

FY 2009- 2012 RYAN WHITE COMPREHENSIVE HIV/AIDS SERVICES PLAN

Prepared by



The Health Councils, Inc.
9600 Koger Blvd., Suite 221
St. Petersburg, Fl. 33702
(727) 217-7070

Adopted

December 3, 2008

David Libby, Chair
Tom Robbins, Chair
Elizabeth Rugg, Executive Director
Collette Tomberlin, Ryan White Program Administrator
Nicole Brown, Community Development Coordinator

TABLE OF CONTENTS

Letter of Concurrence	3
Contributors/Acknowledgements	4
Introduction	5
Executive Summary	7
Section I: Where Are We Now?	9
Chapter 1: Description of Service Area	9
Geography	
Demographic Composition	
Socio-economic Status	
Access to Health Care	
Chapter 2: Epidemiological Profile	14
Current local Epidemic	
Profile of PLWH/A by Age, Gender, Race and Exposure Category	
Emerging Populations/Trends	
Prevalence of Co-morbidities	
Chapter 3: History of Response to the Epidemic	23
Chapter 4: Assessment of Need	24
Unmet Need Estimate	
Gaps in Care	
Prevention Needs	
Chapter 5: Description of Current Continuum of Care	32
Resource Analysis	
Profile of Ryan White Funded Providers	
HIV/AIDS Services Funding	
Chapter 6: Barriers to Care	57
Section II: Where Do We Need to Go?	59
Chapter 7: Continuum of Care for High Quality Core Services	59
Shared vision and values	
Emerging Issues	
Section III: How Will We Get There?	67
Chapter 8: Goals, Objectives and Strategies	67
Section IV: How Will We Monitor Progress?	78
Chapter 9: Implementation, Monitoring and Evaluation Plan	78
Improving Client Level Data	
Measuring Clinical Outcomes	
Fiscal and Program Monitoring	
Section V: Appendices	86
A: Terms and Acronyms	
B: EMA Epidemiology Data	
C: Map of EMA and Non-EMA Ryan White Funded Providers	

December 5, 2008

HIV/AIDS Bureau, HRSA
Rockville, Maryland 20857


Dear Colleagues:


This letter serves as assurance that the West Central Florida Ryan White Care Council has been an active participant in the planning and development of the attached 2009-2012 Comprehensive HIV/AIDS Services Plan for the Tampa – St. Petersburg EMA and consortia area. The plan was developed collaboratively and reflects a wide range of perspectives including members of the planning council, affiliated and unaffiliated consumers, HIV service providers, representatives of community-based organizations and other stakeholders.

The enclosed Plan will guide the Planning Council to provide a continuum of care services that are comprehensive and compassionate. It will be used to guide discussions and decision-making as we continually strive to understand and assess the needs of people living with HIV and AIDS. The goals and strategies outlined in the plan will help us respond to the changing needs of the epidemic and address the unmet health care needs of those not currently in the system.

We concur that this comprehensive plan represents the priorities as set forth by the West Central Florida Ryan White Care Council.

Sincerely,


Wendell Martin
Planning Council Chair


Carla Baity
Planning Council Vice-Chair

CONTRIBUTORS/ACKNOWLEDGMENTS

West Central Florida Ryan White Care Council

Wendell Martin, Chair
Carla Baity, Vice Chair
Michael Amidei
Robbie Bouplon
Gene Bundrock
Barbara Clark-Alexander
Martin Clemmons, Jr.
Linnwood Davis
Laura Dunn
Juanita Escobedo
Tonica Freeman
Jean Getchell
Lois Hall
Denis Hayes

David Hasiba
Laureen Husband
Natalie Jackson
James King
Janet Kitchen
David Konnerth
Brent Laartz
Marshall Lee
Andrew Maldonado
John Melartin
Aritus Miller
Anil Pandya
Donnette Waul-Santiago

Planning and Evaluation Committee Members

James McGarvey, Chair
Martin Clemmons, Jr., Co-Chair
Ginny Boucher
Lisa Cohen
Barb Green
David Hasiba
Lee Luther
Wendell Martin

John Melartin
Patrick Mercier
Marylin Merida
Andrew Paquette
Bob Reynolds
Jim Roth
Jackie Walsch
William Wilbanks, Jr

Grantee Staff

Aubrey Arnold
Dorinda Seth

Produced on behalf of The Ryan White Care Council under contract with the County of Hillsborough, Department of Health and Social Services, Ryan White Program. Funded by HRSA and the State of Florida, Department of Health.

INTRODUCTION

The comprehensive plan guides the actions of the West Central Florida Ryan White Care Council and area partners during the years 2009-2012 as they strive to maintain and improve services for people living with HIV/AIDS so that they enter and stay in care.

Planning has always been a central focus of the Ryan White legislation, and a critical part of Part A and B programs. Since the inception of the Comprehensive AIDS Resources Emergency (CARE) Act now known as the Ryan White Treatment Modernization 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 People Living With HIV/AIDS (PLWH/A) 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?

This comprehensive plan was developed by the West Central Florida Ryan White Care Council in collaboration with representatives from other Ryan White Program parts, prevention planners and numerous local agencies providing a myriad of services to PLWH/As. The plan reflects the vision of the service area for delivering HIV/AIDS care services, particularly in light of limited and decreasing resources.

The local planning council structure emerged in September of 1999 when the Part B Consortium along with the Part A Planning Council combined efforts and became the West Central Florida Ryan White Care Council (The Care Council, Planning Council). This merger was undertaken to prevent duplication of effort and to insure coordination between the program Parts.

The Care Council has incorporated the structure of the planning council, which is required by the Health Resources and Services Administration (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 of streamlining 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 (P&E); Resource Prioritization and Allocation Recommendations (RPARC); Rural Issues; Standards, Issues and Operations (SIOC); and 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/AIDS (PLWH/A), and in the provision of quality service.

Part A, Part B, Part C, Part D 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 Parts A and B also administers some Housing Opportunities for People with AIDS (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 the 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.

EXECUTIVE SUMMARY

The 2009-2012 Comprehensive HIV/AIDS Services Plan developed for the Tampa – St. Petersburg Eligible Metropolitan Area (EMA) and consortia area (combined into our TSA – Total Service Area) is the result of an open community planning process. This plan represents the efforts of many people working together to improve the medical care and support services available to people living with HIV. Input from a wide range of perspectives including members of the planning council, affiliated and unaffiliated consumers, HIV service providers, representatives of community-based organizations and other stakeholders shaped the elements within the plan.

Planning for an area as diverse as the Tampa-St. Petersburg EMA and consortia area presents significant challenges. The urban centers of Tampa, St. Petersburg and Clearwater have multiple health-care resources and social services amidst pockets of high poverty while the rural areas have limited specialized medical care, transportation limitations and severe stigma. With a growing and increasingly complex HIV-infected population in all areas, especially among racial and ethnic minorities, there is a greater need for culturally sensitive services. Developing a comprehensive services plan within the context of the geographic and demographic surroundings of the populations to be served requires extensive effort from all stakeholders.

The combined Total Service Area (TSA) covers 6,836 square miles with an estimated population of 3,771,367 which includes 20.1% of the state's population. The racial composition of the area is 71% White, 12% Black and 15% Hispanic. An estimated 21,674 individuals are homeless, 10.7% live in poverty and 15.9% are uninsured. All eight counties comprising the TSA are designated as health professional shortage areas (HPSA) and medically underserved areas/medically underserved populations areas (MUA/MUP).

As of December 31, 2007, there were an estimated 7,037 persons living with AIDS and another 5,076 individuals living with HIV, for a total of 12,113 living with HIV infection in the eight county service area. This represents a TSA-wide HIV infection prevalence of 321.2 per 100,000 persons. Infections among Whites account for 47.4% of those infected, 37.7% are Black and 13.4% are Hispanic. The data shows a disproportionate impact on minority populations. Blacks are infected with HIV/AIDS at a rate of 1,031 of every 100,000 and 295 of every 100,000 Hispanics are infected compared to 214 of every 100,000 Whites.

Since English is not the primary language for approximately 20% of the patient population, providing complex medical instructions and responding to medical crises requires matching bilingual medical staff with patients or seeking medical interpretive services. This challenge can result in complex scheduling demands to coordinate patient, medical provider and medical interpreter.

The two largest providers of ambulatory outpatient care report that 80%-85% of their case load requires level two or three care. Level two is HIV disease (possibly Centers for Disease Control - CDC defined AIDS) with co-morbid conditions requiring healthcare visits every six to eight weeks. Level three is defined as advanced HIV disease, CDC defined

AIDS, with co-morbid conditions requiring healthcare visits on average every four weeks with phone triage management every one-two weeks. Clinical care providers express a severe need for the expertise of specialist consultation due to the complexity of many of the co-morbid conditions within the PLWH/A population.

Multiple data sources were reviewed and summarized to provide information for developing goals and objectives that ensure a high quality continuum of care for people living with HIV and AIDS in the TSA. The 2009-2012 Comprehensive HIV/AIDS Services Plan will serve as a living document to guide our planning for an effective continuum of care in an environment of diminishing resources and increasing need. The Plan serves as our road map to bring and retain high-need populations into care and to improve the quality and efficiency of the current service delivery system.

SECTION 1: WHERE ARE WE NOW?

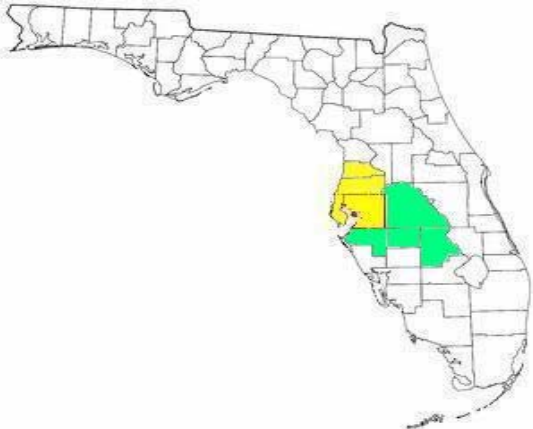
CHAPTER 1: DESCRIPTION OF SERVICE AREA

Geography

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 Part A while all counties in the TSA can access Part B funds.

Geographically, the area served is the central west coast of Florida. The service area includes highly diverse geographic, demographic, and economic factors. The EMA includes Hernando, Hillsborough, Pasco, and Pinellas counties. The Non-EMA counties in the TSA are Hardee, Highlands, Manatee, and Polk.

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 in Hardee County to 3,384 persons per square mile in Pinellas County, the most densely populated county in the state of Florida.



**Geography by County, EMA,
Non-EMA, and TSA**

County	Square Miles	Population Density (persons per square mile)	County	Square Miles	Population Density (persons per square mile)
Hardee	637	43	Hernando	478	328
Highlands	1,028	94	Hillsborough	1,051	1,108
Manatee	741	416	Pasco	745	570
Polk	1,875	301	Pinellas	280	3,384
Total Non-EMA	4,282	233	Total EMA	2,554	1055
Total Service Area	6,836	540	Florida	53,937	340

Source: Florida Statistical Abstract, 2007

Portions of the TSA are popular among tourists, attracting visitors from all parts of the world and the TSA is home to many retirees from other states. Significant number of PLWH/A who are diagnosed elsewhere continue to move to this area during the end stages of their disease to be near their aging and retired parents.

Because the TSA is geographically situated in an area subject to hurricanes and tropical storms, contingency planning is a major factor in caring for PLWH/A during and after one of these events. Electrical power and usual transportation means can be interrupted for weeks.

Demographic Composition

The following tables describe gender and race/ethnicity of the general population of each county in the TSA. Overall, the population is predominately White. While representing 12% of the total TSA population, Blacks range from a low of 3% in Pasco County to a high of 17% in Hillsborough County. Hispanics, who can be of any race, range from a low of 7% in Pinellas County to a high of 39% in Hardee County and represent 15% of the total TSA population. Females average 51% of the population throughout the TSA, with a low of 46% in Hardee County and a high of 52% in Pinellas County.

County	Non-Hispanic White		Non-Hispanic Black		Hispanics		Others		County Totals	
Hardee	14,245	52%	2,318	8%	10,843	39%	216	1%	27,622	100%
Hernando	140,963	86%	7,881	5%	12,415	8%	2,142	1%	163,401	100%
Highlands	71,706	72%	9,220	9%	16,660	17%	1,579	2%	99,165	100%
Hillsborough	686,535	57%	197,794	17%	273,184	23%	39,663	3%	1,197,176	100%
Manatee	238,909	75%	28,179	9%	46,061	15%	4,497	1%	317,646	100%
Pasco	377,187	86%	12,505	3%	38,492	9%	8,603	2%	436,787	100%
Pinellas	752,255	80%	100,315	11%	63,184	7%	29,683	3%	945,437	100%
Polk	400,526	69%	84,190	14%	90,196	15%	9,221	2%	584,133	100%
Total	2,682,326	71%	442,402	12%	551,035	15%	95,604	3%	3,771,367	100%

County	Total Males		Total Females		County Totals	
Hardee	14,915	54%	12,707	46%	27,622	100%
Hernando	78,200	48%	85,201	52%	163,401	100%
Highlands	48,169	49%	50,996	51%	99,165	100%
Hillsborough	586,302	49%	610,874	51%	1,197,176	100%
Manatee	154,793	49%	162,853	51%	317,646	100%
Pasco	211,850	49%	224,937	51%	436,787	100%
Pinellas	456,121	48%	489,316	52%	945,437	100%
Polk	287,565	49%	296,568	51%	584,133	100%
Total	1,837,915	49%	1,933,452	51%	3,771,367	100%

Source: Florida CHARTS, 2007

Socioeconomic Status

As reported in the 2006 US Census American Community Survey, the EMA has an estimated 11.8% individuals living below the federal poverty level (FPL) with Hillsborough County having the highest rate at 12.8% followed by Pinellas at 12.3%, Hernando at 12.2% and Pasco at 9.9%. When considering the non-EMA counties, 10.4% of Polk County, 9.3% of Highlands County, and 8.1% of Manatee County is living below the federal poverty level. Data was not available for Hardee County due to its small population size.

Poverty creates a multitude of problems when treating HIV. Safe and affordable housing is in short supply in the EMA. In May 2008, Hillsborough County ranked 6th and Pinellas County ranked 7th among the top 10 counties with foreclosures in Florida according to RealtyTrac. The City of Tampa Housing and Community Development Division published their HIV/AIDS Housing Plan¹ in September 2007. Their report indicated that there are more than 5,076 persons living with HIV/AIDS that are low-income and in need of some type of housing assistance. Their survey of 515 persons living with HIV/AIDS in the Tampa area found that 85% of respondents are unstably housed. The lack of stable housing and/or utilities can adversely affect an individual's ability to participate in treatment and be adherent to complex treatment regimens.

Homelessness affects individuals in the same way poverty does but to a greater extent. With no permanent address, locating clients to link them with services becomes difficult. Without proper storage and refrigeration, medications may not be as effective even when taken as prescribed. Weakened immune systems, exposure to the elements, poor nutrition, greater stress, and poor hygiene can make an individual more susceptible to a large variety of infections and illnesses, causing further decline and increasing the cost of treatment when care is finally accessed.

The Florida Department of Children and Families estimates in its 2008 Annual Report on Homelessness Conditions in Florida that on any given day there are 59,036 persons in Florida who are homeless. The same report indicates that according to their annual survey the counties represented in this EMA have an estimated 18,482 homeless individuals and the TSA has 21,674 homeless (36.7% of all of the estimated homeless persons in the State of Florida). The rate per 100,000 of homelessness among the general TSA population is 574.7 compared to the rate of homelessness among the PLWH/A population in the TSA at 792.7. The rate in the general EMA population is 673.8 compared to 2,513.2 among the PLWH/A in the EMA. Based on the methodology used to estimate the numbers of homeless individuals in this report, local homeless advocates believe the numbers of homeless individuals are potentially 10% higher than estimated in this report.

¹City of Tampa Housing and Community Development Division. (2007, September). *City of Tampa EMSA HIV/AIDS Housing Plan: Responding to the Need for Supportive Housing for Low Income Individuals and Families Living with HIV/AIDS*. Birmingham, AL: Collaborative Solutions, Inc.

Homelessness by County and Area

County	Number	Percent of FL homeless	County	Number	Percent of FL homeless
Hardee	835	1.4%	Hernando	196	0.3%
Highlands	912	1.5%	Hillsborough	9,532	16.1%
Manatee	472	0.8%	Pasco	4,074	6.9%
Polk	973	1.6%	Pinellas	4,680	7.9%
Total Non-EMA	3,192	5.4%	Total EMA	18,482	31.3%
Total Service Area	21,674	36.7%	Florida	59,036	100%

Source: Florida Department of Children and Families, 2008

According to the US Department of Labor's Bureau of Labor Statistics, Tampa-St. Petersburg lost 1.8% of its jobs over the year ending in June 2008 making this area the second worst in lost jobs among metro areas nationwide. The Tampa Bay area led the State of Florida in job losses with more than 23,100 jobs lost over the past year and unemployment locally at 5.9% in June 2008 which is higher than the state and national levels, both at 5.5%.

The more rural counties in the service area including Hardee, Highlands, Manatee and parts of Hillsborough 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 the economic base is the impact of migrant and seasonal farm workers in the rural counties. Florida provides work for 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. There are an estimated 50,000 migrant workers and their families in the TSA.

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 if services are available locally. Limited transportation funds can be expended quickly when great distances must be traveled. 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.

Access to Health Care

All eight counties comprising the TSA are designated as Health Professional Shortage Areas (HPSA) and Medically Underserved Areas/Medically Underserved Populations (MUA/MUP). Lack of insurance coverage can greatly limit access to health care. According to the 2004 Florida Health Insurance Study, 16.5% of the EMA and 15.9% of the TSA population under age 65 is uninsured. Many uninsured patients present at emergency rooms (ERs) for care. The cost of treatment in an ER is much higher than clinic care, and the care is often uncompensated. For those PLWH/A who are able to work, the threat of losing their jobs due to illness or to the side effects of medications, or discrimination once their diagnosis becomes known, is a daily reality. Many do not have the resources to maintain insurance benefits and manage co-pay and deductible requirements without assistance from programs such as the Ryan White insurance services program. The Grantee surveyed Part A contracted primary care providers and found that 63% of the clients they serve are uninsured. Providers also note that the complexity of co-morbid conditions require the expertise of specialists and that expert consultation is either difficult or impossible to obtain since many of these patients have no health insurance.

Uninsured Residents by County and Area

County	Number	Percent of county	County	Number	Percent of county
Hardee	7,271	30.8%	Hernando	17,292	17.3%
Highlands	11,850	19.3%	Hillsborough	134,309	14.1%
Manatee	46,122	21.0%	Pasco	50,988	18.0%
Polk	74,347	17.7%	Pinellas	139,474	19.0%
Total Non-EMA	139,590	14.7% of non-EMA	Total EMA	342,063	16.5% of EMA
Total Service Area	481,653	15.9% of TSA			

Source: Florida Health Insurance Study-County Estimates, Agency for Health Care Administration, 2004.

