INTEGRATED NEEDS ASSESSMENT
2016-2019

PALM BEACH COUNTY
HIV CARE COUNCIL

Prepared by
Berthline Isma, PhD
Questions? Call Berthline Isma, PhD
Ryan White Health Planner II
Palm Beach County Department of Community Services
810 Datura Street
West Palm Beach, FL 33401

(561) 355-4785
Bisma@pbcgov.org
www.carecouncil.org

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T A B L E O F C O N T E N T S

Acknowledgments

The Palm Beach County (Area 9) jurisdictional HIV Needs Assessment is the product of input and perspective from a broad spectrum of stakeholders in the community including people living with HIV/AIDS (PLWHA), agencies providing HIV patient care and prevention services, and other community stakeholders in Palm Beach County. Their participation brought tremendous value to the process of identifying the unmet needs of PLWHA.

The Palm Beach County Community Services Department wishes to extend their appreciation and thanks to all of the individuals and organizations that participated and contributed to this process. The commitment and collective efforts of these individuals, agencies and organizations will help move Palm Beach County forward in assuring that the needs of our most vulnerable citizens are met, and that new HIV infection is halted.

There were many others who assisted in this project including the Part A and Part B service providers, the data collectors, and Grantee staff listed here. We would like to thank you for supporting this project.

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Shoshana Ringer
Shirley White
Indira Case
Any Pandya
Marie Presmy
Gardy Desravines
Ruby Rodriguez
Patrice Huntley
Mary Jane Reynolds
Shirley Samples
Beatrice Manning

I. Introduction

An HIV/AIDS Needs Assessment is a process of collecting information about the needs of people living with HIV/AIDS (PLWHA) in a specific geographic area. The process involves gathering data from multiple sources on the number of HIV/AIDS cases, the number of PLWHA who are not in care, the needs and services barriers of PLWHA, and current resources available to meet those needs. This information is then analyzed to identify what services are needed, what barriers to services exist, and what service gaps remain.

Special emphasis is also placed on gathering information about the need for services funded by the Ryan White HIV/AIDS program and on the socio-economic and behavioral conditions experienced by PLWHA that may influence their need for an access to services both today and in the future.

Needs Assessment data are specifically mandated for use during Planning Council activities, including the Priority & Allocations and HIV Planning processes. Consumer surveys are administered every three years, and the results are used in Planning Council activities for a three-year period. Other data sources produced during interim years of the cycle, such as epidemiologic data and estimates of unmet need, are used to provide additional context and to better understand consumer survey results.

II. Executive Summary

Overview and Purpose

The 2016 Palm Beach County HIV/AIDS Needs Assessment presents findings on the medical and support service needs, barriers to engaging in medical care, and other factors influencing positive health outcomes for people living with HIV/AIDS (PLWHA) in the Palm Beach County Eligible Metropolitan Area (EMA). The overall goal of this Needs Assessment was to ensure that the PLWHA experience in the local system of care was infused into the data-driven decision making activities of local HIV Planning Council (CARE Council). The information gathered in this process are used to set priorities for the allocation of HIV patient care funds, in the development of the Local Integrated Plan, and in the design of annual service implementation plans.

Epidemiology

The population estimate of Palm Beach County in 2015 was 1,381,632. Of these, 3,289 were people living with HIV (not AIDS) and 4,774 were people living with AIDS. Within the past two years, 2014 and 2015, the number of new AIDS cases reported in Palm Beach County was 336. Of this population, 48.4% were male and 51.6% were female. The county is ethnically and racially diverse.

An examination of demographic characteristics of PHLWHA in the County and PLWHA served by the Ryan White Program suggest that no populations are underserved. Moreover, analyzing HIV and AIDS data trends from 2010 - 2015 suggest the total number of new HIV cases and new AIDS cases in Palm Beach continue to decrease. Also decreasing from 2010-2015 is the number of age adjusted HIV/AIDS deaths in Palm Beach County.

Geographic distribution of the total number of HIV/AIDS cases and total number of HIV/AIDS alive & out of care in 2015 illustrate the highest number of PLWHA along the eastern and southwestern areas of the Palm Beach County map.

Methodology

The integrated Needs Assessment 2016-2019 utilized three data collection strategies including surveys of PLWHA, provider interviews and focus groups of PLWHA. The PLWHA Survey and focus group scripts were similar to those, which were used in the 2003, 2007, 2013, and 2016 Needs Assessments.

Throughout the surveying process, respondent composition goals were proportional to demographic and geographic goals representation in total prevalence of HIV/AIDS in the EMA. Funded-agency representation was proportional to total client share for the same period of time (2016). Efforts were also taken to over-sample out-of-care consumers and members of special populations. Consumer surveys for the 2016 Palm Beach County area HIV/AIDS Needs Assessment were administered in-group sessions at Ryan White HIV/AIDS Program providers. Staff contacts at each location were responsible for session promotion and participant recruitment. Out-of-care consumers were recruited through word of mouth, and staff consumer promotion**.**

Key Findings

Highlights regarding PLWHA Survey Finding

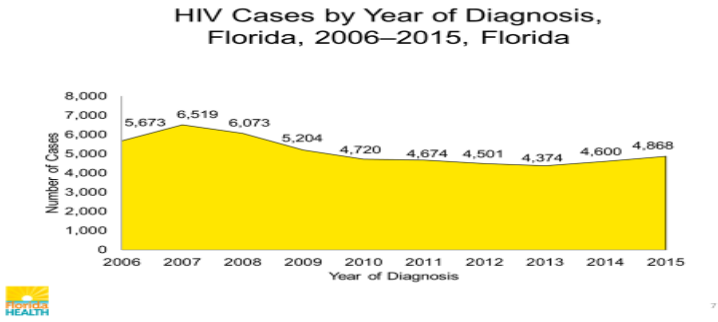
- 357 survey respondents participated in the Integrated Needs Assessment 2016-2019. Of these, 287 (80.4%) indicated they were currently in primary medical care. When asked where they received HIV/AIDS medical care, 330 of the 357 indicated a response. Of the 330 in care correspondent who indicated one primary medical provider, 42.3% said doctor's office and 26.6% said public clinic/health department.
- Out of 287 (80.4%) of the total 357 respondents that indicated, they were currently on antiretroviral (HIV medication) therapy, 122 responded that during the previous five years there had been a period of at least 12 months where they had not gone to the doctor. When asked about the reasons why they missed taking the medication, the three most frequently mentioned reasons were: they forgot to take the medications (48.4%, 59), needed to get my prescription renewed (17.2%, 21), and changed insurance plan (10.6%, 13).
- 57 out of 357 survey respondents indicated they were out of care. When asked about the reasons for not being in care, the three most frequently mentioned reasons included transportation (31.5%, 18), Treatment by staff in the clinic or doctor's (24.5%, 14), and long wait times to get to see the doctor (21.1%, 12).

Data suggested a continuing need for all HIV services that are currently provided; five services were identified as priorities. These include:

1. Outpatient Ambulatory Medical Care
2. Medical Case management
3. Oral Health Care
4. Local Pharmaceutical Assistance
5. Food

Highlights Regarding Trends in Service Utilization, Gaps, and Barriers (2007-2016)

Data analyses for each year's need assessment were conducted to identify trends from 2007 through 2016. Examination of service category utilization, gaps, and barriers has varied in the Needs Assessments conducted over the past ten years. Utilization has remained high from 2007-2016 in laboratory diagnostic testing, primary medical care, and case management services. Gaps in care remained somewhat consistent over time are in the service categories of case management and transportation. Barriers to services have remained low and consistent except for a few notable exceptions in 2015, including health insurance, food bank, and transportation. Overall, newly diagnosed HIV infection cases have decreased 14% over the past ten years. Enhanced laboratory reporting (ELR) laws in 2006 and the expansion of ELR in 2007 led to an artificial peak of newly diagnosed cases of HIV Infection in 2007. This was followed by a general decline in diagnosed cases through 2013. An increase in new HIV infection cases, primarily among white and Hispanic MSM, was observed in both 2014 and 2015.



Source: Florida CHARTS provide Population estimates as of 6/20/2016.

Highlights Regarding Populations of Special Concern

In addition to focusing on PLWHA who are in care and those who are out of care, this Needs Assessment focused on populations of special concern. Four PLWHA populations were examined through survey and focus group responses: African- American heterosexuals, Men who Have Sex with Men (MSM), Haitian men and women, and Youth men and women.

African-American Heterosexual Survey Respondents

Out of the total 357 Needs Assessment survey respondents, 242 (67.7%) respondents indicated they were African-American heterosexuals. 287 (80.4%) indicated they were in HIV/AIDS medical care and 57 (16.0%) were out of care.

African-American Heterosexual Focus Group Respondents

When asked in a focus group, "what has helped to get in care and stay in care?" PLWHA representation from this population indicated family support and insurance provided by Ryan White. During the focus group, when participants were asked why they or others they knew were out of care, the respondents answered that it can be various factors such as fear, lack of knowledge about the disease and available treatment, denial, addiction and barriers to accessing care due to lack of education or financial resources. In addition to issues related to access, participants also discussed complications with medications and problems with side effects and mentioned the relationship with their providers. Participants also expressed frustration on high turnover rates of direct service staff at provider agencies and transportation an issues. They stated that it is difficult to build trust repeatedly when they keep changing case managers. Black PLWH identified negative experiences with clinic personnel as their most important barriers to care, as well as lack of information about services, and stigma. They often felt that services were not respectful. To overcome barriers, they recommended improved communication, more investment in patient education, and respect for them. They also mentioned the housing crisis.

MSM Survey Respondents

16.0% (57 of 357) of all survey respondents identified themselves as MSM. Only seven individuals of this population identified as Transgender (male to female).

MSM Focus group Respondents

When asked in a focus group about the quality of HIV services in Palm Beach County, representation from this population indicated services have been adequate and they have been able to access the services they need. The unique challenges of serving the MSM population include stigma and denial, including fear of learning one's HIV status or disclosing one's HIV-positive status, including fear of disclosure of being a MSM and rejection by family. During the focus group, the respondents identified the reasons for someone not being in care are lack of knowledge about appropriate care and treatment services, depression and stress, lack of information about treatment and availability of services, having to take time off from work to pick up medications, and bad customer service at ADAP. When asked about what would help MSM get back into care or stay in care, respondents identified facing life or death priority, and reducing or eliminating alcohol and drugs. Some identified service gaps and barriers were difficult and time-consuming eligibility process, and need for food bank. They also stated that the ADAP customer service is terrible; and they had unmet needs or difficulty accessing emergency financial assistance, dental health care, and transportation.

Haitian Men and Women Survey Respondents

33 of 357 (10%) of all survey respondents indicated they were Haitian. When asked in a focus group, "what will it take to persuade individuals to go back to the doctor for HIV/AIDS medical care?" individuals from this population indicated counseling, moral support, and knowing where to go. A persistence of stigma about HIV/AIDS in this population, a sense of vulnerability to deportation and a complex non-western system of beliefs about health behavior all make treatment of HIV/AIDS difficult. Further complication factors include lack of educational level and illiteracy in either Creole or English.

Haitian Men and Women Focus Group Respondents

Most Haitians are diagnosed in the public hospital inpatient or emergency room units where they present serious illness. A significant number of older persons of this population use herbalists and spiritual healers before seeking western medical care, and only when their symptoms have become seriously progressed. During the focus group, participants also expressed their ongoing fears and anxieties regarding immigration status and financial and housing insecurities. When asked about what it would take to persuade PLWHA who are not in care to get back into care, respondents cited the need to help people overcome fear. When asked about what services they need but cannot get, the participant's respondents cited their need for help with financial assistance for housing and an increase on the food voucher.

Hispanic Men and Women Survey Respondents

Out of the total 357 Needs Assessment survey respondents, 48 (13.4%) indicated they were Hispanic. When asked in a focus group, "In the past 3 years, have services improved, decline, or remain the same?" members of this population indicated services have improved.

Youth Survey Respondents

When asked if they knew of any PLWHA not in HIV/AIDS medical care, and the reasons for them not being in care respondents cited fear, stigma from the community, and a lack of understanding of how to access services as barriers to being in care.

Youth Focus Group Respondents
Respondents also stated that healthcare providers at times do not always have all the information regarding medications that may be needed. Respondents cited a need for greater education in high schools, including comprehensive sex education. They stated that parents do not want the kids to know about sex, and that youth are not comfortable communicating with their parents. When asked about HIV prevention, respondents stated that many people do not have access to HIV education, and that overall it was considered a very awkward topic. Youth reported that they obtain information mainly from social media, such as YouTube and Facebook.

III. Epidemiology

The data source group for the following sections are Florida Department of Health, HIV/AIDS & Hepatitis Program (2015), AIDS Incidence, AIDS Prevalence, and HIV (Not AIDS) Prevalence.

Palm Beach County Demographics
The population estimate of Palm Beach County in 2015 was 1,381,632. Of these, 3,289 were people living with HIV (not AIDS) and 4,774 were people living with AIDS. Within the past two years, 2014 and 2015, the number of new AIDS cases reported in Palm Beach County was 336. Of these po0pulation, 48.4% were male and 51.6% were female. The county is ethnically and racial diverse. In 2015, 57.6% of the population was White Non-Hispanic, 17.1% were Black Non-Hispanic, 21.4% were Hispanic, and 3.9% was other races/ethnicities. The senior retiree's population plays a large proportion of the county's. The 2015 age distribution in years was follow as: 0-12, 14.1%; 13-19, 7.9%; 20-24, 6.0%; 25-29, 5.8%; 30-39, 11.1%; 40-49, 11.9%; 50-59, 13.8%; 60+, 29.4%. (Florida Department of Health, Bureau of HIV/AIDS Surveillance Section (2015). Epidemiology Profile, Palm Beach County.

People Living with HIV (HIV Not AIDS) Prevalence
As of September 8, 2016, the number of people living with HIV (Not AIDS) in Palm Beach County was 3,289. This translates to an HIV prevalence rate of 238 per 100,000 (100,000 X 3,289/1,381,632). 56.0% of these were non-Hispanic Blacks, 27.7% were non-Hispanic Whites, and 14.7% were Hispanics. 62.6% were males. A greater proportion (50%) was in the older adult age group (age 45+ years) than the younger adult age group (age 20-44; 41%). For adults and adolescents, the most frequent exposure category was heterosexual, for Male who have sex with males (MSM) was 64.2%. All of the 13 pediatric cases (age 0-12) were exposed due to another with/at risk for HIV infection.

People Living with AIDS Prevalence
As of September 8, 2016, the number of people living with AIDS (PLWA) in Palm Beach County was 4,774, representing an AIDS prevalence rate of 346 per 100,000 (100,000 X 4,774/1,381,632). 63.3% of these population were non-Hispanic Blacks, 21.2% were non-Hispanic Whites, and 13.9% were Hispanics. About 63% were males, and 99% were adults at the age of 20+. Similar to the HIV (not AIDS) adult prevalence, a greater proportion of the people living with AIDS were older adults aged 45+ (67%) than younger adults age 20-44 (32%). The exposure categories are similar to those people who are living with HIV. Among adults and adolescents, the most frequent

exposure category was heterosexual, followed by MSM (48.2%). All of the three pediatric cases (age 0-12) were exposed due to a mother with/at risk for HIV infection.

New AIDS Cases Reported Within the Past Two Years (AIDS Incidence)
The number of new AIDS cases reported in Palm Beach County in 2014 and 2015 was 336. 63.3% of these were non-Hispanic Blacks, 21.2% were non-Hispanics Whites, and 13.9% were Hispanics. 63% were males. Among adults and adolescents, the most frequent exposure category was heterosexual, followed by MSM (48.2%). Cases (age 0-12) exposed three pediatrics due to a mother with/at risk for HIV infection.

Disproportionate Impact on Certain Populations
HIV/AIDS has a significant disproportionate impact on Palm Beach County's minority communities, as indicated in the following table:

PLWHA Subpopulations in Palm Beach County through 2015					
	(A) Number of PLWHA (N=8,063)	(B)Percent of All PLWHA (A/8,063)	(C) Number in Total County Population (N=1,381,632)	(D)Percent of Total County Population (C/1,381,632)	(E)HIV/AIDS Prevalence Rate per 100,000 (100,000 X A/C)
Black (non-Haitian)	4,861	60.3%	235,984	17%	351,831
Hispanic	1,150	14.3%	295,928	22%	83,234
MSM	2,769	54.7%	36,462.9	4%	200.411
IDU	288	5.7%	8,892.5	1%	20.844
Haitian Born	1,503	20%	57,297	5%	108.8
Homeless/Housing sustainable	28	1.9%	1,421	0.4%	2,026

Based on the data above table, the HIV/AIDS prevalence rate in the general population of Palm Beach County is 583 per 100,000 populations (100,000 X 8,063/1,381,632).

Populations Underrepresented in the Ryan White Program

Underrepresented populations may be identified by comparing demographics of the PLWHA population in Palm Beach County with the characteristics of PLWHA served by the Ryan White - funded system of care in the county.

PLWHA vs. PLWHA Served, 2015		
Demographics	**PLWHA**	**PLWHA Served**
Race/Ethnicity		
White non-Hispanic	24%	20%
Black non-Hispanic	61%	64%
Hispanic	14%	16%
Asian/Pacific Islander	0%	0%
American Indian	0%	0%
Other/Unknown	1%	0%
Gender		
Male	63%	60%
Female	37%	40%
Age		
0-12	0%	0%
13-44	33%	33%
45+	67%	67%

Analyses of demographic characteristics of PLWHA in the county and PLWHA served by the Ryan White Program show that the populations differ by no more than 5 percentage points, suggesting that no population are underserved.

