. For example, medications are funded from a variety of sources, including Ryan White, yet there continues to be a need for medication funding.

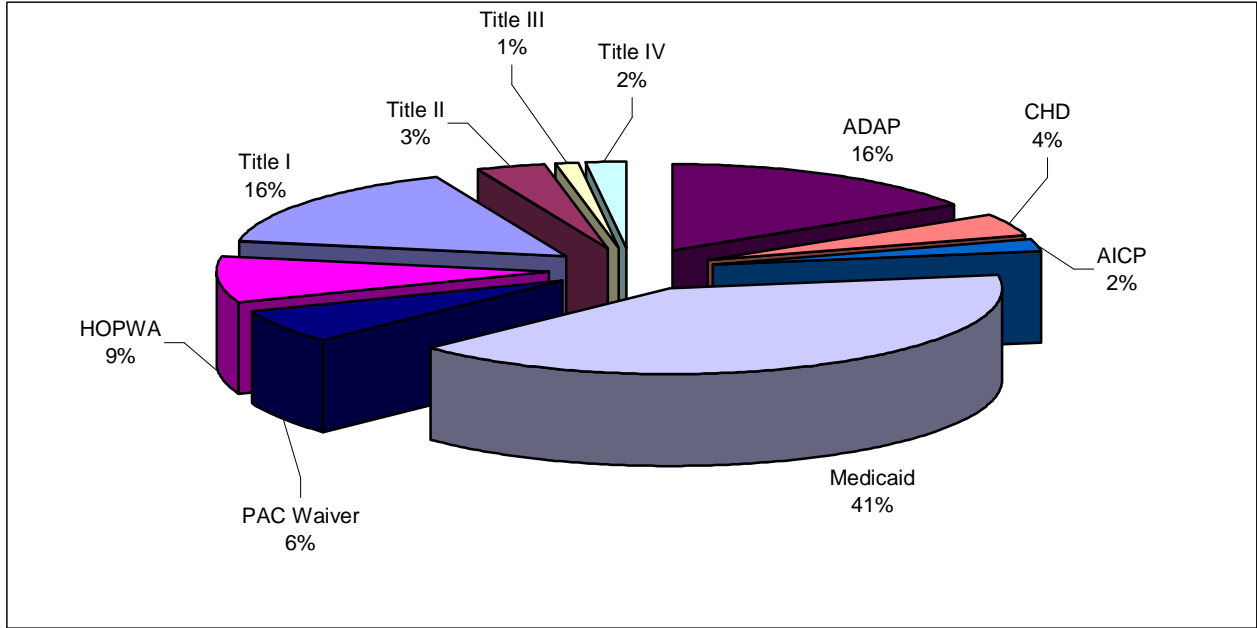
Funding sources included in this analysis are from federal, state, and local government. The streams have been analyzed by the Total Service Area (TSA). Caution must be used when interpreting the data due to a variety of factors including:

- Different fiscal years
- Inability to obtain type of service funding breakouts
- Inaccuracies and/or inconsistencies in the data reported.

It is best to keep in mind that the data presented represents the best available information at a given point in time. In some cases figures may represent actual expenditures (Medicaid and PAC Waiver for example), however, the assumption has been made that all figures are budgeted amounts. Title I and Title II allocations represent contracted amounts.

Figure 3 indicates the funding in the Total Service Area came primarily from Medicaid at 38% of the funds received. The Ryan White Title I represented 15% of funds received, and the AIDS Drug Assistance Program (ADAP) provided 15% of the funding, in the area. Housing Opportunities for People with AIDS (HOPWA) totaled 8%, and Project AIDS Care (PAC Waiver), contributed 6% of the total. Hillsborough County maintenance of effort requirement totaled five percent. General Revenue accounted for 4% and Title II of the Ryan White Care Act, represented three percent of funds. Title IV of the Care Act and the AIDS Insurance Continuation Program (AICP) each represented two percent and Title III and Manatee County government represented one percent each. It should be noted that ADAP and the AIDS Insurance Continuation Program (AICP) are funded through Title II and state General Revenue funds.

**FIGURE 3**  
**TSA Funding Sources 2003/04**



Source: 2004 Funding Stream Analysis

## **SECTION 2: WHERE DO WE WANT TO GO?**

In order to determine where we want to go a statement of guiding principles was adopted by the Care Council to guide the planning process. Currently a review of the principles or value statements is underway. Members of Care Council Committees have been asked to review the statements, discuss their interpretation of the statements and suggest possible revisions and additions. Since this process is underway at the time of this writing, the information included in this section will be revised following completion of this activity.

### **CARE COUNCIL MISSION STATEMENT**

We are a planning body that assesses needs, plans, allocates resources, and evaluates HIV/AIDS services to improve the lives of those infected and affected.

### **CARE COUNCIL GUIDING PRINCIPLES**

- ▶ The Care Council shall support the access to a full continuum of care and support services for all HIV infected individuals throughout the service area.
- ▶ The Care Council shall ensure that care provided under Ryan White contracts is of high quality, provided with regard to protecting confidentiality and dignity of the consumers.
- ▶ The Care Council shall promote adherence to treatment plans.
- ▶ The Care Council shall respond to the changing environment of the AIDS epidemic, including responses to the needs of special populations and underserved communities.
- ▶ The Care Council shall assure compliance of legislatively mandated functions.
- ▶ The Care Council shall support consumer access to culturally and linguistically appropriate treatment and support services.
- ▶ The Care Council shall promote coordination with community resources not funded by Ryan White, including prevention and early intervention services.

Trends and issues are reviewed to assist in determining where we need to go. A summary of the trends and emerging issues for each component in the continuum and specific populations is provided in Table 30.