Residents receive many types of public assistance. Temporary Assistance to Needy Families assists 0.3% of families in the area while Supplemental Security Income (SSI) is accessed by 1.9% of the area's residents and 12.1% of the population is eligible for Medicaid. Recipients of all types of social security, including retired and disabled workers, spouses, children and widows/widowers, is accessed by 20.5% of the general population.

A 2007 survey of HIV+ individuals in the eight county TSA gathered 1,747 responses. Respondents self-reported sources of public assistance to contrast with the general population percentages presented above. Temporary Assistance to Needy Families assists 3.9% of HIV+ respondents' families; Social Security Disability is accessed by 43.6% of HIV+ respondents, and 40.4% of respondents report receiving assistance from Medicaid.

CHAPTER 2: EPIDEMIOLOGICAL PROFILE

Current Local Epidemic

The Florida Department of Health 2007 Epidemiological Profile reports the number of cases in the TSA living with HIV (non-AIDS) is 5,076. The number of individuals reported as living with AIDS is 7,037. The total living cases of HIV (non-AIDS) and AIDS in the TSA are 12,113 accounting for 14% of HIV/AIDS cases in the state of Florida. The number of new reported cases of HIV in the TSA is 982, which represents a rate of 26.0 per 100,000 of the total population and accounts for 16.4% of all new HIV infections in the state of Florida. The number of new AIDS cases reported within the past 2 years (2006 and 2007) is 1,367. The EMA's 604 new AIDS cases for 2007 represent 15.9% of the new AIDS cases throughout Florida. The following table shows the breakdown of PLWH/A in the TSA by gender, race/ethnicity, age and mode of transmission. See Appendix B for EMA specific data.

TSA Prevalence	Group	Number		Rate per 100,000		Percentage		Total HIV/AIDS		
		AIDS	HIV	AIDS	HIV	AIDS	HIV	#	%	rate
Gender	Male	5,179	3,371	281.8	183.4	73.6%	66.4%	8,550	70.6%	465.2
	Female	1,858	1,705	96.1	88.2	26.4%	33.6%	3,563	29.4%	184.3
	Total	7,037	5,076	186.6	134.6	100%	100%	12,113	100%	321.2
Race/Ethnicity	White	3,470	2,269	129.4	84.6	49.3%	44.7%	5,739	47.4%	214.0
	Black	2,526	2,036	571.0	460.2	35.9%	40.1%	4,562	37.7%	1031.2
	Hispanic	940	685	170.6	124.3	13.4%	13.5%	1,625	13.4%	294.9
	Other/Unk.	101	86	105.6	90.0	1.4%	1.7%	187	1.5%	195.6
	Total	7,037	5,076	186.6	134.6	100%	100%	12,113	100%	321.2
Age	0-12	23	37	3.9	6.2	0.3%	0.7%	60	0.5%	10.1
	13-19	71	85	21.7	26.0	1.0%	1.7%	156	1.3%	47.7
	20-24	85	252	38.3	113.5	1.2%	5.0%	337	2.8%	151.8
	25-29	223	493	101.3	224.0	3.2%	9.7%	716	5.9%	325.4
	30-39	1,307	1,377	285.0	300.2	18.6%	27.1%	2,684	22.2%	585.2
	40-49	3,055	1,712	574.2	321.8	43.4%	33.7%	4,767	39.4%	895.9
	50-59	1,745	839	350.6	168.6	24.8%	16.5%	2,584	21.3%	519.2
	60+	528	281	57.4	30.6	7.5%	5.5%	809	6.7%	88.0
	Total	7,037	5,076	186.6	134.6	100%	100%	12,113	100%	321.2
Mode of Transmission	MSM	3,331	2,282			47.3%	44.9%	5,613	46.3%	
	IDU	977	591			13.8%	11.6%	1,568	12.9%	
	MSM/IDU	389	187			5.5%	3.6%	576	4.8%	
	Hetero	2,181	1,929			30.9%	38.0%	4,110	33.9%	
	Other	159	87			2.3%	1.7%	246	2.0%	
	Total	7,037	5,076			100%	100%	12,113	100%	

Source: Florida Department of Health, HIV/AIDS Bureau, 2007

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 (Centers for Disease Control) 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.

Epidemiological data is updated each year and is provided by the State Department of Health to the local areas for analysis. 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. 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.

One issue faced by the TSA is the significant number of individuals migrating here from other areas, which will not be reflected in TSA numbers unless a confirming HIV test is conducted in the state or the individual has a CD4 or viral load test (which became officially reportable in November 2006). Florida also began electronic lab reporting in 2006, but not all labs report electronically at this time. An HIV+ person who converts to AIDS while in the state will be captured in the incidence estimates but the impact of the in-migration upon existing resources could be devastating. The state maintains a database for cases originally reported out of state who are now receiving care in Florida. The Tampa-St. Petersburg EMA and consortia area had 633 of those cases in 2007 which represent more than 5% of the total HIV/AIDS cases in the area.

The following table shows the distribution of the PLWH/A population by county. Hillsborough County has the largest percentage of PLWA and PLWH, 44% and 46%, respectively while Hardee County has the smallest percentage at 1% each.

Distribution of TSA's PLWA/PLWH Population by County

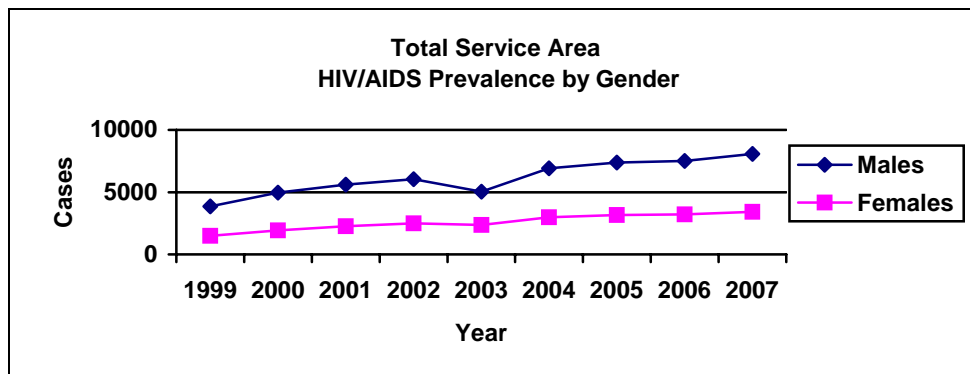
County	% total TSA general population	% PLWA	% PLWH	% PLWHA
Hardee	1%	1%	1%	1%
Hernando	4%	2%	1%	1%
Highlands	3%	1%	2%	1%
Hillsborough	32%	44%	46%	45%
Manatee	8%	7%	7%	7%
Pasco	12%	5%	5%	5%
Pinellas	25%	28%	28%	28%
Polk	15%	13%	11%	12%
TOTAL	100%	100%	100%	100%

Source: Florida Department of Health, December 2007

The Florida Department of Health HARS (HIV/AIDS Reporting System) data excludes the Department of Corrections (DOC). Annually, statewide more than 1,400 HIV+ inmates are released from state correctional institutions with around 300 of them returning to the TSA. According to the Florida DOC, 866 HIV+ state system inmates have been released to the TSA during the last three years. Approximately 2% of all the local jail inmates released are HIV+. The local jail systems report approximately 2,400 releases of HIV+ inmates, but the local jail system estimates are based on actual releases rather than individuals as often the same inmate is incarcerated and released multiple times. According to the Florida Department of Corrections, the average stay in a Florida jail is about 23 - 46 days. The average stay in prison is between three and five years.

Profile of PLWH/A by Age, Gender, Race and Exposure Category

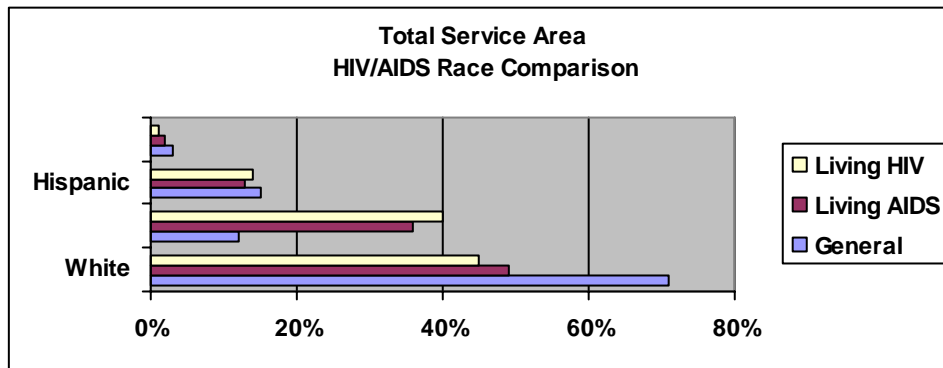
Male PLWHAs - Men continue to represent the greatest number of both HIV and AIDS cases at 66% and 74%, respectively. The number and percentage of HIV and AIDS cases among men has increased, which is to be expected with the most common mode of transmission in the TSA being MSM (men who have sex with men). Analysis of HIV prevalence data over a period of nine years as displayed in the following chart provides an accurate account of trends within the TSA.



The data show that HIV/AIDS has a disproportionate impact on Black males as can be seen in the case data information, as well as the rate data information that follows. Case data shows neither a disproportionate impact on white males nor Hispanic males, but the rate data shows that Hispanic males have a greater burden of HIV/AIDS than do their White male counterparts. White males are approximately 34% of the total population of the TSA. Forty-one percent of the 2006-2007 AIDS incidence in the TSA and 38% of the HIV (non-AIDS) prevalence was found in this population. Black males represent 22% of the AIDS incidence and 21% of the HIV (non-AIDS) prevalence but are only approximately 6% of the TSA's total population. Hispanic males are approximately 8% of the TSA's total population, and represent approximately 9% of the AIDS cases reported in 2006-2007, and 9% of the HIV cases reported in 2007.

Female PLWHAs – The data show that HIV/AIDS has a disproportionate impact on Black females. As with Hispanic males, Hispanic female rate data shows that they have a greater burden of HIV/AIDS than do their White female counterparts. White females are approximately 37% of the total population of the TSA. Eight percent of the 2006-2007 AIDS

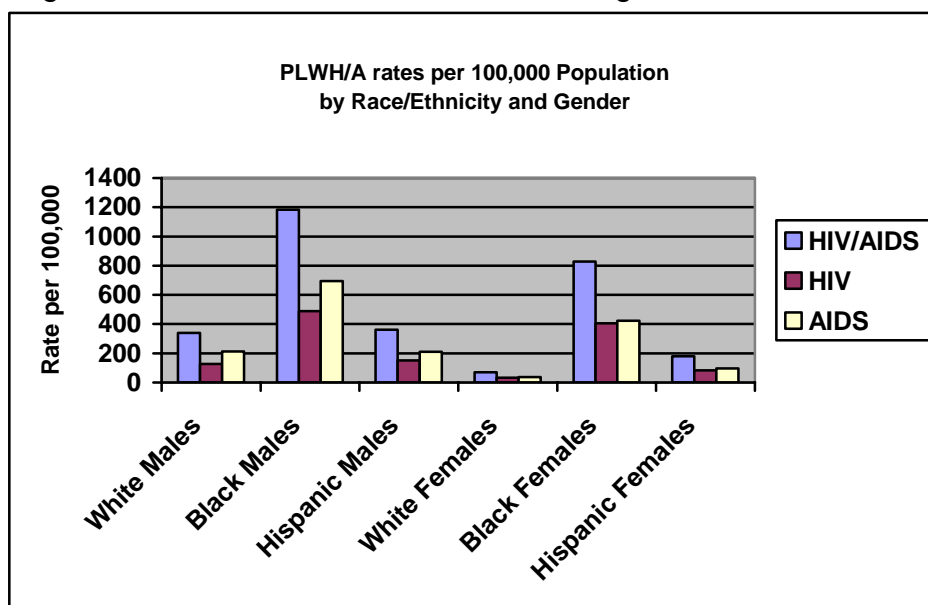
incidence in the TSA and 10% of the HIV (non-AIDS) prevalence was found in this population. Black females represent 15% of the AIDS incidence and 19% of the HIV (non-AIDS) prevalence but are only approximately 6% of the TSA's total population. Hispanic females are approximately 7% of the TSA's total population, and represent approximately 4% of the AIDS cases reported in 2006-2007, and 5% of the HIV cases reported in 2007.



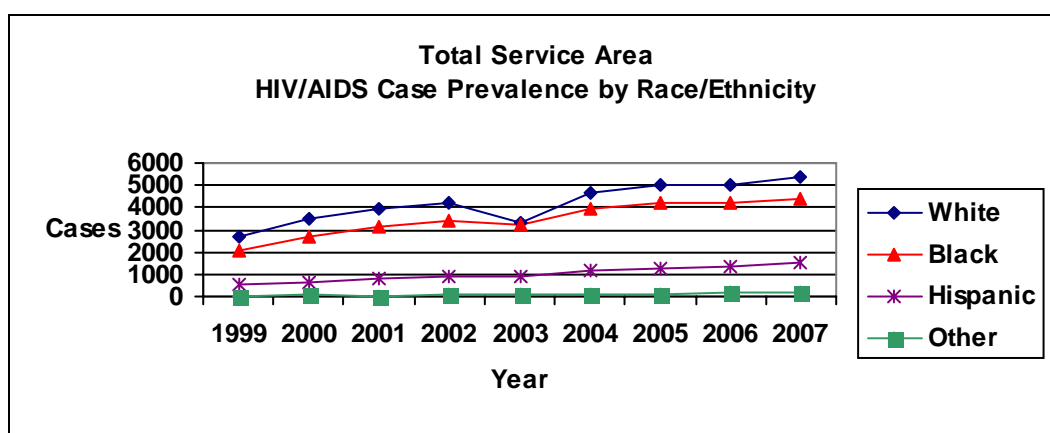
Among Black males, the rate of AIDS is 3.28 times higher than in White males and the rate of HIV is 3.82 times higher. The rate of AIDS is 11.43 times higher in Black females than in White females and the rate of HIV is 12.27 times higher.

Although the rate of AIDS is approximately equal among Hispanic males and White males, the rate of HIV is 1.23 times higher for Hispanic males than in White males. For Hispanic females, the rate of AIDS is 2.62 times higher than White females and the rate of HIV is 2.52 times higher.

An important emerging trend in this TSA is the growing rate of HIV/AIDS among Black females. One marker of this growth can be seen by comparing the rate of HIV and AIDS among Black females in comparison to White males. The rate of AIDS in Black females is two times higher, and the rate of HIV is 3.16 times higher than in White males.



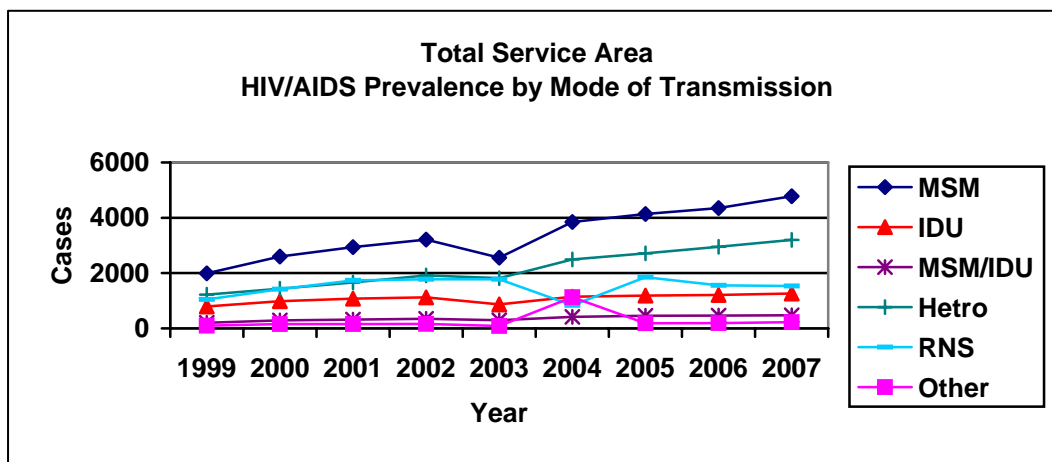
Trends over time show a steady, slight increase among all racial/ethnic population groups.



The following table more clearly illustrates the disproportionate impact among minority populations by gender. These numbers do not include the 633 cases that have migrated to our area since complete demographic data was not available for this group at the time of analysis. The data shows that even though White males represent the largest number of HIV/AIDS cases and the largest percentage of cases in the TSA, minority men and women are more disproportionately impacted by this disease. When reviewing rate per 100,000 data, Black males are most significantly impacted (1,183 per 100,000), followed by Black females (828 per 100,000) and then Hispanic males (361 per 100,000) compared to White males at a rate of 340 per 100,000.

Group (% of pop)	TSA AIDS				TSA HIV				TSA HIV/AIDS			
	# of cases	Rate per 100,000	% cases in TSA	% cases by gender	# of cases	Rate per 100,000	% cases in TSA	% cases by gender	# of cases	Rate per 100,000	% cases in TSA	% cases by gender
MALES												
White (34%)	2,752	212	41%	56%	1,660	128	34%	52%	4,412	340	38%	55%
Black (6%)	1,467	695	22%	30%	1,032	489	21%	32%	2,499	1,183	22%	31%
Hispanic (8%)	595	210	9%	12%	430	151	9%	14%	1,025	361	9%	13%
Other/Unk. (1%)	69	152	1%	1%	56	123	1%	2%	125	275	1%	2%
Total (49%)	4,883	266	73%	100%	3,178	173	66%	100%	8,061	439	70%	100%
Females												
White (37%)	510	37	8%	29%	461	33	10%	28%	971	70	8%	28%
Black (6%)	979	423	15%	55%	936	405	19%	57%	1,915	828	17%	56%
Hispanic (7%)	258	97	4%	15%	223	83	5%	14%	481	180	4%	14%
Other/Unk. (1%)	25	50	<1%	1%	26	52	1%	2%	51	102	<1%	1%
Total (51%)	1,772	92	100%	100%	1,646	85	34%	100%	3,418	177	30%	100%
TSA Total	6,652				4,824				11,479			

Men who have sex with men remain the largest exposure category in the TSA (46% of HIV/AIDS prevalence). Heterosexual transmission is the second most common exposure category (34% of HIV/AIDS) and is the most common exposure category among women (77% of female prevalence). Injection drug use is the third most common known exposure category (13% of HIV/AIDS prevalence).



EMERGING POPULATIONS/TRENDS

Men who have sex with Men (MSM) of all races are severely impacted by HIV/AIDS in the TSA as are women through heterosexual contact. Racial and ethnic minorities make up increasingly larger portions of the epidemic across all age groups and modes of transmission and genders. The data also show increases in infections among our youth and injection drug users.

