PALM BEACH COUNTY EMA

COMPREHENSIVE PLAN 2009-2012

Prepared by

Treasure Coast Health Council, Inc.

Promoting Access to High Quality Healthcare

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www.carecouncil.org and www.tchealthcouncil.org

Funded through the Ryan White HIV/AIDS Treatment Modernization Act of 2006

Department of Community Services, Palm Beach County, Florida

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Department of Community Services
Palm Beach County, Florida

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Letter of Concurrence from the Director of the Department of Community Services

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March 19, 2008

Dear Elected Officials and Concerned Citizens:

This Comprehensive HIV Services Plan is an important tool to improve health care and outcomes for people living with HIV/AIDS in the Eligible Metropolitan Area (EMA), Palm Beach County.

The Plan was developed with cooperation among funding streams, planning council and agencies involved with the care of individuals affected by and infected with HIV/AIDS.

I would like to thank all of the people involved in developing this Comprehensive Plan which allows our community to better address the needs of the people affected by HIV/AIDS.

Sincerely,

Edward L. Rich, Director
Community Services Department

ELR:mrb

Letter of Concurrence from the Director of the Palm Beach County Health Department

FLORIDA DEPARTMENT OF HEALTH

Charlie Crist
Governor

Ana M. Viamonte Ros, M.D., M.P.H.
State Surgeon General

May 15, 2008

Dear Palm Beach County Area Citizens:

It is a pleasure to write a letter of support for the Comprehensive Plan 2009-2012 developed by the Palm Beach County HIV CARE Council. The Palm Beach County area is very fortunate to have the commitment, dedication and expertise of all the volunteers who worked on this community-wide effort. Their hard work is well reflected in the document. I applaud and acknowledge these volunteers who continue to work to bring an end to the HIV/AIDS epidemic.

This Comprehensive Plan puts our community on the right track in addressing the needs of persons living with HIV/AIDS. This plan is an important tool to improve prevention, patient care and health outcomes for persons living with HIV/AIDS in Palm Beach County. With increasing limited resources, it is critical that we continue our collaborative efforts and partnerships to ensure that both HIV prevention and patient care activities are more effective and better coordinated. Our prevention activities need to prevent or delay the onset of illness in persons living with HIV infection. Our patient care system needs to be designed to be able to provide required care and support services accessible to our residents living with HIV infection.

As the epidemic continues to grow and more people learn their HIV status, it becomes increasingly important to be able to link these positive individuals with quality health care. Planning is the key to accomplishing this linkage. I encourage those involved in implementing our area's Comprehensive Plan, including governmental and non-governmental agencies, the Palm Beach County HIV CARE Council, persons living with HIV/AIDS, service providers and community leaders:

- to avoid duplication of services to maximize our resources and
- to utilize the information in this plan to the greatest extent possible in strengthening and improving our systems of comprehensive prevention and care services within Palm Beach County.

Sincerely,

for

Jean M. Malecki, MD, MPH, FACPM
Director, Palm Beach County Health Department

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Letter of Concurrence from the Chair of the Planning Council

PALM BEACH COUNTY
HIV CARE COUNCIL
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28 March 2008

Dear Friends and All Concerned Citizens;

It is with great pride, on behalf of the Palm Beach County HIV CARE Council, that I present this Palm Beach County EMA Comprehensive Plan 2009-2012.

This plan has been developed with extraordinary cooperation across multiple funding streams and agencies involved with the care of those infected and affected by HIV/AIDS, as well as agencies involved with the prevention of further spread of the disease. I am especially appreciative of and commend the community volunteers who developed and incorporated goals and objectives which will improve and strengthen our system of care and prevention in a collaborative effort.

On behalf of the Palm Beach HIV CARE Council I encourage our elected officials and community leaders to familiarize themselves with this plan and use the information to determine and fund policies and priorities in the future. It will only be by working together as set forth in this plan that we will achieve comprehensive and efficient care and effective prevention.

Sincerely,

David J. Begley, Esq.
Chair
Palm Beach County HIV CARE Council

C O N T R I B U T O R S

The Comprehensive Plan 2009-2012 would not have been possible without the active participation of a broad and diverse range of community members. Specifically, the dedication and commitment of the Palm Beach County HIV CARE Council, Planning Committee, Needs Assessment 2007-2010 Data Collection Team, Grantee Staff, and Planning Council Support Staff has enriched this Comprehensive Plan with invaluable insight.