According to the 2015 national point-in-time count study, Florida is one of three states that comprise over 6% of the total national homeless population. The total estimated homeless population in Florida is 41,542. The point-in-time count results for Palm Beach County for 2015 estimate a total homeless population of 1421. Race statistics indicate that, of these, 57% are White, and 40% are Black. Ethnicity statistics indicate that 12% are Hispanic and 88% are non-Hispanic. Of the total homeless population, there was an estimated 28 homeless persons with HIV/AIDS (1.9%). In 2015, the rate of homelessness among PLWHA in Palm Beach County was 0.3% compared to 0.1% among the general population. Thus, the PLWHA rate is 3 times that of the general population rate. The homelessness Point-in-Time count was conducted in January 2017 with the assistance of 240 staff and volunteers. 1607 individuals and families were counted as homeless according to the federal definition of homelessness. The 2017 Point-in-Time count of literally homeless reflects an 11.5% increase from the count conducted two years ago. There was a 49% decrease in unsheltered chronic homeless and a 62% decrease in unsheltered veterans. The prevalence of HIV appears to be more likely in the coastal metropolitan areas; however, there is evidence that both problems are widespread throughout rural areas, yet do not be reported in the same manner. In fact, homelessness is not even defined the same way in rural areas (with migrant farmworker populations) as it is in urban areas. One of the complexities of tracking this vulnerable population is that they are transient.

In the Needs Assessment conducted in 2013, the most frequently cited problems in getting housing were not having enough money for a deposit (18%); inability to find affordable housing (15%); bad credit (14%); being put on a waiting list (14%); and having a criminal record (13%). Additionally, the Needs Assessment revealed that there is a relationship between incarceration and homelessness; among those who were incarcerated during the prior 12 months, 47% were homeless at the time of the survey.[1] Many homeless PLWHA are not being treated and are not being identified for services since they are difficult to target. A higher cost for case managers and disease intervention specialists is incurred because these are problem cases that require a great deal of time and resources. Living with HIV spectrum disease and being homeless is a complicated situation. Maintenance of physical and emotional health is frequently ignored when food, clothing and shelter are of primary concern. Medical appointments are difficult to meet and maintaining complicated HIV drug therapies is a major challenge. Finally, homeless men and women often do not have available to them preventive measures used with other populations who are at risk for HIV. Shelters, food kitchens, and health clinics are model centers for HIV prevention; however, insufficient resources in Palm Beach County limit health education to the homeless and other interventions that others receive. Individuals who are homeless have limited access to health care. Such individuals are vulnerable to increased morbidity and mortality since they lack the care they need. Some barriers to access HIV-related health care in Palm Beach County for the homeless are lack of health insurance, absence of financial resources, and lack of transportation.

Florida Department of Health, Bureau of HIV/AIDS Surveillance Section (2014). Section 2-Table 1b: Background Data Used for the Calculations of AIDS Prevalence, and HIV (not AIDS) Prevalence.

HIV and AIDS Data Trends

The total number of HIV cases in Palm Beach County is generally decreasing. The table below summarizes the decrease of the new cases from a high range of 311 in 2010 to 290 in 2015 as well as a decrease in the rate, from 23.6 to 21.0 per 100,000 populations. (Florida Department of Health, CHARTS Community Health Assessment Resource Tool Set).

Palm Beach County HIV Data

Year	New Cases	Rate per 100,000	Total Population
2010	311	23.6	1,320,309
2011	315	23.7	1,327,313
2012	270	20.0	1,332,023
2013	325	23.9	1,350,078
2014	320	23.5	1,362,383
2015	290	21.0	1,381,632

It may take some years for an infected person with HIV to develop AIDS, therefore, the AIDS data tend to represent HIV transmission that may have occurred may years ago. According to the Bureau of HIV/AIDS, individuals and population disparities in the development of AIDS may include the following factors:

- Late diagnosis of HIV
- Access to/acceptance of care
- Delayed prevention messages
- Stigma
- Prevalence of STDs in the community
- Prevalence of injection drug use
- Complex matrix of factors related to socioeconomic status

Even though the total number of AIDS cases in Palm Beach County continues to increase, the number and rates of new AIDS cases has decreased overtime. The data in the following table show that the number of new cases and rate per 100,000 populations have been decreased from 2010 to 2015, from 311, 23.6 per 100,000 to 290, 21.0 per 100,000 (Florida Department of Health, CHARTS Community Health Assessment Resource Tool Set).

Palm Beach County AIDS Data

Year	New Cases	Rate per 100,000	Total Population
2010	239	18.1	1,320,309
2011	219	16.5	1,327,313
2012	270	20.0	1,350,078
2013	325	23.9	1,350,078
2014	320	23.5	1,362,383
2015	290	21.0	1,381,632

HIV/AIDS DEATHS

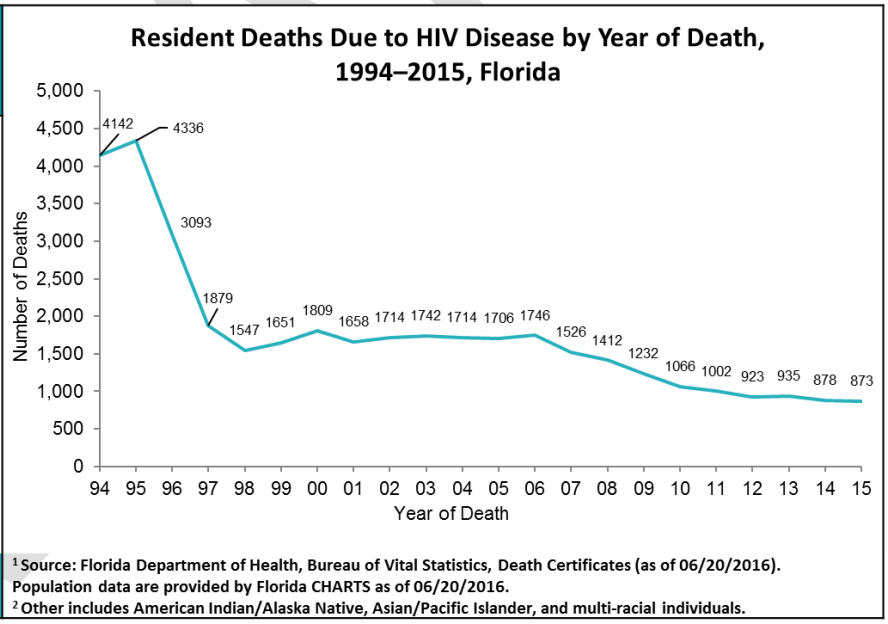
The following table shows the rate of deaths from HIV/AIDS in Palm Beach County and Florida from 2011-2015. The counts in the county have remained similar during this time; however, the rate has been higher than the state. In 2015, the rate of deaths from HIV/AIDS in Palm Beach County was 4.8 per 100,000 while the state's rate was 4.0 per 100,000.

DEATHS FROM HIV/AIDS, PALM BEACH COUNTY AND FLORIDA, 2011-2015

Year	Palm Beach County		Florida	
	Count	Rate	Count	Rate
2011	65	5.0	1,005	5.1
2012	65	4.8	923	4.6
2013	69	4.9	935	4.5
2014	64	4.4	878	4.2
2015	66	4.8	878	4.0
Source: Florida CHARTS, Florida Department of Health, Bureau of Vital Statistics, 2015				

Resident Deaths Due to HIV Disease: 1194-2015, Florida

Resident Deaths Due to HIV in 2015, Florida[1]		
Race/Ethnicity	No.	Rate
NH White Male	209	3.9
NH White Female	46	0.8
NH Black Male	281	18.9
NH Black Female	197	12.3
Hispanic Male	107	4.5
Hispanic Female	19	0.8
NH Other[2]	14	1.6
Total	873	4.4



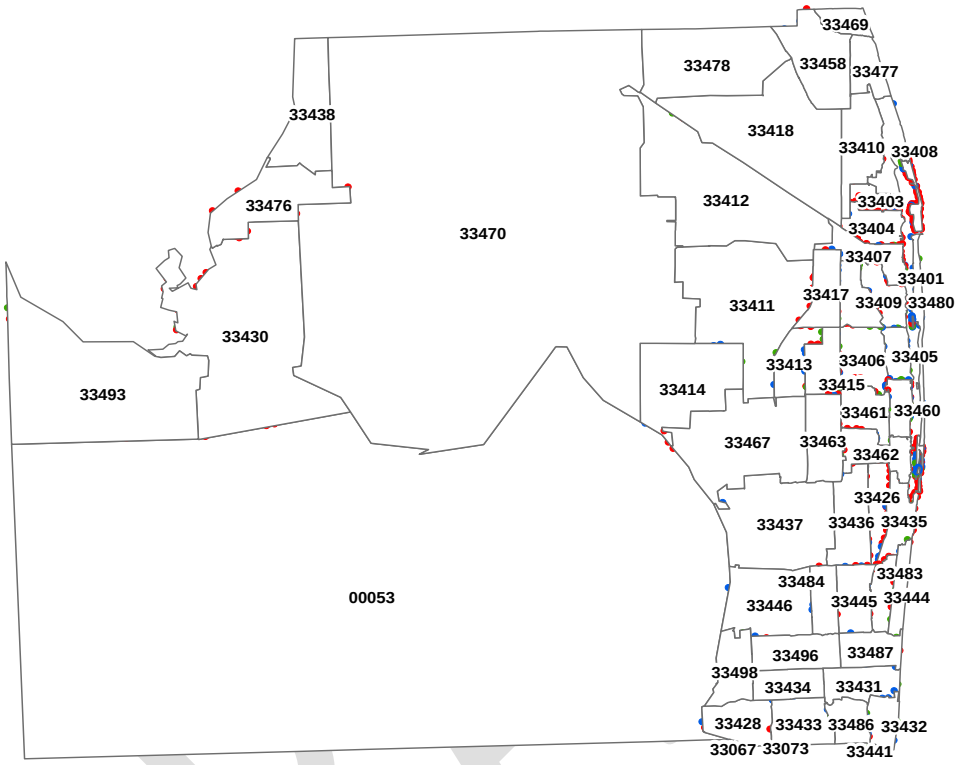
[1] Source: Florida Department of Health, Bureau of Vital Statistics, Death Certificates (as of 06/20/2016). Population data are provided by Florida CHARTS as of 06/20/2016.
[2] Other includes American Indian/Alaska Native, Asian/Pacific Islander, and multi-racial individuals.

The number of HIV-related deaths in 2015 decreased by 0.6% from the previous year, and 80% since the peak year in 1995. Since 2007, deaths have maintained a downward trend.
In 1999, the underlying cause-of-death classification scheme changed from ICD-9 to ICD-10;

Source: Florida Department of Health, Bureau of Vital Statistics, Death Certificates (as of 06/20/2016). Florida CHARTS provided population data (as of 06/20/2016).

Geographic Distribution

Geographic distribution of the total number of HIV/AIDS cases and total number of HIV/AIDS alive & out of care in 2015 illustrate the highest number of PLWHA along the eastern and southwestern areas of the Palm Beach County map.



Excludes Dept. of Corrections, homeless, and cases with unknown zip codes. Data as of 06/30/2015

IV. METHODOLOGY

The Integrated Needs Assessment 2016-2019 utilized three data collection strategies including surveys of PLWHA, focus groups of PLWHA, and provider interviews. The PLWHA survey and focus group script were similar to those, which were used in the 2012 Comprehensive Needs Assessments. With the guidance and approval of the Planning Committee, additional components were added regarding utilization of medical care and case management. Service categories specified in the survey were correlated to those used by the Planning Council and HRSA to facilitate clear analysis. The questions were added to capture data regarding PLWHA who are out of care.

The Needs Assessment was a collaborative process between HIV prevention care stakeholders, the Palm Beach County CARE Council, the Health Council of Southeast Florida, the Community Prevention Partnership, and individual providers of HIV services. To guide the overall process and to provide specific subject matter expertise, a series of groups was formed under the auspices of the Ryan White CARE Council.

The Planning Council provided overall direction to the Needs Assessment process and approved all final work products. As such, the Planning Council consisted of voting members from each collaborating partner. Survey and focus group scripts were similar to those, which were used in the 2003, 2007, 2013, and 2016 Needs Assessments.

Throughout the survey process, respondent composition goals were proportional to demographic and geographic goals representation in total prevalence of HIV/AIDS in the EMA. Funded-agency representation was proportional to total client share for the same period of time (2016). Efforts were also taken to over-sample out-of-care consumers and members of special populations. Consumer surveys for the 2016 Palm Beach County area HIV/AIDS Needs Assessment were administered in-group sessions at Ryan White HIV/AIDS Program providers. Staff contacts at each location were responsible for session promotion and participant recruitment. Out-of-care consumers were recruited through word of mouth, and staff consumer promotion.

Inclusion criteria were an HIV or AIDS diagnosis and residency in Palm Beach County. Participants were self-selected and self-identified according to these criteria. Surveys were administered in English and Creole, with staff and bilingual interpreters available. Participation was voluntary, anonymous, and monetarily incentivized; and respondents were advised of these conditions verbally and in writing. Most surveys were completed in 20 to 40 minutes.
357 consumer surveys were collected from September to January 2017 during 10 survey sessions at 9 survey sites.

PLWHA Survey

A 77-item survey was developed and implemented to collect information from PLWHA regarding service priorities and needs. Demographic data elements included gender, sexual orientation, race, ethnicity, age, and geographic area of residence. The data collector determined if the respondent was in or out of primary medical care by asking the following questions:

"Have you received one of the following HIV-related primary care services within the past 12 months?"

HIV/AIDS medical care
Lab work for CD4 T-cell count
Lab work for a viral load test

Respondents identified as "out of care" were asked five additional questions relating to being out of primary medical care. Respondents identified as being "in care" were asked additional questions regarding access to and availability of services. In addition, the respondents in care were asked if during the past five years there had been a period of at least 12 months when they were not receiving HIV-related primary medical care (not HIV/AIDS medical care, no lab work for CD4 T-cell count or no lab work for a viral load test).

The Health Council of Southeast Florida administered three hundred fifty-seven (357) surveys to PLWHA in locations, including clinics and high-risk neighborhoods. Surveys were also promoted and distributed at community forums and other appropriate venues. After completing the survey, each respondent received a $15 gift card.

Surveys were collected during September 22, 2016 through January 5, 2017. Data were entered into the survey posted on Survey Monkey, and then exported from Survey Monkey into an Excel database for further analysis.

PLWHA Focus Groups

Focus groups were conducted with populations of special concern:

- African-American Heterosexuals
- Men who Have Sex with Men (MSM)
- Haitian Men and Women
- Youth

Provider agency staff who were representatives of or persons who work closely with the population of special concerns recruited focus group participants. At the beginning of each focus group, the definition of being "in primary medical care" was reviewed, as were the HIV services that would be discussed during the focus group. Focus group participants maintained anonymity and agreed to maintain confidentiality. At the end of each focus group session, each participant was given a $25 Publix gift card.

Data Analyses

The survey analyses were performed using Excel and Survey Monkey. Tables were created to summarize and illustrate survey responses. As needed, data were analyzed by sub-populations including gender, race, ethnicity, geographic region and sexual orientation as well as populations of special concerns.

IV.KEY FINDINGS

A. PLWHA AND PROVIDER INTERVIEWS FINDINGS

Provider interviews were conducted with Ryan White Part A funded organizations.
Provider Interview responses included information about providers' efforts to:

- Address racial, gender, and geographic disparities
- Improve services
- Mitigate barriers to delivering services to PLWHA
- Enhance efforts to collaborate and coordinate with other organizations
- Plan for expansion of service delivery

In analyzing providers' responses, several main categories or themes emerged. These categories or themes, as well as more specific responses, are listed in the following sections.

Capacity Building Opportunities:

- Conducting workshops for power of attorney for children if parents are deported; held in Lantana
- Food security: RW is not taking full advantage of food bank networks; agencies should be working with United Way, who is the collective impact backbone organization; agencies need to be involved in this process; food vouchers should be a supplement to the food bank network
- Develop EIS quality markers for all agencies
- Clarify expectations of MCM: level of knowledge of staff; communication with clinical providers; in-house vs. out-of-house MCM
- For MAI, develop a model of (1) Patient-Centered Medical Home; (2) Behavioral health integration; (3) Integrated care coordination as a model program and extension of SPNS project

Administrative Functions:

- Identify ways to feedback QM information back into the system of care

- Inefficiencies in Specialty Medical referrals: require language matching; coordination with case managers; coordination with transportation and providers site selection… might consider allowing agencies receiving OAMC to do their own specialty medical referrals, or move it entirely into OAMC

- Clarify budget submission requirements for services that are reimbursed based on CPT-codes

- List specific required elements for service category proposal narratives; review Part A RFP for specific elements in local RFP
- Require agencies to document and map referral relationships for medical and support services
- Clarify three-year contracting process at bidder's conference
- Document referral relationships in agency proposals
- Clarify legal ad procedure: would eliminating it be a problem for agencies outside the county
- Consider extending the submittal deadline

Programmatic Functions:

- Food security: RW is not taking full advantage of food bank networks; agencies should be working with United Way, who is the collective impact backbone organization; agencies need to be involved in this process; food vouchers should be a supplement to the food bank network
- Citizens for Improved Transit are using Uber/Lyft for Medical Transportation; CSC contracts with them for medical appointments…RW should consider working with CIT
- EIS should be evaluated on the speed at which people are linked to care
- Develop EIS quality markers for all agencies
- Sliding fee scale: how is payment collected and managed across network
- Open Peer Mentoring to multiple agencies to allow sharing of clients
- Clients requesting Emergency Housing should be screened for substance abuse services and referred appropriately

1. CHARACTERISTICS OF PLWHA SURVEY RESPONDENTS

The 2016 client survey includes 357 PLWH who completed all of most of the survey. Throughout the surveying process, sampling was monitored to ensure that the demographic characteristics of survey respondents represented the diversity of the PLWHA population in Palm Beach County. As shown in the following table, using this stratified sampling methodology resulted in a survey sample similar to the demographic profile of PLWHA in the Palm Beach County EMA. The Florida Department of Health HIV /AIDS & Hepatitis Program provided HIV/AIDS Case Prevalence data cited in this section.