Men Who Have Sex with Men (MSM), represent 53% of the TSA's AIDS prevalence and 49% of its HIV prevalence. Over the last two years, 50% of all new AIDS diagnosis was among this population. In addition, MSM represented 52% of all new HIV cases reported in 2006 and 55% of new HIV cases reported in 2007. Of all male PLWH/As in the EMA, 73% are MSM. Although the AIDS incidence and mortality among MSM have declined since the mid 90's due in part to the increased availability and success of antiretroviral therapies, the rate of decrease has slowed over the past five years, especially among minorities. The 2006 death rate per 100,000 for Black males in Tampa-St. Petersburg was 36.1 compared to 5.4 for Hispanic males and 7.1 for White males. Minority men have a much shorter survival time between an AIDS diagnosis and death. The median survival time for total deaths from 1998-2007 is 35 months for Black males and 37 months for Hispanic males compared to 53 months for White males. As indicated in recent CDC reports and fact sheets, a serious concern to the health care system is the potential for significant increases in HIV infection among MSM due to a resurgence of risky behavior and extraordinarily high seroprevalence rates among some MSM populations such as gay men of color and young gay men. Gay men of color seem significantly disproportionately impacted even among

MSM. The following table shows the minimum PLWH/A rates among MSM as described in the Florida Department of Health's Out in the Open report. Rates were not calculated for all counties due to the smaller size of the MSM population in those areas.

County	White MSM One in...	Black MSM One in...	Hispanic MSM One in...
Hillsborough	22	12	33
Manatee	54	15	47
Pasco	71	Not available	91
Pinellas	26	14	27
Polk	65	30	114
State of Florida	29	12	18

Source: Florida Department of Health, 2007

Women of childbearing years (13-44) make up approximately 14% of the total AIDS cases in the TSA and approximately 22% of all the HIV cases. The CDC reports that most women are infected through heterosexual contact with an infected male partner, often their only partner. In the TSA, 74% of AIDS cases and 81% of the HIV cases among females are attributed to heterosexual transmission according to the State of Florida, HIV/AIDS Bureau HARS statistics. In the Department of Health's report, Organizing to Survive, the disproportionate impact on minorities within this population is easily seen. The following table shows the PLWH/A rates among women. Rates were not calculated for counties with less than 150 total PLWH/As among women.

County	White Women One in...	Black Women One in...	Hispanic Women One in...
Hillsborough	1,007	92	403
Manatee	1,768	76	472
Pasco	1,585	170	640
Pinellas	1,382	110	578
Polk	1,143	109	678
State of Florida	1,281	68	472

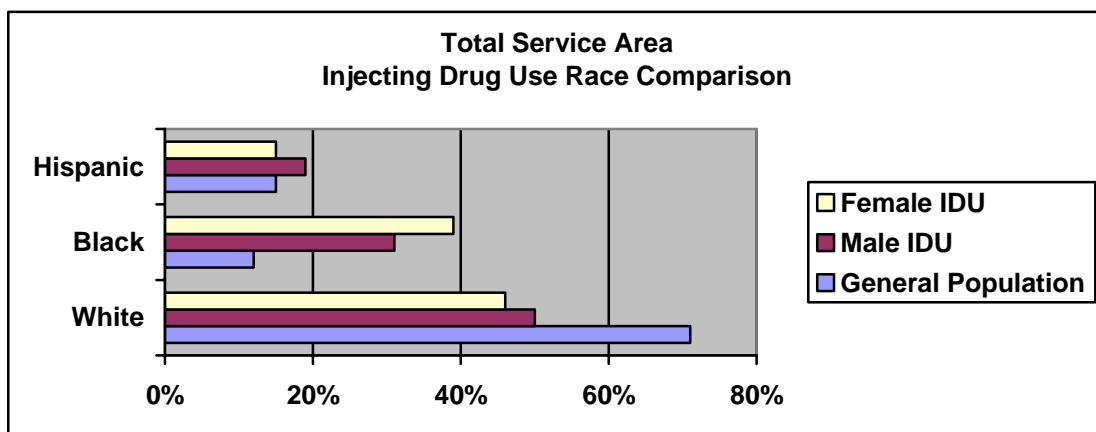
Source: Florida Department of Health, 2007

The unique challenges presented to the system of HIV care by this population are reflective of the socio-economic characteristics of women in the general population. These factors include higher rates of unemployment and poverty. Based on the Florida DOH Office of Evaluation and Data Analysis CHARTS and U.S. Census data, in Hillsborough County, for example, the percentage of families with a female head of household living in poverty is twice as high as the national average (25% vs. 12.3%). Women of childbearing years in the TSA who are infected with HIV tend to be poor, young, Black and living in disenfranchised communities in economically deprived neighborhoods. In addition to high crime rates, such

neighborhoods are usually designated as Medically Underserved Areas (MUAs). MUAs lack sufficient medical clinics and providers in proportion to the population (i.e., East Tampa in Hillsborough and Bayview in Pinellas). The risk of contracting HIV, or for those already infected, the risk of becoming re-infected or acquiring other STDs, is greater for women who are financially dependent on male partners. This dependence puts them in a disadvantaged position when trying to negotiate safer sexual behaviors. Women also experience gender-specific manifestations of HIV disease, such as recurrent vaginal yeast infections, herpes simplex virus ulcerations, human papillomavirus, and pelvic inflammatory disease that require specialized and costly medical care.

Women with HIV are likely to receive fewer health care services and HIV medications compared to men with HIV, not only because of the lack of health insurance but also because of their lack of awareness and testing. Service providers for this population often report that women may postpone taking medications or keeping medical appointments to take care of others' needs, or because of economic or transportation problems. Like men with HIV/AIDS, women may fear disclosure of their status due to fear of rejection and discrimination by friends, providers, family and their church congregation. It is not rare for women with children to consider their HIV infection as the least of their problems; more pressing and urgent are issues such as lack of income, housing, access to health care for their children, possible abusive relationships and caring for other family-related concerns. Women also tend to have a shorter time between an AIDS diagnosis and death. The median survival time for total deaths from 1998-2007 is 25 months for Hispanic females, 33 months for Black females and 37 months for White females compared to 53 months for White males.

Injection Drug Users (IDU) represent 13% of the TSA's HIV/AIDS prevalence. MSM/IDU transmission accounts for an additional 7% of the HIV/AIDS prevalence in 2007. Among males who report transmission via IDU in the TSA, White males (50%) represent the highest in this group with Black males representing 31% and Hispanic males 19%. Reported transmission by IDU among females is highest among Whites (46%) and Blacks (39%) followed by Hispanics (15%). The following table clearly illustrates that injection drug use has a disproportionate impact on Black and Hispanic populations.



Youth ages 13 to 24 years account for approximately 2% of the living AIDS cases and 7% of the HIV (non-AIDS) cases. This age group represents 5% of the new AIDS cases over the past two years and 14% of the new HIV cases. There is a disproportionate impact among the minority populations in this age group. While Hispanics represent 15% of the general population in all age groups combined, they represent 14% of the HIV/AIDS cases among the 13-24 year age group alone. Blacks represent 12% of the TSA's general population and an overwhelming 61% of HIV/AIDS cases in this age group with Black males being the hardest hit group with 32% of the cases.

The disproportionate impact on minorities can further be seen in the poverty levels among this age group. According to the 2000 Kids Count Census data, 35% of Black children and 23% of Hispanic children live below the poverty level and 13% of teens drop out of high school in the TSA. Poverty and unstable housing affects this population because basic survival needs must be met first before patients and/or their caretakers are willing and able to focus on medical care. Missed appointments and lack of treatment adherence results in the need to re-evaluate treatment plans and repeat appointments and diagnostic tests. Teenage patients report that the absence of an adult caretaker or the stigma and lack of HIV knowledge on the part of the adult caretaker is a persistent barrier in receiving the necessary social support that would help them fully engage in care.

Census data shows five percent of children have difficulty speaking English. The local University of South Florida (USF) Department of Pediatrics Infectious Diseases Division provides primary medical care to HIV positive youth from birth to age 24. They estimate that 15-20% of their patients and/or their adult caretakers have limited English proficiency requiring complex scheduling between patient, caretaker and a bilingual medical provider or medical interpreter. The USF program staff is currently studying the fact that more than 30% of their clients have an IQ of less than 70. The lower the IQ of the young patient, the less likely they are to be able to follow medical guidance and learn to manage their illness as they age. USF staff note that the majority of their patients face numerous medically complex issues that are often intertwined with significant social support deficits and developmental concerns.

The growing diversity of the infected population points to an increasing need for cultural and age appropriate HIV care services, outreach and prevention efforts in the Total Service Area.

Prevalence of Co-Morbidities

When HIV Infection exists with co-morbid conditions, the complexity and cost of providing care increases dramatically. Individuals with a history of sexually transmitted diseases are likely to have a compromised immune system and are more likely to contract opportunistic infections. The rate of infectious syphilis per 100,000 PLWH/A is 339.7 and the rate for Chlamydia is 548.8. The rate per 100,000 for gonorrhea is 862.4 and the rate for Hepatitis C is 8,789.2. The rate for substance abuse is 16,646.3 and the rate of chronic mental illness is 4,730.0. These conditions must all be considered in planning an effective care continuum.

CHAPTER 3: HISTORY OF RESPONSE TO THE EPIDEMIC

The Tampa – St. Petersburg EMA and surrounding counties which help comprise the TSA have a long history of responding to the HIV 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.

Florida established AIDS case surveillance in 1981 when the first case of AIDS was diagnosed in the state. Active surveillance began in 1984, and Florida was the first state to establish voluntary, confidential HIV counseling and testing at all county public health units in 1987. Tampa – St. Petersburg was designated as an EMA in 1992 and combined with the local consortia in 1999 to form the West Central Florida Ryan White Care Council.

Florida began HIV reporting in 1997 and mandatory lab test reporting in 2005. Each level of reporting brings us more sound epidemiological data to help the planning council make funding decisions, track emerging trends and plan programming.

Over the years, the local area has evolved and grown its system of HIV care to respond to changes in the epidemic and its affected populations. New developments in treatment and care have been incorporated to allow broader access to medications, adherence strategies, varied approaches to substance abuse and mental health treatment and intensive treatment for severe need populations. As the epidemic increasingly effects individuals traditionally disenfranchised from the health and social service system – such as homeless, youth, women, and people of color – the TSA is developing more avenues to coordinate, link and retain these individuals in care.

It is increasingly difficult to provide high quality, comprehensive services to eligible individuals due to expanding caseloads, rising health care costs and clients in need of more supportive services to help them enter and remain in care.

The planning council has consistently funded the HRSA-defined core services at a high level – greater than 80%. With decreased or flat funding, the Planning Council has had to discontinue funding to some of the support services (housing, legal, rehabilitation services) in order to maintain this commitment to the core services. Part A funding to the EMA was just over \$7 million dollars in 1999 and increased to \$8.5 million in 2001, an increase of 19%. However, during this same three year period, the HIV/AIDS prevalence increased by 47%. It is not possible to keep up with the increasing need for services at this rate, yet the gap between funding increases and the increase in HIV/AIDS prevalence has continued to grow. From 2001 through 2008, the HIV/AIDS prevalence has increased by 67% and the number of outpatient/ambulatory medical care clients has increased by 13% while the funding has only increased by 4.5%

CHAPTER 4: ASSESSMENT OF NEED

To determine the need in our local area, many factors are considered. There are estimated to be more than 3,500 individuals in our total service area who are positive but are not yet aware of their status. These undiagnosed cases represent 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.

Florida is also experiencing in-migration of individuals already infected, both aware and unaware, as well as migration throughout the state between service areas. The 2008 client survey (n=1,747) revealed that 27.5% of respondents were initially diagnosed somewhere other than Florida. The Florida Bureau of HIV/AIDS keeps an out of state database to track individuals who are currently receiving care in Florida counties. Currently, there are 633 individuals in our TSA from out of state; 520 in the EMA counties and 113 in the non-EMA counties.

Unmet Need Estimate

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 and/or the provision of anti-retroviral therapy.

The term “service gap” applies to all service needs of all PLWH/A *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.

Unmet Need Framework*

Population Size	TSA	EMA	Non-EMA
A. Number of persons living with AIDS (PLWA)	7,037	5,541	1,496
B. Number of Persons living with HIV (PLWH)	5,076	4,051	1,025
Care Patterns			
C. Number of PLWA who received the specified primary care in the previous 12 month period	5,076	3,985	1,091
D. Number of PLWH (Aware, non-AIDS) who received the specified primary care in the previous 12 month period	3,358	2,684	674
Results			
E. Number PLWA not in care	1,961	1,556	405
F. Number PLWH not in care	1,718	1,367	351
G. Total PLWH/A aware and not in care	3,679	2,923	756

*Data through December 2007

Rows A and B of the Unmet Need Framework Table provide populations estimates. Florida has had HIV reporting since July 1, 1997. The Florida HARS (HIV/AIDS Reporting System) data are specifically tailored to each EMA and consortia. 2007 HARS data was used to determine the number of people reported as living with HIV (non AIDS) and the number of people reported with AIDS.

Rows C and D of the Unmet Need Framework Table provide estimates of numbers of people in care. Estimates are based on the number and percent of people in care according to the HRSA definition (received HIV primary medical care as evidenced by one of the following in a defined 12-month time frame: viral load testing, CD4 count and/or the provision of anti-retroviral therapy).

The State took the lead in developing the unmet need methodology for all EMAs and consortia. The current year estimate has been refined and updated based on guidance from HRSA.

Numbers in care were estimated as follows: The state performed a match with ADAP (AIDS Drug Assistance Program) and HARS to assess which of the living and reported HIV/AIDS cases had at least one ADAP service (RX and/or lab as defined by the framework) in 2007. Additionally, Florida's Department of Health collaborated with the Agency for Health Care Administration to gain access to a database with names and other key variables of Medicaid cases who received the specified HIV primary medical care services in the most recent 12-month period as defined by the Framework. This year the State has also negotiated to access data from the local counties health department databases or HMS (Health Management System) to cross-reference with HARS. Florida was able to account for individuals who were initially reported out of state but received care in a Florida county in 2007. The State has had electronic lab reporting since November of 2006, but not all labs report electronically at this time. The State also hired staff to manually enter lab data that

was not reported electronically. These data were used to match against those living cases from the HARS database, giving a percent of PLWH/A in care.

Rows E and F of the Unmet Need Framework Table provide estimates of unmet need. Data sources were HARS, ADAP, Medicaid and local data described above. Number in-care is subtracted from living HIV and AIDS cases to obtain the number and percent not in care according to the HRSA definition. Thirty percent (30%) of the area's PLWH/A who are aware of their status are not receiving care.

One of the biggest challenges faced has been determining the demographics, location and needs of persons not in care. Many attempts to collect information from this population have been made 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 PLWH/A in the rural areas of Hillsborough County, including migrant laborers, farm workers and other minority groups which we strongly suspect are not in care but we do not have data to indicate the number.

Several attempts to determine the reasons why people who are aware of their status have decided not 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 Planning Council approached the State 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.

A fourth attempt was made at a World AIDS Day event. Volunteers distributed surveys to event participants, but no usable unmet need data was collected.

In addition, 56 respondents to the client survey also reported themselves as never being in care. This group was not asked the same questions as they identified themselves as still out of care, but their reasons for not receiving care and barriers to care have been identified in the following table:

Barriers to Care (Most to Least Common)
• Don't know where to go
• Lack of transportation
• Service sites too far away
• Don't know how to apply
• Dealing with other health problems
• Don't want people to know I have HIV
• Need evening/weekend appointment
• Had to wait too long for appointment

According to CDC, HIV's impact remains greatest among gay and bisexual men of all races and among black men and women. The State HIV/AIDS Bureau sorts data on those who *are* accessing care from the reported cases to give us some idea of those that are not in care. Thirty-two percent of males and 25% of females are not in care; 39% of those over age 60 do not access care; 21% of Hispanics, 30% of Blacks, and 33% of Whites are not accessing care. Individuals with heterosexual exposure seem less likely to access care in our area with 27% of heterosexually exposed females and 39% of heterosexually exposed males not accessing care.

Plans to find people not in care and encourage them to get into care have been an integral part of the recent MAI Capacity Building Project in the EMA. Marketing tools have been developed in English and Spanish to target Blacks and Hispanics. The marketing tools have been distributed in targeted communities most disproportionately impacted. A resource directory of community resources available has been compiled and distributed to local agencies as well.

Additional work is also being done with the Planning 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 the focus on core services. The Planning Council is exploring ways to collaborate with prevention and early intervention providers.

Currently, results of the unmet need framework are utilized primarily in the allocation of MAI funds. Programs funded under this initiative have been designed using different service delivery models and a concerted effort to expand and enhance the variety of services available was considered by exploring best practices through the MAI Capacity Building study. A program geared specifically toward minority women of child-bearing age was implemented in two counties, but has been reprogrammed due to limited success. A

substance abuse program targeting Blacks and Hispanics is meeting with success in the two counties of implementation.

The number of people with unmet need is utilized in overall prioritizations and service allocations to assure that funding for primary care and medications is in place so that there are services to provide to individuals once they are convinced to enter care. To this end, the Planning Council has implemented service caps and limits to increase capacity for new clients to enter care.

In an effort to better understand means of estimating, assessing, and addressing unmet need, the Grantee requested and received Technical Assistance on unmet need through HRSA. The technical assistance indicated a basically sound method of estimating the unmet need given the data limitations and noted the most difficulty seemed to lie in finding the number in private care.