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I N T R O D U C T I O N

The Palm Beach County HIV CARE Council has developed the Comprehensive Plan 2009-2012 which will function as a road map for the maintenance and improvement of the Continuum of Care. The plan reflects the on-going changes to our system of care to meet the needs of those affected and in care as well those not currently in care. The plan will guide our Continuum of Care through 2012.

The Comprehensive Plan 2009-2012 is the result of tremendous community dedication and input. The community has a great commitment to completing the activities and accomplishing the goals set forth in the Implementation Plan, Section 3.

With this plan, the EMA expresses its hope and determination that our system of care must and will include all PLWHA who are aware of their status, and that the community as a whole will overcome the barriers to care, fill the gaps in services and provide a high quality, efficient and effective system of care.

E X E C U T I V E S U M M A R Y

The purpose of the Comprehensive Plan 2009-2012 is to function as an aid to the community in developing the ideal system of care specifically for Palm Beach County. With the implementation of this plan, our hope is that the Continuum of Care will:

- Ensure the availability and quality of all 13 core medical services within the EMA
- Eliminate disparities in access to core medical services and support services for individuals with HIV among disproportionately affected sup-populations and historically underserved communities
- Specify strategies for identifying individuals who know their HIV status but are not in care, informing them about available treatment and services, and assisting them in the use of those services
- Include a discussion of clinical quality measures
- Include strategies that address the primary health care and treatment needs of those who know their HIV status and are not in care, as well as the needs of those currently in the HIV/AIDS care system
- Provide goals, objectives, timelines, and appropriate allocation of funds (as determined by the needs assessment)
- Include strategies to coordinate the provision of service programs for HIV prevention, including outreach and early intervention service, and
- Include strategies to coordinate services for the prevention and treatment of substance abuse

Where We Are Now: What Is Our Current System of Care?

Palm Beach County is located on the east coast of Florida. The land area of Palm Beach County is 2,000 square miles. The eastern portion of the county is heavily populated, while the western area is a lower density agricultural area with several more densely populated towns and residential areas. The 2007 estimated population, according to U.S. Census Bureau, was 1,299,341. The racial make up of the county's population includes 66% White, not-Hispanic, 16% Black, not-Hispanic and 16% Hispanic. Twenty-seven percent (27%) of the population is 60 years of age and over and 77% are over 19 years of age. Fifty-one point six (51.6%) of the population are female and 48.4% are male.

The historical patterns established by the epidemic in the EMA persist and increase with respect to those who become infected and their modes of exposure. Of the 4,414 people living with AIDS in the EMA, 64.7% are Black, not Hispanic, 23.1% are White, not Hispanic and 11.1% are Hispanic. AIDS Incidence over the past two years (2006-2007) indicate a percentage decrease of the new AIDS cases for African Americans (-25.1%), White, not Hispanic (-27%), and Hispanic (-8.1%). Of the 2,798 HIV (not AIDS) cases in the EMA, 61.5% are Black, not Hispanic, 25.4% are White, not Hispanic, and 11.8%

are Hispanic. HIV diagnoses over the past two years (2006-2007) indicate a percentage increase of the new HIV cases for African Americans (12.8%), White, not Hispanic (21.7%), and Hispanic (15.5%) populations. Women currently account for 36.6 % of the live AIDS cases and 43.5 % of live HIV cases. The male to female ratio is decreasing for AIDS cases and increasing among HIV cases. In 1998 the male to female ratio for adult AIDS cases was 1.9:1, and in 2007 the ratio is 1.3:1. In 1998 the male to female ratio for adult HIV cases was 1.2:1 and in 2007 the ratio is 1.7:1.

Palm Beach County has been receiving Ryan White funding since 1991. There has always been a commitment from the community to plan locally. All HIV/AIDS funding sources, including Ryan White Part A and B, HOPWA, State General Revenue, Veterans Administration and Medicaid work closely together in order to meet the needs of PLWHA in Palm Beach County.