**Table 30: Trends and Emerging Issues by Service Category and Population**

<b>Service Category</b>	<b>Trends and Emerging Issues</b>
Ambulatory/Outpatient Care	<ul style="list-style-type: none"> <li data-bbox="375 193 667 1493">➤ Despite treatment advances, many challenges persist. The total cost to care for the HIV infected has not changed substantially. However, while the majority of the cost had previously been in the hospital setting, the costs are now being realized as outpatient care (including diagnostic testing) and medications. With improvements in the standard of care, clients are living longer. Coupled with a steady increase of new infections each year, there is an exponentially higher total cost for outpatient care. In addition, revisions to the Care Act requiring greater emphasis on seeking out infected persons not already in care are expected to further strain available resources.</li> <li data-bbox="667 193 813 1493">➤ Caring for long term survivors and the long term adverse effects of treatment has implications in both funding and care provision. Resources will be stretched even thinner with the treatment of hepatitis C and other co-infections, aseptic necrosis and lipodystrophy.</li> <li data-bbox="813 193 919 1493">➤ Programs that link testing to medical care and get people diagnosed and treated earlier in their disease are needed. The emergency departments are a prime target for this initiative.</li> <li data-bbox="919 193 1024 1493">➤ Changes are occurring in eligibility criteria, services offered and reimbursement levels of various payer sources (including Medicaid) which may further stretch Ryan White programs.</li> <li data-bbox="1024 193 1065 1493">➤ There is a lack of providers with HIV experience and some specialties in rural areas.</li> <li data-bbox="1065 193 1138 1493">➤ HRSA policy allowing VA recipients to obtain care from Ryan White prior to accessing VA could further strain the Ryan White system.</li> </ul>

<p>Care Act Reauthorization</p>	<ul style="list-style-type: none"> <li>➤ Emphasis on outreach to HIV infected persons not currently in care without additional</li> <li>➤ Possible focus on HRSA designated “core services” could create larger service gaps in support services.</li> <li>➤ Active participation in the reauthorization process by consumers of services is needed.</li> <li>➤ Expanding the role of the AETC to include mental health and substance abuse professionals would assist the community-based care system in better serving HIV+ clients.</li> </ul>
<p>Case Management</p>	<ul style="list-style-type: none"> <li>➤ With the changing disease there needs to be a review of the role of case management and the use of an acuity level model.</li> <li>➤ Salary levels continue to be low which impact retention of staff.</li> <li>➤ Turnover for staff and difficulty in recruiting for position vacancies hinders the agencies’ ability to provide care; new staff that is being trained can not perform optimally and other staff must shoulder an added caseload. Turnover also impacts client retention in care, and may disrupt continuity of care for those remaining in care.</li> <li>➤ Support for case managers in the form of training and technical assistance on emerging trends within the HIV infected population is critical and funding must be identified for this purpose.</li> <li>➤ Developing a career ladder or certification process for case managers needs to be explored to improve retention and also insure that qualified staff work in the programs.</li> <li>➤ Case managers are seeing clients with more complex needs such as hepatitis co-infections.</li> <li>➤ Differing eligibility determination processes and requirements create additional administrative overhead and reduce the time that case managers can devote to clients.</li> </ul>

<p>Drug Reimbursement</p>	<ul style="list-style-type: none"> <li>➤ ADAP funding increases and the addition of new, expensive drugs to treat HIV and co-infections have not kept pace with the number of new clients eligible for the program. If this trend continues, it is possible that non-enrolled clients will develop more opportunistic infections, and experience a decrease in quality and length of life if other funding sources to support medications are not available.</li> <li>➤ Other funding sources for medications are not expected to increase in significant amounts to offset shortfalls in funding for medications.</li> <li>➤ New methods to encourage adherence to treatment regimens must be developed and implemented, to maximize the benefits of medication therapy.</li> <li>➤ Medication side effects management can result in the need for additional medications including those needed to treat psychiatric issues.</li> <li>➤ Medicare drug coverage will begin in 2006. Required out-of-pocket and co-pay expenses may be difficult for some clients to afford.</li> </ul>
<p>Health Insurance/ Co-pays</p>	<ul style="list-style-type: none"> <li>➤ AICP funding was expanded in calendar year 2005 and ISP (Insurance Services Program) clients needing premium assistance were transitioned to AICP. AICP continues to have sufficient funding to enroll new applicants, but the ISP is maintaining a handful of premium assistance slots to protect against future reductions in AICP funding.</li> <li>➤ A fund has been established to provide co-pay assistance for Hillsborough County Health Care recipients.</li> <li>➤ A small percentage of ISP clients have medication co-payment needs that exceed the current monthly benefit allowance.</li> <li>➤ Changes in Medicaid PAC Waiver eliminated some services and seriously limited other services. This may mean more requests on the Ryan White-funded health insurance.</li> <li>➤ Other public providers of health insurance plans (Ex: County governments) have changed eligibility criteria, covered services, and formularies that effectively exclude HIV+ individuals from participation.</li> <li>➤ Increased co-payments and deductibles for individuals with VA coverage, and the Medicare prescription plan may lead to greater demand on Ryan White resources.</li> </ul>

Housing	<ul style="list-style-type: none"> <li>➤ Housing continues to be a highly ranked need in the TSA. Funding through Ryan White is limited, due to the prioritization and subsequent allocation of funds for medical care, prescriptions and case management. Coordination with other providers of housing services is essential.</li> <li>➤ Affordable housing options in safe areas are limited. Individuals, single parents and families, and those recently released from substance abuse treatment or incarceration may have a difficult time accessing housing. Rural areas have even greater shortages of housing.</li> <li>➤ Affordable housing is more likely to be substandard. It is difficult to maintain good health in unhealthy environmental conditions.</li> <li>➤ Homeless individuals encounter many barriers to care. Adherence to treatment even when it is received is often difficult.</li> </ul>
Legal Services	<ul style="list-style-type: none"> <li>➤ There has been an increase in the number of requests for assistance regarding insurance continuation, including COBRA coverage, portability of insurance, pre-existing condition coverage and private disability insurance claims. Legal work in this area is essential to maximize private sector involvement and lessen the burden on the public sector funding.</li> </ul>
Mental Health	<ul style="list-style-type: none"> <li>➤ Treatment of dual-diagnosis of HIV and mental illness, or multiple diagnoses which may include substance abuse, hepatitis infection, is becoming more complicated due to possible drug interactions as well as brain chemistry changes. Whenever feasible, mental health services should be coordinated with other medical treatment.</li> <li>➤ Treatment of clinical and sub-clinical depression as well as other mental health issues is necessary as a major component in treatment adherence, due to high occurrence rates among PLWH and the impact of these conditions on overall health.</li> <li>➤ HIV infected individuals should have access to individual and group therapy, mental health providers with prescriptive authority, and support groups.</li> <li>➤ The need for age-specific and culturally relevant interventions continues to grow.</li> <li>➤ Community mental health providers need additional training beyond HIV 101 to better serve HIV+ clients.</li> </ul>