Gaps in Care

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, but the gap may appear high if there is no (or limited) provider for the service. The following tables provide service gap information:

Services needed but not received (from highest to lowest %)

TSA	EMA	Non-EMA
Dental/Oral Health (33.5%)	Dental/Oral Health (33.0%)	Dental/Oral Health (37.6%)
Emergency Financial Assistance (25.3%)	Emergency Financial Assistance (26.4%)	Housing Assistance (19%)
Health Insurance (19.7%)	Health Insurance (20.0%)	Food Bank or Food Vouchers (17.5%)
Food Bank or Food Vouchers (19.2%)	Food Bank or Food Vouchers (19.4%)	Emergency Financial Assistance (17.1%)
Client Advocacy (18.4%)	Client Advocacy (18.6%)	Health Insurance (16.7%)
Housing Assistance (17.7%)	Housing Assistance (17.5%)	Client Advocacy (16.3%)
Transportation (14.5%)	Transportation (14.2%)	Transportation (16.3%)
Legal Support (13.7%)	Legal Support (14.3%)	Buddy/Companion Services (11.4%)
Nutritional Counseling (12.4%)	Nutritional Counseling (13.1%)	Early Intervention Services (10.6%)
Mental Health (12%)	Mental Health (12.7%)	Legal Support (9.7%)
Buddy/Companion Services (11.6%)	Case Management (11.9%)	Rehabilitation (9.2%)
Case Management (11.5%)	Buddy/Companion Services (11.7%)	Case Management (8.4%)
Rehabilitation (10.4%)	Rehabilitation (10.5%)	Medications (7.8%)
Early Intervention Services (10.1%)	Early Intervention Services (9.9%)	Outreach (7.8%)
Outreach (9.5%)	Outreach (9.7%)	Outpatient Medical Care (7.6%)

Medications (8.8%) Treatment Adherence (7.3%) Outpatient Medical Care (6.7%) Home Health Care (6.5%) Other Support Services (6.1%) Health Education/Risk Reduction (5.9%) Adult Day or Respite Care (5.4%) Child Daycare (3.4%) Substance Abuse (3.1%) Hospice Services (3.0%) Child Welfare (2.3%)	Medications (8.9%) Treatment Adherence (7.3%) Home Health Care (6.6%) Other Support Services (6.5%) Outpatient Medical Care (6.3%) Health Education/Risk Reduction (5.9%) Adult Day or Respite Care (5.5%) Child Daycare (3.2%) Substance Abuse (3.2%) Hospice Services (3.1%) Child Welfare (2.3%)	Nutritional Counseling (7.2%) Treatment Adherence (6.8%) Mental Health (6.7%) Health Education/Risk Reduction (6.2%) Home Health Care (5.7%) Adult Day or Respite Care (4.4%) Child Daycare (4.4%) Other Support Services (3.9%) Child Welfare (2.5%) Substance Abuse (2.0%) Hospice Services (1.5%)
---	---	--

Services needed but not received (from highest to lowest %)

Blacks	Hispanics	Women
Dental/Oral Health (32.2%)	Dental/Oral Health (35.3%)	Dental/Oral Health (34.1%)
Emergency Financial Assistance (28.5%)	Food Bank or Food Vouchers (24.5%)	Emergency Financial Assistance (25.9%)
Housing Assistance (24%)	Emergency Financial Assistance (23.4%)	Food Bank or Food Vouchers (19.7%)
Food Bank or Food Vouchers (20.3%)	Client Advocacy (18.1%)	Housing Assistance (18.8%)
Transportation (18.8%)	Health Insurance (17.8%)	Client Advocacy (18.3%)
Client Advocacy (18.7%)	Nutritional Counseling (17.8%)	Transportation (17.4%)
Health Insurance (17.8%)	Housing Assistance (16.3%)	Health Insurance (17.2%)
Legal Support (12.5%)	Buddy/Companion Services (14.5%)	Buddy/Companion Services (13.1%)
Case Management (12.4%)	Transportation (14.1%)	Case Management (13%)
Nutritional Counseling (12.4%)	Early Intervention Services (12.7%)	Rehabilitation (12%)
Buddy/Companion Services (11.6%)	Legal Support (12.6%)	Legal Support (12%)
Rehabilitation (11.4%)	Rehabilitation (12.2%)	Nutritional Counseling (11.4%)
Mental Health (10.6%)	Outreach (11.6%)	Outreach (10.7%)
Early Intervention Services (9.8%)	Other Support Services (11.3%)	Mental Health (10.5%)
Medications (9.6%)	Mental Health (11.2%)	Early Intervention Services (9.2%)
Outreach (9.1%)	Case Management (11.1%)	Treatment Adherence (8.6%)
Treatment Adherence (9.0%)	Home Health Care (10.6%)	Medications (8.5%)
Other Support Services (7.6%)	Treatment Adherence (9.0%)	Other Support Services (7.0%)
Outpatient Medical Care (7.6%)	Medications (8.9%)	Outpatient Medical Care (6.9%)
Health Education/Risk Reduction (7.5%)	Outpatient Medical Care (8.7%)	Child Daycare (6.2%)
Home Health Care (6.7%)	Adult Day or Respite Care (8.2%)	Health Education/Risk Reduction (6.1%)
Adult Day or Respite Care (5.6%)	Health Education/Risk Reduction (7.4%)	Home Health Care (6.0%)
Child Daycare (5.4%)	Hospice Services (5.0%)	Adult Day or Respite Care (5.7%)
Child Welfare (4.1%)	Substance Abuse (4.5%)	Substance Abuse (3.7%)
Substance Abuse (3.8%)	Child Daycare (3.0%)	Hospice Services (3.5%)
Hospice Services (3.2%)	Child Welfare (2.5%)	Child Welfare (3.3%)

Service gap information is used to guide the comprehensive planning process to assist in determining where new funding should be allocated if it becomes available. It is also used

to guide programming for Minority AIDS Initiative (MAI) services and to determine where additional cooperative agreements or service linkages should be developed.

Prevention Needs

Prevention planning occurs through a mechanism of local planning bodies called Community Planning Partnership (CPP) and the statewide initiative known as the Florida Community Planning Network (FCPN). Most recent priority populations were determined using a multi-step methodology. Data from new HIV cases reported from 2005 through 2007 is ranked by percent of cases followed by identifying case rates per 100,000 for disproportionately impacted populations groups and a CPP ranking. Each population's rankings are totaled and divided by three for a final priority rank. The 2006 target populations have been included for reference.

Top Prevention Priority Populations for the TSA

RANK	2006 Target Populations for Areas 5/6/14	2008 Target Populations for Areas 5/6/14
1	Black MSM (Men who have Sex with Men)	Black MSM (Men who have Sex with Men)
2	White MSM (Men who have Sex with Men)	White MSM (Men who have Sex with Men)
3	Black Heterosexual	Black Heterosexual
4	Hispanic MSM (Men who have Sex with Men)	Hispanic MSM (Men who have Sex with Men)
5	Black IDU (Injection Drug User)	White Heterosexual
6	Hispanic IDU (Injection Drug User)	White IDU (Injection Drug User)

Local prevention planners have developed strategies to align prevention and early intervention services with the CDC's Advancing HIV Prevention Initiative. This initiative aims to reduce barriers to early diagnosis of HIV infection and increase access to quality medical care, treatment, and prevention services for those living with HIV. Local prevention plans address each of the four strategies: 1) HIV testing in medical care, 2) new models for HIV testing, 3) Prevention with Positives and 4) decreasing perinatal transmission.

Prevention planners participate in the local community planning process and work with local clinics for primary care, mental health and substance abuse treatment, ASOs (AIDS Service Organizations), CBOs (Community Based Organizations), correctional/jail facilities, schools, housing agencies, homeless shelters and local media outlets to target individuals in need of prevention messages. While all DIS (Disease Intervention Specialists) staff, county health department clinicians and jail linkage staff provide counseling, testing, prevention messages, and linkages to care and treatment, the following table lists specific programs throughout the TSA. Each of these programs targets one or more priority populations.

Program	Program description
Healthy Relationships Program	Healthy Relationships is a five-session, interactive group program for persons who are HIV+ to share common experiences and develop decision-making and problem-solving skills. The development of these skills will enable participants to make informed safe decisions about disclosure and safer sex practices. The Health Relationships programs target Black and Hispanic Heterosexuals and Black, White and Hispanic MSMs.
Partnership for Health Program	Partnership for Health (PfH) is a brief, clinic based, counseling program for men and women living with HIV/AIDS. A clinician delivers messages to individuals about safer sex, disclosure and HIV prevention as a part of their office visit. The program is designed to improve patient-provider communication and increase the patient's knowledge, skills, and motivations to practice safer sex.
CRCS – Comprehensive Risk Counseling and Services	CRCS – Comprehensive Risk Counseling and Services is an intensive, individual level, client-centered risk reduction intervention for people at high risk for HIV infection or transmission.
One on One Consultation provided by HIV/AIDS Prevention and Training Consultant	One on One Consultation is provided to clients by and HIV/AIDS Prevention and Training Consultant. These consultations are done over the phone or in person at the local health department, in the client's home or in a confidential setting at their place of work. HIV infected clients are educated on all aspects of the disease including prevention and linkage to care, as well as being informed of resources in the community.
TOPWA (Target Outreach for Pregnant Women Act)	TOPWA intervention targeting pregnant women at-risk for HIV/AIDS who are not receiving proper prenatal care. There is an emphasis on minority women.
SISTA (Sisters Informing Sisters about Topics on AIDS)	SISTA (Sisters Informing Sisters about Topics on AIDS) is a peer-led, skill-building intervention project to prevent HIV infection in African American women. The goal of SISTA is to reduce sexual risk behavior by heterosexually-active African American women at highest risk for HIV by giving women the social and behavioral skills they need to adopt HIV risk-reduction strategies. Discussions of self-esteem, relationships, and sexual health are gender and culturally relevant and include behavioral skills practice, group discussions, lectures, role-playing, a prevention video, and take-home exercises.
VOICES/VOCES (Video Opportunities for Innovative Condom Education and Safer Sex)	VOICES/VOCES is a single-session, video-based HIV/STD prevention program designed to encourage condom use and improve condom negotiation skills. The program is based on the theory of reasoned action, which explains how behaviors are guided by attitudes, beliefs, experiences, and expectations of other persons' reactions. VOICES/VOCES is grounded in extensive formative research exploring the culture- and gender-based factors that can facilitate behavior change. It is aimed at African-American and Latino adult male and female clinic clients.

CHAPTER 5: DESCRIPTION OF CURRENT CONTINUUM OF CARE

The continuum of care is a coordinated delivery system encompassing a comprehensive range of health and support services that meet the needs of People Living with HIV/AIDS (PLWH/A) in all stages of illness. 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 any of the 60 licensed testing sites, hospital emergency rooms, private physician's offices and outreach programs throughout the TSA. Both confidential and anonymous testing is available and requires pre-and post-test counseling. 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 again occurs.

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 within the four county EMA as well as within six additional 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 infants, and prevent HIV infection in adolescents through early intervention and community outreach and education. In addition to Ryan White Part A funding, this program is funded through a variety of sources which 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 simultaneously. 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 acute care six days per week. 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 consultations, 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 the University of South Florida Main Campus, with the Adult HIV clinic. A gynecologist provides on site colposcopies and sub-specialty gynecological care.

The Mother-Baby Care program follows youth through pregnancies providing the infection disease 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 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 Adolescent Medical Trials Unit are provided in three University of South Florida clinics located in Hillsborough and Pinellas Counties that are conveniently located for patients in the most populated sections of the TSA.

In order to prevent mother-to-child transmission, the Perinatal HIV Prevention Program was developed as a collaborative community program funded by Ryan White Parts A, B, D and the Florida Department of Health's Children's Medical Services (CMS). The Program identifies pregnant HIV+ women and educates 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 obstetric visits are included as is a comprehensive education component. Although there were 69 HIV exposed infants in the TSA during 2007, there has been only one HIV positive perinatal case, according to the State of Florida, Bureau of HIV/AIDS HARS data.

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 and an experienced client with limited needs may navigate the system of care without assistance at any point on the continuum. The Planning Council adopted a policy that anyone presenting for Ryan White Part A funded services must show proof of primary care in the past year.

Ambulatory/outpatient care, often referred to as primary care is available in all of the counties within the TSA. 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. 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 PLWA 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 include the Hillsborough County Indigent Health Care Plan which pays for inpatient care and a portion of outpatient services for qualified low income individuals up to 100% FPL (Federal Poverty Level). Pinellas County Social Services supports a limited number of outpatient services.

Private insurance also funds care for those individuals that are covered, frequently through employers. The state operated AIDS Insurance Continuation Program (AICP) helps individuals pay for premiums, deductibles and co-pays, as do Parts A and B of the local Ryan White Programs.

Medical case management within the TSA is client centered with collaborations and linkages to health care, psychosocial, and other services to ensure timely, coordinated access to medically appropriate levels of health and support services and continuity of care. Services are available throughout the TSA and take place at the client's home, hospital and clinic or provider offices.

Medical 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.

Medications play a significant role in maintaining health and quality of life of HIV infected individuals. Medications make up the single largest expenditure in the treatment of HIV. In the TSA, medications represented 52% of the budgeted figures for all identified funding streams in 2008. This does not include payments for co-pays under the health insurance or AICP programs.

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 low. However, 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.

HIV-related medications are provided through a variety of sources available within the TSA 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, increased co-pays and formulary restrictions/revisions make medications a service category with the potential for dramatic change and negative financial impact for the Ryan White programs.

Health insurance services are available to HIV+ individuals within the TSA to provide financial assistance to maintain continuity of health insurance or to receive medical benefits under a health insurance program. 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.

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 within the TSA is through the Florida Department of Health Bureau of HIV/AIDS run AICP (AIDS Insurance Continuation Program). AICP operates statewide by providing payment for premiums and in some cases, co-payments and deductibles to allow symptomatic and asymptomatic 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.

Additional assistance for payment of health insurance coverage is available within the TSA through Ryan White Parts A and B and the state general revenue funded HIV services program. Individuals can receive up to \$400 per month for insurance premium assistance and up to \$175 per month to assist with co-pay and deductibles.

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.

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 stress 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 the need for mental health 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.

In addition to mental health services funded through Ryan White within the TSA, HIV+ individuals may also access services through sliding fee scales, Medicaid, pro-bono assistance from private providers, State of Florida projects and private insurance. Many providers are multi-services agencies offering a comprehensive range of services, or providing linkages to other providers in the community.

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.

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. Specific considerations must be given to interaction of HIV medications and agents prescribed by the dentist. Patients in advanced stages of the disease may already be taking antibiotics to prevent opportunistic infections, so additional agents should be used with caution. A thorough medical history as well as knowledge of potential interactions is essential for the clinician.

Although there continues to be a need for additional specialty dental care within the TSA for individuals with HIV, funding for dental care is available through Ryan White, Medicaid and county health and social services departments.

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.

Injection drug use (IDU) is the third ranked mode of transmission in the TSA. In general, addicts who are HIV+ are 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.

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: 1) Detoxification Services, 2) Residential Treatment, 3) Day/Night Treatment, and 4) 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 also funded in the TSA through the State of Florida, Ryan White and SAMSHA (Substance Abuse and Mental Health Administration). 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.

In addition to the core services, **support services** such as transportation, housing assistance, legal assistance and food bank/nutritional supplements are available throughout the EMA, and to a lesser degree within the non-EMA counties. These services are necessary in order to get people into care and maintain them in care to improve their medical care outcomes.

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 four 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 City of Tampa HOPWA program convened a coalition and conducted an in-depth analysis of housing needs. 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 and Skilled Nursing/Hospice Care.

Legal assistance is provided by 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. Waiting lists for legal assistance exist in most areas.

Nutritional supplements are provided in the TSA through Part A. Food banks are funded in the EMA through Part A, but are limited in the non-EMA counties. 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.

Support services are funded through a variety of sources throughout the TSA, including the State's Transportation Disadvantaged Program, Medicaid, Ryan White, State General Revenue, Homeless Coalitions, non-profit Legal Aid Programs, food banks and county health and social services projects.

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 (Statewide

Coordinated Statement of Need) 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.

The full resource analysis report includes wait list, hours of operation, languages spoken, public transportation accessibility and contact information for each provider. Findings from the report show that 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 areas 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.

The following tables include a summary of key providers by area and county.

**RESOURCE INVENTORY
EMA Counties**

CORE MEDICAL SERVICES	
Outpatient /Ambulatory Health Services	Community Health Centers of Pinellas (Pinellas) Hernando County Health Department (Hernando) Hillsborough County Health Department (Hillsborough) Lee Davis Neighborhood Service Center (Hillsborough) North Tampa Community Health Center (Hillsborough) Pasco County Health Department (Pasco) Pinellas County Health Department (Pinellas) St. Anthony’s Pinellas Care Clinic (Pinellas) St. Joseph’s Community Care (Hillsborough) St. Joseph’s Tampa Care Clinic (Hillsborough) St. Pete Free Clinic (Pinellas) Suncoast Community Health Center (Hillsborough) USF Department of Pediatrics (Hillsborough, Pinellas) US Veteran’s Administration (Hernando, Hillsborough, Pasco, Pinellas)
AIDS Drug Assistance Program (ADAP)	Hernando County Health Department (Hernando) Hillsborough County Health Department (Hillsborough)

	<p>Pasco County Health Department (Pasco) Pinellas County Health Department (Pinellas)</p>
<p>AIDS Pharmaceutical Assistance (local)</p>	<p>AB Specialty Pharmacy (Pasco) Community Health Centers of Pinellas (Pinellas) Daystar Life Center (Pinellas) Hernando County Health Department (Hernando) Hillsborough County Health Department (Hernando, Hillsborough, Pasco, Pinellas) Lincourt Pharmacy (Hernando, Hillsborough, Pasco, Pinellas) Neighborly Care Network (Pinellas) Pasco County Health Department (Pasco) PHS General and Medical Assistance (Pinellas) Pinellas County Health Department (Pinellas) Salvation Army (Hernando, Pinellas) St. Pete Free Clinic (Pinellas) Suncoast Community Health Center (Hillsborough) UF College of Dentistry (Pinellas)</p>
<p>Oral Health Care</p>	<p>Community Health Centers of Pinellas (Pinellas) Dental Research Clinic (Hillsborough) Good Samaritan Clinic (Pasco) Hernando County Health Department (Hernando) Hillsborough County Health Department (Hillsborough) St. Joseph's via Dolphin Dental (Pinellas) Lee Davis Neighborhood Service Center (Hillsborough) North Tampa Community Health Center (Hillsborough) Pasco County Health Department (Pasco) PHS General and Medical Assistance (Pinellas) St. Pete College Dental Clinic (Pinellas) Suncoast Community Health Center (Hillsborough)</p>
<p>Early Intervention Services</p>	<p>Hernando County Health Department (Hernando) Hillsborough County Health Department (Hillsborough) Pasco County Health Department (Pasco) Pinellas County Health Department (Pinellas)</p>
<p>Health Insurance Premium & Cost Sharing Assistance</p>	<p>The Health Councils, Inc. (Hernando, Hillsborough, Pasco, Pinellas)</p>
<p>Home Health Care</p>	<p>Daughter on Call (Pinellas) Visiting Nurses Association (Hernando) Helen Ellis home Care (Pinellas) Home Health Works (Pasco, Pinellas) Neighborly Care Network (Pinellas) Nurse Core (Pinellas) Suncoast Waiver Support Services (Pasco)</p>
<p>Home and Community-Based Health Services</p>	<p>Daughter on Call (Pinellas) Visiting Nurses Association (Hernando) Helen Ellis home Care (Pinellas) Home Health Works (Pasco, Pinellas) Neighborly Care Network (Pinellas) Nurse Core (Pinellas)</p>