As shown in the following table, of the 357 survey respondents, 45.3 % (162) were male compared to 62.8% (8,063) of the PLWHA in the area. Females were 51.5 (184) of survey respondents while only 37.2% (2,998) of the PLWHA in are female.

Comparison of HIV/AIDS Case Prevalence in Palm Beach County with Survey Respondents by gender

Gender	HIV/AIDS Case Prevalence Through 2015*		Survey Respondents (N=357)	
	Number	Percent	Number	Percent
Male	5,065	62.8%	162	45.3%
Female	2,998	37.2%	184	51.5%
Transgender (Male to Female)	0	0	7	2.0%
Other	0	0	4	1.2%
Total	8,063	100%	357	100%
*Source: Florida Department of Health, HIV/AIDS & Hepatitis Program (as of 8/08/16).				

Overall, Black not Hispanic survey respondents were somewhat over-represented at 67.7% (242) compared to Black Not Hispanic PLWHA in the county (60.3%, 4,861). In contrast, White not Hispanic were under-represented as 19.0% (68) of the survey respondents were Hispanic while 23.9% (1,924) of PLWHA in Palm Beach County Are White not Hispanic.

Comparison of HIV/AIDS Case Prevalence in Palm Beach County with Survey Respondents by Race and Ethnicity

Race/Ethnicity	HIV/AIDS Case Prevalence Through 2015*		Survey Respondents (N=357)	
	Number	Percent	Number	Percent
Black Not Hispanic	4,861	60.3%	242	67.7%
White Not Hispanic	1,924	23.9%	68	19.0%
Hispanic	1,150	14.3%	47	13.2%
Other/Unknown	128	1.5%	0	0
Total	8,063	100.00	357	100.00
*Source: Florida Department of Health, HIV/AIDS & Hepatitis Program (as of 8/08/16). Discrepancy in the numbers.				

As a summarized in the following table, the distribution of respondents by age range was similar to the distribution of PLWHA in the EMA. Age ranges 45-49, 50-59, and over 60 were somewhat underrepresented and ages below 24, 25-29, and 40-44 were overrepresented compared to PLWHA in the county.

Comparison of HIV/AIDS Case Prevalence in Palm Beach County with Survey Respondents by Age Range

Age	HIV/AIDS Case Prevalence Through 2015*		Survey Respondents (N=357)	
	Number	Percent	Number	Percent
Below 24	254	3.2%	3	1%
25-29	398	4.9%	16	5%
30-39	1,137	14.10%	45	11%
40-44	850	10.5%	39	10%
45-49	1,197	14.8%	64	18%
50-59	2,595	32.10%	124	37%
60+	1,632	20.2%	66	18%
Unknown	0	0	0	0
Total	8,063	100.0%	357	100%
*Source: Florida Department of Health, HIV/AIDS & Hepatitis Program (as of 8/08/16). Discrepancy in the numbers.				

The survey sample was similar to several special populations tracked by the Florida Department of Health, HIV/AIDS & Hepatitis Program. These special populations include heterosexuals, men who have sex with men (MSM), Haitian born, Hispanics, and 50+ age group.

The risk category "Heterosexual" was overrepresented with 61.9% (221 of 357) of survey respondents compared to 54.8% (4,423) of the HIV/AIDS case prevalence. MSM were underrepresented with 16% (57 of 357) of the survey sample compared to 36.4% (2,940) of PLWHA in the county. Haitian Born was slightly overrepresented with 9.2% (33 of 357) of the respondents compared to 18.6% (1,503) of PLWHA in the county. Hispanic persons were underrepresented with 14% (48 of 357) of respondents compare with 14.3% (1,150) of PLWHA case prevalence in Palm Beach County. The 50+ age group was also underrepresented with 15.7% (56 of 357) compared with 20.2% (1,632) of PLWHA in Palm Beach County.

Comparison of HIV/AIDS Case Prevalence in Palm Beach County with Survey Respondents by Special Population

Age	HIV/AIDS Case Prevalence Through 2015*		Survey Respondents (N=357)	
	Number	Percent	Number	Percent
Heterosexual	4,423	54.8%	221	61.9%
MSM	2,940	36.4%	57	16%
Haitian Born	1,503	18.6%	33	9.2%
Hispanic	1,150	14.3%	48	14%
50+ age group	1,632	20.2%	56	15.7%
*Source: Florida Department of Health, HIV/AIDS & Hepatitis Program (as of 8/08/16).				

Surveys were administered throughout the four main geographic areas of the county to ensure a broad and representative sample – especially in the western area of the county, which has a disproportionately high rate of cases. As shown in the following table, the survey sample was proportional to the number of PLWHA in the central and northern areas of the county.

Comparison of HIV/AIDS Case Prevalence in Palm Beach County with Survey Respondents by Geographic Area

Geographic Location	HIV/AIDS Cases Alive through 2015 EXEL DOC (N= 8,063)		Survey Respondents (N=357)	
	Number	Percent	Number	Percent
Central County	4389	57.0%	210	59.0%
North County	644	5.9%	24	7.0%
South County	2280	29.0%	73	20.4%
West County	750	9.9%	50	14.0%
No response	n/a	n/a	0	0%
Source: Florida Department of Health, HIV/AIDS & Hepatitis Program				

Respondents were asked where they were living when they first tested positive for HIV. Off all respondents, 72.5% (259) indicated they first tested positive in the same county they live in now (39, 11.0% to another county in Florida). Respondents who said they were living in another state accounted for 12.0% (43) and 9 (2.5%) were living outside the United States. The table below summarizes frequencies and includes the percentages of all respondents and of those who responded to this question.

Residence at Time of Testing Positive

Survey Question 12. Where were you living when you first tested positive for HIV?		
	Survey Respondents (N=357)	
	Number	Percent of all respondents
In the same county I live in now	259	72.5%
In another county in Florida	39	11.0%
In another state	43	12.0%
Outside of the United States	9	2.5%
No response	7	1.9%
Total	357	100%

As summarized in the following table, most of the PLWHA in the EMA are in care as are the survey respondents

Comparison of in Care and Out of Care Survey Respondents with PLWHA in Palm Beach County EMA

PLWHA	Palm Beach EMA*		Survey Respondents (N=357)	
	Number	Percent	Number	Percent
In Care	7,142	88.6%	287	80.4%
Out of Care	921	12.2%	57	16.0%
No response	0	0	13	4%
Total	8,063	100%	357	100%
*FDOH, Epidemiological Profile, Partnership 009. Continuum of HIV Care, 2015				

Socioeconomic Characteristics of Survey Respondents

As summarized in the following tables, 27.4% (98) of respondents indicated a category that was less than a high school graduation level of education.

Throughout the surveying process, sampling was monitored to ensure that the demographic and social characteristics of survey respondents represented the diversity of the PLWHA population in Palm Beach County. Using this stratified sampling methodology resulted in a survey sample similar to the profile of PLWHA in the Palm Beach County EMA.

Level of Education Completed

Survey Question 8. What is the highest level of education that you have completed?		
	All Respondents (N=357)	
	Number	Percent
High school graduation	132	37.0%
Less than high school graduation	98	27.4%
Some college	71	20.0%
Post graduate	9	2.5%
Completed college	35	9.8%
No response	12	3.36
Total	357	100%

When asked to indicate their work situation in the past year, 10.6% (38) indicated they were working full-time job and 10.3% (37) said they were looking for a job/unable to find employment. "Not working", the most frequently reported situation, was reported by 48.1% (172) of all respondents.

Employment Situation in the Past Year

Survey Question 10. What best describes your current work situation?		
	All Respondents (N= 357)	
	Number	Percent
Working full-time job	38	10.6%
Working part-time job	51	14.3%
Student	10	2.8%
Looking for a job/unable to find employment	37	10.3%
Retired	49	13.7%
Not currently working	172	48.1%
I have been unemployed for over a year	63	17.6%
No response	7	1.9%

Respondents were asked the following two questions in order to determine their income status, (Question 73) "What was your total income last month? (Include all of the money you received, plus the money anyone else who lives with you received. Include money from government assistance, except food stamps)?" and (Question 74) "How many people are supported by this income? (Total number of household members including yourself).

Respondents by Income Status

Income Status	All Respondents (N=357)	
	Number	Percent
No income (0.00)	112	31.4%
Under $500	28	7.8%
$500-$749	69	19.3%
$750-$999	48	13.4%
$1,000-$1,249	35	10.0%
$1,250-$1,499	15	4.2%
$1,500-$1,749	9	2.5%
$1,750-$1,999	5	1.4%
$2,000-$2,249	10	2.8%
$2,250-$2,499	5	1.4%
$3,000 or more	7	1.9%
No response	14	3.9%
Total	357	100%

Respondents by Household Members

Income Status	All Respondents (N=357)	
	Number	Percent
1	225	63.0%
2	59	16.5%
3	18	5.1%
4	10	2.8%
5 or more	9	2.5%
No response	36	10.1
Total	357	100%

The next section is divided into four parts as follows:
. Findings regarding PLWHA Survey Respondents Who Are Currently in Care
. Findings regarding PLWHA Survey Respondents Who Are Now in Care, But Have Been out of Care within the Past Five Years
. Findings regarding PLWHA Survey Respondents Who Are Out of Care
. Findings regarding a Comparison of PLWHA Survey Respondents Who Are Out of Care with PLWHA Survey Respondents Who Are in Care

PLWHA are considered to be "in care" if they have received …
"…one of the following HIV-related primary medical care services within the past 12 months:
. HIV/AIDS medical care
. Lab work for CD4 count
. Lab work for viral load count

PLWHA who do not meet these criteria are considered to be "out of care".

2. PLWHA WHO ARE CURRENTLY IN PRIMARY MEDICAL CARE

Survey respondents were identified as being "in primary medical care' if they met the criteria established by Health Resources and Services Administration (HRSA) as follows:

"…in receipt of one of the following HIV-related primary medical care services within the past 12 months:

- HIV/AIDS medical care
- Lab work for CD4 count
- Lab work for viral load count

As summarized in the following table, 88.6% (7,142) of the PLWHA in the county are in care compared to 80.4% of the survey respondents.

Comparison of in Care and Out of Care Survey Respondents with PLWHA in Palm Beach County EMA

PLWHA	Palm Beach EMA* 2015		Survey Respondents (N=357)	
	Number	Percent	Number	Percent
In Care	7,142	88.6%	287	80.4%
Out of Care	921	12.2%	57	16.0%
No response	0	0	13	3.6%
Total	8,063	100%	357	100%
*FDOH, Epidemiological Profile, Partnership 009. Continuum of HIV Care, 2015				

Survey respondents who were identified as being in care were asked to describe their frequency of utilization and prioritization of the twenty-six service categories in the continuum of care. In addition, in accordance with HRSA guidelines they were asked, about their history and experience being in care, as well as out of care.

Of all 357 respondents, 80.4% (287) were identified as being in primary medical care and 57 (16.0%) of out of care.

In or Out of Care

Survey Question 13. Were you in care for HIV/AIDS between June 1st 2015 and May 31st 2016?		
	Respondents (N= 357)	
	Number	Percent
In Care	287	80.4%
Out of Care	57	16.0%
No response	13	3.6%
Total	357	100%

Access to Health Care

Most to the respondents who are in care indicated that they received medical care at either a doctor's office (42.3%, 151) or at the Health Department (28.8%, 95 out of 330).

Medical Care Provider

Survey Question 17. Where did you regularly receive your HIV/AIDS medical care between June 1st 2015 and May 31st 2016?		
	In Care Respondents (N=357)	
	Number	Percent
Walk-in/Emergency clinic	16	4.5%
Doctor's office	151	42.3%
Hospital emergency room	6	1.7%
Veteran's Administration	2	0.6%
Public clinic/Health Department	95	26.6%
HIV clinic	28	7.8%
Federally Qualified Community Health Center (FQHC)	32	9.0%
No response	27	7.5%
Total	357	100%

All 287 respondents who are in care were asked to identify barriers to getting the services they needed during the past 12 months. The 57 (19.8%) who responded they had barriers to getting services most frequently mentioned the following:

- Transportation problems (6.3%, 18)
- Treatment by staff in the clinic or doctor's office (4.8%, 14)
- Long wait times to get to see the (4.2%, 12).

The following table summarizes all responses to this question.

Barriers to Getting Services

Survey Question 51. If you had problems receiving services between June 1st and May 31st 2016. What were some of the reasons?		
	In Care Respondents (N=357)	
	Number	Percent
This does not apply to me. I had no problems receiving services	229	64.1%
I did not know where to get services	22	6.2%
I could not get an appointment	6	1.7%
I could not get transportation	15	4.2%
I could not get child care	1	0.3%
I could not pay for services	14	4.0%
I did not want people to know that I have HIV	26	7.3%
I could not get time off work	8	2.3%
I was depressed	22	6.2%
I had a bad experience with the staff	21	5.8%
Services were not in my language	3	0.8%
I did not qualify for services	13	3.6%
Other (please specify)	18	5.0%
No response	26	7.3
Limited services Sometimes I am not eligible due to my immigration status I have TPS Appointment take too long Lack of communication Did not like timeline I did not go back because I was asked for too many documents Waiting time to long at health department Migrated to USA Everyone knows you are HIV when you go in the room		

All 287 respondents who are in care were asked to identify problems they have had trying to get needed services. The 44 (15.3%) who responded that they had problems trying to access needed services most frequently mentioned the following:

- Transportation problems (44, 15.3%)
- Food Bank (50, 17.4%)
- Housing (70, 24.4%)
- Dental Oral Health (59, 20.5%)

Survey Question. Have you had any of the following problems while trying to get needed services?		
	In Care Respondents (N=357)	
	Number	Percent
Mental Health	34	9.5%
Food Bank	50	14.0%
Transportation	44	12.3%
Health Insurance	44	12.3%
Housing	70	19.6%
Dental Oral Health	59	16.5%
Outpatient Medical Care	22	6.2%
Nutritional counseling	39	11.0%

More than half (63.8%, 62) of in care respondents who cited problems while trying to get needed services said they had encountered more than one problem. The table below summarizes the number and percentage of respondents by the number of problems cited.

Number of Problems
While Trying to Get Needed Services

Number of Problems	In Care Respondents Who Answered this Question (N= 98)	
	Number	Percent
One	37	37.7%
Two to Four	60	61.2%
More than Four	1	1.1%
Total	98	100%

A little under quarter (19.6%, 70) of in care respondents reported they lack of permanent housing. 21 (5.8%) said because they did not have enough money for deposit, and (10, 2.8%) said that they did not qualify for housing assistance.

Number of Reasons for Missing HIV Medication

Survey Question 21. What are some of the reasons why you missed taking your HIV medication? Mark all that apply.		
	In Care Respondents Who Had Been Missing taking HIV Medication (N=122)	
	Number	**Percent**
Cost	5	4.1%
Change of Insurance Plan	13	10.6%
Needed to get my prescription renewed	21	17.2%
Forgot	59	48.4%
I had side-effects	5	4.1%
My Eligibility documentation for ADAP was not completely timely	10	8.2%
Other (please specify)	9	7.4%

Out of 287 (80.4%) of the total 357 respondents that indicated, they were currently on antiretroviral (HIV medication) therapy, 122 responded that during the previous five years there had been a period of at least 12 months where they had not gone to the doctor. When asked about the reasons why they missed taking the medication, the three most frequently mentioned reasons were: they forgot to take the medications (48.4%, 59), needed to get my prescription renewed (17.2%, 21), and changed insurance plan (10.6%, 13).

3. PLWHA WHO ARE NOW IN CARE, BUT HAVE BEEN OUT OF CARE WITHIN THE PAST FIVE YEARS

The 287 respondents who are currently in care were asked if there had been a period during the last 5 years where they had not gone to the doctor for at least 12 months. Of the 287 respondents in care, 19.8% (57) responded in the affirmative. The table below summarizes all responses to this question.