<p>Oral Health Services</p>	<ul style="list-style-type: none"> <li>➤ Dental clinics at the Health Department may not have the ability to perform all procedures due to limited equipment and staffing. There are a limited number of other dental providers but as they are often private practices, availability of appointments is sometimes limited.</li> <li>➤ There is a waiting list for services in Pinellas County.</li> <li>➤ Emergency dental services are difficult to obtain.</li> <li>➤ There are problems with no-shows by clients in dental services, and transportation to the Hillsborough County Health Department is frequently cited as the reason.</li> </ul>
<p>Prevention/Education Early Intervention</p>	<ul style="list-style-type: none"> <li>➤ The increasing HIV and hepatitis infections and AIDS cases within the African American population and among women.</li> <li>➤ HIV/AIDS within the county jails and state prison population has begun to be addressed in the state. This population continues to need linkage with community-based services upon release.</li> <li>➤ Emphasis on funding of faith based or abstinence-only programs are an incomplete method which may not reach some populations in greatest need.</li> <li>➤ Overall funding levels not keeping pace with need.</li> <li>➤ The need for increased programs within Hispanic and other ethnic minority communities and among youth.</li> <li>➤ The Centers for Disease Control and Prevention's (CDC) initiatives regarding testing, prevention and early intervention will impact the provision of services, including: <ul style="list-style-type: none"> <li>○ Making testing a routine part of medical care</li> <li>○ Creating new models for diagnosing infections outside medical settings</li> <li>○ Preventing new infections by working with people diagnosed with HIV and their partners</li> <li>○ Further decreasing mother-to-child HIV transmission by incorporating HIV testing in the routine battery of prenatal tests.</li> </ul> </li> <li>➤ The high cost of rapid testing may make it impractical to implement on a large scale.</li> </ul>

Substance Abuse	<ul style="list-style-type: none"> <li>➤ The political climate in the TSA has not been favorable to the development or expansion of harm reduction treatment models.</li> <li>➤ Public housing restrictions against substance use and criminal backgrounds of prospective tenants, as well as local government pressure on private landlords to curb illegal activity in neighborhoods limits housing options for HIV+ substance abusers.</li> <li>➤ Waiting lists for residential treatment beds and the need for treatment programs designed for HIV+ individuals can prevent substance abusers from getting treatment.</li> <li>➤ Anecdotal information suggesting an increase in the use of methamphetamine poses challenges for substance abuse treatment providers, and further complicates treatment for HIV.</li> <li>➤ After care coordination and life skills training are crucial to maintain clients in care.</li> </ul>
Transportation	<ul style="list-style-type: none"> <li>➤ Formal systems that require advance notice do not always meet the needs of our clients.</li> <li>➤ Limited transportation in rural areas –funds often run out before the month ends.</li> <li>➤ Uncertainty of funding levels across all counties.</li> <li>➤ Transportation for parents with young children, who can not be left alone, can be difficult.</li> <li>➤ Clients have logged complaints about inappropriate treatment from cab drivers.</li> <li>➤ Sensitivity training is an ongoing need.</li> <li>➤ Cabs may not show up during prime operating times due to the ability to make more on metered fares as opposed to contracted fares. There have also been problems with return rides not showing up to take client home.</li> <li>➤ Sicker clients may face additional barriers with transportation, due to the lack of energy and the sometimes long waits for pick-up on return trips.</li> <li>➤ Client no-show rate is an on-going issue in transportation.</li> <li>➤ Lack of discounted bus passes in Pinellas County makes the cost of providing service higher than in Hillsborough County.</li> <li>➤ Single-day bus passes are the only type available through current funding. Monthly passes can assist clients in meeting a multitude of needs.</li> </ul>

Treatment Adherence	<ul style="list-style-type: none"> <li>➤ Adherence to treatment regimens remains a priority. Providers need to design and implement better interventions to assist clients with adherence. With the adherence issue being key to the success of treatment, the Care Council needs to focus on making services user-friendly. We must examine how medical care is provided to ensure it is conducive to the development of provider/patient relationship building in culturally appropriate ways.</li> </ul>
<b>Population</b>	<p style="text-align: center;"><b>Trends and Emerging Issues</b></p> <ul style="list-style-type: none"> <li>➤ HIV/AIDS cases among children and adolescents are increasing particularly in Hillsborough County. New born cases are not showing increases.</li> <li>➤ Adolescents transitioning into the adult system of care may fall out of care.</li> <li>➤ Medication resistance may be seen in younger people.</li> <li>➤ Adherence among adolescents is particularly problematic.</li> <li>➤ Children who have lost parents are most frequently placed with relatives. Little support is available from the child welfare system for these families.</li> <li>➤ There has been an increase in the number of late presenters (8 to 10 years old) who were most likely perinatally exposed, but not previously tested.</li> <li>➤ Increased risk behaviors, including teen pregnancy is a concern for adolescents and youth with mental health issues.</li> <li>➤ Children and adolescents may not be aware of their status due to a parent or guardians fear of disclosure.</li> <li>➤ Adolescents not completing high school have limited employment options as adults and are more likely to continue to depend on publicly-funded care.</li> <li>➤ Life skills and job training is needed among this population.</li> </ul>

Incarcerated/Formerly Incarcerated	<ul style="list-style-type: none"> <li>➤ Releases can occur with little notice making the establishment of linkages to care difficult. Without immediate access to care and support services, individuals may fall out of care.</li> <li>➤ Life skills and job training is needed among this population.</li> </ul>
Low Income	<ul style="list-style-type: none"> <li>➤ As co-payment and share of cost requirements increase, and financial eligibility guidelines tighten, knowledge of acceptable ways to enhance income while on disability is needed.</li> </ul>
Minorities	<ul style="list-style-type: none"> <li>➤ HIV rates are increasing in minority populations. Many are also low income.</li> <li>➤ Language barriers exist for Hispanic, Asian and Caribbean clients in the TSA.</li> <li>➤ Culturally sensitive treatment and appropriate support services are necessary to ensure effective care.</li> <li>➤ Issues of legal status are also problematic as illegal aliens are not eligible for Medicaid. In the case of migrant workers, continuity of care is extremely difficult.</li> <li>➤ Life skills and job training is needed among this population.</li> </ul>
Women	<ul style="list-style-type: none"> <li>➤ HIV rates are increasing for women.</li> <li>➤ Women may have additional responsibility of child care which can impact their adherence.</li> <li>➤ There is a need for child care services for working women.</li> <li>➤ Life skills and job training is needed among this population.</li> <li>➤ Recent legislative changes made HIV testing routine in the first and third trimester of pregnancy.</li> </ul>