	Suncoast Waiver Support Services (Pasco)
Hospice Services	Hernando-Pasco Hospice (Hernando, Pasco) Hospice of the Florida Suncoast (Pinellas) Life Path Hospice (Hillsborough)
Mental Health Services	Catholic Charities (Hernando) Community Food Bank (Hillsborough) Counseling Center of Plant City (Hillsborough) Counseling Center of Tampa Bay (Hillsborough) Crisis Center of Tampa Bay (Hillsborough) Directions for Mental Health (Pinellas) Family Service Association of Greater Tampa (Hillsborough) Francis House (Hillsborough) Good Samaritan – Adherence Corp. (Pinellas) Growing Counseling Center (Hernando) Harbor Behavioral Healthcare (Hernando, Pasco, Pinellas) Mental Health Care, Inc (Hillsborough) Northside Mental Health Center (Hillsborough) North Tampa Community Health Center (Hillsborough) Operation PAR (Pinellas) PEMHS, Inc. (Pinellas) St. Anthony’s Pinellas Care Clinic (Pinellas) St. Vincent de Paul (Pinellas) Suncoast Center for Community Health (Pinellas) Suncoast Community Health Center (Hillsborough)
Medical Nutrition Therapy	Hillsborough County Health Department (Hernando, Hillsborough, Pasco, Pinellas) Neighborly Care Network (Pinellas) St. Anthony’s Pinellas Care Clinic (Pinellas) St. Joseph’s Tampa Care Clinic (Hillsborough)
Medical Case Management (including Treatment Adherence)	AIDS Service Association Pinellas (Pinellas) Di’s Imani (Hillsborough, Pinellas) Gulf Coast Jewish Family Services (Hernando, Hillsborough, Pasco) Harbor Behavioral Healthcare (Hernando, Pasco) Hernando County Health Department (Hernando) Hillsborough County Health Department (Hillsborough) Metropolitan Charities (Hillsborough, Pinellas) Operation Hope (Pinellas) Pasco County Health Department (Pasco) Pinellas County Health Department (Pinellas) St. Anthony’s Pinellas Care Clinic (Pinellas) St. Joseph’s Tampa Care Clinic (Hillsborough) Tampa Bay AIDS Network (Pinellas) THAP (Hillsborough)
Substance Abuse Services– Outpatient	ACTS (Hillsborough) Counseling Center of Tampa Bay (Hillsborough) DACCO (Hillsborough) Directions for Mental Health (Pinellas) Family Service Association of Greater Tampa (Hillsborough) Francis House (Hillsborough)

	<p>Growing Counseling Center (Hernando) Gulf Coast Jewish Family Services (Hillsborough) Lighthouse Gospel Mission (Hillsborough) Operation PAR (Hillsborough, Pasco) Phoenix House (Hernando, Hillsborough, Pasco, Pinellas) St. Vincent de Paul (Pinellas) Suncoast Center for Community Health (Pinellas) WestCare Foundation (Pinellas)</p>
SUPPORT SERVICES	
Case Management (non-Medical)	<p>Operation Hope (Pinellas) Metropolitan Charities (Hillsborough, Pinellas)</p>
Emergency Financial Assistance	<p>AIDS Service Association Pinellas (Pinellas) Catholic Charities (Hernando, Hillsborough, Pasco, Pinellas) Crisis Center of Tampa Bay (Hillsborough) Daystar Life Center (Pinellas) Gulf Coast Jewish Family Services (Hernando, Hillsborough, Pasco) He Cares Ministry (Pinellas) Mercy House (Hillsborough) Mid Florida Community Services (Hernando, Pasco) PHS General and Medical Assistance (Pinellas) Pinellas Opportunity Council (Pinellas) Salvation Army (Hernando, Hillsborough, Pasco, Pinellas) St. Joseph's Community Care (Hillsborough) St. Pete Free Clinic (Pinellas) St. Vincent de Paul (Hillsborough) Tampa Bay AIDS Network (Pinellas)</p>
Food Bank/Home-Delivered Meals	<p>Abundant Life Ministries (Pinellas) AIDS Service Association Pinellas (Pinellas) Calvary Church (Hernando) Calvary Church of the Nazarene (Pasco) Christ Church of Palm Harbor (Pinellas) Church of God (Pinellas) Clearview United Methodist (Pinellas) Community Food Bank (Hillsborough) Dayspring Presbyterian Church (Hernando) Daystar Life Center (Pinellas) ECHO (Hillsborough) Emergency Relief Food Pantry (Pinellas) First Baptist Church of Brooksville (Hernando) FEAST, Inc (Pinellas) Food With Care (Hernando, Hillsborough, Pasco, Pinellas) Good Samaritan – Adherence Corp. (Pinellas) Gulf Coast Jewish Family Services (Hernando, Hillsborough, Pasco) He Cares Ministry (Pinellas) Lighthouse Gospel Mission (Hillsborough) Meals on Wheels (Hernando, Hillsborough, Pinellas) Metropolitan Ministries (Hillsborough) Mid Florida Community Services (Pasco)</p>

	<p>Nativity Catholic Church (Hillsborough) Operation Hope (Pinellas) RCCS Food Bank (Pinellas) Salvation Army (Hernando, Pasco, Pinellas) SHARE (Hernando, Hillsborough) St. Anne Catholic Church (Hillsborough) St. Anthony's Pinellas Care Clinic (Pinellas) St. Joseph's Community Care (Hillsborough) St. Joseph's Tampa care Clinic (Hillsborough) St. Pete Free Clinic (Pinellas) St. Vincent de Paul (Hillsborough) Tampa Bay AIDS Network (Pinellas) Tampa Bay Dream Center (Hillsborough) Tarpon Springs Shepard Center (Pinellas) Wesley United Methodist Church (Pinellas)</p>
Health Education/Risk Reduction	<p>AIDS Institute (Hernando, Hillsborough, Pasco, Pinellas) AIDS Service Association Pinellas (Pinellas) Coalition for a Safe and Drug Free St. Pete (Pinellas) Francis House (Hillsborough) Gulf Coast Jewish Family Services (Hillsborough) Metropolitan Charities (Pinellas) St. Anthony's Pinellas Care Clinic (Pinellas) THAP (Hillsborough)</p>
Housing Services	<p>Achieve Tampa Bay (Pinellas) Boley Center (Pinellas) Brooksville Housing Authority (Hernando) Achieve Tampa Bay (Hernando, Hillsborough) Catholic Charities (Hernando, Hillsborough, Pasco, Pinellas) City of Tampa Housing Authority (Hillsborough) Clearwater Housing Authority (Pinellas) Community Service Foundation (Pinellas) Gulf Coast Jewish Family Services (Hernando, Pasco) Harbor Behavioral Healthcare (Hernando, Pasco, Pinellas) Pasco Public Housing Authority (Pasco) Pinellas County & Dunedin Housing Authority (Pinellas) Plant City Housing Authority (Hillsborough) Public Housing Authority (Hernando) St. Petersburg Housing Authority (Pinellas) St. Vincent de Paul (Pinellas) THAP (Hillsborough)</p>
Legal Services	<p>Bay Area Legal Services (Hernando, Hillsborough, Pasco, Pinellas) Community Law Program (Pinellas) Community Legal Services of Mid Florida (Hernando) Gulf Coast Legal Services (Pinellas)</p>
Medical Transportation Services	<p>American Red Cross Transportation (Pinellas) Gulf Coast Jewish Family Services (Pasco/Hernando) Hillsborough Co. Sunshine Line (Hillsborough) Neighborly Care Network (Pinellas) St. Anthony's Pinellas Care Clinic (Pinellas)</p>

	Suncoast Community Health Center (Hillsborough) Transportation Disadvantaged Program (Pinellas)
Outreach services	Dawn Center of Hernando (Hernando) Good Samaritan – Adherence Corp. (Pinellas) Harbor Behavioral Healthcare (Hernando, Pasco, Pinellas) Metropolitan Charities (Pinellas) Pinellas Technical Education Center (Pinellas)
Psychosocial Support Services	AA – Pinellas Central Office (Pinellas) AIDS Service Association Pinellas (Pinellas) Boley Center (Pinellas) Dawn Center of Hernando (Hernando) Di's Imani (Hillsborough, Pinellas) Directions for Mental Health (Pinellas) Family Service Association of Greater Tampa (Hillsborough) Francis House (Hillsborough) Growing Counseling Center (Hernando) Gulf Coast Jewish Family Services (Hillsborough) Harbor Behavioral Healthcare (Hernando) Mental Health Care, Inc (Hillsborough) Metropolitan Charities (Hillsborough, Pinellas) Operation PAR (Hillsborough, Pinellas) Phoenix House (Hernando, Hillsborough, Pasco, Pinellas) Project CARE (Hillsborough) St. Joseph's Tampa Care Clinic (Hillsborough) St. Pete Free Clinic (Pinellas) Suncoast Center for Community Health (Pinellas) Tampa Bay AIDS Network (Pinellas) Tampa Bay Alliance of the Mentally Ill (Hillsborough) THAP (Hillsborough) Wesley United Methodist Church (Pinellas)
Referral for Health Care/Supportive Services	AIDS Service Association Pinellas (Pinellas) Gulf Coast Jewish Family Services (Hernando, Hillsborough, Pasco) Metropolitan Charities (Pinellas) Metropolitan Ministries (Hillsborough) Mid Florida Community Services (Hernando, Pasco) Tampa Bay AIDS Network (Pinellas)
Rehabilitation Services	24 Hour Skilled Nursing Care (Pinellas) Morton Plant – Barrett Rehabilitation (Pinellas) Nurse Core (Pinellas) Tandem Health Care of Brandon (Hillsborough)
Respite Care	Achieve Tampa Bay (Hernando, Hillsborough, Pinellas) Catholic Charities (Hernando) Daughter on Call (Pinellas) Francis House (Hillsborough) Neighborly Care Network (Pinellas) St. Pete Free Clinic (Pinellas) Tampa Bay AIDS Network (Pinellas) Tandem Health Care of Brandon (Hillsborough)
Treatment	AIDS Service Association Pinellas (Pinellas)

Adherence Counseling	Good Samaritan – Adherence Corp. (Pinellas) Operation Hope (Pinellas) Tampa Bay AIDS Network (Pinellas)
----------------------	---

**RESOURCE INVENTORY
Non-EMA Counties**

CORE MEDICAL SERVICES	
Outpatient /Ambulatory Health Services	Central Florida Health Care (Hardee, Highlands, Polk) Good Samaritan Free Clinic (Polk) Hardee County Health Department (Hardee) Highlands County Health Department (Highlands) Lakeland Volunteers in Medicine (Polk) Manatee County Rural Health Services (Manatee) Polk County Health Department (Hardee, Polk) US Veteran’s Administration (Hardee, Highlands, Manatee, Polk)
AIDS Drug Assistance Program (ADAP)	Hardee County Health Department (Hardee) Highlands County Health Department (Highlands) Manatee County Health Department (Manatee) Manatee County Rural Health Services (Manatee) Polk County Health Department (Hardee, Polk)
AIDS Pharmaceutical Assistance (local)	Hardee Health Center (Hardee) Highlands County Health Department (Highlands) Hillsborough County Health Department (Hardee, Highlands, Manatee, Polk) Lakeland Volunteers in Medicine (Polk) Lincourt Pharmacy (Hardee, Highlands, Manatee, Polk) Polk County Health Department (Hardee, Polk) Positive Healthcare (Hardee, Highlands, Polk)
Oral Health Care	Central Florida Health Care (Hardee, Highlands, Polk) Good Samaritan Free Clinic (Polk) Hardee County Health Department (Hardee) Highlands County Health Department (Highlands) Lakeland Volunteers in Medicine (Polk) Manatee County Rural Health Services (Manatee) Polk County Health Department (Hardee, Highlands, Polk)
Early Intervention Services	Hardee County Health Department (Hardee) Highlands County Health Department (Highlands) Manatee County Health Department (Manatee) Manatee County Rural Health Services (Manatee) Polk County Health Department (Hardee, Polk)
Health Insurance Premium & Cost Sharing Assistance	The Health Councils, Inc. (Hardee, Highlands, Manatee, Polk)
Home Health Care	Bayada Nurses (Manatee, Polk)
Home and Community-Based Health Services	Bayada Nurses (Manatee, Polk)

Hospice Services	Life Path Hospice (Hardee, Highlands, Polk) Tidewell Hospice of SW Florida (Manatee)
Mental Health Services	Counseling Center of Plant City (Polk) Manatee County Rural Health Services (Manatee) Manatee Glens (Manatee) Marge Brewster Center (Highlands) Peace River Center (Hardee, Highlands, Polk) Tri-County Human Services (Hardee, Highlands, Polk) Winter Haven Hospital Behavioral Health (Hardee, Highlands, Polk)
Medical Nutrition Therapy	Highlands County Health Department (Highlands) Manatee County Rural Health Services (Manatee) Meals on Wheels Plus (Manatee) Trinity Charities (Manatee)
Medical Case Management (including Treatment Adherence)	Di's Imani (Manatee) Gulf Coast Jewish Family Services (Hardee, Highlands, Polk) Highlands County Health Department (Highlands) Manatee County Rural Health Services (Manatee) Polk County Health Department (Polk) Positive Healthcare (Hardee, Highlands, Polk)
Substance Abuse Services—Outpatient	Good Samaritan Free Clinic (Polk) Lighthouse Gospel Mission (Manatee) Manatee Glens (Manatee) Peace River Center (Hardee, Highlands, Polk) Phoenix House (Hardee, Highlands, Manatee, Polk) Tri-County Human Services (Hardee, Highlands, Polk) Winter Haven Hospital Behavioral Health (Hardee, Highlands)
SUPPORT SERVICES	
Case Management (non-Medical)	Gulf Coast Jewish Family Services (Hardee, Highlands, Polk)
Emergency Financial Assistance	Gulf Coast Jewish Family Services (Hardee) Salvation Army (Highlands, Manatee, Polk) Trinity Charities (Manatee)
Food Bank/Home-Delivered Meals	Calvary Church (Hardee) Church of the Nazarene (Highlands) Food With Care (Hardee, Highlands, Manatee, Polk) Good Samaritan Free Clinic (Polk) Gulf Coast Jewish Family Services (Hardee) Lighthouse Gospel Mission (Manatee, Polk) Manatee County Rural Health Services (Manatee) Meals on Wheels Plus (Manatee) Salvation Army (Highlands, Manatee, Polk) Trinity Charities (Manatee)
Health Education/Risk Reduction	AIDS Institute (Hardee, Highlands, Manatee, Polk) Positive Healthcare (Hardee, Highlands, Polk) Trinity Charities (Manatee)
Housing Services	Hardee Health Center (Hardee) Polk County Health Department (Hardee, Highlands, Polk) Public Housing Authority (Highlands, Manatee, Polk)

Legal Services	Florida Rural Legal Services (Hardee, Highlands, Manatee, Polk) Gulf Coast Legal Services (Manatee) Heart of Florida Legal Aid (Hardee, Polk) Legal Aid of Manasota (Manatee)
Medical Transportation Services	Meals on Wheels Plus (Manatee)
Outreach services	Meals on Wheels Plus (Manatee)
Psychosocial Support Services	Crossroads Community Church (Polk) Di's Imani (Manatee) Manatee County Rural Health Services (Manatee) Manatee Glens (Manatee) Phoenix House (Hardee, Highlands, Manatee, Polk) Trinity Charities (Manatee)
Referral for Health Care/Supportive Services	Gulf Coast Jewish Family Services (Hardee, Highlands, Polk) Hardee Health Center (Hardee) Salvation Army (Highlands)
Rehabilitation Services	
Respite Care	Meals on Wheels Plus (Manatee)
Treatment Adherence Counseling	Manatee County Rural Health Services (Manatee) Positive Healthcare (Hardee, Highlands, Polk)

PROFILE OF RYAN WHITE FUNDED PROVIDERS

The provider maps in Appendix C give a snapshot of the EMA and non-EMA funded providers available in each county, but it does not include the large number of private practitioners available.

Hardee County is the most rural county in the TSA with the fewest number of HIV/AIDS cases. The Hardee County Health Department provides HIV-related primary care, treatment adherence education, lab tests, ADAP, case management with limited nutrition and dental services. Residents of Hardee County may receive services in Polk County through the Ryan White Part C program. HOPWA services for Hardee County are managed through neighboring Highlands County.

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

In **Hernando County**, the 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. As in

Pasco County, access to some specialty care is limited, but can be accessed in the nearby urban centers if payment source and transportation are available.

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

Also a rural county, **Highlands County** is also served by the Polk County Part C 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.

Highlands County is also a healthcare manpower shortage area and faces the same issues with regard to specialty referral as Hardee County.

Hillsborough County is the largest county in the EMA and has the highest number of HIV/AIDS cases. There are numerous providers within the county.

A collaborative effort between Tampa General Hospital, the University of South Florida's (USF) 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, 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 funded by Part A to determine eligibility for program services.

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 provider, DACCO (Drug Abuse Comprehensive Coordinating Office), 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 (Tampa Bay AIDS Network). 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, medical education, advocacy and treatment adherence services under the Minority AIDS Initiative program are provided. Services are available after hours as needed or in the client's home.

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 Part C program provides funding for services along with Part B and Emerging Communities Funds. 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.

Pasco County is a fast-growing bedroom community for Hillsborough County; however, it remains largely rural, particularly in the eastern portion of the county. 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. 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 eligible clients in the county.

Pinellas County is the most densely populated county in 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.

A collaborative effort between the Pinellas Care Clinic and the Pinellas County Health Department provides an infectious disease physician in the Largo Health Department two days per week to better serve clients in the northern part of the county. This coordinated effort increases access to a growing number of individuals needing HIV primary care.

Services include HIV related primary care, treatment adherence education, health education, labs, dietician, mental health and 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 services for HIV infected veterans at the Bay Pines VA Healthcare System.

AIDS Services Association of Pinellas (ASAP) provides medical case management, support groups, client and community education, testing and prevention, and CRCS – Comprehensive Risk Counseling and Services. ASAP provides a food and personal needs pantry and limited emergency financial assistance. There are two offices, one serving the southern portion of the county in St. Petersburg, and one in the northern portion in Clearwater.

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.

Pinellas County Social Services provides limited financial and medical assistance to eligible residents and the Pinellas County Health Department provides ADAP services. The Health Department also provides counseling, testing and linkage to 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 and food vouchers.

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

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 Parts B and C 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). The Health Department also provides counseling, testing and linkage to HIV medical care within the Pinellas County jail.

HIV/AIDS Services Funding

The funding stream analysis is an important component of the planning process. In order to more accurately allocate Ryan White Program 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 for 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 certain data at a county specific level
- Inability to obtain type of service funding breakouts
- Allocations which are made to multiple counties within the TSA
- Inaccuracies and/or inconsistencies in the data as reported to The Health Councils, Inc.

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 (e.g., Medicaid, the AIDS Insurance Continuation Program-AICP and Part A and B); however, the

other figures are budgeted amounts. In addition, reallocations may occur throughout the year within a funding source.