Out of Care within the Past 5 Years

During the past five years, has there been a period of at least 12 months when you did not go to the doctor for HIV/AIDS medical care?		
	In Care Respondents (N=357)	
	Number	**Percent**
Yes	57	16.0%
No	287	80.4%
No Response	13	3.6%
Total	357	100.0%

The following table lists all the reasons respondents cited for being out of care. Note that respondents were told to "check any or all that apply". The three most frequently mentioned reasons are as follows:

- I did not have medical insurance (19.3%, 11)
- I could not afford care (19.3%, 11)
- I was afraid of being identified as HIV-positive (19.3%, 11)

Out of Care Reasons

Survey Question 14. What prevented you from getting HIV/AIDS medical care during this time?		
	In Care Respondents Who Had Been Out of Care and Returned to Care (N=57)	
	Number	Percent
I did not have medical insurance	11	19.3%
I could not afford care	11	19.3%
I had heard bad things about the medications and their side effects	6	10.5%
I knew where to go but I did not want to go there	4	7.0%
I was afraid of being identified as HIV-positive	11	19.3%
I was using drugs or alcohol	5	8.7%
I found it difficult to apply for insurance	8	14.0%
Other (Please specify)	9	15.7%
No transportation Homeless Family problems Just because I started working so I missed my appointment I couldn't miss school Could not get off from work Long waiting period at the clinic		

The table below summarizes the number of reasons respondents identified for having been out of HIV/AIDS medical care. (29.8%, 17) cited only one reason, while less than half (49.1%, 28) cited two or more reasons, suggesting that PLWHA who are out of care may need to overcome multiple problems in order to get into and stay in care.

Number of Reasons for Having Been Out of Care

Numbers of Reasons	In care Respondents Who Had Been Out of Care and Returned to Care (N=57)	
	Number	Percent
1	17	29.8
2 to 4	28	49.1
5 to 8	12	21.1
Total	57	100.0%

4. PLWHA WHO ARE OUT OF CARE

Per HRSA's definition, PLWHA have not received primary medical care and are "out of care" if they have not had at least one of the following during the last 12 months:

- HIV/AIDS medical care
- Lab work for CD4 county
- Lab work for viral load count

As summarized in the following table, 12.0% of PLWHA in Palm Beach County are out of care compared 16.0% of survey respondents.

Comparison of in Care and Out of Care Survey Respondents with PLWHA in Palm Beach County EMA

PLWHA	Palm Beach EMA* 2015		Survey Respondents (N=357)	
	Number	Percent	Number	Percent
In Care	7,142	88.0%	287	80.4%
Out of Care	921	12.0%	57	16.0%
No Response	0	0	13	3.6
Total	8,063	100%	357	100%
*FDOH, Epidemiological Profile, Partnership 009. Continuum of HIV Care, 2015				

Demographics

The following table compares the demographic characteristics of PLWHA not in care with all PLWHA in the EMA. As seen in the table, the data show that Blacks and males have slightly higher percentages of persons out of care relative to their proportion among the PLWHA population as a whole.

PLWHA Not in Care and all PLWHA[2]		
Demographics	Number	Percentage
Race/Ethnicity	**%**	**%**
Black	63%	60%
White	20%	24%
Hispanic	15%	14%
Gender	**%**	**%**
Male	67%	63%
Female	33%	37%
Age	**%**	**%**
0-24	3%	3%
25-29	4%	5%
30-39	16%	14%
40-44	11%	11%
45-49	15%	15%
50-59	29%	32%
60+	23%	20%
Exposure Category	**%**	**%**
MSM	35%	36%
IDU	8%	7%
Heterosexual	55%	55%

An analysis of PLWHA out of care by zip code shows that the highest concentrations are in the far western and eastern (coastal) portions of the county. The zip codes with the highest concentrations of PLWHA out of care are also the ones that have the highest prevalence of PLWHA, as described above. These zip codes represent the following areas of Palm Beach County: West Palm Beach (33401, 33404, and 33407); Belle Glade (33430); Boynton Beach (33435); Delray Beach (33444); and Lake Worth (33460, 33463).

Unmet Need Trends, 2011-2015

The following table shows the percent of unmet need for PLWA and PLWH for 2011-2015.

Unmet Need, 2011-2015

Population	2011	2012	2013	2014	2015
PLWH	56%	59%	58%	43%	41%
PLWHA	35%	38%	38%	28%	27%
Total PLWHA	43%	46%	46%	34%	33%

[2] Florida Department of Health, HIV/AIDS Section (2016). *Epidemiological Profile, Palm Beach County*.

As seen in the table, the unmet need percentage for both PLWH and PLWA was similar from 2011 to 2013 but decreased substantially in 2014 and 2015 (which were similar to each other). This can be attributed to improvement in outreach and linkage to care efforts, and increased accuracy of data collection. In 2014, the Florida Department of Health HIV/AIDS Section made significant efforts to improve the completeness of the eHARS lab data, including researching all newly diagnosed cases in 2014 who never received a CD4 or viral load test. The state epidemiologists matched data with Careware and ADAP to get the most complete data for care. All cases diagnosed between 1980 and 1995 who were not in care in the past several years were manually reviewed. Many were found to be deceased or moved out of state, and their records were updated accordingly.

When asked about the reasons for not being in care, the three most frequently mentioned reasons were:

- Transportation (31.5%, 18)
- Treatment by staff in the clinic or doctor's office (24.5%, 14)
- Long wait times to get to see the doctor (21.0%, 12)

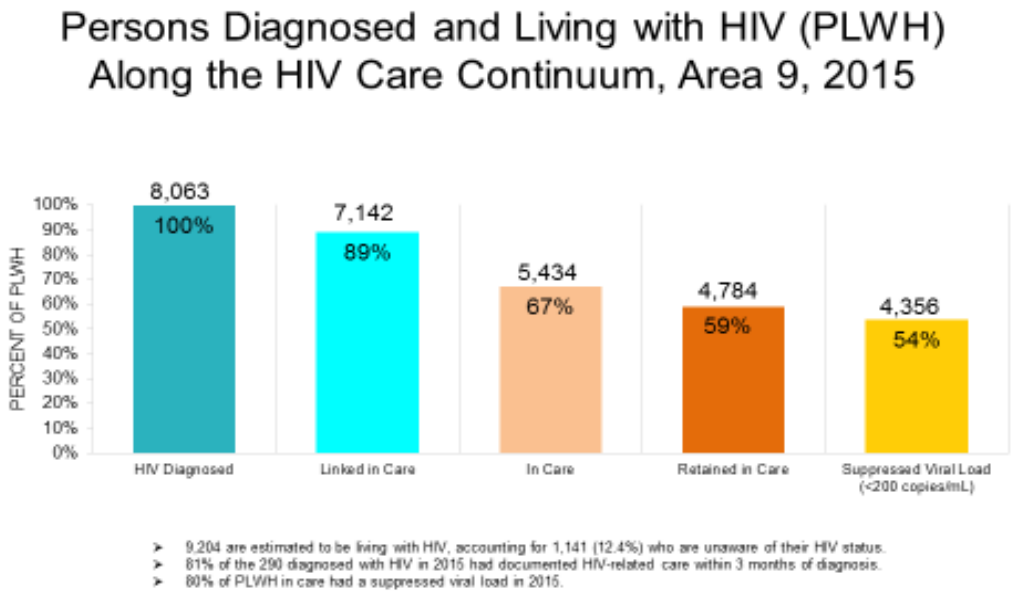
Reasons for Not Getting Medical Care

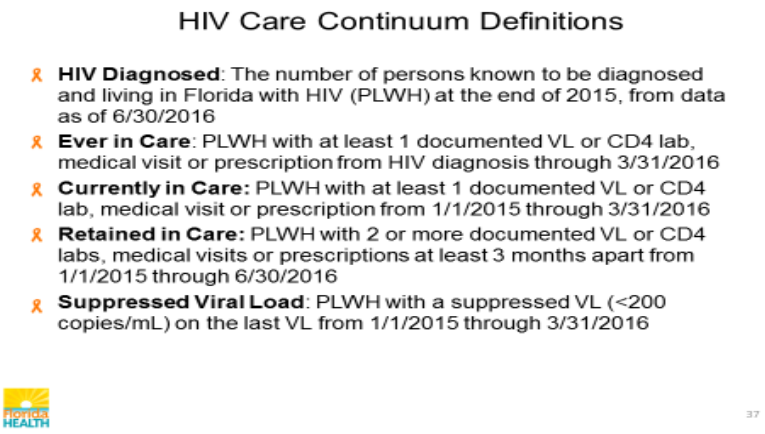
Survey Question 14. What was the reasons why you are not in care?		
	Out of Care Respondents (N=57)	
	Number	Percent
Transportation	18	31.5%
Treatment by staff in the clinic or doctor's office	14	24.5%
Language barrier	1	1.7%
Long wait times to get to see the doctor	12	21.0%
Child care	4	7.0%
I am unavailable during hours of operation	9	15.7%
Drug User Ready to give up No private place to go Everybody knows your business at the clinic People I knew at the health center Scared to go get help I get so angry sometimes with my husband My family is ashamed of me Newly diagnosed Could not get Medicaid, denied medical services I hate to go to the clinic HIV is not going anywhere		

5.Care Continuum 2015 EMAs

Persons Diagnosed and Living with HIV (PLWH)

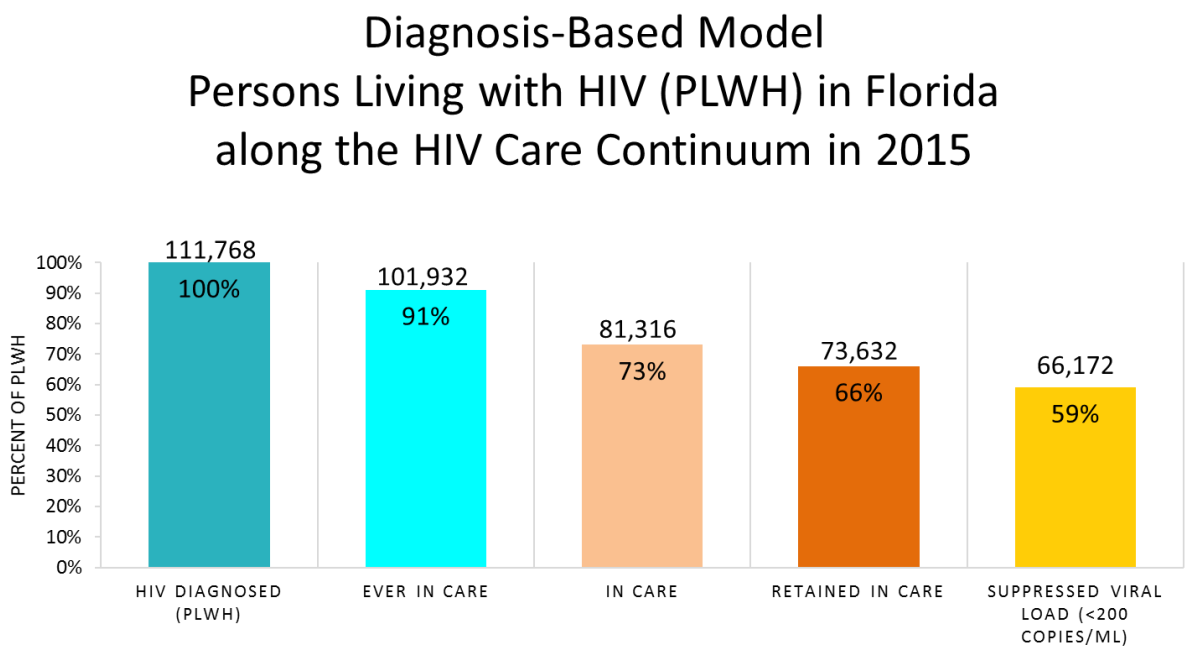
As well as understanding the number of new HIV cases in Florida, it is also important to be aware of the overall prevalence, or number of people living with HIV in the state. This data is tracked because it informs decisions related to resource allocation and to ensure all people with HIV in Florida have access to the care they need. Figure 3 presents the stages of HIV Care of the people living with HIV in Florida. This model is updated annually.





Source: HIV Continuum of Care Slide Set, Florida Department of Health, 2015

The statewide number and percentages of persons living with HIV in each phase of the HIV Care Continuum is presented in the Figure below. These do not include Department of Correction (DOC) cases. There is a decrease in percentage following each phase, with greatest difference occurring between the "Ever in Care" and "In/Retained in Care" phases.



127,589 are estimated to be living with HIV, accounting for 15,821 (12.4%) who are unaware of their HIV status.
83% of the 4,868 diagnosed with HIV in 2015 had documented HIV-related care within 3 months of diagnosis.
81% of PLWH in care had a suppressed viral load in 2015.
Source: HIV Continuum of Care Slide Set, Florida Department of Health, 2015

The HIV Care Continuum for the EMA illustrates the HIV epidemic in West Palm Beach, and reflects both the number and percentage of HIV-infected persons engaged in each stage of the continuum. The West Palm Beach EMA is currently using the data from the HIV Care Continuum for two specific purposes: (1) planning and resource allocation, and (2) improving health outcomes across care continuum stages. In planning and resource allocation, the EMA in collaboration with the Florida Department of Health has developed Geographic Information System (GIS) density maps to locate hot spots of disease throughout Palm Beach County. The use of GIS and spatial data analysis has allowed the EMA to document changes in both the geographical concentration and the distribution of HIV disease in Palm Beach County. The result of the GIS density maps revealed three areas of HIV concentration within the county. The identification of these areas has allowed the EMA to determine existing disparities within the HIV-infected population. Moreover, the detection of the hot spot areas has encouraged the EMA to target dollars for culturally appropriate care, HIV prevention strategies, and testing events. As the EMA develops overlays for HIV testing sites, Ryan White providers, and hospitals, HIV viral density maps will provide further insight regarding the distribution of risk factors among various demographic groups. The goal is to continue the development of novel prevention strategies, encourage more testing, and create targeted social marketing and community outreach, with a focus on condom distribution sites for the Florida Department of Health. The use of GIS will continue to guide planning, resource allocation and the delivery of HIV/AIDS medical and support services in Palm Beach County.

To address health outcomes at each care continuum stage, data from the care continuum has allowed the EMA to decipher which stage of the continuum impacts the most number of HIV-infected persons. The tracking of stages has encouraged the EMA to support programs that will increase the number of HIV-Infected persons in each stage of the continuum; ultimately increasing the number of individuals with suppressed viral loads. For example, with the EMA noting the number of individuals linked to care in the HIV Care Continuum, funding allocations went to support an additional three Early Intervention Services (EIS) programs in West Palm Beach in an effort to identify, educate, and link more people living with HIV into care for the area. In addition, the EMA has compared the HIV Care Continuum data from funded agencies to encourage better treatment adherence for the HIV-Infected persons of West Palm Beach. Constant monitoring and observations of both medical and support service utilization has highlighted areas of improvement within the HIV Care Continuum. In supporting HIV-infected persons as they move from one stage in the continuum to the next, the West Palm Beach EMA has made a number of improvements within the area to address emerging gaps along the continuum:

Linkage to Care Stage: The EMA has moved from funding one EIS program to funding four EIS programs in the area. Not only does the latter ensure greater efforts to identifying newly diagnosed individuals who are positive in the area, it also works to find individuals who are known positives and are lost to care with additional staff on the ground in high-risk behavior areas. The EMA is striving to adhere to the National HIV/AIDS Strategy update 2020 with the collaboration of a network of EIS provider within the area. The four providers meet monthly in an EIS work group to discuss their efforts and ensure there are resolutions to challenges with finding positive individuals in West Palm Beach who are newly diagnosed or lost to care.

Retention in Care Stage: The EMA has strived to support programs that will encourage HIV positive individuals to stay in care. Funding allocations for Peer Mentors have encouraged positive individuals to adhere to treatment, seek those support services that eliminate barriers to care, and trust in a growing relationship that someone "just like them" as gone through the process and are living a life that is completely willing to embrace medical care. Moreover, the EMA has developed, in collaboration with Florida Department of Health, GIS density maps to define HIV hot spots and create a provider overlay in an effort to see where there is the need for additional services to retain positive individuals in care.

On ART Stage: The EMA funds a Local Pharmacy Assistance Program (LPAP) to assure the availability of both HIV and supplemental medications for persons waiting for ADAP or Medicaid enrollment to be completed. In addition, the Health Insurance Continuation Program supports clients to enroll in health insurance plans under the Affordable Care Act (ACA). The EMA pays for premiums, copays, deductibles and ADAP wrap-around costs. The support of clients in health insurance increases the accessibility of medications and other medical services.

Viral Load Suppression Stage: The EMA has worked to keep programs that encourage HIV treatment adherence through the continued allocations for support services and intense focus on low-income populations. Moreover, the EMA has ensured psychosocial and substance abuse services are in existence in the area to retain positive individuals, in medical care, which can ultimately contribute to viral suppression of the disease.

The West Palm Beach EMA has recognized the need for additional data in order to measure health disparities in relation to race, gender, sexual orientation, and age along the HIV Care Continuum. The EMA has invested in a new data management system (Provide Enterprise, PE), which can determine by agency and individual provider who is initiating ART treatments, what really happens to the "dropouts" along the HIV Care Continuum, and differences in access to care across subpopulations. As reporting in PE is further developed, the EMA will have an increased capacity to use care continuum data in health planning, prioritization of services and monitoring of health outcomes. Care Continuum data, stratified by agency, provider, risk category, and sub-population type will be the key information source for the monitoring and evaluation strategies discussed below.

6. Prioritization of Services Categories

Respondents who are in care were asked to identify the five service categories they considered most important to them.