## **SECTION 3: HOW WILL WE GET THERE?**

Locally a five-year planning cycle has been adopted. However, the comprehensive plan is updated annually as determined by the Planning and Evaluation Committee. Due to policy, regulatory and funding level changes in both Ryan White as well as other funders of HIV services, and unpredicted changes in the local service continuum; goals and objectives are reviewed on an annual basis to determine their continued relevance. Activities are identified for specific years in the five-year planning process and may also be adjusted to reflect emerging needs.

Other updates may include expanding or refining sections of the plan based on work that has been accomplished during the year. For example, guiding principles and a discussion on the continuum of care are currently underway and appropriate updates to the plan will be made when consensus is reached.

### **A. Goals, Objectives and Activities**

As the West Central Florida Ryan White Care Council is a combined Title I and Title II planning body, considerations for both HRSA and State of Florida requirements must be made in developing the comprehensive plan. Florida has identified specific goals at the statewide level and to the extent possible, local consortia are expected to include activities to support those initiatives. HRSA has outlined comprehensive plan content and directives regarding areas of focus (such as coordination with substance abuse treatment and prevention) are indicated

**GOAL 1: ENSURE THAT PEOPLE WITH HIV ACHIEVE AND MAINTAIN OPTIMAL HEALTH AND WELL BEING.**

**Objective 1(A): Each county will have access to a minimum of one HIV-qualified primary care provider.**

	<b>Task Required to Accomplish Objective</b>	<b>Person Responsible</b>	<b>Target Date</b>
Task 1	Survey public providers of primary care every six months to determine if standard is met.	Health Services Advisory Committee	April , annually

**Objective 1(B): Providers will be knowledgeable about funding sources for health care and pharmaceuticals including anti-retroviral therapy, and will enroll clients in appropriate programs as soon as possible after obtaining the client's informed consent.**

	<b>Task Required to Accomplish Objective</b>	<b>Person Responsible</b>	<b>Target Date</b>
Task 1	Monitor impact of Medicare Part D on access to health care and medications, co-payments and out-of-pocket requirements on clients.	Health Services Advisory Committee	Ongoing
Task 2	Monitor changes in compassionate use programs from pharmaceutical companies for impact on clients.	Health Services Advisory Committee	Ongoing
Task 3	Inform clients of clinical trial opportunities.	Primary care providers	Ongoing
Task 4	Monitor AIDS Insurance Continuation Program (AICP) wait lists and Ryan White funded- Insurance Services Program utilization.	Health Service Advisory Committee	Ongoing

**Objective 1(C): Providers will develop ways to enhance adherence among clients in order to contribute to improved health outcomes.**

	<b>Task Required to Accomplish Objective</b>	<b>Person Responsible</b>	<b>Target Date</b>
Task 1	Utilize results of MAI capacity building project to determine best practices for enhancing adherence among underserved populations.	Grantee	March, 2006
Task 2	Develop and implement pilot program to compare health outcomes among underserved populations utilizing new approaches.	Grantee	February, 2007

**Objective 1(D): Providers who initiate an anti-retroviral regimen in pregnant women will coordinate all services required for the successful completion of anti-retroviral therapy, during pregnancy, during the labor and delivery period, and during the newborn period. Providers of prenatal and maternal/fetal care will develop plans with neonatal/child health care providers to assure anti-retroviral therapy for the newborns.**

	<b>Task Required to Accomplish Objective</b>	<b>Person Responsible</b>	<b>Target Date</b>
Task 1	Monitor Title I and II funded programs serving pregnant women to determine that currently accepted PHS guidelines are being followed.	Grantee	Ongoing
Task 2	Determine what activities are being undertaken by AETC with regard to HIV training to obstetrical practices.	Health Services Committee	June, 2006
Task 3	Explore the extent to which hospitals and OB providers follow accepted treatment protocols.	Perinatal Task Force	Ongoing

**GOAL 2: IMPROVE ACCESS TO CARE FOR PLWAH.**

**Objective 2(A): All contracted providers will initiate and ensure culturally focused and linguistically appropriate interventions and treatment.**

	<b>Task Required to Accomplish Objective</b>	<b>Person Responsible</b>	<b>Target Date</b>
Task 1	Conduct an assessment of cultural competence among providers as part of MAI capacity building project.	MAI Capacity Development Contractor	February, 2006
Task 2	Report findings to Care Council and RPARC.	Grantee/MAI Capacity Development Contractor	March, 2006
Task 3	RPARC to recommend resources to be devoted to cultural competency activities.	RPARC	May, 2006
Task 4	RFA to address cultural competency activities to be developed as determined with Care Council input.	Grantee/Care Council	July, 2006
Task 5	Cultural competency activities implemented.	Contracted provider	March, 2007

**Objective 2(B): Methods for identifying, enrolling and maintaining difficult to serve populations in primary care will be explored.**

	<b>Task Required to Accomplish Objective</b>	<b>Person Responsible</b>	<b>Target Date</b>
Task 1	Utilize results of MAI project to determine which subpopulations require focus.	MAI Capacity Development Contractor	February, 2006
Task 2	Conduct review of best practices to determine possible program designs that assist underserved populations with retention in care.	Planning and Evaluation Committee/Minority Advocacy Committee	July, 2006

Task 3	Client grievances will be investigated by Grantee in accordance with adopted policies.	Grantee	Ongoing
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**Objective 2(C): Update estimates of the number of individuals aware of their status but not in care, on an annual basis.**

	<b>Task Required to Accomplish Objective</b>	<b>Person Responsible</b>	<b>Target Date</b>
Task 1	Work with the state to further refine unmet need estimate methodology.	Planning and Evaluation Committee	Ongoing
Task 2	Conduct annual demographics and epidemiology report including trends and cumulative living cases.	Planning and Evaluation Committee	Annually