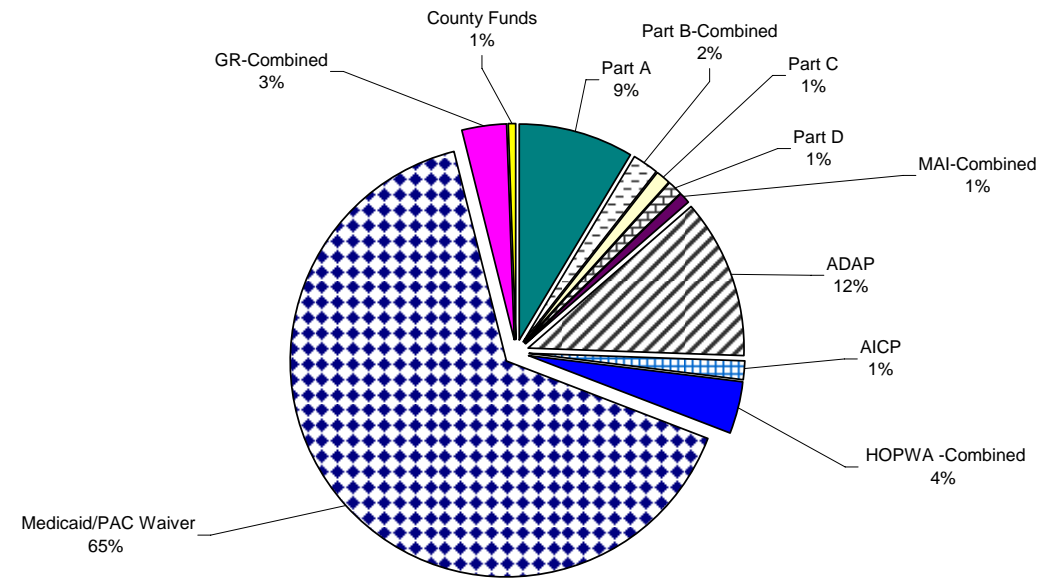
As shown in the chart below, Medicaid is the largest funding source for all services in the Total Service Area (TSA), accounting for 65% of total funding. This includes the Medicaid Project AIDS Care Waiver (PAC) funds for services. The AIDS Drug Assistance Program (ADAP) represents 12% of the total service area expenditures, while Ryan White Part A accounts for another 9% of funds received in the area. Housing Opportunities for Persons with AIDS (HOPWA) funds, including money that flows from the federal government (EMA) through the State or local government (non-EMA), totals 4% of the funding.

General Revenue (GR) (both County Health Department and Network) accounts for 3% of the funds. General Revenue state allocations are available through two funding streams. First, each county health department receives an annual allocation for HIV/AIDS patient care. In addition, the state allocates funds to be utilized for a "Network" of counties in a geographical area of the state. The eight counties that represent the Suncoast General Revenue Network area are the same as those that make up the Total Service Area.

Ryan White Part B represents 2% of PLWH funds received in the area. General Part B funds and Part B Emerging Communities funds received in the area are combined in Figure 2. Ryan White Part C and Ryan White Part D each represent 1% of total area funding. Ryan White Minority AIDS Initiative (MAI) funds were previously a portion of Part A but are now a separate grant. MAI and Part B MAI combined account for 1% of TSA funding.

The AIDS Insurance Continuation Program (AICP) funds represent 1% of funds received. Combined county governments (Hillsborough, Manatee and Pinellas) also represent 1% of the funds.

Funding Sources - TSA



*Excluded funding sources include, but are not limited to, Veteran's Administration, Medicare and private funding.
Source: 2008 Funding Stream Analysis

**CHAPTER 6:
BARRIERS TO CARE**

Barriers can limit or prevent PLWH/A from receiving available services that are essential to improving or maintaining their health and well-being. Barriers to care were identified by case managers, local “experts”, and clients responding to surveys. Barriers cited by case managers and experts are as listed in the following table and sorted by area.

Barriers to Care, Case Managers and Experts

Reason	TSA (n=115)	EMA (n=92)	Non-EMA (n=23)
Lack of transportation	43.5%	43.5%	43.5%
Lack of affordable housing	67.8%	76.1%	34.8%
Shortage of funding for needed services	42.6%	42.4%	43.5%
Lack of specialty medical care	8.7%	6.5%	17.4%
Lack of on-going assistance for utilities	10.4%	10.9%	8.7%
Lack of staff training	2.6%	2.2%	4.4%
Poor coordination of services	8.7%	8.7%	8.7%
Concerns regarding confidentiality	1.7%	2.2%	0%
Lack of providers for services	13.9%	10.9%	26.1%
PLWHA not involved in advocacy	6.1%	5.4%	8.7%
Service caps	2.6%	2.2%	4.4%
Stigma	14.8%	10.9%	30.4%
Not eligible for services	7.0%	8.7%	0%
Compliance/adherence among PLWHA	17.4%	20.7%	4.4%
Education about HIV progression	0.9%	1.1%	0%
Education about HIV prevention	5.2%	3.3%	13.0%
Need for job training and placement assistance	13.0%	15.2%	4.4%
Motivating PLWHA to get into care	8.7%	8.7%	8.7%
Lack of child care	2.6%	3.3%	0%
Waiting lists	16.5%	19.6%	4.4%
Clients not legal residents	6.1%	5.4%	8.7%
Language barriers	7.0%	6.5%	8.7%
Cultural barriers	5.2%	6.5%	0%
Service locations inconvenient	3.5%	2.2%	8.7%
Service hours are inconvenient	0%	0%	0%
Other	0.9%	0%	4.4%

“Other” reasons cited included cultural insensitivity.

Barriers cited by clients are as listed in the following table and sorted by area.

Barriers to Care- Client Survey, by TSA, EMA and Non-EMA

Reason	TSA % (n=966)	EMA% (n=841)	Non-EMA% (n=119)
I don't want people to know I have HIV	33.9%	32.8%	42.0%
Transportation problems	33.3%	33.4%	31.1%
Had to wait too long for service	26.1%	26.3%	24.4%
Service sites located too far away	25.6%	25.8%	24.4%
Didn't know where to apply	21.3%	22.0%	16.0%
Other health problems	20.9%	21.5%	15.1%
Didn't know how to apply	18.8%	19.9%	11.8%
Needed evening appointment	15.2%	15.7%	12.6%
Application process too complicated	14.7%	14.7%	13.4%
Cost of service is too high	14.3%	15.1%	7.6%
Turned down/not eligible	14.0%	14.6%	8.4%
On waiting list	13.9%	14.4%	10.9%
Trouble communicating	8.8%	9.2%	5.9%
Drug or alcohol addiction	7.1%	7.5%	5.0%
Too busy taking care of partner	3.9%	4.0%	2.5%
Too busy taking care of child	3.8%	3.8%	4.2%
Other	15.0%	15.8%	8.4%

“Other” reasons cited included specific reasons the client was determined ineligible, length of time they had been on a waiting list, Medicare donut hole and various complications of getting through the process to receive assistance.

Each of the surveys shows that stigma is still a major barrier to care, especially in the more rural, non-EMA counties. The responses by clients indicate that getting to service sites, either due to limited transportation or time/distance to travel present barriers to accessing care. The case managers and experts also note that transportation is a barrier. Lack of affordable housing and funding shortages are also noted as significant barriers by case managers and experts.

SECTION II: WHERE DO WE NEED TO GO?

CHAPTER 7: CONTINUUM OF CARE FOR HIGH QUALITY CORE SERVICES

SHARED VISION AND VALUES

In order to determine where we want to go a mission statement and guiding principles were adopted by the Care Council to guide the planning process.

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 under served 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.

Emerging Issues

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 below.

Outpatient/Ambulatory Care

- 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.
- 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 and other co-infections, tuberculosis, aseptic necrosis and lipodystrophy.
- Programs that link testing to medical care and get people diagnosed and treated earlier in their disease are needed.
- Changes are occurring in eligibility criteria, services offered and reimbursement levels of various payer sources (including Medicaid) which may further stretch Ryan White programs.
- The rural areas have a lack of specialty providers and providers with HIV experience.
- HRSA policy allowing VA recipients to obtain care from Ryan White prior to accessing the VA could further strain the Ryan White system.
- The in-migration of individuals from other areas could be devastating on already stretched resources.

Medical Case Management

- Salary levels continue to be low which impact retention of staff.
- 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.
- 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.
- 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.
- Case managers are seeing clients with more complex needs such as hepatitis co-infections.
- Differing eligibility determination processes and requirements create additional administrative overhead and reduce the time that case managers can devote to clients.

Drug Reimbursement

- 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.
- Other funding sources for medications are not expected to increase in significant amounts to offset shortfalls in funding for medications.
- Medication side effects can result in the need for additional medications including those that treat psychiatric issues.

- The ADAP Wrap Around Pilot Project (AWAPP) began July 2006 and was designed to help clients who fall in to 135% to 150% of the Federal Poverty Guidelines.
- Medicare drug coverage began in 2006. Required out-of-pocket and co-pay expenses can be difficult for some clients to afford and the system can be difficult to maneuver.

Health Insurance

- 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.
- The Medicaid Reform pilot in Duval and Broward counties has begun and forces clients to pick a new health care plan. The focus is on switching to private managed care plans, HMO's and Provider Service Networks. Plans are given the flexibility to change the scope, amount, and duration of services provided. This pilot has the potential to spread to the rest of Florida and could adversely affect the PLWHA population.
- A fund has been established to provide co-pay assistance for Hillsborough County Health Care recipients.
- A small percentage of ISP clients have medication co-payment needs that exceed the current monthly benefit allowance.
- 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.
- 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.
- Increased co-payments and deductibles for individuals with VA coverage, and the Medicare prescription plan may lead to greater demand on Ryan White resources.

Housing

- 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.
- Affordable housing options in safe areas are limited. Recent increases in housing prices and decreases in rental options have further strained the housing options in the TSA.
- 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.
- Homeless individuals encounter many barriers to care. Adherence to treatment even when it is received is often difficult.

Legal Services

- 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.

Mental Health

- 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.
- 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 rates of occurrence among PLWH and the impact of these conditions on overall health.
- The PLWHA population is steadily aging due to advances in treatment and new studies have shown those over age 50 are at a significantly higher risk of developing depression.
- The need for age-specific and culturally relevant interventions continues to grow.
- Community mental health providers need additional training beyond HIV 101 to better serve HIV+ clients.

Oral Health

- 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 and availability of appointments is an issue.
- There is a waiting list for services in several counties in the TSA.
- Emergency dental services are difficult to obtain.
- There are problems with no-shows by clients in dental services and transportation is frequently cited as the reason.

Prevention/Early Intervention

- Increasing HIV and hepatitis infections and AIDS cases within the Black population and among women.
- Four counties in the TSA are ranked in Florida's top 20 for having the highest numbers of PLWH/As.
- 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.
- Emphasis on funding of faith based or abstinence-only programs are an incomplete method which may not reach some populations in greatest need.
- Overall funding levels not keeping pace with need.
- The need for increased programs within Black, Hispanic, and other ethnic/ racial minority communities and among youth.
- The Centers for Disease Control and Prevention's (CDC) initiatives regarding testing, prevention and early intervention will impact the provision of services, including:

- Making testing a routine part of medical care for all patients in health care settings.
- Screening those at high risk for HIV at least once per year.
- The CDC is recommending that written consent not be required for testing and that prevention counseling should not be required when the patient is tested in a health care setting.
- Further decreasing mother-to-child HIV transmission by incorporating HIV testing in the routine battery of prenatal tests and then repeating the screening in the third trimester.

Substance Abuse

- The political climate in the TSA has not been favorable to the development or expansion of harm reduction treatment models.
- Public housing restrictions against substance use and the 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.
- Waiting lists for residential treatment beds and the need for treatment programs designed for HIV+ individuals can prevent substance abusers from getting treatment.
- Anecdotal information suggesting an increase in the use of methamphetamines poses challenges for substance abuse treatment providers, and further complicates treatment for HIV.
- After care coordination and life skills training are crucial to maintain clients in care.

Transportation

- Formal systems that require advance notice do not always meet the needs of our clients.
- Limited transportation in rural areas –funds often run out before the month ends.
- Uncertainty of funding levels across all counties.
- Transportation for parents with young children, who can not be left alone, can be difficult.
- Clients have logged complaints about inappropriate treatment from cab drivers. Sensitivity training is an ongoing need.
- 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 the client home.
- 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.
- Lack of discounted bus passes in Pinellas County makes the cost of providing service higher than in Hillsborough County.
- Single-day bus passes are the only type available through current funding. Monthly passes can assist clients in meeting a multitude of needs.
- Rising gas prices have increased public transportation fares and made it difficult for those with their own vehicles to afford fuel.

Treatment Adherence

- 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 a 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 culturally appropriate provider/patient relationships.

Children/Adolescents

- Adolescents transitioning into the adult system of care may fall out of care.
- Medication resistance may be seen in younger people.
- Adherence among adolescents is particularly problematic.
- Children who have lost parents are most frequently placed with relatives. Little support is available from the child welfare system for these families.
- 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.
- Increased risk behaviors and teen pregnancy are a concern for adolescents and youth with mental health issues.
- Children and adolescents may not be aware of their status due to a parent or guardians fear of disclosure.
- Adolescents not completing high school have limited employment options as adults and are more likely to continue to depend on publicly-funded care.
- Life skills and job training is needed among this population.

Incarcerated/Formerly Incarcerated

- 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.
- Life skills and job training is needed among this population.

Minorities

- HIV rates are increasing in minority populations, especially among the Black population.
- Stigma and other underlying factors contribute to growing racial/ethnic disparities among PLWH/A.
- In the TSA, minorities are disproportionately affected by HIV/AIDS. As illustrated in the table, in Hillsborough County, 1 in every 89 Black individuals is infected with HIV and 1 in every 315 Hispanics compared to 1 in every 345 Whites. In Manatee County, 1 in every 80 Black individuals is infected with HIV and 1 in every 381 Hispanics compared to 1 in every 754 Whites. The data is less reliable for the counties with smaller population groups, but still useful for a general comparison.

County	Black PLWH/A One in...	White PLWH/A One in...	Hispanic PLWH/A One in...
Hardee	83	1096	471
Hernando	343	1215	428
Highlands	117	1707	463
Hillsborough	89	345	315
Manatee	80	754	381
Pasco	198	857	611
Pinellas	103	389	307
Polk	125	753	564

- Language barriers exist for Hispanic, Creole, Asian and Caribbean clients in the TSA.
- Culturally sensitive treatment and appropriate support services are necessary to ensure effective care.
- 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. Life skills and job training is needed among this population.

Women

- HIV rates are increasing for women, especially black heterosexual women.
- Women may have additional responsibility of child care which can impact their adherence.
- There is a need for child care services for working women.
- Life skills and job training is needed among this population.
- Recent legislative changes made HIV testing routine in the first and third trimester of pregnancy.

Low income

- 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.
- The AIDS Wrap Around Pilot Program (AWAPP) is a new project that helps clients between 135% and 150% of the Federal Poverty Guidelines obtain prescription drugs. This program is targeted at those who fall into the Medicare Part D “donut hole”.

CARE Act Reauthorization – Ryan White Treatment Modernization Act

- Revisions to the CARE Act, or Ryan White Treatment Modernization Act, requiring greater emphasis on seeking out infected persons not already in care are expected to further strain available resources.
- Focus on HRSA designated core services could create larger service gaps in support services.
- Active participation in the reauthorization process by consumers of services is needed.

- 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.

SECTION III: HOW WILL WE GET THERE?

CHAPTER 8: GOALS, OBJECTIVES AND STRATEGIES

The following tables outline the goals, objectives and tasks for the Planning Council including target dates of completion and estimated impact on clients and services. Locally a three-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 three-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.

As the West Central Florida Ryan White Care Council is a combined Part A and Part B 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:	Identify individuals who know their HIV status and are not receiving services, for informing the individuals of and enabling the individuals to utilize the services.	
Objective #: 1A	Update estimates of the number of and determine service needs and barriers of individuals aware of their status but not in care.	
Estimated impact	Clients: 413-443 Services – outpatient/ambulatory medical care, AIDS pharmaceutical assistance (local), oral health care, health insurance assistance, mental health services, medical case management, substance abuse services, medical transportation, food bank, treatment adherence counseling, housing assistance	
	TASK REQUIRED TO ACCOMPLISH THE ABOVE OBJECTIVE	TARGET DATE
Task: 1	Work with the state to further refine unmet need estimate methodology.	July 2011
Task: 2	Conduct annual demographics and epidemiology report including trends and cumulative living cases.	July 2009, July 2010, July 2011
Task: 3	Utilize surveillance office staff and data to determine if individuals who have tested positive are accessing care	September 2010
Task: 4	Review local data on service caps to determine if a larger number of individuals are able to access services. Determine if caps need to be re-evaluated.	August 2009
Task: 5	Create linkages with non Ryan White service providers (homeless coalitions, substance abuse providers, mental health providers, etc) who track individuals who are HIV+ but are out of care	December 2010
Task: 6	Conduct review of best practices on unmet need to determine how other areas have identified HIV+ individuals who are out of care and engaged them into care	March 2011
Task: 7	Educate individuals about what it means to be 'in care' and integrate a readiness tool into the service delivery system.	March 2012

Goal #2:	Eliminate disparities in accessing services among the affected subpopulations (i.e.: youth, sex workers, MSM, etc.).	
Objective #: 2A	Increase the number of underserved and marginalized populations of PLWHA receiving care.	
Estimated impact	Clients: 1700-1900 Services – outpatient/ambulatory medical care, AIDS pharmaceutical assistance (local), oral health care, health insurance assistance, mental health services, medical case management, substance abuse services, medical transportation, food bank, treatment adherence counseling, housing assistance	
	TASK REQUIRED TO ACCOMPLISH THE ABOVE OBJECTIVE	TARGET DATE
Task: 1	All contracted providers will initiate and ensure culturally focused and linguistically appropriate interventions and treatment. Encourage providers to continually provide cultural competency training for new staff.	July 2009
Task: 2	Appropriate funding to increase the number of underserved populations in primary care according to Needs Assessment findings and other available data	July 2009, July 2010, July 2011
Task: 3	Support efforts to tie funding to subgroups and geographic areas that have been found to have the most severe need	July 2009
Task: 4	Assess cultural sensitivity of provider agencies via client satisfaction surveys.	July 2011
Task: 5	Support campaigns and programs that work to lower stigma.	March 2012
Task: 6	Promote improved communication between Department of Corrections and local agencies that assist recently incarcerated populations.	November 2009
Task: 7	Identify HIV+ Women of Childbearing Age and educate them regarding risks and available services.	October 2009
Task: 8	Track current statistics on co-morbidities and co-infections to determine areas to address.	December 2009
Task: 9	Prioritize the populations that receive care for targeting funding allocations.	February 2010
Task: 10	Address the migrant population.	December 2009
Task: 11	Improve linkages to care for former inmates.	September 2009