The five most frequently selected service categories include the following:
Primary Medical Care (93.0%, 267)
Dental/Oral Health (70.7%, 203)
Medications (93.7%, 269)
Case Management (91.3%, 262)
Food Bank or Food Vouchers (66.2%, 190)

Five Most Important Services

Which five services do you think are most important for people with HIV/AIDS?		
	In Care Respondents N=287	
	Number	**Percent**
Primary Medical Care	267	93.0%
Dental/Oral Health	203	70.7%
Medications	269	93.7%
Case Management	262	91.3%
Food Bank or Food Vouchers	190	66.2%

Five Most Important Services

Service Category	In Care Respondents (N=287)	
	#	%
Primary Medical Care	267	93.0%
Medical Specialist	52	18.1.0%
Case management	262	91.3%
Medications	269	93.7.0%
Dental/Oral Health	203	70.7%
Health Insurance	40	14.0%
Mental Health Services	27	10.0%
Substance Abuse Outpatient	4	1.4%
Nutritional Counseling	9	3.1%
Early Intervention Services	40	14.0%
Home Health Care	4	1.4%
Food Bank or Food Vouchers	190	66.2%
Transportation	50	17.4%
Outreach	19	6.6%
Health Education/Risk Reduction	30	10.4%
Treatment Adherence	18	6.3%
Legal Support	19	6.6%
Rehabilitation	2	0.69%
Emergency Financial Assistance	40	14.0%
Peer Mentoring	12	4.2%
Housing	80	28.0%
Support Groups	41	14.3%
Other	2	0.69%
No Response	3	1.1%

7. SERVICE UTILIZATION, GAPS, AND BARRIERS

Survey respondents in care were asked to describe their level of utilization of the twenty-seven service categories prioritized by the Planning Council. The 287 respondents in care described their utilization of each survey categories as one of the following:

- "I received this service" if they utilize the service
- "I needed this service but was unable to get it" to show possible gaps in services
- "I needed this service but was unaware if it was offered or how to access" to show barriers to service utilization
- "I did not need this service" if they do not utilize the service

Utilization: "I received this service"
The five most frequently utilized "I received this service" services:

Medications (93.7%, 269)
Primary Medical Care (93.0%, 267)
Home Health Care (21.0%, 60)
Case Management (91.3%, 262)
Dental/Oral Health (70.7%, 203)

Gaps: "I needed this service but was unable to get it"
The five top ranked "I needed this service but was unable to get it" services:

Dental/Oral Health (20.5%, 59)
Health Insurance (15.3%, 44)
Case Management (11.8%, 34)
Outpatient Medical Care (7.6%, 22)
Housing (8.7%, 25)

In and out of Care section of this report, data from respondents who are out of care report several service gaps. When respondents who are not in HIV/AIDS medical care were asked what services would help them get into care, "housing" (60%), "Food Voucher" (58%), and "transportation" (57%).

Barriers

The top five services in the "I needed this service but was unaware if it was offered or how to access" categories were:

1. Food Bank or Food Vouchers (14.3%)
2. Housing (20.2%)
3. Transportation (12.7%)
4. Peer Mentoring (9.9%)
5. Legal Support (8.5%)

The following table summarizes all responses regarding utilization, gaps, and barriers with the top five ranked services highlighted for emphasis.

Service Utilization, Gaps, and Barriers												
	Utilization			**Gaps**					**Barriers**			
	Received this service			**Needed this service was unable to get**					**Needed this service but was unaware if it was offered or how to access**			
	Rank	**#**	**%**	**Rank**	**#**	**%**	**Rank**	**#**	**%**	**Rank**	**#**	**%**
CORE SERVICES												
Outpatient Medical Care: Regular doctor visits for HIV medical care	3	267	77.4%	3	22	6.4%		21	6.1%		35	10.1 %
Case Management: Case managers help clients receive services and then follow-up on their care	5	262	74.6%	4	34	9.7%		23	6.6		32	9.1 %
Medications: Pills for HIV and related issues	4	269	78.0%		31	9.0%		26	7.5%		19	5.5 %
Dental/Oral Health: General teeth and mouth care, dentures, oral surgery, etc.	6	203	59.0%	5	59	17.2%		29	8.04%		53	15.4 %
Health Insurance: Helps pay insurance costs or co-pays if client has private insurance		206	59.9%	4	44	12.8%		28	8.1%		66	12.2 %
Mental Health Services: Professional counseling, therapy, or support groups		148	42.7		21	6.1%		34	9.8%		144	41.5 %
Substance Abuse Treatment: Professional counseling for drug or alcohol addiction		68	19.7%		9	2.6%	5	29	8.4%	5	239	69.3 %
Nutritional Counseling: Professional counseling for healthy eating habits		158	46.3%		18	5.3%		39	11.4%		126	37.0 %
Early Intervention Services: Assistance getting a doctor appointment, HIV		149	43.2%		16	4.6%		28	8.1%		152	44.1 %

counseling and testing, linkage and referral to medical care												
Home Health Care: Professional healthcare services in client's home by a licensed/certified home-health agency		60	70.4%		11	3.2%	3	28	8.1%	3	246	71.3 %
Hospice Services: Nursing and counseling services for the terminally ill and their family		41	12.0%		10	2.9%		21	6.1%	2	271	79.0 %
SUPPORT SERVICES												
Food Bank or Food Vouchers: Food bags, grocery certificates, home-delivered meals, and nutritional supplements		190	54.4%		20	5.7%	5	50	14.3%		89	25.5 %
Transportation: Help getting to the doctor's office and other HIV related appointments		185	53.3%		14	4.0%	5	44	12.7%		104	30.0 %
Outreach: Someone who finds people with HIV not in care and helps them to visit their doctor and get services they may need		113	33.0%		16	4.07%		25	7.3%	1	188	55.0 %
Health Education/Risk Reduction: Someone who tells clients about HIV, how it's spread, current medications, and how to live with HIV		211	60.8%		10	2.9%		27	7.8%		99	28.5 %
Treatment Adherence: Instructions on how to take HIV medications properly		215	62.7%		14	4.1%		28	8.2%	2	86	25.1 %
Legal Support: Help clients with HIV related legal issues (will, living will, etc.)		140	40.8%		13	3.8%	3	29	8.5%		161	46.9 %
Rehabilitation: Physical therapy, speech therapy, low vision training, etc.		79	23.1%		9	2.6%		29	8.5%		225	65.8 %
Peer Mentoring: Support and counseling from community members		152	44.4%		18	5.3%	3	34	9.9%		138	40.4 %

Housing: Help finding and/or maintaining a place to live	5	118	34.1%	5	25	7.2%	5	70	20.2%		133	38.4 %
Other:		0	0.0%		1	0.5%		13	3.8%	4	202	95.7 %

B. TRENDS IN SERVICE UTILIZATION, GAPS, AND BARRIERS (2007-2016)

Needs Assessments were conducted in 2007, 2010, 2013, and 2016. The tables below contain service utilization, gaps, and barrier data from each study. Service categories used to analyze utilization, gaps, and barriers have varied slightly in the five Needs Assessments. Therefore, it was not possible to analyze trends for those categories that were not included in all Needs Assessments. For example, Spiritual/Religious Counseling was a service that was included in earlier Needs Assessments, but was removed from the list of services used after the 2007 Needs Assessment. The list of service categories in the 2016 data collection instrument includes only the services in the current continuum of care that were prioritized by the Care Council in 2016. In some cases, this has resulted in nonconsecutive rankings in the tables below.

Utilization: "I received this service"
Although rates of utilization have changed for the following services, they have remained highly utilized from 2007 through 2016. The following table lists the top 5 services of utilization in 2016.

Service categories that Remain Highly Utilized since 2007

Service Categories	2007 N=252		2010 N=296		2013 N=211			2016 N=287		
	rank	%	rank	%	rank	#	%	rank	#	%
Laboratory Diagnostic Testing	2	71%	3	75.7%	1	202	95.7%	n/a	n/a	n/a
Primary Medical Care	4	56.3%	2	76.0%	2	196	92.9%	3	267	93.0%
Case Management	1	74.6%	6	57.8%	4	172	81.5%	5	262	91.2%
Oral/Dental Health	3	57.5%	5	59.5%	5	160	75.8%	6	203	70.7%
Medical Specialist	8	40.0%	4	61.1%	6	159	75.4%	n/a	n/a	n/a
***No category *Medical Specialist* prior to 2016**										

The following services significantly increased utilization from 2007 through 2016. The following table lists the services from the highest to lowest rankings of utilization in 2016.

Service Categories that Significantly Increased in Utilization Since 2007

Service Categories	2007		2010		2013			2016		
	N=252		N=296		N=211			N=287		
	rank	%	rank	%	rank	#	%	rank	#	%
Primary Medical Care	4	56.3%	2	76.0%	2	196	92.9%	3	267	93.0%
Medications	17	31.0%	1	76.4%	3	190	90.0%	3	269	93.7%
Transportation	6	45.6%	7	40.2% %	9	103	48.8%	5	185	64.4%

The following services (listed from the highest to lowest rankings of utilization in 2016) significantly decreased in utilization from 2007 through 2016.

Utilization of Service Categories Across the 2007, 2010, 2013, and 2016

Service Categories	2007 N=252		2010 N=296		2013 N=211		2016 N=287	
	rank	%	rank	%	rank	%	rank	%
CORE SERVICES								
Outpatient Medical Care								
Primary Medical Care	4	56.3%	2	76.0%	2	92.9%	3	77.4%
Case Management	1	74.6%	6	57.8%	4	81.5%	2	74.6%
Medication	17	31.0%	1	76.4%	3	90.0%	3	78.0%
Dental/Oral Health	3	57.5%	5	59.5%	5	75.8%	2	59.0%
Health Insurance	14	34.9%	8	34.9%	13	39.3%	11	59.9%
Mental Health Services	9	38.1%	13	29.7%	12	39.8%	10	42.7%
Substance Abuse Treatment								
Substance Abuse Residential	24	22.8%	19	11.1%	21	16.1%	18	19.7%
Nutritional Counseling	n/a		11	31.8%	8	53.1%	12	46.3%
Early Intervention Services	5	51.6%	17	17.6%	20	27.0%	23	43.2%
Home Health Care	22	15.9%	22	8.1%	26	7.1%	20	17.4%
SUPPORT SERVICES								
Food Bank or Food Vouchers	10	37.7%	9	33.4%	7	53.6%	8	54.4%
Transportation	6	45.6%	7	40.2%	9	48.8%	5	53.3%
Outreach	11	36.1%	18	15.9%	22	15.2%	10	33.0%
Health Education/Risk Reduction	n/a	n/a	10	32.4%	11	44.5%	12	60.8%
Treatment Adherence	12	35.7%	10	32.4%	10	46.4%	9	62.7%
Legal Support	12	34.9%	14	27.7%	16	32.7%	10	40.8%
Rehabilitation	n/a	n/a	19	11.1%	24	10.4%	26	23.1%
Emergency Financial Assistance	13	57.5%	15	20.3%	19	28.9%	20	
Peer Mentoring	n/a	n/a	n/a	n/a	17	31.8%	18	44.4%
Housing	n/a	n/a	n/a	n/a	18	30.8%	19	34.1%
Support groups	n/a	n/a	12	30.1%	14	37.4%	n/a	n/a

Only HRSA service categories and "Support Groups" were used in the 2010 survey. Therefore, the categories "HIV Prevention", Support group, and "Vocational Rehabilitation" were not used (as in previous years) and "Health Education/Risk Reduction" and "Rehabilitation Services" were added to the 2010 survey. Peer Mentoring and Housing were in the 2013 survey.

Service Gaps: "I needed this service but was unable to get it"

This section includes data from the 2007, 2010, 2013, and 2016 Needs Assessments regarding services, which respondents indicated they "needed this service but was unable to get". The table below lists the service gaps that remained somewhat consistent from 2007 through 2013.

Service Gaps that Remained Somewhat Consistent Across the 2007, 2010, 2013, and 2016

Service Categories	2007 N=252		2010 N=296		2013 N=211		2016 N=287	
	rank	%	rank	%	rank	%	rank	%
CORE SERVICES								
Primary Medical Care	25	6.3%	13	3.7%	12	1.9%		6.4%
Case Management	21	10.7%	7	7.4%	5	7.1%	5	9.7%
SUPPORT SERVICES								
Transportation	9	21.4%	3	14.2%	3	9.5%	3	12.7%
Health Education/Risk Reduction	n/a	n/a	11	4.7%	12	1.9%		7.8%
Only HRSA service categories and "Support groups" were used in the 2010 survey. Therefore, the category "HIV Prevention not used (as in previous year) and "Health Education / Risk Reduction" was added to the 2010 survey.								

C. HIGHLIGTS REGARDING POPULATION OF SPECIAL CONCERN

Previous Part A grant application have included sections that focused on the following

1. Men who Have Sex with Men (MSM)
2. Haitian Men and Women
3. African American
4. Latin/Hispanic Men and Women

This Needs Assessment focused on similar populations of special concerns as follows,

1. African American
2. Men who Have Sex with Men (MSM)
3. Haitian Men and Women
4. Youth

For this Needs Assessment, focus groups were conducted with PLWHA from each of the four populations listed above. The following section highlights service delivery issues within all six of these populations of special concern. In addition, PLWHA survey data regarding the populations of special concern are compared with aggregated PLWHA survey data.

1. AFRICAN AMERICAN HETEROSEXUAL

Unique Challenges

African American heterosexuals face many barriers to care and experience many factors that complicate their care. Poverty, limited education, lack of health insurance, and lack of transportation continue to be a significant problem for this population. Many African-American heterosexual PLWHA are not well informed about HIV/AIDS or do not feel the need to be tested until they become symptomatic. Additionally, there are high rates of reported stigma attached to HIV/AIDS. These factors create a culture of denial that results in late testing and diagnosis. Many of that population struggle with family rejection and the stigma of HIV, which affects adherence to medical regimens as well as their ability to disclose their HIV status to family, friends, or sexual partners. Further, some of them subscribe to HIV/AIDS conspiracy beliefs, reflecting mistrust of the health care system.

African-American women may feel disempowered in their relationships with men. African-American women who are of childbearing age are also at high risk for dropping out of care despite the high need for pre-and post-natal care, preventive care, screening, and other services, as well as HIV-related adherence counseling. Women may also prioritize their family's need before their own health care needs. Finally, for women, additional factors such as partner domestic violence compound safety, security, and preventive health behaviors.

Service Gaps

The Needs Assessment 2016-2019 survey included 242 African-American heterosexual respondents. 64% reported they were in care. 23% had either no schooling or an education level less than High School, 64% were unemployed during the prior 12 months, and 87% were living at the poverty level.

Out of Care African-American Heterosexuals

All out of care respondents were asked to describe their current situation regarding being out of care. The most frequently mentioned description by African-American heterosexuals was, "I had been receiving medical care of HIV, but I stopped more than 12 months ago, "75%)". The second question most frequently described situation for African-American heterosexuals was "I have not been recently diagnosed but have never been in care ") 10%)". When asked what services they needed to get into primary medical care, African-American heterosexual out of care respondents cited housing (54%), financial assistance (54%), substance abuse treatment (48%) treatment adherence services (50%), and food (40%)

Miami-Dade HIV/AIDS Partnership (2010). Silence is Death: The Crisis of HIV/AIDS in Florida's Black Communities.

In care African American Heterosexuals

Among African-American heterosexuals in care respondents, the most frequently reported services gaps ("I needed this service but was unable to get it") were food bank or food vouchers, housing, and emergency financial assistance (13%); and legal support and case management (8% of each). The most frequently cited barriers to services ("I need this service but was unaware if it was offered") were legal support, financial assistance, and support groups (11% each).

African-American Heterosexuals Focus Group Findings

Focus groups respondents reported that barriers to getting medical care where the fear, denial, shame and stigma, not knowing where to go, and long waits in the clinic. Factors that would help PLWHA get into care were reported to be assurance of confidentiality, money, and insurance. Respondents in care reported that funding, case management, insurance helped them get into and stay in care. Respondents felt that over the past 3 years' services have declined due to reduced funding. They felt services have been inadequate in quantity and quality.

Data Highlights Related to African-American Heterosexuals Survey Respondents

73 (37.5%) are out of care and 123(63%) are in care.
75 (38.7%) are male and 120 (61%) are female.
39 (19.9%) had either no schooling or an education level less than high school.
125 (64%) had been unemployed during the past 12 months.
169 (87.3%) are at or below the poverty level.

Out of 357 Needs Assessment survey respondent, 242 respondents indicated they were African-American heterosexuals. 287 (80.4%) indicated they were in HIV/AIDS medical care and 57 (19.8%) were out of care. When asked in a focus group, "What has helped to get in care and stay in care?" PLWHA representation from this population indicated family support and insurance provided by Ryan White. During the focus group, when participants were asked why they or others they knew were out of care, the respondents answered it can be various factors such as fear, lack of knowledge about the disease and available treatments, denial, addiction and barriers to accessing care due to lack of education or financial resources. In addition to issues related to access, participants also discussed complications with medications and problems with side effects and mentioned the relationship with their providers. Participants also expressed frustration on high turnover rates of direct service staff a provider and transportation is an issue. They said its difficult build trust repeatedly when they keep changing the case management. Black PLWHA identified negative experiences with clinic personnel as their most important barriers to care, lack of information about services, and stigma. They often felt that services were neither respectful. To overcome barriers, they recommended improved communication, more investment in patient education, and respect for them. They also mentioned the local housing crisis.

Focus Group Findings: Themes and Notable Quotes

Reasons for not going to the doctor for HIV/AIDS medical care

- Lack of knowledge about appropriate care and treatment services
- Fear (Some people are afraid to find out their status)
- Waiting list
- Time
- "A lot of people don't want to go sit at the clinic. They don't have the time and patience".
- Stigma and shame

What will it take to persuade individuals to go back to the doctor for HIV/AIDS medical care?