The Comprehensive Needs Assessment 2007-2010 was approved by the CARE Council in October 2007. The following are several highlights from the report.

The five most frequently utilized, "need and use", services for all respondents were: Case Management 74.6% (188), Laboratory/Diagnostic Testing 71.0% (179), Dental Care 57.5% (145), Ambulatory Primary Outpatient Medical Care 56.3% (142), HIV Prevention 51.6% (130).

The five services most frequently described as "need, can't get", suggesting gaps in services were: Housing 33.7% (85), Direct Emergency Assistance 32.5% (82), Food 32.1% (81), Complementary Therapies 27.4% (69), Drug Reimbursement (prescriptions) 26.6% (67).

Data from respondents who are out of care suggests similar service gaps. When asked what supportive services the respondents who are out of care need in order to enter primary medical care, the most frequently named services included financial services (direct emergency assistance), housing, and food.

Needs assessments were conducted in 2000, 2003, and 2007. In addition to data analyses for each year's needs assessment, analyses were conducted to identify trends from 2000 through 2007.

Utilization Trends: "Need and Use" included:

- Case management, laboratory diagnostic testing, dental care, and ambulatory primary outpatient medical care services *remained highly utilized* from 2000 through 2007. Case management functions as the gateway to services.
- HIV prevention, transportation, counseling, direct emergency assistance, housing, buddy companion, day respite, home health care, and vocational rehabilitation services *significantly increased in utilization* from 2000 through 2007.
- Food bank, drug reimbursement, and hospice services *significantly decreased in utilization* from 2000 through 2007. The following table lists the services from the highest to lowest rankings of utilization in 2007.

Service Gap Trends: "Need, Can't Get" included:

- Housing, direct emergency assistance, complementary therapy, dental care, health insurance continuation, transportation, clinical trials, mental health, peer advocacy, case management, ambulatory primary outpatient medical service gaps *remained fairly consistent* from 2000 through 2007.
- Food bank, drug reimbursement, buddy companion, day respite, counseling, home health care, hospice, translation, laboratory diagnostic testing services gaps *significantly increased* from 2000 through 2007.
- "Legal Services/Permanency" is the only service category that *significantly decreased* in the percentage of respondents who "need, can't get" that service from 2000 through 2007.

Additional analysis on service utilization among seven special populations, which include Haitian, Latin/Hispanic, Black heterosexual males and females, Men who have sex with men (MSM), Recently released from incarceration, Women who are recovered and/or currently using substances, Women of child-bearing age (WCBA) (15-44 years), was conducted.

Among the variety of problems while trying to access services that were mentioned, the most frequently mentioned included the following: Transportation (40.4%, 61), Not wanting people to know they have HIV (28.5%, 43), Not knowing how to apply (27.8%, 42).

Respondents were asked what best describes their situation regarding being out of care. Of the 148 out of care respondents, 35.1% (52) had never been in care, 37.2% (55) had been receiving care, but had stopped more than 12 months ago, and 21.6% (32) said they were recently diagnosed and had not entered primary care.

When asked about the reasons for not being in care, the six most frequent responses were:

- "I am afraid of being identified as HIV positive." 39.9% (59)
- "I am too embarrassed or ashamed to go." 36.5% (54)
- "I know where to go, but I do not want to go there." 36.5% (54)
- "I do not have medical insurance and couldn't afford care." 34.5% (51)
- "I have heard bad things about the medications and their side effects." 34.5% (51)
- "I am not ready to deal with my HIV status." 31.8% (47)

When asked to "check all that apply" regarding why PLWHA were not in care, service providers and respondents not in care cited a wide range of reasons. Overall, providers cited each reason at a higher rate than PLWHA. Providers and PLWHA alike frequently identified the following reasons:

- Afraid of being identified as HIV-positive.
- Do not have medical insurance, cannot afford care.
- Heard bad things about medications and the side effects.
- Not ready to deal with HIV status.

When the respondents who are not in primary medical care were asked what services, other than medical care and medication, they need to get into primary medical care the three most frequently chosen responses were financial assistance, food and housing.

Provider respondents were asked the same question and indicated more frequently than PLWHA that mental health services were needed, 66.7% compared to 18.9% respectively. Likewise, providers indicated more frequently than PLWHA that substance abuse treatment was needed, 55.6% compared to 30.4% respectively.