Goal #3:	Coordinate the provision of services with programs for HIV prevention (including outreach and early intervention).	
Objective #: 3A	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.	
Estimated impact	Clients: 733-897 Services– outpatient/ambulatory medical care, AIDS pharmaceutical assistance (local), mental health services, medical case management, substance abuse services, treatment adherence counseling	
	TASK REQUIRED TO ACCOMPLISH THE ABOVE OBJECTIVE	TARGET DATE
Task: 1	The Care Council will assign participants to serve on Patient Care Planning Group (PCPG) and report back to the Care Council.	Participants selected annually and reports delivered following PCPG meetings
Task: 2	Local HIV/AIDS Program Coordinators (HAPCs) will participate on the Care Council and Planning and Evaluation Committees.	June 2009
Task: 3	A report on testing and counseling sites will be provided to the Planning and Evaluation Committee annually as part of the Executive Summary report.	August 2009, 2010, 2011
Task: 4	Coordinate with outreach workers to increase community knowledge of HIV services.	December 2011

Goal #4:	Coordinate the provisions of services with programs for the prevention and treatment of substance abuse. (including programs that provide comprehensive treatment service for such abuse)	
Objective #: 4A	The Care Council will coordinate with substance abuse prevention providers to identify issues related to the HIV care and treatment continuum.	
Estimated impact	Clients: 258-274 Services – substance abuse services	
	TASK REQUIRED TO ACCOMPLISH THE ABOVE OBJECTIVE	TARGET DATE
Task: 1	Assure that substance abuse treatment providers are represented on the Care Council.	June 2009
Task: 2	Seek continued involvement from substance abuse treatment providers on the Planning and Evaluation Committee.	June 2009
Task: 3	Develop and disseminate a best practices protocol for PLWH who are in need of mental health and/or substance abuse treatment and incorporate into standards of care.	January 2012
Task: 4	Improve linkages between substance abuse/mental health providers and HIV providers.	May 2011
Task: 5	Identify and address barriers to entry for PLWHA into substance abuse treatment programs.	January 2011
Task: 6	Promote HIV-friendly substance abuse treatment service provision.	March 2012

Goal #5:	Address adherence initiatives.	
Objective #: 5A	Develop ways to enhance adherence among clients in order to contribute to improved health outcomes.	
Estimated impact	Clients: 4300-4500 Services – outpatient/ambulatory medical care, mental health services, medical case management, substance abuse services	
	TASK REQUIRED TO ACCOMPLISH THE ABOVE OBJECTIVE	TARGET DATE
Task: 1	Utilize results of MAI capacity building project to determine best practices for enhancing adherence among underserved populations.	December 2009
Task: 2	Analyze health outcomes data of PLWHA. Develop and implement strategies to improve health outcomes.	October 2011
Task: 3	Enhance and expand support group activities.	September 2010
Task: 4	Encourage peer mentoring to support care and treatment.	September 2011

Goal #6:	Minority AIDS Initiative (issues of minority access and disparity in the area)	
Objective #: 6A	Methods for identifying, enrolling and maintaining difficult to serve populations in primary care will be explored.	
Estimated impact	Clients: 1700-1900 Services – outpatient/ambulatory medical care	
	TASK REQUIRED TO ACCOMPLISH THE ABOVE OBJECTIVE	TARGET DATE
Task: 1	Utilize results of MAI project to determine which subpopulations require focus.	June 2009
Task: 2	Review and utilize best practices to determine possible program designs that assist underserved populations with retention in care.	April 2010
Task: 3	Client grievances will be investigated by Grantee in accordance with adopted policies.	As grievances are received
Task: 4	Increase the number of minority health professionals in the Ryan White system of care.	March 2012
Task: 5	Finalize minimum standards of care for Blacks and Hispanics.	April 2009
Task: 6	Expand and enhance outreach activities to racial and ethnic minorities.	August 2011

Goal #7:	Program coordination and linkages between Parts A, B, C, D and AETC.	
Objective #: 7A	The Care Council will coordinate with other Ryan White programs on an ongoing basis. Expand coordination and linkages with non-Ryan White funded providers in accordance with HRSA objectives.	
Estimated impact	Clients: 4300-4500 Services – outpatient/ambulatory medical care, AIDS pharmaceutical assistance (local), oral health care, health insurance assistance, mental health services, medical case management, substance abuse services, medical transportation, food bank, treatment adherence counseling, housing assistance	
	TASK REQUIRED TO ACCOMPLISH THE ABOVE OBJECTIVE	TARGET DATE
Task: 1	Assure that Parts C and D, and AETC are represented on the Care Council.	May 2009, 2010, 2011
Task: 2	Coordinate planning and needs assessment activities across program parts.	August 2009, 2010, 2011
Task: 3	Provide letters of support and background information for agencies seeking funding to develop/expand these services.	When requested
Task: 4	Coordinate with HOPWA needs assessment and planning efforts.	July 2009, 2010, 2011
Task: 5	Seek out a volunteer workgroup who will coordinate all of the information from all services (public and private) to report activities from areas 5/6/14 to improve communication and effectively market events and activities.	March 2012

Goal #8:	Build capacity in your area.	
Objective #: 8A	All contracted providers will initiate and ensure culturally focused and linguistically appropriate interventions and treatment, participate in established customer satisfaction program, and participate in available capacity-building opportunities.	
Estimated impact	Clients: 4300-4500 Services – outpatient/ambulatory medical care, AIDS pharmaceutical assistance (local), oral health care, health insurance assistance, mental health services, medical case management, substance abuse services, medical transportation, food bank, treatment adherence counseling, housing assistance	
	TASK REQUIRED TO ACCOMPLISH THE ABOVE OBJECTIVE	TARGET DATE
Task: 1	Improve information dissemination mechanisms for providers to be aware of capacity building opportunities that exist in the community.	December 2011
Task: 2	Survey public providers of primary care annually to determine if there is adequate access to an HIV-qualified primary care provider and their services.	April 2009, 2010, 2011
Task: 3	Conduct annual customer satisfaction surveys for all service providers. Review data from satisfaction surveys to determine areas for improvement, both system-wide and as individual providers.	September 2009, 2010, 2011
Task: 4	Ensure HIV community is part of the public health planning efforts in the region.	December 2011
Task: 5	Increase the number of medical specialty care providers.	March 2012
Task: 6	Expand and enhance the safety net system for PLWHA by increasing the communication between providers and bringing in agencies currently outside the Ryan White network.	February 2012
Task: 7	Strengthen and expand linkages between key points of entry and the HIV continuum of care system	January 2012

Objective #: 8B	The Grantee/Lead Agency will fully implement an information management system to allow for the tracking of quantitative and qualitative data and continually seek ways to improve communication with service providers.	
Estimated impact	Clients: 4300-4500 Services – outpatient/ambulatory medical care, AIDS pharmaceutical assistance (local), oral health care, health insurance assistance, mental health services, medical case management, substance abuse services, medical transportation, food bank, treatment adherence counseling, housing assistance	
	TASK REQUIRED TO ACCOMPLISH THE ABOVE OBJECTIVE	TARGET DATE
Task: 1	Improve methods for collecting and reporting data on service provision with full training of providers on using the Ryan White Information System.	March 2012
Task: 2	Fully implement data collection system.	March 2009
Task: 3	Conduct regularly scheduled meeting with providers	November 2009, 2010, 2011
Task: 4	Conduct case manager training as funding permits.	January 2009, 2010, 2011
Objective #: 8C	Improve education on the role of the Care Council and its committees while supporting an environment of volunteerism and advocacy.	
Estimated impact	Clients: 11,136-11,824 Services – outpatient/ambulatory medical care, AIDS pharmaceutical assistance (local), oral health care, health insurance assistance, mental health services, medical case management, substance abuse services, medical transportation, food bank, treatment adherence counseling, housing assistance	
	TASK REQUIRED TO ACCOMPLISH THE ABOVE OBJECTIVE	TARGET DATE
Task: 1	Determine training needs for Care Council and committee members.	September 2009
Task: 2	Develop content and schedule of trainings; conduct trainings	October 2009, April 2010
Task: 3	Maintain Care Council website that provides links for volunteer and advocacy opportunities.	March 2012
Task: 4	Develop a mechanism for service providers and other community groups to notify clients of volunteer opportunities.	March 2012
Task: 5	Designate a Care Council member or group to coordinate public information and advocacy.	March 2012

Objective #: 8D	Review and enhance performance-based standards and outcome measures for all funded services. Evaluate minimum standards of care and make revisions as needed.	
Estimated impact	Clients: 4300-4500 Services – outpatient/ambulatory medical care, AIDS pharmaceutical assistance (local), oral health care, health insurance assistance, mental health services, medical case management, substance abuse services, medical transportation, food bank, treatment adherence counseling, housing assistance	
	TASK REQUIRED TO ACCOMPLISH THE ABOVE OBJECTIVE	TARGET DATE
Task: 1	Review all performance standards and outcome measures including provider input in the process and align with the Quality Management program.	June 2011
Task: 2	Conduct reviews on QM data.	December 2010
Task: 3	Review minimum standards of care for all services and revise as needed to align with service philosophy and definition and include any revisions in new contracts.	September 2011
Objective #: 8E	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.	
Estimated impact	Clients: 4300-4500 Services – outpatient/ambulatory medical care, AIDS pharmaceutical assistance (local), oral health care, health insurance assistance, mental health services, medical case management, substance abuse services, medical transportation, food bank, treatment adherence counseling, housing assistance	
	TASK REQUIRED TO ACCOMPLISH THE ABOVE OBJECTIVE	TARGET DATE
Task: 1	Monitor impact of Medicare Part D on access to health care and medications, co-payments and out-of-pocket requirements on clients.	September 2009
Task: 2	Monitor changes in compassionate use programs from pharmaceutical companies for impact on clients.	August 2011
Task: 3	Inform clients of clinical trial opportunities.	As available
Task: 4	Monitor AIDS Insurance Continuation Program (AICP) wait lists and Ryan White funded- Insurance Services Program utilization.	June 2009, 2010, 2011

In order to meet the established goals, the Planning Council considers all aspects of the needs assessment to determine funding allocations with data flowing up from the committee-based structure. When establishing service priorities, the Planning and Evaluation Committee reviews the service utilization from the consumer and case manager/expert surveys, expenditures and allocations to each service category across public funding streams and estimates of unmet need. The committee then discussed the implications of the service rankings, availability of other funding sources to support services, waiting list and unmet need data to further refine the priority recommendations.

Once the priorities were adopted, the Resource Prioritization and Allocation Recommendation Committee (RPARC) met to begin the process of allocating dollar amounts to specific categories. The process included a review of the funding stream analysis, current and historical expenditures by category. Needs assessment data, specifically from the consumer survey and focus groups assisted in determining the gaps in core services. Funding Stream Analysis and Resource Analysis Reports identified other community resources which were providing core services. The committees considered all this data in developing priorities and allocations.

On an ongoing basis, the RPARC monitors program expenditures through reports developed by the Grantee staff. Funds may be reallocated during the year to support core services. The following table illustrates current Ryan White funding for the TSA.

Service Categories	Total FY08 Funding Part A, B MAI, and GR	
	Amount	Percent
1. Core Services for FY 08 Sub-total	\$10,279,382	84%
Outpatient /Ambulatory Health Services	\$3,431,064	28%
AIDS Pharmaceutical Assistance (local)	\$2,078,330	17%
Oral Health Care	\$681,918	6%
Health Insurance Premium & Cost Sharing Assistance	\$679,681	6%
Mental Health Services	\$231,529	2%
Medical Case Management (including Treatment Adherence)	\$2,738,710	22%
Substance Abuse Services - outpatient	\$438,150	4%
2. Support Services for FY 08 Subtotal	\$651,562	5%
Case Management (non-Medical)	\$180,000	1%
Food Bank/Home-Delivered Meals	\$344,757	3%
Medical Transportation Services	\$110,100	1%
Direct Client Services Fund	\$16,705	<1%
3. Total Service Dollars	\$10,930,944	89%
4. Clinical Quality Management Activities	\$60,000	1%
5. Grantee Administration	\$1,323,114	10%
6. Total Planned Budget	\$12,314,058	100%

The Planning Council performs a thorough Funding Stream Analysis as part of the needs assessment process. Results of the needs assessment reveal existing resources available for the following core medical services:

- Hospice
- Home Health Services
- Home and Community Based Health Services
- Early Intervention services
- Medical Nutrition Therapy
- AIDS Drug Assistance Program

Therefore although the Planning Council considers these services when planning for a full continuum of care, no Part A funding is currently allocated for the above core medical services.

Hospice, home health care and home and community based health services are provided through the Florida Medicaid Program as well as through local hospice organizations.

Medical nutrition therapy for PLWH/A within the TSA is available through primary care providers following an established formulary as well as through other local resources.

The local Part A AIDS pharmaceutical assistance program is well established within the TSA and functions as an extension of the ADAP for the ADAP administered by the Florida Department of Health. The local pharmaceutical assistance program maintains a formulary which is more expansive than ADAP and both programs are well integrated, being managed by the same staff within local health departments.

SECTION IV: HOW WILL WE MONITOR PROGRESS?

CHAPTER 9: IMPLEMENTATION, MONITORING AND EVALUATION PLAN

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. Ongoing 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, Health Services Advisory Committee and Care Council, 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. Improving client level data reporting will allow the Planning Council to make better decisions that are data driven.

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 any changes to Medicaid or Medicare Part D will have an effect on planning and service provision, but 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.

Improving Client Level Data

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 has worked in collaboration for the past several years with Hillsborough County's Information and Technology Services Department (ITS) in developing a web based data collection system to use for all reporting and invoicing purposes. The automated system, named the Ryan White Information System (RWIS) was launched in March 2008 after many months of internal testing. A

security review by an outside consultant determined that the system meets all current security standards mandated by the Health Insurance Portability and Accountability Act (HIPAA) as well as all prevailing Florida statutes governing the collection and confidentiality of HIV/AIDS information. RWIS generates a unique client identifier to ensure an unduplicated record across multiple HIV funding sources. All contracted providers have been trained and are now entering and reporting data. The grantee held multiple on-site training sessions with specific providers to assist them with their unique automation challenges. These sessions help ensure that all providers are moving through the implementation phase appropriately.

The grantee participated in the Florida client level data vetting session in February 2008 and is working closely with HRSA as the data collection elements are finalized. If modifications are necessary to RWIS to be in compliance, the grantee expects any programming adjustments to be completed and tested by January 2009. HRSA will receive the data through an electronic file transfer, planned as a component of the grantee's web based system. The data will be reviewed for utilization and service trends among specific demographic groups. As a future enhancement, all outcomes measures which are now collected through a separate mechanism will be incorporated into RWIS. This will provide one comprehensive data source for Continuous Quality Improvement (CQI) purposes, summary level outcomes reports and analysis for planning and resource allocation activities of the Planning Council.

Measuring Clinical Outcomes

The Grantee, the Planning Council, program and clinical staff of the provider community have continued to collaborate to implement the QMP (Quality Management Program) for the TSA with an increased focus on establishing Continuous Quality Improvement Plans per service category and addressing any deficiencies in the service delivery system and continuum of care. The vision of the QMP is "To create a strong and varied system of care that mirrors the diverse customer base, promotes diverse community partnerships, maximizes resources, and attract and retain the top talent in the work force." The mission of the QMP is "to advance the health and well-being of all PLWH/A within the total service area which includes the four counties that make up the EMA and four additional surrounding counties by creating and delivering innovative and state-of-the-art quality HIV care."

The overarching goals of the Quality Management Program are to:

- Focus on cost effectiveness and quality of care thru monitoring and evaluation of the core services, support services, administrative mechanisms, and planning processes,
- Monitor compliance with Public Health Service (PHS) guidelines and localized standards of care by medical providers,
- Assess the assistance provided by support services to facilitate the identification of HIV+ persons who may not know their HIV status and are not in care and to assist them in accessing medical and support services that will ultimately facilitate their entry into care,

- Align quality management findings with the Planning Council's priority setting/resource allocation activities and comprehensive and strategic HIV health planning activities, and
- Align quality management findings to grant management functions, specifically procurement and contract negotiations, billing and reimbursement and program management functions.

The QMP is supported through four organizational units 1) the Ryan White Program Grantee, 2) the Planning Council, 3) Ryan White Program funded providers, and 4) RNT & Associates Development Group, Inc. (contracted entity to coordinate QMP activities for the EMA).

Currently the program focuses on evaluating the appropriateness and quality of services provided to PLWH/A, pursuing opportunities for improving the service delivery system. Quality Management activities included streamlining and fine-tuning the following eight medical outcomes.

- CD4 count and viral load at the time of first test, with dates of first tests, where available
- Results of individual CD4 count labs with dates
- Results of individual viral load labs conducted with dates
- PLWH/A access to antiretroviral and opportunistic infection therapies, with date
- Occurrence of co-infections (TB, Hepatitis C)
- For PLWH/A women, access to an annual pap smear with date of examination
- For PLWH/A infants – reduced level of perinatal transmission and ensuring access to appropriate clinical protocol/guidelines for pregnant women and HIV exposed infants
- Measuring missed medical appointments and access to treatment adherence or health education counseling, including number of visits

The following clinical outcomes have also been measured for all supportive services:

- Demonstration of medical outcome improvement per client accessing supportive services
- Compliance with local Standards of Care, PHS Guidelines, HRSA/HAB QMP Guidance, and Healthy People 2010
- QMP Service Specific Logic Models

A measurement tool, for each service category, was used by providers on a quarterly basis and data entered into the QMP web based data management system for analysis and reporting.

QMP measurement tools have been developed to link Ryan White grant management and administrative functions. The newly developed Grantee Office Logic Model (GOLM) and measurement tool will be piloted by staff in October 2008 and preliminary results will be used to fine-tune established administrative functions and alignment with the Quality

Management Program. It is anticipated that preliminary reports will be available in early spring of 2009.

The QMP measurement tools developed for each service category were designed to identify clinical/medical outcomes and are aligned with the appropriate data analysis methodology. Providers are contractually required to complete the measurement tool for each PLWH/A receiving a service during a specified period of time. Completed measurement tools, per service and individual client, are entered into the QMP database. The data is then analyzed and presented to the Grantee, participating providers, and the Health Services and Planning and Evaluation Committees respectively for interpretation and identification of system wide challenges and successes. Where appropriate, Continuous Quality Improvement initiatives are identified for implementation. A final report is generated and shared with the Planning Council to integrate in their strategic health planning and priority setting and resource allocation activities. Measurement tools were developed for **Primary Care** using PHS Guidelines, Department of Health and Human Services (DHHS) and local standards of care.