- Insurance
- Trust and confidence
  "Some staff, patient in there that might be nosey, they'll tell the whole world you are sick".
- Confidentiality

For in care participants, what has helped to get in care and stay in care?
In care, participants said continue funding of services have helped to get and stay in care:

- Funding, case management, if you know that you got insurance, you can get the help, other than that you can't get service".

"If I had insurance I would be more of a person that would stay in care".

In the past 3 years, have services improved, declined, or remain the same?
Participants felt that over the past 3 years' services have declined due to reduced funding:

- "Cost of living is going up, funding is going down".
- "They are cutting all of the funds, if they are cutting it, what can we do?"
- Waiting list for housing

Additional Comments

Participants shared the need to have more agencies in the area.

"We need more agency in the center of West Palm Beach to help people of color, don't have to worry about getting their information all over town".

I would like to know, what happens to the funding that agencies are holding, needs to go to other agency that are doing things to help people of color."

2. MEN WHO HAVE SEX WITH MEN (MSM)

Unique Challenges

The unique challenges of serving the MSM population include stigma and denial, including fear of learning the HIV status or disclosing HIV-positive status; discrimination and homophobia, including fear of disclosure of being a MSM; and the rejection by family, community, or partner. Psychological health issues, such as depression, partner violence, and low self-esteem can contribute to neglect of HIV care.

Service Gaps

The Needs Assessment 2016-2019 included 57 respondents who identified themselves as MSM 50% of these were in care. 20% had high school graduate.

Out of Care MSM Respondents

83% said they had been receiving medical care for HIV, but had stopped more than 12 months previously. Their most frequently identified reasons for being out of care were "I was depressed and "I did not feel sick" (50% each). When out of care MSM respondents were asked to identify the services that they need in order to get into primary care, the four most selected services were financial assistance, substance abuse treatment, food, and housing and treatment adherence services.

In Care MSM Respondents

Among MSM in care respondents, the frequently reported service gaps ("I needed service but was unable to get it") were transportation and housing (10% each). The most frequently cited barriers to services ("I needed this service but was unaware if it was offered") were peer mentoring, and early intervention services.

MSM Focus Group Findings

17.3% (57) of all survey respondents identified themselves as MSM. Only seven individuals of this population identified as Transgender (male to female). When asked in a focus group about the quality of HIV services in Palm Beach County, representation from this population indicated services have been adequate and they have been able to access the services they need. During the focus group, the respondents identified the reasons for someone not being in care or lack of knowledge about appropriate care and treatment service, depression and stress, lack of information about treatment and availability of services, having to take time off from work to pick up medications, bad customer service at ADAP. When asked about what would help MSM get back into care or stay in care, respondents identified facing life or death priority, reducing or eliminating alcohol and drug. Some identified service gaps and barriers were difficult and time-consuming eligibility process, needs for food bank; the ADAP customer service is terrible; and unmet needs or difficulty accessing emergency financial assistance; dental health care, and transportation.

Data Highlights Relate to MSM Survey Respondents

- 17.3% (57) of all respondents identified themselves as MSM.
- 23 (51%) are out of care and 22 (48%) are in care.
- 7 (2.0%) identified as Transgender (male to female)
- 1 (1.2%) reported being a migrant or seasonal worker.

Focus Group Findings: Themes and Notable Quotes

Reasons for not going to the doctor for HIV/AIDS medical care

- Fear
  "Don't know that it is an anonymous type of thing; think they will be labeled them".

- Stigma

- "Unaccepting, homosexual"

What will it take to persuade individuals to go back to the doctor for HIV/AIDS medical care?

Participants reported getting seriously ill, confidentiality, counseling and mentoring would persuade PLWHA to go back to HIV/AIDS medical care.

- Illness
  "Severe illness, that's what's going to take him here,…other substances so that's another problem..."

- Confidentiality
  "Confidentiality, key factor for anyone-we need to let these people know everything we do is confidential".

- Counseling and Mentoring
  "By using a mental counselor or professional that can communicate effectively with the person'.

For in care participants, what has helped to get in care and stay in care?

In care, participants expressed availability of care, insurance, support and assistance programs would help to get PLWHA in care and stay in care.

- Availability of Care and Insurance
  "Availability of medical care and insurance was a major factor; at the time for me there were no financial barriers, medical community was very important".

- Support
  "Initially got me into treatment was a wonderful doctor, started meds right away, reason I stayed in, my need to survive, I'm too beautiful to die, undetectable in less than a year".

- "Social support group"

- Assistance Programs

In the 3 years, have services improved, declined, or remain the same?

Overall respondents said services in the past 3 years have improved.

- "I think Palm Beach County does a very good job"

Quantity and Quality of Services

Participants shared quantity and quality of services has been adequate, and they have been able to access the services they need.

- "My experience of accessing services, pretty impressed so far"
- "Everything is okay".

Additional Comments

Participants requested additional services be added to the system of care, and challenges in the referral process to services.

- Request of additional services
  "what about like a gym? Some sort of passes since our physical health is so important for gym memberships".

- Challenges in the referral process to services
  "Services are wonderful, support group, can do better, outreach, and help a lot more people".

3. HAITIAN MEN AND WOMEN

Unique Challenges

Providing services to PLWHA of Haitian descent can be extremely difficult, given the community mistrust of government activities and apprehension accessing the medical care system. A feeling of stigma about HIV/AIDS in this population, a fear of deportation and/or incarceration, and a complex non-western system of beliefs about health behavior all make treatment of HIV/AIDS difficult. Other factors include a low educational level, a low level of English ability, and illiteracy in either Creole or English. Most Haitians are diagnosed in the public hospital inpatient or emergency room units where they present with serious illness. A significant number of older persons of this population use non-traditional healing methods such as Haitian herbalists and spiritual healers before seeking western medical care, and then only when their symptoms have seriously progressed[13].

Additional challenges arise from immigration status. In Florida, only people with an AIDS-defining diagnosis plus a documented disability are eligible for Medicaid. This policy excludes a significant number of legal immigrants living with AIDS who are not disabled and thousands of HIV positive client. Many immigrants are not connected to care due to lack of basic knowledge of the American health care system. Undocumented immigrants are ineligible for most public assistance programs. This places additional pressure on the Ryan White program and creates challenges for getting people tested and into treatment. In addition, undocumented immigrant is often reluctant to seek care largely because they fear deportation. When they do seek care, they are likely to be late presenters who are sicker and thus cost more to treat. [14]

Service Gaps

The Needs Assessment 2016-2019 survey included 33, on Haitian respondents. 82% of the respondents were in care. Half were unemployed during the prior 12 months, one-half (47%) had less than high school degree, and
86% lived at the poverty level.

<u>Out of Care Haitian Respondents</u>

When out of care Haitians were asked to describe their situation, 80% said they had been receiving medical care for HIV, but has stopped more than 12 months previously. The most identified reasons for being out of care were “I did not want people to know that I have HIV” (50%), “I could not pay for services” and “I was not ready to deal with having HIV” (45% each).
When out of care Haitian to identify the services that they need in order to get into primary medical care, the most selected services that thy need in order to get into primary medical care were treatment adherence services (57%) and case management (45%).

[13]Miami-Dade HIV/AIDS Partnership (2010)
[14]Miami-Dade HIV/AIDS Partnership (2010)

In Care Haitian Respondents

Among Haitian in care respondents, the most frequently reported service gaps ("I needed this service but was unable to get it") were emergency financial assistance (18%), housing and legal support (10% each). The most cited barriers to services ("I needed this service but was unaware if it was offered") were food bank or food vouchers (40%); emergency financial assistance, and transportation (18%); and legal support (10%).

Haitian Focus Group Findings

Participants reported that reasons for not getting care included fear, stigma, not knowing where to go, family obligations, and not having anyone to help. They felt that counseling, moral support, having a place to go, would help PLWHA get into care. A desire to live was reported to the reason for getting care. Challenges to getting care were reported to be beliefs in the supernatural and lack of insurance. Respondents felt that over the past 3 years, services have declined and their quantity and quality has been inadequate.

Data highlights related to Haitian survey respondents:
33 (10.9%) of all respondents indicated they were Haitian.
28 (97.0%) said they are straight (heterosexual)
23 (82.1%) reported being a migrant or seasonal worker.
24 (85.7%) were living at a poverty level

Focus Group Findings: Themes and Notable Quotes

Reasons for not going to the doctor for HIV/AIDS medical care

- Fear
  "A lot of people, afraid to go to the doctor, they feel that if they go people will know and it's offending".

- Lack of Knowledge and Assistance

"I know some people, different problem, if you have a good job, good insurance, when they go to the clinic, they say I cannot accept, he loses the job, not going to the doctor, still stick, doesn't know where to go to get help"

- Some people don't know where to go, Haitian Community".

What will it take to persuade individuals to go back to the doctor for HIV/AIDS medical care?

Participants shared counseling, and moral support will persuade individuals to go back to the doctor for HIV/AIDS medical care.

- Counseling
  "They need someone to talk".

- Moral Support
  "They don't like people to know that they are HIV positive because they are afraid. They think if someone find out, everybody going to know. Our culture, they will worry about who give it to me, I am going to give it to somebody else. What can we do if they don't want help?"

For in care participants, what has helped to get in care and stay in care?

Participants wants to live life as the motivation to get in care and stay in care.

- Wants to live life
  "Because we want to live, to see my grandkids".
  "I don't care about other people"
  "I don't want to die now"

In the past 3 years, have services improved, declined, or stayed the same?

Participants felt that services have declined in the past 3 years.

- "Down
- "People don't spend time with you anymore"
- "Turn over case management"
- "Thankful for the food vouchers"

Quantity and Quality of Services

Participants all agreed the quantity and quality of services have been inadequate.

- "Used to receive all of services, food bank or food vouchers during the holiday, doesn't receive it anymore, have not gotten medication for 3 months, blood pressure".

- "Food bank is not enough"

Additional Comments

Participants share their belief in the supernatural a request to obtain more services.

- "She thinks that it could be supernatural, but she is still going to the doctor".

- "I need more services than I'm getting".

- "Need transportation, need a cab voucher, on list for housing 3 years ago, can't afford where I'm staying now with my kids, no food voucher"

4.Youth Services

Unique Challenges

Unique challenges of serving Youth PLWHA include concerns regarding confidentiality, stigma, long waits for appointments for denial care, stress of worrying about future services, and fear of the society as a whole.

Service Gaps

The Needs Assessment 2016-2019 survey include 16 respondents. 60% of the respondents were in care. Half were unemployed during the prior 12 months.

Out of Care Youth Respondents

When out of care Youth were asked to describe their situation, 60% said they had been receiving medical care for HIV, but had stopped more than 12 months previously. Their most frequently identified reasons for being out of care were "I did not want the society to judge me" (40%). "I could not pay for services" and "I was not ready to deal with having HIV" (50%). When out of care Youth respondents were asked to identify the services that they need in order to get into primary care, the most frequently selected services were counseling or mental health services (60%) and case management (40%).

In care Youth Respondents

Among Youth in care respondents, the most frequently reported service gaps ("I needed this service but was unable to get it") were counseling (18%), emergency financial assistance (39%), and transportation (40%). The most frequently cited barriers to services ("I needed this service but was unaware if it was offered") were food bank or food vouchers (39%); emergency financial assistance, transportation (19%), and legal support (9%).

Youth Focus Group Respondents

When asked if they knew of any PLWHA not in HIV/AIDS medical care, and the reasons for them not being in care respondents cited fear, stigma from the community, and a lack of understanding of how to access services as barriers to being in care. Respondents also stated that healthcare providers at times do not always have all the information regarding medications that may be needed. Respondents cited a need for greater education in high schools, including comprehensive sex education. They stated that parents do not want the kids to know about sex, and that youth are not comfortable communicating with their parents. When asked about HIV prevention, respondents stated that many people do not have access to HIV education, and that overall it was considered a very awkward topic. Youth reported that they obtain information mainly from social media, such as YouTube and Facebook.

Focus Group Findings: Themes and Notable Quotes

Reasons for not going to the doctor for HIV/AIDS medical care
Participants expressed that fear and time were factors in not going to the doctor for HIV/AIDS

- Time
  "He can't get time off from work to make lab and Dr.'s appointments"

- Fear
  "I don't want my parents to find out that I'm HIV positive"

- "Maybe because he's afraid to tell his parents that he has HIV and he will kick out"

What will it take to persuade individuals to go back to the doctor for HIV/AIDS medical care?
Participants voiced that family and getting sick would persuade individuals to go back to the doctor for HIV/AIDS medical care.

- Society
  "People needs to stop pointing fingers"
  "Needs to educate about HIV

- Sickness
  "Infection..."

- Stigma
  "Health Education/Risk Reduction
  "Outreach

For in care participants, what has helped to get in care and stay in care?
Participant's shared family support has helped to get in care and stay in care.

- Family
  "I'm open about it"
  "You take care of yourself
  "Family is more important"

- Extra Support
  "Has been a big part of being a support system"
  "People in this clinic"
  "Wanted to give up plenty of time"

Quantity and Quality of Services
Participants shared that services in both quantity and quality have been adequate and that they have been able to access the services they need.

- "I think they're fine"

- “People are very caring here”
- “They’ve got people who speak difference languages here”
- “Good programs”.

Additional Comments

Participants said they felt as though they were treated poor; they would like that to change.

- “They treat you like low-income”
- “Like you are poor”
- “Coming here makes me feel poor”
- “I’ve seen it happen, I’ve gotten upset”

Appendix A.

SURVEY OF PEOPLE LIVING WITH HIV/AIDS
PALM BEACH COUNTY
2016

Date_____

Time_____

Name of interviewer (please print clearly and sign name)

_____
Print

_____
Signature

Venue (i.e. provider and/or location, such as "respondents home")
_____

Survey #_____

GIFT CARD #: _____

Questions? Contact Indira Case
Health Care Council of Southeast Florida
600 Sandtree Drive, Suite 101

Office Phone: (561) 844-4220 ext. 2700
Fax: (561) 844-3310
Email: icase@hcsef.org

Introduction

1. The Palm Beach County HIV CARE Council is conducting a survey on the needs of PLWHA who reside in Palm Beach County. This survey is one of the tools being used to gather information. The survey will serve as the basis for planning to better accommodate Persons Living with HIV/AIDS in Palm Beach County.

2. This survey is strictly voluntary and anonymous. Please do not write your name anywhere on this survey.

3. Please complete only one survey.

4. It will take about 15-20 minutes to complete this survey.

5. As a token of our appreciation, the interviewer will give you a $10.00 gift certificate after you complete the entire survey.

Thank you for taking the time to help us with this important project. Your answers will provide valuable information for the planning and delivery of vital services to our community.

Notes to the Interviewer

There are a number of advantages in having a questionnaire administered by an interviewer rather than self-administered the respondent. Most importantly, interview surveys give higher response rates than mail or phone surveys. Second, respondents seem more reluctant to turn down interviewers. Third, interviewers can answer questions for respondents, probe for answers and clarify confusing matters, thereby obtaining relevant responses. Finally, interviewers can observe behavior and pace the questioning if the respondent becomes tired or upset.

General Guidelines for Interviewing:

1. Try to have fun.
Relax and enjoy yourself. This is an opportunity to forget about your worries for a while and concentrate on someone else. Take a couple of deep breaths and "meet the respondents where they are".

2. Have a pleasant and appropriate appearance and demeanor.
Dress in a fashion similar to those you are interviewing. If unsure how you should dress, dress modestly. Your demeanor should be pleasant and communicate a genuine interest in getting to know the respondent. Relax and be friendly.

3. Provide a private and confidential setting. Try to do the interview in a private place where no one will overhear your discussion. If you must do the interview in a public setting, be sure no one is near enough to hear.

4. Read the Introduction to the respondent to emphasize that all survey material is strictly anonymous. No names will be used in gathering or reporting the information.

5. Become thoroughly familiar with the Survey
Study the survey carefully - maybe five or six times. Practice by reading aloud. The goal is to be able to read the survey without error and without stumbling over words. Think of yourself as an actor studying lines for a play. Also, be prepared to give guidance when a respondent does not understand a particular question.

6. Read the wording of each question exactly
Be careful with your wording, even when clarifying questions or probing for answers so that your wording does not distort the answer. In other words, try not to "lead the witness".

7. Record each response exactly
Record answers. Include details for "other" responses as they are stated by the respondent the respondent states them. Please do not summarize, paraphrase or correct bad grammar.

8. Probe for responses when necessary
Sometimes respondents will respond to a question with an obviously inappropriate answer. This might simply indicate they misunderstood the question. You may have to repeat the question or rephrase the question and check to make sure the respondent understands. If a respondent answers "Other" to any question, please ask them to be specific.

9. Coordinate efforts to make sure the situation is well controlled.

Whenever more than one interviewer is involved in a survey (e.g. with the help of an interpreter), it is essential that efforts be carefully coordinated and controlled to ensure that everyone is working from the same page.

10. Before the respondent leaves, please validate each survey by reviewing the entire survey (including the cover page) for missing information, unanswered questions, or inappropriate responses. If you find any, re-ask the question or probe for clarification in order to complete that item.

11. Return surveys to Berthline Isma:
810 Datura Street, West Palm Beach, FL 33401
Office phone: 561-355-4785
Fax: 561-242-6702
Email: Bisma@pbcgov.org

Palm Beach County EMA
COMMUNITY NEEDS ASSESSMENT

Anonymous Persons Living with HIV/AIDS (PLWHA) Survey 2016

INTERVIEWER READ: "We are having PLWHA fill out this survey so that you are able to tell your local HIV/AIDS Planning Group what services <u>YOU</u> need. Your input will help the Planning Group make important decisions about how federal and other funds are used in Palm Beach County.