PLWHA respondents who are out of care were asked what would be some reasons they would enter primary medical care. The most frequently cited reasons were:

- "When I get sick and know I need care." 64.9% (96)
- "When I am ready to deal with my illness." 33.8% (50)
- "Someone else with HIV/AIDS reaches out to me." 30.4% (45)

Provider respondents were asked to identify the reasons that would prompt PLWHA to enter primary medical care. Providers and PLWHA alike most frequently cited the following two reasons:

- "Get sick and know they need care."
- "Ready to deal with illness."

Providers were more likely than PLWHA to attribute entering primary care to the potential influence of an outreach worker, a referral, or a culturally sensitive health care provider.

The data in this section highlights some socioeconomic differences between survey respondents who are in care and respondents who are out of care, for example:

- Overall, out of care respondents reported a lower level of educational achievement than in care respondents.
- Respondents who are in care were more likely to report being "on disability" than respondents who are out of care. Similar percentages of both the in care and out of care respondents are employed, 35.4% and 34.5% respectively. A higher percentage of respondents who are out of care indicated that they were not employed, 50% compared to 34.5% of the in care respondents.
- When the respondents were asked where they currently reside, out of care respondents indicated that they were homeless at a much higher rate than the in care respondents, 17.6% and 1.6% respectively. Of the 30 respondents who said they are homeless, 4 (13.3%) said they were in care and 26 (86.7%) were out of care. In addition, the out of care respondents indicated that they are "staying/living with family or friends" at a higher percentage than the in care respondents, 31.1% and 18.3% respectively.
- Respondents' 2006 annual household size and income were compared to Federal Poverty Levels (FPL). A higher percentage of the out of care respondents were living at or below 100% of the FPL than the in care respondents, 85.1% and 66.3% respectively.

- Respondents were asked if, during the past 12 months, they traded sex for money or drugs. 33.8% of the respondents who are out of care indicated that they had traded sex for money or drugs compared to only 9.5% of the respondents who are in care.

The 252 respondents who are currently in care were asked if there had been a period during the last 5 years during which that they have been out of care for more than twelve months. Of the 252 respondents in care, 17.5% (44 out of 252) responded in the affirmative.

The 44 respondents who had been out of care for more than 12 months anytime during the past five years were asked to describe their circumstances during that time. The most frequently reported situation (by 54.4% of respondents) was "I had been receiving medical care for HIV, but I stopped for more than 12 months."

The three most commonly mentioned reasons respondents cited for being out of care included "I was using drugs and alcohol." (34.1%), "I was afraid of being identified as HIV-positive." (29.5%), "I was too embarrassed or ashamed to go." (22.7%)

The forty-four in care respondents who were out of care for more than 12 months within the past five years were asked what services, other than medical care and medications, they needed to get into primary medical care. The three most frequently identified services included financial assistance (direct emergency assistance), housing, and food.

The 44 respondents who are currently in care but had been out of care for more than 12 months over the past five years, were asked to identify the reasons for returning to primary medical care. The most frequently identified reasons were "I got sick and knew I needed care", "I was ready to deal with my illness", and "A family member or friend helped get me into care."

Additional analysis was conducted on seven populations of special concern [Haitian, Latin/Hispanic, Black heterosexual males and females, Men who have sex with men (MSM), Recently released from incarceration, Women who are recovered and/or currently using substances, Women of child-bearing age (WCBA) (15-44 years)] who are out of care.

The State of Florida and Palm Beach County's top seven priority populations for HIV/AIDS prevention in order of rank are HIV Positive, Black heterosexual, White MSM, Black MSM, Hispanic MSM, Black IDU and Hispanic heterosexual. In April 2005, the Community Planning Partnership (CPP) the local prevention planning body conducted the *HIV Prevention Survey of PLWH/As in Palm Beach County*. Highlights of the findings can be found in Section 1.

In 2006, the Florida Department of Health, Department of Epidemiology determined the out of the total number of HIV+ aware population of 6,856, it is estimated that 4,952 (72%) PLWHA are receiving primary medical care services, and 1,904 (28%) are out of care.