**Objective 2(D): Determine service needs and barriers of individuals who are aware of their status but are not in care.**

	<b>Task Required to Accomplish Objective</b>	<b>Person Responsible</b>	<b>Target Date</b>
Task 1	Develop methodology and data collection instruments to determine the needs of individuals aware of their status but not in care and the barriers to care.	Planning and Evaluation Committee	February, 2006
Task 2	Implement methodology and review findings on a quarterly basis.	Planning and Evaluation	Quarterly, Ongoing

**GOAL 3: ENSURE THAT HIV CARE AND SUPPORT SERVICES ARE HIGH QUALITY.**

**Objective 3(A): Establish and enhance performance-based standards and outcome measures for all funded services.**

	<b>Task Required to Accomplish Objective</b>	<b>Person Responsible</b>	<b>Target Date</b>
Task 1	Review all performance standards and outcome measures.	QM Contractor	October, 2005
Task 2	Meet with providers to review proposed revisions to standards.	QM Contractor	October-December, 2005
Task 3	Finalize new standards and align with QM process.	QM Contractor	January-February, 2006
Task 4	Conduct quarterly reviews on QM data.	Grantee, Planning and Evaluation Committee	Quarterly, Ongoing

**Objective 3(B): Evaluate minimum standards of care on an on-going basis and make revisions as needed.**

Task 1	Develop service philosophies and definitions as part of the QM process.	QM Contractor	March, 2006
Task 2	Review minimum standards of care for all services and revise as needed to align with service philosophy and definition.	Health Services Advisory Committee, Planning and Evaluation Committee	April, 2006-September 2006
Task 3	Include revised standards into new contracts.	Grantee	October, 2006 and ongoing

**Objective 3(C): The Grantee/Lead Agency will fully implement an information management system to allow for the tracking of quantitative and qualitative data.**

	<b>Task Required to Accomplish Objective</b>	<b>Person Responsible</b>	<b>Target Date</b>
Task 1	Develop new methods for collecting and reporting data on service provision.	Grantee	September, 2005
Task 2	Train providers on new MIS system	Grantee	December, 2005
Task 2	Fully implement data collection system.	Grantee	March, 2006

**Objective 3(D): Establish and implement a customer satisfaction program.**

	<b>Task Required to Accomplish Objective</b>	<b>Person Responsible</b>	<b>Target Date</b>
Task 1	Conduct annual customer satisfaction surveys for all service providers.	Grantee/Providers	Annually
Task 2	Review data from satisfaction surveys to determine areas for improvement, both system-wide and as individual providers.	Grantee	Annually

**Objective 3(E): Improve knowledge of capacity-building opportunities available to service providers on an on-going basis.**

	<b>Task Required to Accomplish Objective</b>	<b>Person Responsible</b>	<b>Target Date</b>
Task 1	Develop information dissemination mechanism for providers to be aware of capacity building opportunities that exist in the community.	Grantee	December, 2006

**GOAL 4: ENSURE THAT A COMPREHENSIVE CONTINUUM OF HIV PRIMARY CARE/TREATMENT AND RELATED PSYCHO-SOCIAL AND SUPPORT SERVICES ARE AVAILABLE THROUGHOUT THE TSA. PSYCHO-SOCIAL AND SUPPORT SERVICES INCLUDE, BUT ARE NOT LIMITED TO: TRANSPORTATION, MENTAL HEALTH, SUBSTANCE ABUSE TREATMENT, FOOD HOUSING, CASE MANAGEMENT, AND CHILD SERVICES.**

**Objective 4(A): Expand coordination and linkages with non-Ryan White funded providers in accordance with HRSA objectives.**

	<b>Task Required to Accomplish Objective</b>	<b>Person Responsible</b>	<b>Target Date</b>
Task 1	Provide letters of support and background information for agencies seeking funding to develop/expand these services.	Care Council Chair	Ongoing
Task 2	Coordinate with HOPWA needs assessment and planning efforts.	Care Council members, Planning and Evaluations Committee	October, 2005-September, 2007

**Objective 4(B): Improve communication between Grantee/lead agency and service providers on an on-going basis.**

	<b>Task Required to Accomplish Objective</b>	<b>Person Responsible</b>	<b>Target Date</b>
Task 1	Conduct quarterly meeting with providers	Grantee	Quarterly, Ongoing
Task 2	Conduct case manager training as funding permits.	Grantee	As funding permits

**Objective 4(C): Encourage an environment that supports volunteerism and advocacy.**

	<b>Task Required to Accomplish Objective</b>	<b>Person Responsible</b>	<b>Target Date</b>
Task 1	Contract for Care Council website that provides links for volunteer and advocacy opportunities.	Grantee	March, 2006
Task 2	Develop a mechanism for service providers and other community groups to notify clients of volunteer opportunities.	Membership Committee	September, 2006
Task 3	Designate a Care Council member to coordinate public information and advocacy.	Care Council	Annually

**Objective 4(D): Improve education on the role of the Care Council and its committees on an on-going basis.**

	<b>Task Required to Accomplish Objective</b>	<b>Person Responsible</b>	<b>Target Date</b>
Task 1	Determine training needs for Care Council and committee members.	Planning Council Support, Membership Committee	August, 2006
Task 2	Develop content and schedule of trainings.	Planning Council Support	January, 2007
Task 3	Conduct trainings.	Planning Council Support, Membership Committee, TA providers	January, 2006- Ongoing

**GOAL 5: THE CARE COUNCIL WILL PROMOTE COORDINATION AND LINKAGES ACROSS RYAN WHITE TITLES, AND HIV AND SUBSTANCE ABUSE PREVENTION IN THE TSA.**

**Objective 5(A): The Care Council will coordinate with prevention providers to identify service gaps between HIV prevention providers and the care and treatment continuum on an ongoing basis.**

	<b>Task Required to Accomplish Objective</b>	<b>Person Responsible</b>	<b>Target Date</b>
Task 1	The Care Council will assign participants to serve on FCPN and report back to the Care Council.	Care Council	Ongoing
Task 2	Local HIV/AIDS Prevention Coordinators (HAPCs) will participate on the Care Council and Planning and Evaluation Committees.	HAPCs, Care Council, Planning Council Support	Ongoing
Task 3	A report on testing and counseling sites will be provided to the Planning and Evaluation Committee annually.	HAPCs, Planning Council Support	June, Annually