Some questions are personal; however, the information you provide helps us better determine how to make our services better. To ensure your privacy, we will combine all the information we receive so no one will be able to identify you as an individual.

Please tell your friends about this survey. We want to hear from as many people who are living with HIV/AIDS as possible.

If you have completed this survey within the past month, do not complete it again."

Please check the appropriate box like this ☑ when answering multiple choice questions.

SECTION A: DEMOGRAPHICS

INTERVIEWER SAY: "Let's begin by finding out some basic things about you. Please remember that you will never be identified as an individual but rather as part of the whole group of people that take this survey."
Read the following questions. Probe to clarify, if necessary.

1. Survey # _____

2. What is your Zip Code? _____

3. What is your gender? *(check one only)*

☐ Male ☐ Female ☐ Transgender (Male to Female) ☐ Transgender (Female to Male)

☐Other, please specify: _____

4. How do you identify yourself? *(check one only)*

☐ Heterosexual ☐ Lesbian ☐ Bisexual ☐ MSM (men who have sex with men)

5. What is your race? *(check one only)*

☐ White/Caucasian ☐ Black or African American

☐ Asian ☐ Native Hawaiian or Pacific Islander

☐ American Indian or Alaskan Native ☐ Mixed/more than one race

6. What is your ethnicity? *(check one only)*

☐ Hispanic/Latina/o ☐ Non-Hispanic/Latina/o ☐ Haitian

7. What year were you born? _____

8. What is your education level?

☐ Less than high school graduate ☐ Post graduate

☐ High school diploma/GED ☐ Completed College

☐ Some college

9. What county do you live in currently?

☐ Yes ☐ No

10. What best describes your current work situation?

☐ Working full-time job ☐ Working part-time job ☐ Student

☐ Looking for a job/unable to find employment ☐ Retired ☐ Not currently working

☐ I have been unemployed for over a year

11. How old were you when you first tested positive for HIV?
_____Years of age.

12. Where were you living when you first tested positive for HIV?

☐In the same county I live in now

☐In another county in Florida. County: _____

☐In another state: _____

☐Outside of the United States. Country: _____

13. Were you in care for HIV/AIDS **between June 1st 2015 and May 31st 2016?**

☐ Yes

☐ No

If not in care, please skip to question 15

13. What are the reasons why you are not in care?

☐Transportation

☐ Treatment by staff in the clinic or doctor's office

☐ Language barrier

☐ Long wait times to get to see the doctor

☐ Child care

☐ I am unavailable during hours of operation

14. In which Florida County or counties did you get your HIV/AIDS medical care between **June 1st 2015 and May 31st 2016?**

_____

15. If you get your HIV/AIDS medical care in a different county than you live, please indicate why. **Please mark only one answer.**

☐ This does not apply to me. I got medical care in the same county I live in.

☐ Services were not available in my county

☐ Dissatisfied with services provided in my county

☐ I did not want people to know that I have HIV

☐ I got care at a clinic that is located closer to where I live or work

☐ Other:_____

16. Where did you **regularly** receive your HIV/AIDS medical care **between June 1st 2015 and May 31st 2016? Please Mark only one answer.**

☐ Walk-in/Emergency clinic

☐ Doctor's office

☐ Hospital emergency room

☐ Veteran's Administration

☐ Public clinic/Health Department

☐ HIV clinic

☐ Federally Qualified Community Health Center (FQHC) debated yes or no?

☐ Other:_____

17. Are you on antiretroviral (HIV medication) therapy?

☐ Yes

☐ No

18. How many times in the past month have you missed your HIV medications?

☐ 0

☐ 1-3

☐ 4-6

☐ 7-9

☐ 10+

19. Did you miss any of your HIV medications over the past month?

☐ Yes

☐ No

20. If yes, what are some of the reasons why you missed taking your HIV medication? **Mark all that apply.**

☐ This does not apply to me. I took all of my medication

☐ Cost ☐ Change insurance plan

☐ Needed to get my prescription renewed

☐Forgot

☐ I had side-effects

☐ My **Eligibility documentation** for ADAP was not completed timely

☐ Other: _____

21. In your last blood test, was your viral load **greater** than 1000?

☐ Yes

☐ No

☐ I don't know

22. In your last blood test, was your viral load **below** 200?

☐ Yes

☐ No, but it has been going down

☐ No

☐ I don't know

23. In the past month, how often did you smoke cigarettes?

☐ Every day

☐ Some days

☐ Not at all

24. In the past month, how often did you consume marijuana?

☐ Every day

☐ Some days

☐ Not at all

25. In the past month, how often did you consume illegal drugs other than marijuana (cocaine, crack, meth, heoin, Mara to provide etc)?

☐ Every day

☐ Some days

☐ Not at all

26. In the past month, how often did you share needles?

☐ Every day

☐ Some days

☐ Not at all

27. In the past month, how often did you have unprotected sex?

☐ Every day

☐ Some days

☐ Not at all

28. Have you been hospitalized for an HIV/AIDS related condition **between June 1st 2015 and May 31st 2016?** If so, what was it for?

☐Yes:_____

☐No

29. The first set of questions relate to services provided to people with HIV/AIS. We are very interested in your use of these services because it allows us to identify gaps in services that we can try to fix.

The services bellow **May** or **May not** be available in your area. Please fill in the boxes next to the services that you have used or needed **in the past 12 months.**	I received this servic without difficulty	I received this service but it was difficult to get	I needed this service but was unable to get it	I did not need this service
Outpatient Medical Care: Visits to doctor's office or cli for HIV medical care	☐	☐	☐	☐
Case Management: Case managers help clients receive services and then follow-up on their care	☐	☐	☐	☐
Medications: Pill for HIV and related issues	☐	☐	☐	☐
Dental/Oral Health: General teeth and mouth care, dentures, oral surgery, etc.	☐	☐	☐	☐
Health Insurance: Helps pay insurance costs or co-pays if client has private insurance	☐	☐	☐	☐
Mental Health Services: Professional counseling, therapy, or support groups	☐	☐	☐	☐
Substance Abuse Treatment: Professional counseling for drug or alcohol addiction	☐	☐	☐	☐
Nutritional Counseling: Professional counseling for healthy eating habits	☐	☐	☐	☐
Early Intervention Services: Assistance getting a doctor appointment, HIV counseling and testing, linkage and referral to medical care	☐	☐	☐	☐
Home Health Care: Professional healthcare services in a client's home by a licensed/certified home-health agency	☐	☐	☐	☐
Hospices Services: Nursing and counseling services for t terminally ill and their family	☐	☐	☐	☐
Food Bank or Food Vouchers: Food bags, grocery certificates, home-delivered meals, and nutritional supplements	☐	☐	☐	☐
Transportation: Help getting to the doctor's office and other HIV-related appointments	☐	☐	☐	☐

Outreach: Someone who finds people with HIV not in care and helps them to visit their doctor and get services they may need	☐	☐	☐	☐
Health Education/Risk Reduction: Someone who tells clients about HIV, how it's spread, current medications, and how to live with HIV	☐	☐	☐	☐
Treatment Adherence: Instructions on how to take HIV medications properly	☐	☐	☐	☐
Legal Support: Help clients with HIV-related legal Issues (will, living will, etc)	☐	☐	☐	☐
Rehabilitation: Physical therapy, occupational therapy, Speech therapy, low vision training, etc.	☐	☐	☐	☐
Peer mentoring: Support and counseling from community members	☐	☐	☐	☐
Housing: Helping find and/or maintaining a place to live	☐	☐	☐	☐
Other: Is there a service you need that is not listed above?	☐	☐	☐	☐

30. If you had problems receiving services **between June 41st 2015 and May 31st 2016**, what were some of the reasons? **Mark all that apply.**

☐ This does not apply to me. I had no problems receiving services

☐ I did not know where to get services

☐ I could not get an appointment

☐ I could not get transportation

☐ I could not get childcare

☐ I could not pay for services

☐ I did not want people to know that I have HIV

☐ I could not get time off work

☐ I was depressed

☐ I had a bad experience with the staff

☐ Services were not in my language

☐ I did not qualify for services

☐ Other: _____

31. Do you have insurance?

☐ Yes

☐ No

If No skip

32. Has your health insurance status or plan changed **between June 1st 2015 and May 31st 2016?**

☐ Yes from uninsured to insured

☐ Yes from insured to uninsured

☐ Yes, I changed insurance plan

☐ No I have been insured for all that period

☐ No, I have been uninsured for all that period

33. What are some of the reasons why you do not have health insurance? **Mark all that apply**

☐ This does not apply to me. I have health care insurance

☐ I have not looked into it

☐ My employer does not offer insurance

☐ I am not eligible for Medicaid or Obama Care (also known as Marketplace)

☐ I find the premiums too expensive

☐ I didn't look worth it

☐ Other: _____

If **you do not currently have health care insurance, skip to question 51**

34. What type of health care insurance do you have?

☐ Medicaid

☐ Employer-sponsored private insurance

☐ Market place insurance through the ACA (Obamacare)

☐ Medicare

☐ ADAP Premium Plus AIDS Drug Assistance Program (ADAP)

☐Veterans

☐ Tricare

☐ Other private insurance

35. How would you rate your satisfaction with the health care insurance that you have currently?

☐ I am very satisfied

☐ I am satisfied

☐ Neutral

☐ I am dissatisfied

☐ I am very dissatisfied

36. I you rated your satisfaction with your insurance as neutral or below, what are some aspects of your insurance are you dissatisfied with? **Mark all that apply.**

☐ This does not apply to me. I am satisfied with my health insurance

☐ The co-pays on visits/medications are too high

☐ My premiums are too high

☐ My deductible is too high

☐ It does not cover all the providers I want (eg. I had to change doctors)

☐ I do not like my doctor but I cannot find another one in my area that my insurance will cover

☐ I don't understand how it works

37. Do you have a specific doctor that you see regularly for your HIV medical care?

☐ Yes

☐ No (skip to question 54)

38. How would you rate your satisfaction with the health care doctor that you usually see for your HIV/AIDS care?

☐ I am very satisfied

☐ I am satisfied

☐ Neutral

☐ I am dissatisfied

☐ I am very dissatisfied

39. If you rated your satisfaction with your provider as neutral or below, what are some reasons why you are not fully satisfied with the health care provider that you usually see for your HIV/AIDS care (if you do not have a usual provider, than think about the last provider that you saw)? **Mark all that apply**

☐ This does not apply to me. I am satisfied with my health care provider

☐ I feel like my health care provider judges me

☐ I feel like I cannot trust my health care provider doesn't know enough about HIV/AIDS

☐ I feel like I cannot trust my health care provider

☐ I feel like my health care provider doesn't really listen to me

☐ I feel like my health care provider doesn't care about me

☐ The duration of the visit is too short and rushed

☐ It takes a long time to get an appointment

☐ It is far to go for the appointment

☐ Other:_____

40. **Between June 1st 2015 and May 31st 2016**, have you had difficulty getting HIV medications for any of the following reasons?	Yes	No	Not Applicable
A) Long wait to get an appointment with my Case worker or Doctor	☐	☐	☐
B) Difficulty with the ADAP application process	☐	☐	☐
C) Difficulty seeing my case worker or doctor at least twice a year to remain enrolled in ADAP	☐	☐	☐
D) Unenrolled from ADAP without an explanation	☐	☐	☐

E) Are you aware that ADAP funds may cover costs associated with your health insurance policy, including co-payments, deductibles, or premiums to purchase or maintain health insurance policy	☐	☐	☐
F) Have you been made aware of the "hardship exemptions" that can pay for health insurance coverage based on hardships which affect your ability to pay for health insurance coverage	☐	☐	☐

41. Have you disclosed your HIV status to anyone other than your health care provider?

☐ Yes

☐ No

42. Who have you disclosed your HIV status to? **Mark all that apply**

☐ This does not apply to me. I have not disclosed my HIV status to anyone other than my health provider

☐ Current partner

☐ Friends

☐ Family

☐ Everyone I have a sexual encounter with

43. Did you talk to your partner about taking medication to prevent HIV (PrEP)?

☐ Yes and he/she is taking medication

☐ Yes but he/she decided not to take medication

☐ No, but he/she is also HIV positive

☐ No, I do not know there are medications to prevent HIV

☐ No, I have not yet had that conversation

44. How much do you feel you are engaged with your care?

☐ Not much, I am still figuring out my diagnosis

☐ I have to go to my appointments because of the Ryan White requirements

☐ Quite engaged, I try to go to all my appointments, take all my medication, etc.

☐ Very engaged, I do all I can to be healthy and I have great support from providers and from friends/family/partner

45. Were you in city or county Jail (not prison) **between June 1st 2015 and May 31st 2016?**

☐ Yes ☐ No

46. Did the city or county Jail (not prison) medical staff know you had HIV/AIDS?

☐ Yes ☐ No

47. Did you get your HIV medication in Jail without interruption?

☐ Yes ☐ No

48. When you were released from city or county Jail (not prison), which of the following did you receive? (***Mark all that apply***)

☐ Information about finding housing

☐ Referral to medical care

☐ Referral to case management

☐ A _____day(s) supply of HIV medication to take with me

☐ Other: _____

☐ None of the above

49. Were you in prison between June 1st 2015 and May 31st 2016?

☐ Yes ☐ No

50. Did the prison medical staff know you had HIV/AIDS?

☐ Yes ☐ No

51. Did you get your HIV medication in prison without interruption?

☐ Yes ☐ No

Definitions: Household for this section means, the total number of persons living in the home.

52. In the past year **(June 1st 2015 and May 31st 2016),** how many nights have you NOT had a place of your own in which to sleep? _____

53. Have you been continuously homeless for a year or more?

☐ Yes ☐ No

54. Have you had four or more times of homelessness in the past three years?

☐ Yes ☐ No

55. Which of the following best describes your current living situation? If multiples answers apply to you, select the answer that refers to where you stayed last night.

☐ Apartment/house/trailer that I own

☐ Apartment/house/trailer that I rent

☐ At my parent's/relative's apartment/house/trailer-Permanent Situation

☐ At my parent's/relative's apartment/house/trailer-Temporary Situation

☐ Someone else's apartment/house/trailer-Permanent Situation

☐ Someone else's apartment/house/trailer-Temporary Situation

☐ In a rooming or boarding house

☐ In a "supportive living" facility (assisted Living Facility)

☐ Transitional housing such as a half-way house or hotel or motel room

☐ Nursing home

☐ Homeless (on the street/in car/abandoned building)

☐ Homeless shelter

☐ Domestic violence shelter

☐ Other housing provided by the city or state

☐ Hospice

☐ In Jail/prison

☐ Other (specify): _____

56. Have you moved two or more times in the past six months?

☐ Yes ☐ No

57. If you moved two or more times in the past six months, why did you have to move? **Mark all that apply**

☐ This does not apply to me. I did not have to move twice or more during the past six months

☐ I didn't have enough money for the deposit

☐ I could not find affordable housing

☐ I had bad credit

☐ I was put on the waiting list

☐ I had a mental/physical disability

☐ I had a criminal record

☐ I feel I was discriminated against

☐ I had no transportation to search for housing

☐ I didn't qualify for housing assistance

☐ I had substance use issues

☐ Other (specify): _____

58. Think about your housing situation now: do any of the following stop you from doing what you need to do to stay healthy? **Mark all that**

☐ I don't have a private room

☐ I don't have a place to store my medications

☐ I don't have a telephone where someone can call me

☐ I don't have enough food to eat

☐ I don't have money to pay for rent

☐ I don't have heat and/or air conditioning

☐ I don't want anyone to know I have HIV

☐ I can't get away from drugs (in the neighborhood)

☐ None of the above

59. Approximately how long have you lived at your current residence?

☐ Less than 1 month

☐ 1-2 months

☐ 3-6 months

☐ 6 months – 1 year

☐ More than 1 year

☐ I don't know

60. Are you currently own or rent (eg: own house/apartment/trailer)?

☐ I rent

☐ I own

☐ Neither (Not paying for housing)

61. If you rent, did you receive housing assistance **between June 1st 2015 and May 31st 2016**? **Mark all that apply**

☐ This does not that apply to me.

☐ Yes and I will still currently receive housing assistance

☐ Yes but I do not receive assistance any more

☐ I have not received assistance between June 1st 2015 and May 31st 2016

62. How much do you and/or your household pay monthly for the rent or mortgage? If you receive assistance, this is not necessarily the amount of your rent, but how much you and your household members actually pay?_____

63. In the past year, have you had to do any of these things to have a place to sleep? **Mark all that apply**

☐ Sleep in a car

☐ Trade sex for a place to spend the night or money for rent

☐ Sleep at a family member/friend's house

☐ Sleep on the streets, in a park, or in another outdoor place

☐ Sleep in a shelter

☐ None of these

63. What was your total income last month? (Include all of the money you received, plus the money anyone else who lives with you received. Include money from government assistance, except food stamps).