Palm Beach County EMA conducted a Special Project of National Significance (SPNS) study entitled *Care System Assessment Demonstration (CSAD).* The study was completed in August 2005. The purposes of the project were to assess the HIV/AIDS system of care and to determine the barriers to care faced by persons living with HIV/AIDS who are not in regular primary care, especially those from racial and ethnic minority groups.

A description of the Continuum of Care, Resource Inventory, Profiles of the Ryan White providers (RDR 2007, GIS mapping of PLWHA zip codes and service locations and the findings from the Provider Survey) are located a the end of Section 1.

Overall, there was a very low number of respondents who said they "can get, won't use" the services, which suggests there may be few barriers to services. The services most frequently selected by respondents as "can get, won't use" were: Clinical Trials 8.7% (22), Peer Advocacy 6.7% (17), Specialty Outpatient Medical Services 6.7% (17), Substance Abuse Treatment-Residential 6.0% (15), Complementary Therapies 5.6% (14).

Needs assessments were conducted in 2000, 2003, and 2007. In addition to data analyses for each year's needs assessment, analyses were conducted to identify trends from 2000 through 2007. Overall, the percentages of respondents indicating that they "can get, but won't use" specific services has *remained very low and fairly consistent* in the last three needs assessments.

The CARE Council considered the findings and data discussed above in the creation of the Comprehensive Plan 2009-2012.

Where Do We Need To Go: What System of Care Do We Want?

The current Continuum of Care is a partnership of state and federal funding sources, planning authorities, medical and social support agencies, and people who are living with HIV/AIDS that provides a system of care for persons living with HIV/AIDS. The goal of the Continuum of Care is to improve and maintain optimal health for persons living with HIV/AIDS.

The system of care that Palm Beach County wants is one that provides the highest possible standard of care for all PLWHA in the EMA and conforms to all federal, state and local principles. The significant issues, critical concerns, areas of focus from Health Resources and Services Administration (HRSA), Centers for Disease Control and Prevention (CDC), Florida Bureau of HIV/AIDS, and the Palm Beach County HIV CARE Council are listed below in Section 2. Our Continuum of Care within the EMA has adopted these concepts and has built the Comprehensive Plan 2009-2012 to support and implement them all.

How Will We Get There: How Does Our System Need to Change to Assure Availability of and Accessibility to Core Services?

Based on the goals of Healthy People 2010 as well as the findings from the Comprehensive Needs Assessment 2007-2010 completed in October 2007 the following goals were created in order to improve the current system of care, and enhance the planning for the system of care. The objectives and activities build on the current evaluation process and providing measures by which our performance and progress can be evaluated. Achieving these goals will ensure the provision of high quality care and treatment services to all PLWHA in our EMA.

The goals developed during the planning process relate to and support all of HRSA's guiding principles. A detailed description of each goal (with objectives and activities) is included in Section 3.

How Will We Monitor Our Progress: How Will We Evaluate Our Progress in Meeting Our Short and Long Term Goals?

The implementation of the plan that will be in effect FY 2009-2012 will be monitored by the Palm Beach County HIV CARE Council. The Implementation Plan will be reviewed annually to ensure the goals, objectives and activities are completed.

S E C T I O N 1

Where Are We Now: What Is Our Current System of Care?

A. Description of the Eligible Metropolitan Area

Palm Beach County is located on the east coast of Florida. The land area of Palm Beach County is 2,000 square miles. The eastern portion of the county is heavily populated, while the western area is a lower density agricultural area with several more densely populated towns and residential areas. The 2007 estimated population, according to U.S. Census Bureau, was 1,299,341. The racial make up of the county's population includes 66% White, not-Hispanic, 16% Black, not-Hispanic and 16% Hispanic. Twenty-seven percent (27%) of the population is 60 years of age and over and 77% are over 19 years of age. Fifty-one point six (51.6%) of the population are female and 48.4% are male.

11.5% are living below 100% poverty level. Of the population living below 100% poverty level 47.9% are White, 27.7% are Black and 22.4% are Hispanic. Of the unemployed population 55.9% are White, 23.8% are Black, 18.4% are Hispanic. A mid-1998 Florida Department of Health Services report indicates there were 65,263 seasonal farm workers in the county. Many of these workers are from the Caribbean, Central America, and Mexico. During the past ten years, many immigrant workers have become employed in construction, landscaping, and other jobs throughout the county, especially the suburban central and coastal areas which have experienced rapid growth in housing and retail construction.