**Objective 5(B): The Care Council will coordinate with substance abuse prevention providers to identify issues related to the HIV care and treatment continuum on an ongoing basis.**

	<b>Task Required to Accomplish Objective</b>	<b>Person Responsible</b>	<b>Target Date</b>
Task 1	Assure that substance abuse treatment providers are represented on the Care Council.	Planning Council Support	Ongoing
Task 2	Invite substance abuse treatment providers to participate in the Planning and Evaluation Committee.	Planning Council Support	Ongoing

**Objective 5(C): The Care Council will coordinate with other Ryan White Titles on an ongoing basis.**

	<b>Task Required to Accomplish Objective</b>	<b>Person Responsible</b>	<b>Target Date</b>
Task 1	Assure that Titles III and IV, and AETC are represented on the Care Council.	Planning Council Support	Ongoing
Task 2	Coordinate planning and needs assessment activities across titles.	Grantee, Planning Council Support	Ongoing

## **SECTION 4: HOW WILL WE MONITOR PROGRESS?**

A variety of monitoring processes are used to determine how successful the efforts of the Care Council are in providing a high quality continuum of care. Monitoring of the comprehensive plan goals and objectives is undertaken by the Planning and Evaluation Committee. Quality management initiatives conducted by the Grantee, and shared with the Planning and Evaluation Committee, also provide an opportunity to evaluate and monitor progress in providing quality services. Finally, fiscal and program monitoring of individual providers gives an additional opportunity for assessing progress and providing technical assistance with program operations.

Monitoring and evaluation activities do not occur in a vacuum. A number of factors must be considered over time including the changing environment, regulations and requirements, and data limitations.

It is clear that changes to Medicaid, Medicare Part D and possible impacts from CARE Act reauthorization will have an effect on planning and service provision. At this time it is impossible to know the full impact on Ryan White funded services and on the continuum of care. As such, goals, objectives and activities should be seen as fluid; adjusting as needed to respond to funding and policy changes. In addition, indicators (definition of success for a given objective) and measures (a measurable factor or variable that indicates progress toward an objective) may also be refined as needed.

Data limitations can also impede the ability to monitor plan performance. While consideration is given to the ability to collect specific data when developing measures, there may be a lack of baseline or other comparison data to measure improvement against. Many performance measures in the past were process measures (e.g. Were activities completed in expected time frame?) as opposed to outcome based measures (e.g. How did health of client improve as a result of the service?). This is being improved through the quality management system; however it may take several years to have enough data to conduct trend analyses.

The availability of funds to collect new data, or to develop new ways of collecting data, are limited but must be considered in planning. The Grantee is working on improving the MIS system but at this time there is not sufficient experience with the new system to know what limitations may arise.

### **A. Comprehensive Plan Monitoring**

The plan monitoring grid is outlined in the previous section, and includes the activities geared to assist in reaching adopted goals and objectives. The Planning and Evaluation committee reviews progress over a three-month period. Activities that have been accomplished or are in process are reviewed and determinations regarding additional work are made. If an activity is not accomplished, the reasons for the shortfall are assessed, a determination is made regarding the value of the

activity, and recommendations for corrective action, assignment to another committee or deletion from the plan is made.

## **B. Quality Management**

The quality management program was undertaken by the Grantee in 2003 utilizing the services of two different contractors. Since then, introductory training sessions were held for all providers, Grantee staff and Planning Council members to discuss service level outcomes measurement and process mapping. Process maps were developed for each Ryan White service category which illustrates a visual overview of what services are provided and how services are provided. A SWOT (Strengths, Weaknesses, Threats and Opportunities) analysis was conducted with members of the Planning Council, and core goals and objectives for a strategic plan were developed.

A standardized customer satisfaction survey was developed so that comparisons could be made between providers of a specific service in order to identify best practices which could improve service delivery. In the past, each provider was required to conduct a satisfaction survey, but developed and conducted surveys independently. A minimum satisfaction rating of 85% is required to meet the standard.

A balanced scorecard, which provides a snapshot of how things have been, how they are now (current indicators), and what the future might bring (leading indicators) is being refined. By adopting quantifiable and measurable goals, a “balance” between different types of measures is achieved.

Service definitions are being developed as well as revised standards of care and outcomes for funded services. Revisions to the dashboard and summary of performance are also underway. This will provide the capability to view performance and identify current outcome status in meeting performance based measures.

As the quality management program becomes integrated into service delivery, the Grantee and Planning Council will be better able to plan for services and evaluate the effectiveness of services.

## **C. Fiscal and Program Monitoring**

Fiscal and program monitoring is conducted by Grantee staff through a site visit at least once per year for each contract (22 contractors in 2005). Some providers may have more than one contract and are usually monitored for all contracts at the same time. Monitoring tools specific to each service, as well as a general monitoring tool for all services are revised each year as needed. Program monitoring tools have a numeric scale that rates performance. Service providers must meet a minimum of 95% compliance to fully meet contract requirements.

Program monitoring generally involves a review of 10% (minimum is 20 records) of active client records. This equates to approximately 2,000 client records in 2005. If concerns are identified during that portion of the monitoring, an additional 10% of records may be reviewed.

Fiscal reviews are made by the same reviewers that conduct the program reviews. Staff members are cross-trained to increase their knowledge and to get a comprehensive picture of services provided. This also improves their ability to offer technical assistance to programs. Fiscal reviews include a review of accounting systems and controls, budget and contract expenditures, purchasing procedures, and property management.

Within two weeks of the completion of the site visit, a report on findings is issued. If fiscal or programmatic concerns are identified, a corrective action plan must be submitted by the contractor within one month of the site visit. The Grantee monitors compliance with the corrective action plan to assure that proposed actions are addressing the concerns noted.

Additional reporting requirements include monthly invoices, quarterly reports, Care Act Data Reports (CADR), audits and client satisfaction survey results. Audits are reviewed by Hillsborough County Debt Management and fiscal policies must be in compliance with OMB Circular A-133.

## GLOSSARY

**ADAP**- AIDS Drug Assistance Program. Provides medication to low and moderate income individuals with HIV disease, who have limited or no coverage from private insurance or Medicaid.