The following identifies an analysis of the medical/clinical outcomes measured in the first quarter of the 2008 Program Year for Primary Care and Case Management. The results are based on a total of 3,815 unique clients representing approximately 77% of the total PLWH/A in care. (N=4,973)

A total of 1,583 (40%) PLWH/A received at least one unit of primary care service during the first quarter of 2008 Ryan White Program year. This does not mean that the rest of the PLWH/A (2,454) were not engaged in primary care, but rather that these clients did not have a primary care visit during the reporting period. A total of 1,121 (71%) male and 462 (28%) female PLWH/As received services during this quarter. Of the women served a total of 233 (50%) had a pap smear in the last twelve months. This remains an area of concern for the TSA and it has been identified as an area of focus for the development of a Continuous Quality Improvement Plan for women in care. Dialogue with the two providers whose focus is women and children has already been initiated. A new QMP measurement tool for accurate documentation of outcomes specific to women and infant care has been developed.

The primary care providers collected data regarding the following medical/clinical outcomes tied to the QMP clinical performance standards:

- Current and prior CD4 counts
- Current and prior viral loads
- CD4 counts <200
- Number of clients with a CD4 count
- Tuberculosis skin test (PPD - purified protein derivative) planted, resulted and those clients with a PPD contraindicated
- Hepatitis C screening and results
- Number of clients with a CDC defined AIDS Diagnosis

Reported CD4 counts have been analyzed and the results reveal that 321(20%) of the PLWH/A receiving primary care had a CD4 count <200. Of those clients with a CD4 <200 a total of 279 (87%) are taking PCP (pneumocystis carinii pneumonia) prophylaxis. The TSA is committed to an incremental increase of at least 2% of PLWH/A with a CD4<200 and taking PCP prophylaxis within the next year. The number of CD4 counts <200 decreased by 1% in the last year, and there was an 18% increase in the number of CD4<200 that were either taking or had been offered PCP prophylaxis treatment (69% in 2007 compared to 87% in 2008).

The TSA is currently documenting 99% of clients on HAART and with an undetectable viral load for all clients receiving primary care services. Of the 1,574 (99%) documented viral loads, a total of 801 (51%) reported a current undetectable viral load. The TSA has also begun reporting clients with a prior documented viral load for comparison purpose. A total of 1,413 (89%) had a prior viral load reported. However, those clients on HAART were not distinguished. In the future a comparison of clients' on HAART therapy and an undetectable viral load will be made.

Clinical outcomes related to specific co-morbidities and HIV/AIDS were also measured. Tuberculosis is a major indicator of a PLWH/A health status. Tracking the number of PLWH/A that are positive provides the TSA data to initiate strategies for care, outreach, and assessment. There were a total of 1,362 (86%) clients where a TB skin test was not contraindicated. Of those a total of 943 (69%) received the TB skin test. Efforts by the providers have yielded a 16% incremental increase in the number of planted TB skin tests as compared to last year. Of those receiving the test, 19 (2%) resulted positive, 698 (74%) resulted negative, 1 (0.1%) was unknown, 23 (2%) had no reported outcome, and 86 (9%) did not return for interpretation. The total number of skin tests planted and not interpreted in 2007 was 28 (5.6%). In 2008, the total tests planted and not interpreted was 24 (2.5%) which represents an incremental improvement of 3.1% from 2007 to 2008. The remaining 116 (12%) of the TB skin tests performed were still pending an interpretation.

A total of 1,560 (99%) of 1,583 PLWH/A were screened for Hepatitis C. A total of 1,326 (85%) resulted negative, 191 (12%) resulted positive, and 66 (4%) had no documented result. The number of undocumented Hepatitis C results decreased by 12% from last year's findings. The TSA is committed to an additional 2% incremental increase in the number of documented Hepatitis C screening with documented results. The providers along with the Grantee and the Planning Council will collaborate to develop appropriate strategies to decrease the number of undocumented Hepatitis C results.

Quality management indicators for **case management** include adherence to local and statewide standards of care, and measuring clinical outcome of improved CD4 count and viral loads for all PLWH/A receiving services. Currently, a total of 7% (57 of 810) PLWH/A receiving case management services had improved CD4 counts. An analysis of the clients receiving primary care and case management services, at least 1% decreased their viral load to an undetectable status (<75 VL) as compared to their previous viral load test. The TSA is committed to an increase of at least 3% in the number of PLWH/A with demonstrated increases in CD4 counts and decreases in viral load.

In addition to measuring outcomes related to the local standards of care, clinical outcomes have been established and are monitored for **dental, mental health, substance abuse, treatment adherence** and **food services**. A baseline has been established for each of these services based on data collected during the first quarter of 2008. Reports have been generated based on the first quarter data and are currently under review by service providers with a request for comments prior to forwarding to the Planning Council. The results of the QMP activities and service specific outcomes are reported to the Planning Council. A training session was held to broaden the understanding for council members related to integrating the QMP findings into the Planning Council priority setting and resource allocation process.

The TSA has undertaken the following Continuous Quality Improvement (CQI) initiatives to align its Quality Management Program and to augment its service delivery system. Results of these CQI initiatives are shared with the Planning Council and integrated in the strategic health planning activities, decision support related to priority setting and resource allocation, and when appropriate findings are integrated in the Standards of Care.

- Women and Children Primary Care Services: Based on findings from previous QMP data analysis, the network of providers decided to construct a separate QMP measurement tool to gather clinical outcomes for women and children. The newly developed measurement tool clearly focuses on standards of care established for women and children, e.g., AZT protocol and time sensitive labs and medical visits.
- Treatment Adherence: Providers have agreed to develop a standardized “Client Risk Assessment Methodology and Instrument,” for implementation in the third quarter of the current program year. The risk assessment will include specific clinical outcomes to be measured through the QMP, and a newly developed measurement tool to capture outcomes in treatment adherence tied to the client’s risk assessment.
- The Customer Satisfaction Survey has been successfully integrated in the QMP database to ensure alignment and analysis between QM Clinical Outcomes and the Customer Satisfaction Survey. A total of 15 service providers funded through the Ryan White Program, were asked to participate in the data collection. The results presented herein are based on a total of 508 individual surveys, representing a 73% increase in the 294 surveys received and analyzed in 2007-2008.

The 508 respondents to the satisfaction survey represent a sampling of 10% of the client base (N=4973) PLWH/A. The number of responses varied between data elements, as some clients did not respond to some of the elements measured. Each of the areas for evaluation provided a range of satisfaction weights from Outstanding (3), to Good (2), or Needs Improvement (1). The following represents major findings of the client surveys received.

Demographic of clients completing the survey revealed that 58%/297 were males and 35%/177 were females, and <1%/4 identified as transgender. (No Response=6%/30). Twenty percent identified their ethnicity as Hispanic, and 74% as Non-Hispanic. The racial breakdown indicated that the majority of the respondents identified as Black/African

American 40%/205 and White/Caucasian as 39%/198. The majority of the respondents, 43%/217 identified Pinellas as their county of residence, while 34%/175 identified Hillsborough as their county of residence. Manatee County returned 8% of collected surveys, Polk County returned 6%, Highlands and Pasco each returned 3% of collected surveys, Hernando County returned 2% and Hardee County returned 1%.

Surveys from primary care settings totaled 142/28% of all respondents. Respondents rated Respect (91%) as the highest rated in client satisfaction. Explanation of the Grievance Procedure was the lowest rated, at 83%, across services.

The top ranked domain in case management was Respect at 87% of all respondents, and Explanation of the Grievance Procedure ranked the lowest at 60%. The explanation of the Grievance Procedure is identified as a critical service component requiring attention during the final quarter of the 2008 Program Year.

Findings of the Customer Satisfaction Survey are shared during provider meetings and appropriate CQI plans developed. Both the findings and any proposed CQI plans are then shared with the Planning Council's Health Services Advisory and Planning and Evaluation Committees for monitoring.

Fiscal and Program Monitoring

The Grantee includes both fiscal and programmatic areas of the contract into one monitoring visit to provide a more meaningful comprehensive picture of the service provider activities. A comprehensive monitoring tool is used to evaluate the contractor's performance in both fiscal and programmatic contractual requirements. There is one general monitoring tool covering basic contract compliance issues used for all service contractors and then an additional tool specific to the type service being provided by the contractor. All of these monitoring tools are reviewed annually and updated as needed to comply with any changes in grant requirements or to address any new areas identified as appropriate. The program monitoring tools have a numeric rating scale. Service providers must achieve at least a 95% compliance to fully meet contract requirements.

Program monitors review 10% (or a minimum of 20) of the active client records during the monitoring site visits. The comprehensive monitoring tools previously mentioned are utilized to ensure uniform accuracy and compliance scoring. For those contractors who deliver more than one type service, 10% of the active client records for each service category are reviewed. Approximately 2,200 active client records will be reviewed for compliance during FY 2008 monitoring site visits. If significant concerns are identified during the record reviews, additional records above the 10% are examined. Once the monitoring site visits are completed, a written report on the findings is prepared by the Grantee and sent to the contractors within two weeks of the site visit.

In addition to monitoring contractors through annual site visits, all contractors are required to submit monthly fiscal reports and quarterly programmatic reports to the Grantee. These reports are reviewed for contract compliance. When concerns are identified through the

review of these reports, the Grantee takes appropriate action immediately and does not wait for the annual site visit to address issues.

In the event fiscal or programmatic-related concerns are identified during the site visit process, a corrective action plan is developed within one month of the completion of the site visit. The Grantee then follows up on the contractor's progress in completing the corrective action steps until all issues are satisfactorily resolved.

SECTION V: APPENDICES

APPENDIX A: TERMS AND ACRONYMS

ADAP (AIDS Drug Assistance Program) - State-administered program authorized under Part B of the Ryan White Program that provides FDA-approved medications to low-income individuals with HIV disease who have limited or no coverage from private insurance, Medicaid, or Medicare.

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

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

AIDS Pharmaceutical Assistance (local) - Local pharmacy assistance programs implemented by Part A or Part B Grantees to provide HIV/AIDS medications to clients. This assistance can be funded with Part A grant funds and/or Part B base award funds. Local pharmacy assistance programs are **not** funded with ADAP earmark funding.

Aseptic necrosis - A condition that results 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.

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 Part A and Part B Ryan White Program funds.

Case Management (non-Medical) - The provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatments, as medical case management does. See also *Medical Case Management*

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.

Child care services - The provision of care for the children of clients who are HIV-positive while the clients attend medical or other appointments or Ryan White Program-related meetings, groups, or training.

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) – A planning group responsible for the development of the Comprehensive HIV/AIDS Prevention Plan.

Comprehensive Plan - An official document adopted by the local Ryan White Program 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.

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.

Early intervention services (EIS) - Counseling individuals with respect to HIV/AIDS; testing (including tests to confirm the presence of the disease, tests to diagnose to extent of immune deficiency, tests to provide information on appropriate therapeutic measures); referrals; other clinical and diagnostic services regarding HIV/AIDS; periodic medical evaluations for individuals with HIV/AIDS; and providing therapeutic measures.

Eligible Metropolitan Area (EMA) - Geographic area eligible to receive Part A funds under the Ryan White Program. For purposes of this document, the EMA includes Hernando, Hillsborough, Pasco and Pinellas counties.

Emergency financial assistance - The provision of short-term payments to agencies or establishment of voucher programs to assist with emergency expenses related to essential utilities, housing, food (including groceries, food vouchers, and food stamps), and medication when other resources are not available.

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

Food bank/home-delivered meals/ Nutritional Supplements - The provision of actual food or meals or nutritional supplements. It does not include finances to purchase food or meals. The provision of essential household supplies such as hygiene items and household cleaning supplies should be included in this item. Includes vouchers to purchase food.

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

Grantee - The recipient of Ryan White Program 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 Resources and Services Administration (HRSA) - Agency of the U.S. Department of Health and Human Services that is responsible for administering the Ryan White Program.

Health education/risk reduction - The provision of services that educate clients with HIV about HIV transmission and how to reduce the risk of HIV transmission. It includes the provision of information; including information dissemination about medical and psychosocial support services and counseling to help clients with HIV improve their health status.

Health Insurance Premium & Cost Sharing Assistance - The provision of financial assistance for eligible individuals living with HIV to maintain a continuity of health insurance or to receive medical benefits under a health insurance program. This includes premium payments, risk pools, co-payments, and deductibles.

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 and Community-based Health Services - Skilled health services furnished to the individual in the individual's home based on a written plan of care established by a case management team that includes appropriate health care professionals. Services include durable medical equipment; home health aide services and personal care services in the home; day treatment or other partial

hospitalization services; home intravenous and aerosolized drug therapy (including prescription drugs administered as part of such therapy); routine diagnostics testing administered in the home; and appropriate mental health, developmental, and rehabilitation services. Inpatient hospitals services, nursing home and other long term care facilities are **NOT** included.

Home Health Care - The provision of services in the home by licensed health care workers such as nurses and the administration of intravenous and aerosolized treatment, parenteral feeding, diagnostic testing, and other medical therapies.

Hospice services - Room, board, nursing care, counseling, physician services, and palliative therapeutics provided to clients 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 clients.

Housing services - The provision of short-term assistance to support emergency, temporary or transitional housing to enable an individual or family to gain or maintain medical care. Housing-related referral services include assessment, search, placement, advocacy, and the fees associated with them. Eligible housing can include both housing that does not provide direct medical or supportive services and housing that provides some type of medical or supportive services such as residential mental health services, foster care, or assisted living residential services.

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 - The provision of services to individuals with respect to powers of attorney, do-not-resuscitate orders 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 Ryan White Program. It does **not** include any legal services that arrange for guardianship or adoption of children after the death of their normal caregiver.

Linguistics services - The provision of interpretation and translation services.

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

Medical Case management services (including treatment adherence) - A range of client-centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic re-evaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact, and any other forms of communication.

Medical nutrition therapy - Therapy provided by a licensed registered dietitian outside of a primary care visit and includes the provision of nutritional supplements. Medical nutrition therapy provided by someone other than a licensed/registered dietitian should be recorded under psychosocial support services.

Medical transportation services - Conveyance services provided, directly or through voucher, to a client so that he or she may access health care services.

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

Mental health services - Psychological and psychiatric treatment and counseling services offered to individuals with a diagnosed mental illness, conducted in a group or individual setting, and provided by a mental health professional licensed or authorized within the State to render such services. This typically includes psychiatrists, psychologists, and licensed clinical social workers.

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.

Oral health care - Diagnostic, preventive, and therapeutic services provided by general dental practitioners, dental specialists, dental hygienists and auxiliaries, and other trained primary care providers.

Outpatient/Ambulatory medical care - The provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting. Settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not outpatient settings. Services 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, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties). Primary medical care for the treatment of HIV infection includes the provision of care that is consistent with the Public Health Service's guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies.

Outreach Services - Programs that have as their principal purpose identification of people with unknown HIV disease or those who know their status so that they may become aware of, and may be enrolled in care and treatment services (i.e., case finding), not HIV counseling and testing nor HIV prevention education. These services may target high-risk communities or individuals. Outreach programs must be planned and delivered in coordination with local HIV prevention outreach programs to avoid duplication of effort; be targeted to populations known through local epidemiologic data to be at disproportionate risk for HIV infection; be conducted at times and in places where there is a high probability that individuals with HIV infection will be reached; and be designed with quantified program reporting that will accommodate local effectiveness evaluation.

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 Ryan White Program funds and to determine the best ways of meeting each priority.

Psychosocial support services - The provision of support and counseling activities, child abuse and neglect counseling, HIV support groups, pastoral care, caregiver support, and bereavement counseling. Includes nutrition counseling provided by a non-registered dietitian but excludes the provision of nutritional supplements.

Referral for health care/supportive services - The act of directing a client to a service in person or through telephone, written, or other type of communication. Referrals may be made within the non-medical case management system by professional case managers, informally through support staff, or as part of an outreach program.

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

Resource Allocation - Process by which dollars of Ryan White Program funding are allocated to specific priority service categories.

Respite care - The provision of community or home-based, non-medical assistance designed to relieve the primary caregiver responsible for providing day-to-day care of a client with HIV/AIDS.

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 outpatient - the provision of medical or other treatment and/or counseling to address substance abuse problems (i.e., alcohol and/or legal and illegal drugs) in an outpatient setting, rendered by a physician or under the supervision of a physician, or by other qualified personnel.

Substance abuse services residential - The provision of treatment to address substance abuse problems (including alcohol and/or legal and illegal drugs) in a residential health service setting (short-term).

TB - Tuberculosis.

Treatment adherence counseling - The provision of counseling or special programs to ensure readiness for, and adherence to, complex HIV/AIDS treatments by non-medical personnel outside of the medical case management and clinical setting.

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

APPENDIX B: EMA EPIDEMIOLOGY DATA

EMA Prevalence	Group	Number		Rate per 100,000		Percentage		Total HIV/AIDS		
		AIDS	HIV	AIDS	HIV	AIDS	HIV	#	%	rate
Gender	Male	4,181	2,788	313.8	209.2	75.5%	68.8%	6,969	72.7%	523.0
	Female	1,360	1,263	96.4	89.6	24.5%	31.2%	2,623	27.3%	186.0
	Total	5,541	4,051	202.0	147.7	100%	100%	9,592	100%	349.7
Race/Ethnicity	White	2,875	1,901	146.9	97.1	51.9%	46.9%	4,776	49.8%	244.1
	Black	1,850	1,544	580.9	484.8	33.4%	38.1%	3,394	35.4%	1065.6
	Hispanic	737	529	190.3	136.6	13.3%	13.1%	1,266	13.2%	326.9
	Other/Unk.	79	77	98.6	96.1	1.4%	1.9%	156	1.6%	194.8
	Total	5,541	4,051	202.0	147.7	100%	100%	9,592	100%	349.7
Age	0-12	17	28	4.0	6.6	0.3%	0.7%	45	0.5%	10.5
	13-19	52	69	21.8	28.9	0.9%	1.7%	121	1.3%	50.7
	20-24	61	205	37.4	125.8	1.1%	5.1%	266	2.8%	163.3
	25-29	167	372	103.4	230.2	3.0%	9.2%	539	5.6%	333.6
	30-39	1,019	1,084	299.1	318.2	18.4%	26.8%	2,103	21.9%	617.3
	40-49	2,449	1,417	615.2	356.0	44.2%	35.0%	3,866	40.3%	971.2
	50-59	1,373	668	374.3	182.1	24.8%	16.5%	2,041	21.3%	556.4
	60+	403	208	62.2	32.1	7.3%	5.1%	611	6.4%	94.4
	Total	5,541	4,051	202.0	147.7	100%	100%	9,592	100%	349.7
Mode of Transmission	MSM	2,817	1,946			50.8%	48.0%	4,763	49.7%	
	IDU	744	450			13.4%	11.1%	1,194	12.4%	
	MSM/IDU	319	167			5.8%	4.1%	486	5.1%	
	Hetero	1,542	1,421			27.8%	35.1%	2,963	30.9%	
	Other	118	67			2.1%	1.7%	185	1.9%	
	Total	5,541	4,051			100%	100%	9,592	100%	

Source: Florida Department of Health, HIV/AIDS Bureau, 2007