B. Epidemiological Profile

The complete report of the most recent HIV/AIDS data available from the Florida Department of Health, Bureau of HIV/AIDS through 2007 as of April 14, 2008 (excluding Department of Corrections) is included in Appendix C of this report.

Highlights of HIV/AIDS trends in Palm Beach County from the Florida Department of Health report include:

- Black not Hispanics accounted for 62% of all new AIDS cases, 55% of all new HIV cases, and 65% of HIV/AIDS case deaths.
- Among Black, not Hispanic HIV cases increased 12.8% and AIDS incidence decreased 25.1% between 2006 and 2007.
- Among White, not Hispanics HIV cases increased 21.7% and AIDS incidence decreased 27% between 2006 and 2007.

- Among Hispanics HIV cases have increased 15.5% and AIDS incidence decreased 8.1% between 2006 and 2007.
- Among males, MSM was the mode of exposure for 47.8% of new AIDS cases and 52.9% of new HIV cases.
- Among females, heterosexual transmission continues to be the predominant mode of HIV exposure.
- The ratio of male and female adult AIDS cases continues to decrease. In 1997, the male to female ratio was 1.9:1 compared to 1.3:1 in 2007.
- The ratio of male and female adult HIV cases has slightly increased since 1998, the opposite trend of that for AIDS cases. In 1998, the male to female ratio was 1.2:1 compared to 1.7:1 in 2006. According to the Bureau of HIV/AIDS the relative increases in male HIV cases might be attributed to proportional increases in HIV transmission among MSM, which may influence future AIDS trends.

HIV cases tend to represent the most recent trends of the HIV/AIDS epidemic. While the total number of HIV cases in Palm Beach County continues to increase, the number and rate of new cases has decreased over time. The data in the table to the right summarized the decrease in the number of new cases from 552 in 1998 to 358 in 2006 as well as a decrease in the rate, from 51.2 to 27.7 per 100,000 population (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
1998	552	51.2	1,077,422
1999	695	62.8	1,107,053
2000	468	41.1	1,137,532
2001	457	39.4	1,160,977
2002	585	49.1	1,190,653
2003	543	44.6	1,218,508
2004	457	36.6	1,249,598
2005	397	31.2	1,272,335
2006	358	27.7	1,290,600

Because it may take many years for people infected with HIV to develop AIDS, AIDS cases tend to represent HIV transmission that may have occurred many years ago. The Bureau of HIV/AIDS suggests that individual 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 non-HIV STDs in the community
- prevalence of injection drug use
- complex matrix of factors related to socioeconomic status

Although the total number of AIDS cases in Palm Beach County continues to increase, the number and rates of new AIDS cases has decreased over time. Between 2005 and 2006 there was a slight increase of 3% (11 new AIDS cases). The data in the table to the right show that the number of new cases and rate per 100,000 population decreased between 1996 to 2006, from 759, 74.3 per

Palm Beach County AIDS Data

Year	New Cases	Rate per 100,000
1996	759	74.3
1997	559	53.2
1998	477	44.3
1999	432	39.0
2000	503	44.2
2001	453	39.0
2002	513	43.1
2003	444	36.4
2004	436	34.9
2005	360	28.3
2006	371	28.7

100,000 to 371, 28.7 per 100,000 (Florida Department of Health, CHARTS Community Health Assessment Resource Tool Set).

As with new HIV and new AIDS cases, the number of age adjusted HIV/AIDS deaths has dramatically decreased since 1996, dropping from 306 deaths in 1996 to 162 deaths in 2006 with a concomitant decrease in rates per 100,000 population from 32.2 to 12.9.

The data in the table to the right show that while there has been a decrease in rates among all races, grave disparities still exist between racial categories. For example, the death rate among Blacks decreased from 149.5 in 1996 to 64.5 in 2006 but this rate is still 18 times higher than the rate for Whites and 13 times higher than the rate for Hispanics (Florida Department of Health, CHARTS Community Health Assessment Resource Tool Set).