**AETC** - AIDS Education Training Center. Provides education and training for primary health care professionals and other AIDS-related personnel. Funded through the Ryan White CARE Act.

**AHEC**- Area Health Education Center. Centers that exist to enhance access to quality health care by improving the supply and distribution of health care professionals in under served areas by facilitating community and academic partnerships.

**AICP** - AIDS Insurance Continuation Program. Assists HIV+ individuals in maintaining health insurance coverage when they are no longer able to work. Covers insurance premiums, deductibles and co-pays.

**AIDS** - Acquired Immunodeficiency Syndrome

**Ambulatory/Outpatient Medical Care** - Provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist or nurse practitioner in an outpatient, community—based and/or office-based setting. This includes diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, care of minor injuries, education and counseling on health and nutritional issues, minor surgery and assisting at surgery, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care.

**Aseptic necrosis** - A condition that result from poor blood supply to an area of the bone causing bone death. The dead areas of the bone are weakened and can collapse.

**ASO** - AIDS Service Organization. Provides medical or support services primarily or exclusively to populations infected with or affected by HIV disease.

**Buddy/Companion Services** - Activities provided by volunteers/peers to assist the client in performing household or personal tasks, and providing mental and social support to combat the negative effects of loneliness and isolation.

**Care Council** - The planning body whose function is to establish a plan for delivery of HIV care services and establish priorities for the use of Title I and Title II CARE Act funds.

**Case Management** - A range of client-centered services that link clients with health care, psychosocial and other services to insure timely, coordinated access to medically appropriate levels of health and support services, continuity of care, on-going assessment of the client's and other family members' needs and personal support systems, and inpatient case management services that prevent unnecessary hospitalization or that expedite discharge, as medically appropriate, from inpatient facilities. Key activities include: initial comprehensive assessment of the client's needs and personal support systems; development of a comprehensive, individualized service plan; coordination of the services required to implement the plan; client monitoring to assess the efficacy of the plan; and periodic re-evaluation and revision of the plan as necessary over the life of the client. May include client-specific advocacy and/or review of utilization of services.

**CBO** - Community Based Organizations. Provides services to locally defined populations, which may or may not include populations infected with or affected by HIV disease.

**CDC**- Centers for Disease Control and Prevention.

**CD4 Count** - The absolute number of CD4+ lymphocytes per cubic millimeter of blood. The CD4+ count is used as a marker of the progression of HIV-related immunosuppression. Under the CDC definition, an HIV+ person with a CD4 count of less than 200 cells/mm of blood is considered to have AIDS.

**Client Advocacy** - Assessment of individual need, provision of advice and assistance in obtaining medical, social, community, legal, financial and other needed services. Advocacy does not involve coordination and follow-up on medical treatments.

**Child Welfare Services** - Assistance in placing children younger than 20 in temporary (foster care) or permanent (adoption) homes because their parents have died or are unable to care for them due to HIV-related illness.

**CMS**- Children's Medical Services, State of Florida.

**Community Planning Partnership (CPP)** - Responsible for the development of the Comprehensive HIV/AIDS Prevention Plan.

**Comprehensive Plan** - An official document adopted by the local Ryan White CARE Act governing body, which sets forth long-term Goals, Objectives and Policies regarding issues impacting HIV infected individuals.

**Co-morbidity** - The existence of more than one disease or condition such as HIV and hepatitis.

**Continuum of Care** - A coordinated delivery system, encompassing a comprehensive range of health and social services that meet the changing needs of People Living with HIV in all stages of illness.

**Cultural Competence** - The knowledge, understanding, and skills to work effectively with individuals from differing cultural backgrounds.

**Day or Respite Care** - Home- or community-based medical assistance designed to relieve the primary care giver responsible for providing day-to-day care of the client or client's child.

**Direct Client Services Fund (DCSF)** - Fund established by the Grantee to pay for HRSA eligible services for Ryan White clients when no contracted provider exists in the client's geographic area.

**Direct Emergency Financial Assistance** - Provision of short-term payments to agencies, or establishment of voucher programs, to assist with emergency expenses related to food, housing, rent, utilities, medications or other critical needs.

**Drug Reimbursement Program:** Ongoing service/program to pay for approved pharmaceuticals or medications for persons with no other payment source. Subcategories include:

- a. State administered AIDS Drug Assistance Program (ADAP), or
- b. Local/Consortium Drug Reimbursement Program: A program established, operated, and funded locally by a Title I EMA or a consortium to expand the number of covered medications available to low-income patients and/or to broaden eligibility beyond that established by a State- operated Title II or other State-funded Drug Reimbursement program.

**Early Intervention Services (EIS)** - Counseling, testing and referral services to PLWH who know their status but are not in primary medical care or who are recently diagnosed and are not in primary care for the purpose of facilitating access to HIV-related services.

**Eligible Metropolitan Area (EMA)** - Geographic area eligible to receive Title I funds under the Ryan White CARE Act. For purposes of this document, the EMA includes Hernando, Hillsborough, Pasco and Pinellas counties.

**Florida Community Planning Group (FCPG)** - An organization of all local HIV community prevention planning groups.

**Food Bank/Home delivered Meals/Nutritional Supplements** - Provision of food, meals, or nutritional supplements.

**“Funding of last resort”** - HRSA policy regarding the expenditure of Ryan White CARE Act funds as last payer.

**Grantee** - The recipient of CARE Act funds. For purposes of this document, the Grantee is Hillsborough County Department of Health and Social Services.

**HAART** - Highly Active Antiretroviral Therapy. A prescribed regimen of medications used in the treatment of HIV disease.

**Health Education/Risk Reduction** - Provision of information, including dissemination about medical and psychological support services and counseling, or the preparation H/distribution of materials in the context of medical and psychological support services to educate clients with HIV about methods to reduce the spread of HIV.

**Health Insurance** - A program of financial assistance for eligible individuals with HIV disease to maintain a continuity of health insurance or to receive medical benefits under a health insurance program.

**Health Resources and Services Administration (HRSA)** - Agency of the U.S. Department of Health and Human Services that is responsible for administering the CARE Act.

**Hepatitis C** - A liver disease caused by the hepatitis C virus (HCV), which is spread by contact with the blood of an infected person.