☐ No income ($0.00)

☐ Under $500

☐ $500 - $749

☐ $750 - $999

☐ $1,000 - $1,249

☐ $1,250 - $1,499

☐ $1,500 - $1,749

☐ $1,750 - $ 1,999

☐ $2,000 - $2,249

☐ $2, 250 – 2,499

☐ $3,000 or more

64. How many people are supported by this income? (Total number of household members including yourself)

☐ 1

☐ 2

☐ 3

☐ 4

☐ 5 or more

65. Including yourself, how many members of our household are HIV positive?

☐ 1

☐ 2

☐ 3

☐ 4

☐ 5 or more

66. Please indicate the size of your current home: (Mark one)

☐ Single room occupancy (SRO)/studio

☐ 1 bedroom

☐ 2 bedroom

☐ 3 bedroom

☐ None, I am homeless

67. Is there anything else you would like to tell us about your housing situation or healthcare services that was not covered in this survey?

_____
_____
_____

"THANK YOU for taking the time to provide this information. Your responses will affect how *your* local HIV/AIDS funding is spent." Present participant with a gift card.

Appendix B.

Integrated Needs Assessment 2016-2019
Focus Group Script

Introduction:

Facilitator: "Welcome to the 2016-2019 Needs Assessment Focus Group. My name is _____, and I will be facilitating this group. This is _____; he/she will be assisting with this session. Over the next hour we will be talking about HIV/AIDS care in Palm Beach County. At the end, each of you will receive a $25.00 gift card to Publix for your participation."

Overview of the Needs Assessment purpose and process:
Facilitator: "Every three years a large county-wide Needs Assessment is conducted in Palm Beach County. This Needs Assessment is required for all areas that receive Ryan White CARE Act funding. The information that you provide will help the CARE Council plan to meet the needs of People Living with HIV/AIDS in our county by prioritizing and allocating funding to service categories. Your input will help to identify service gaps, and help to assess the overall function of the HIV/AIDS system of care. Data in the Needs Assessment process is obtained through 5 focus groups; this is one of them, as well as 357 surveys."

Statement of confidentiality:
Facilitator: This focus group session will be recorded by _____ for accurate transcription of what is being said. Before I begin can everyone here agree that whatever is said during this focus group will be strictly confidential? PAUSE "Can we all agree to that?"

Focus Group Guidelines and Definitions:
Facilitator: "I would like to hear from all of you. In order to allow that to happen let's speak one at a time.
We will be talking about People Living with HIV/AIDS that are in and out of care in Palm Beach County. The federal government has adopted a definition for what is considered to be in primary medical care. This definition is written on your handout. People Living with HIV/AIDS are considered to be in primary medical care if they have had at least one of the following in the past 12 months 1.) a viral load test (blood test to see how much virus is in the system), 2). a CD4 test (blood test to see how strong the immune is) 3.) received anti-retroviral therapy."

Unmet Need:
Facilitator:

1. "Do you know of any People Living with HIV/AIDS in Palm Beach County who know they are positive but are not in HIV/AIDS medical care?"
   Allow participants to discuss.

2. "Why do you think they have not gone to the doctor for HIV/AIDS medical care?"
   Allow participants to discuss.

3. "What do you think it would take to persuade them to go back to the doctor for HIV/AIDS medical care?"
   Allow participants to discuss.

4. "Now we are going to discuss your personal pattern of care. Since you were diagnosed with HIV/AIDS, have you been continuously going to the doctor for HIV/AIDS medical care?"
   Allow participants to discuss.

5. "For those of you who have always been in care, what helped you to get in care and stay in care?"
   Allow participants to discuss.

6. "For those of you, who were out of care for sometime or are currently out of care, please tell us about your situation.

   Out of care for sometime:
   - If you have been in care at one point, how long were you in care?
   - How long have you been out of care?
   - What prevented you from receiving care?
   - Are you still out of care?
   - If yes, what would help you get back into care?
   - If no, what helped you get you back into care?

   Allow participants to discuss.

   Currently out of care:
   - How long have you been out of care?
   - What prevents you from receiving care?

   Allow participants to discuss.

7. Do you have any additional comments about the difficulties and challenges to getting and staying in care and/or what would help people to get and stay in care?"
   Allow participants to discuss.

HIV/AIDS Services

Facilitator: “For those of you who have ever received HIV/AIDS services I would like to talk to you about your service needs and the quality of those services. On your handout there is a list of services. Let’s focus on your own experiences as well as what you may have heard from friends.

8. “For the services that you ARE using:
   - Where are you currently getting these services?
   - Are these services meeting your needs?
   - How could these services be improved?
   - Are these services easy to access and easy to use?”

   Allow participants to discuss.

9. “For the services you are NOT using:
   - Are they services that you want but are unable to get, unaware they are offered, or have difficulty signing up for?
   - What are the specific barriers you face in accessing these services?”

   Allow participants to discuss.

10. “In the past 3 years do you think the services in general have improved, declined or remained the same?”
    Allow participants to discuss.

    “Has there been a sufficient amount of the services available (quantity)?”
    Allow participants to discuss.

    “Has the quality of the services been adequate?”
    Allow participants to discuss.

    “Have you been able to access the services that you need?”
    Allow participants to discuss.

11. “Do you have any final thoughts or comments on HIV/AIDS services in Palm Beach County?”
    Allow participants to discuss.

1. Closure:

Facilitator: “I would like to thank each of you for attending this focus group. Your input is very valuable. Your responses will help the CARE Council plan for a system of care that works for all PLWHA in Palm Beach County.

Focus Group Handout

Definition for in Care

The federal government has adopted a definition for what is considered to be in primary medical care. PLWHA are considered to be in primary medical care if they have had at least one of the following in the past 12 months 1.) a viral load test, 2). a CD4 test 3.) received anti-retro viral therapy.

Service Category:

Service Category
CORE SERVICES
Outpatient Medical Care: Regular doctor visits to doctor's office or clinic for HIV medical care
Primary Medical: Regular doctor visits for HIV medical care
Laboratory Diagnostic Testing
Medical Specialist: Eye doctor, woman's doctor (GYN), Dermatology, etc.
Nurse Care Coordination: RN acts as clients' main link to medical services
Case Management: Case managers help clients receive services and then follow-up on their care
Medications: Pills for HIV and related issues
Dental/Oral Health: General teeth and mouth care, dentures, oral surgery, etc.
Health Insurance: Helps pay insurance costs or co-pays if client has private insurance
Mental Health Services: Professional counseling, therapy, or support groups
Substance Abuse Treatment: Professional counseling for drug or alcohol addiction
Residential:
Outpatient:
Nutritional Counseling: Professional counseling for healthy eating habits
Early Intervention Services: Assistance getting a doctor appointment, HIV counseling and testing, linkage and referral to medical care
Home Health Care: Professional healthcare services in client's home by a licensed/certified home-health agency
Hospice Services: Nursing and counseling services for the terminally ill and their family
SUPPORT SERVICES
Food Bank or Food Vouchers: Food bags, grocery certificates, home-delivered meals, and nutritional supplements
Transportation: Help getting to the doctor's office and other HIV related appointments
Outreach: Someone who finds people with HIV not in care and helps them to visit their doctor and get services they may need
Health Education/Risk Reduction: Someone who tells clients about HIV, how it's spread, current medications, and how to live with HIV
Treatment Adherence: Instructions on how to take HIV medications properly
Legal Support: Help clients with HIV related legal issues, SSI SSDI hearings (will, living will, etc.)
Rehabilitation: Physical therapy, speech therapy, low vision training, etc.
Emergency Financial Assistance: Help paying for utilities, appliances, etc.
Linguistics Services: Interpretation & translation services
Peer Mentoring: Support and counseling from community members
Housing: Help finding and/or maintaining a place to live
Support groups
Other: A service that is not listed above _____

Appendix C.

PALM BEACH COUNTY HIV CARE COUNCIL
PART A - RYAN WHITE CARE ACT GRANT
MARCH 1, 2017- FEBRUARY 28, 2018

SERVICE CATEGORY DEFINITIONS

CORE MEDICAL SERVICES

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.

Laboratory Diagnostic Testing (Not a HRSA defined service, included in OAMC services, no separate SOC, old definition)

HIV viral load testing, CD4/CD8, CBC with diff., blood chemistry profile, & other FDA approved routine tests for the treatment of patients with HIV disease. In addition, routine tests pertinent to the prevention of opportunistic infections (VDRL, IGRA, AFB, pap smear, toxoplasmosa, hepatitis B, & CMV serologies) & all other laboratory tests as clinically indicated (e.g. HCV serology) that are generally accepted to be medically necessary for the treatment of HIV disease & its complications and have an established Florida Medicaid or Medicare reimbursement rate, as well as new tests that may not have an established reimbursement rate.

AIDS Pharmaceutical Assistance

The purpose of a Local AIDS Pharmaceutical Assistance Program (LPAP) is to provide therapeutics to treat HIV/AIDS or to prevent the serious deterioration of health arising from HIV/AIDS in eligible individuals, including measures for prevention and treatment of opportunistic infections. An LPAP is a program to ensure that clients receive medications when other means to procure medications are unavailable or insufficient. As such, LPAPs are meant to serve as an ongoing means of providing medications for a period of time. Each LPAP is to establish a LPAP Board that will develop a formulary that meets the needs of the jurisdiction and each LPAP Board must have a process in place to add or delete medications in a timely manner as the need changes.

Local AIDS Pharmaceutical Programs provide:

• HIV medications that are not included in the ADAP formulary

• Medications when the ADAP financial eligibility is restrictive
• Medications if there is a protracted State ADAP eligibility process and/or other means of accessing medications are not available (i.e., pharmaceutical company assistance programs)

Specialty Outpatient Medical Care * (Not a HRSA defined service)
Short term treatment of specialty medical conditions and associated diagnostic outpatient procedures for HIV positive patients based upon referral from a primary care provider, physician, physician assistant, registered nurse. Specialties may include, but are not limited to, outpatient rehabilitation, dermatology, oncology, obstetrics and gynecology, urology, podiatry, pediatrics, rheumatology, physical therapy, speech therapy, occupational therapy, developmental assessment, and psychiatry.

Oral Health Care

Oral HealthCare (Dental Services) will encompass dental screenings, prophylaxes, fillings, simple extractions, as well as periodontal and other advanced treatments. Clinical interventions are based on treatment guidelines and recognized clinical protocols established legal and ethical standards. As such, Oral Health Care shall be provided based on the following priorities:

- Prevention of oral and/or systemic disease where the oral cavity serves as an entry point
- Elimination of presenting symptoms
- Elimination of infection, preservation of dentition and restoration of functioning

Emergency, diagnostic, preventive, hygiene, basic restorative, limited oral surgical, and limited endodontic services rendered by dentists and dental hygienists.

Early Intervention Services (EIS)
Includes counseling individuals with respect to HIV/AIDS; testing (including tests to confirm the presence of the disease, tests to diagnose the extent of immune deficiency, tests to provide information on appropriate therapeutic measures); referrals to appropriate services based on HIV status; linkage to care and education and health literacy training for clients to help them navigate the HIV care system; other clinical and diagnostic services regarding HIV/AIDS; periodic medical evaluations for individuals with HIV/AIDS; and providing therapeutic measures. Services shall be provided at specific points of entry. Coordination with HIV prevention efforts and programs as well as prevention providers is required. Referrals to care and treatment must be monitored. Grantee may modify targeted areas to include additional key points of entry.

Health Insurance Premium & Cost Sharing Assistance
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.
An annual cost benefit analysis that includes an illustration of the greater benefit of using Ryan White funds for Insurance/Costs-Sharing Program vs. having the client on ADAP. Documentation of the low-income status of the client must be available. Insurance programs must cover comprehensive primary care services and a full range of HIV medications. Funds may not be used for social security.

Medical Nutrition Therapy * (No SOC, HRSA Policy 16-02 definition)
Medical Nutrition Therapy includes:
• Nutrition assessment and screening
• Dietary/nutritional evaluation

• Food and/or nutritional supplements per medical provider's recommendation
• Nutrition education and/or counseling
These services can be provided in individual and/or group settings and outside of HIV Outpatient/Ambulatory Health Services.

Home and Community-Based Health Services
Includes 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.

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.

Medical Case Management Services (including treatment adherence)
Medical Case Management is the provision of a range of client-centered activities focused on improving health outcomes in support of the HIV care continuum. Activities may be prescribed by an interdisciplinary team that includes other specialty care providers. Medical Case Management includes all types of case management encounters (e.g., face-to-face, phone contact, and any other forms of communication). Key activities include:

- Determining eligibility status
- Initial assessment of service needs
- Development of a comprehensive, individualized care plan
- Timely and coordinated access to medically appropriate levels of health and support services and continuity of care
- Continuous client monitoring to assess the efficacy of the care plan
- Re-evaluation of the care plan at least every 6 months with adaptations as necessary
- Ongoing assessment of the client's and other key family members' needs and personal support systems
- Treatment adherence counseling to ensure readiness for and adherence to complex HIV treatments
- Client-specific advocacy and/or review of utilization of services

In addition to providing the medically oriented services above, Medical Case Management may also provide benefits counseling by assisting eligible clients in obtaining access to other public and private programs for which they may be eligible (e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, other state or local health care and supportive services, and insurance plans through the health insurance Marketplaces/Exchanges).

Peer Mentor Program * (Not a HRSA defined service; Service Category under MCM)
The goal of the Peer Mentor program is to improve HIV-related health outcomes and reduce health disparities for at risk communities through HIV peer education. Peers shall be persons

living with HIV from the community, not working as licensed clinical professionals, who share key characteristics with target population which shall include: a. community membership, gender, race/ethnicity, b. disease status or risk factors, c. sexual orientation, d. salient experiences, e.g. former drug use, sex work, incarceration. The Peer Mentor will use shared characteristics/experiences to act effectively as a trusted educator, mentor for adopting health behavior, role model, and empathic source of social and emotional support.
The contributions of HIV-positive peers shall include: adherence to medical care (keeping appointments, responding to physician referrals, and picking up medications); linking to medical care and support services; self-management of disease; emotional support and reduced risk behaviors.

SUPPORT SERVICES

Non-Medical Case Management Services

Non-Medical Case Management Services (NMCM) provide guidance and assistance in accessing medical, social, community, legal, financial, and other needed services. Non-Medical Case management services may also include assisting eligible clients to obtain access to other public and private programs for which they may be eligible, such as Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturer's Patient Assistance Programs, other state or local health care and supportive services, or health insurance Marketplace plans. This service category includes several methods of communication including face-to-face, phone contact, and any other forms of communication deemed appropriate by the RWHAP Part recipient. Key activities include:

- Determining eligibility status
- Initial assessment of service needs
- Development of a comprehensive, individualized care plan
- Continuous client monitoring to assess the efficacy of the care plan
- Re-evaluation of the care plan at least every 6 months with adaptations as necessary
- Ongoing assessment of the client's and other key family members' needs and personal support systems

Emergency Financial Assistance (EFA)

Provision of short-term payments to agencies or establishment of voucher programs to assist with emergency expenses related to essential utilities, housing, food, and medication when other resources are not available. EFA funds are only to be used as a last resort. Clients may receive up to 12 accesses per year for no more than a combined total of $1,000 during the grant year.

Emergency Financial Assistance- HIV Medications/Prior Authorization (EFA-PA) * (Not a HRSA defined service)

Emergency Anti-Retroviral medications provided to clients on a limited or short-term basis when no other payer sources are available. Medications purchased under this program must be purchased at Public Health Service (PHS) prices or less.
EFA-PA can be used to fund dispensing fees associated with ADAP/LPAP medications.
It is required that EFA-PA medication be purchased at the lowest possible cost, preferably 340B Program pricing. Where possible clients need to obtain their medications through a 340B covered entity or pharmacy that is under contract with the 340B Program.

All EFA-PA programs will use available standards of care to inform their services and will operate in accordance with legal and ethical standards. The importance of maintaining confidentiality is critical and all programs must comply with the Health Insurance Portability and Accountability Act (HIPAA) standards for information disclosure.

Food Bank/Home Delivered Meals- Nutritional Supplements * (Not a HRSA defined service, No SOC, old Nutritional Supplements definition)
Provision of nutritional supplement prescribed as a treatment for diagnosed wasting syndrome. Counseling linked to Primary Medical Care, Nurse Care Management or Human Services Management.

Food Bank/Home Delivered Meals
Provision of actual food or meals. 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.

Housing Services
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.

Legal Services
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 include legal services for permanency planning for an individual or family where the responsible adult is expected to pre-decease a dependent (usually a minor child) due to HIV/AIDS; includes the provision of social service counseling or legal counsel regarding 1. The drafting of wills or delegating powers of attorney, and 2. Preparation for custody options for legal dependents including standby guardianship, joint custody or adoption. It does not include legal services for criminal defense, or for class-action suits unrelated to access to services eligible for funding under the Ryan White HIV/AIDS Program.

Medical Transportation Services
Includes conveyance services provided, directly or through voucher, to a client so that he or she may access health care services; including services needed to maintain the client in HIV/AIDS medical care.
Records must be maintained that track both services provided and the purpose of the service (e.g., transportation to/from what type of medical or support service appointment). Clients shall not receive direct payment for transportation services.

Substance Abuse Residential Services
Provision of treatment to address substance abuse problems (i.e., alcohol and/or legal and illegal drugs) in a residential health services setting (short-term). Provides room and board with substance abuse treatment and counseling, (including specific HIV counseling) in a secure, drug-free state-licensed residential (non-hospital) substance abuse detoxification and treatment

facility. This treatment shall be short term. Anyone providing direct counseling services must be under the supervision of staff possessing a postgraduate degree in the appropriate counseling-related field, or a Certified Addiction Professional (CAP). Part A funds may not be used for hospital