**HIV Disease** - The entire spectrum of the natural history of the human immunodeficiency virus, from post infection through clinical definition of AIDS.

**Home Health Care** - Therapeutic, nursing, supportive and/or compensatory health services provided by a licensed/certified home health agency in a home/residential setting in accordance with a written, individualized plan of care established by a case management team that includes appropriate health care professionals. Component services are defined separately below:

- a. Para-Professional Care: Homemaker, home health aide, and personal/attendant care
- b. Professional Care: Routine and skilled nursing, rehabilitation and mental health
- c. Specialized Care: Intravenous and aerosolized medication treatments, diagnostic testing, parenteral feedings and other high tech services
- d. Durable medical equipment: Prosthetics, devices and equipment used by clients in a home/residential setting, e.g., wheelchairs, inhalation therapy equipment or hospital beds.

**Hospice Care -**

- a. Home-Based Hospice Care: Nursing care, counseling, physician services, and palliative therapeutics provided by a hospice program to patients in the terminal stages of illness in their home setting.
- b. Residential Hospice Care: Room, board, nursing care, counseling, physician services, and palliative therapeutics provided to patients in the terminal stages of illness in a residential setting, including a non-acute care section of a hospital that has been designated and staffed to provide hospice services for terminal patients.

**Housing Assistance** - This assistance is limited to short-term or emergency financial assistance to support temporary and/or transitional housing to enable the individual or family to gain and/or maintain medical care. Use of Titles I, II and IV funds for short-term or emergency housing must be linked to medical and/or health-care services, or be certified as essential to a client's ability to gain or maintain access to HIV-related medical care or treatment.

**Housing-Related Services** - This includes assessment, search, placement and advocacy services provided by professionals who possess an extensive knowledge of local, State and Federal housing programs and how they can be accessed.

**Housing Opportunities for People with AIDS (HOPWA)** - A program of the U.S. Department of Housing and Urban Development that provides housing and support services for low-income people with HIV/AIDS and their families.

**IDU** -Injecting Drug User

**Incidence** - The number of new cases of a disease that occur in a specified period of time.

**Legal Services** - Legal services directly necessitated by a person's HIV status including: preparation of Powers of Attorney, Do Not Resuscitate Orders, wills, trusts, bankruptcy proceedings, and interventions necessary to ensure access to eligible benefits including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the CARE Act.

**Lipodystrophy** - A change in body fat distribution linked to individuals receiving HAART.

**Medications** - Prescription drugs to prolong life or prevent the deterioration of health.

**Mental Health Services** - Psychological and psychiatric treatment and counseling services, including individual and group counseling, provided by a mental health professional licensed or authorized within the State, including psychiatrists, psychologists, clinical nurse specialists, social workers, and counselors.

**MSM** - Men who have sex with men.

**Needs Assessment** - The process of gathering and analyzing information from a variety of sources in order to determine the current status and unmet needs of a defined population or geographic area. The focus may be on a single issue or on a wide range of issues.

**Nutritional Counseling** - Provision of education and/or counseling provided by licensed/registered dietician outside of a primary care visit.

**Oral Health** - Diagnostic, prophylactic and therapeutic services rendered by dentists, dental hygienists and similar professional practitioners.

**Other Support Services** - Direct support services not listed such as translation/interpretation services.

**Outreach Services** - Programs which have as their principle purpose identifying people with HIV disease so that they may become aware of and may be enrolled in care and treatment services. Outreach services do not include HIV counseling and testing, or HIV prevention education.

**Permanency Planning** - The provision of social service counseling or legal counsel regarding:

- a. The drafting of wills or delegating power of attorney; and
- b. The preparation for custody options for legal dependents including stand-by guardianship, joint custody, or adoption.

**PLWA** - Person Living with AIDS.

**PLWH** - Person Living with HIV.

**Primary Prevention** - Any prevention services provided to uninfected persons to reduce their risk and remain uninfected, or to infected persons to reduce their risk of transmitting infection, or to person who do not know their HIV status so that they may reduce risky behaviors and learn status.

**Priority Setting** - The process used by the Care Council to establish service priorities for the allocation of CARE Act funds and to determine the best ways of meeting each priority.

**Program Support** - Activities that are not service oriented or administrative in nature, but contribute to or help to improve service delivery. Such activities may include capacity building, technical assistance, program evaluation (including outcome assessment), quality assurance, and assessment of service delivery patterns.

**Psychosocial Support Services** - Individual and/or group counseling services other than mental health counseling, which is provided to clients, family and/or friends by non-licensed counselors. May include psychosocial providers, peer counseling/support group services, care giver support/bereavement counseling, drop-in counseling, benefits counseling, and/or nutritional counseling or education.

**Referral** - The act of directing a person to a service in-person or through telephone, written, or other forms of communication. Referral may be made formally from one clinical provider to another, within a case management system by a professional case manager, informally through support staff or as part of a services program.

**Rehabilitation Care** - Services provided by a licensed or authorized professional in accordance with an individualized plan of care which is intended to improve or maintain a client's quality of life and optimal capacity for self-care. This definition includes physical therapy, speech pathology, and low-vision training services.

**Resource Allocation** - Process by which dollars of CARE Act funding are allocated to specific priority service categories.

**Ryan White Comprehensive AIDS Resources Emergency (CARE) Act** - Federal legislation to improve the quality and availability of care for individuals and families affected by HIV.

**Secondary Prevention** - Services intended to prevent progression of disease in persons who are infected.

**STD** - Sexually Transmitted Disease. Any disease which the primary means of transmission occurs from sexual contact. Examples include syphilis, gonorrhea, chlamydia, and genital herpes.

**Substance Abuse Services** - Provision of treatment and/or counseling to address substance abuse problems (including alcohol, legal and illegal drugs), provided in an outpatient or residential health service setting.

**TB** - Tuberculosis.

**Transportation** - Conveyance services provided to a client in order to access health care of psycho-social support services. May be provided routinely or on an emergency basis.

**Treatment Adherence Services** - Provision of counseling or special programs to ensure readiness for adherence to complex HIV/AIDS treatments.

**TSA** - Total Service Area. For purposes of this document, the TSA includes Hardee, Hernando, Highlands, Hillsborough, Manatee, Pasco, Pinellas and Polk counties.

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