Palm Beach County
Age Adjusted HIV/AIDS Death Data

Year	Number of Deaths	Total Population Rate per 100,000	White Rate per 100,000	Black Rate per 100,000	Hispanic Rate per 100,000
1996	306	32.2	13.6	149.5	17.6
1997	191	19.1	6.0	106.1	15.3
1998	135	12.9	3.9	73.9	6.7
1999	138	13.2	5.6	59.7	8.3
2000	165	15.3	5.7	75.4	11.0
2001	147	13.3	3.7	73.2	5.5
2002	157	13.8	3.9	71.9	1.5
2003	156	13.4	4.2	68.0	6.5
2004	175	14.9	4.9	70.8	9.7
2005	149	12.4	3.7	50.0	7.6
2006	162	12.9	3.5	64.5	4.9

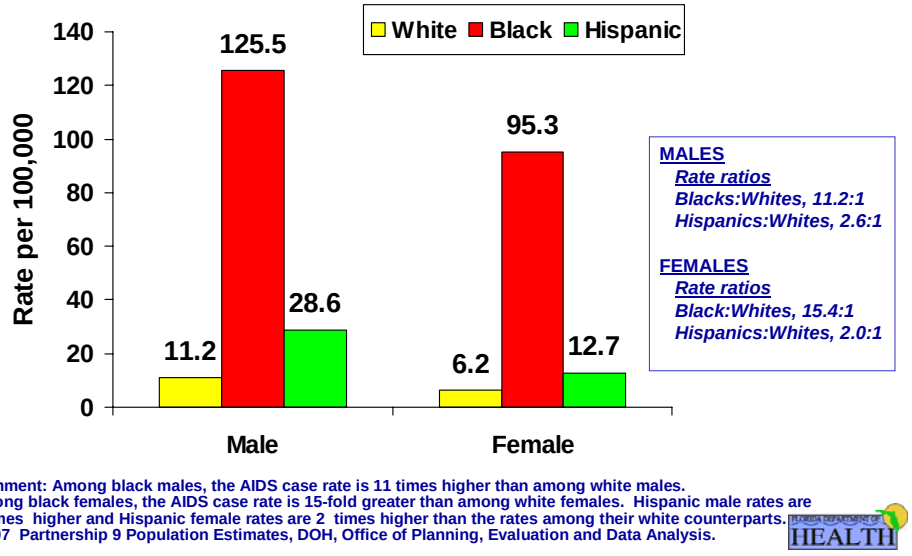
Of the 4,414 people living with AIDS in the EMA, 64.7% are Black, not Hispanic, 23.1% are White, not Hispanic and 11.1% are Hispanic. The historical patterns established by the epidemic in the EMA persist and increase with respect to those who become infected and their modes of exposure. AIDS Incidence over the past two years (2006-2007) indicate a percentage decrease of the new AIDS cases for African Americans (-25.1%), White, not Hispanic (-27%), and Hispanic (-8.1%).

Of the 2,798 HIV (not AIDS) cases in the EMA, 61.5% are Black, not Hispanic, 25.4% are White, not Hispanic, and 11.8% are Hispanic. HIV diagnoses over the past two years (2006-2007) indicate a percentage increase of the new HIV cases for African Americans (12.8%), White, not Hispanic (21.7%), and Hispanic (15.5%) populations.

Women currently account for 36.6 % of the live AIDS cases and 43.5 % of live HIV cases. The male to female ratio is decreasing for AIDS cases and increasing among HIV cases. In 1998 the male to female ratio for adult AIDS cases was 1.9:1, and in 2007 the ratio is 1.3:1. In 1998 the male to female ratio for adult HIV cases was 1.2:1 and in 2007 the ratio is 1.7:1.

The distribution of AIDS in the EMA is uneven across demographic categories. In Palm Beach County as of 2007, AIDS case rates per 100,000 population among males is 11.2 White, 125.5 Black and 28.6 Hispanic. The AIDS case rate per 100,000 population among females is 6.2 White, 95.3 Black, and 12.7 Hispanic. As displayed in the graph below, the Black male population has AIDS case rates 11 times higher than the White male population. The Black female population has AIDS case rates 15 times that of the White female population.

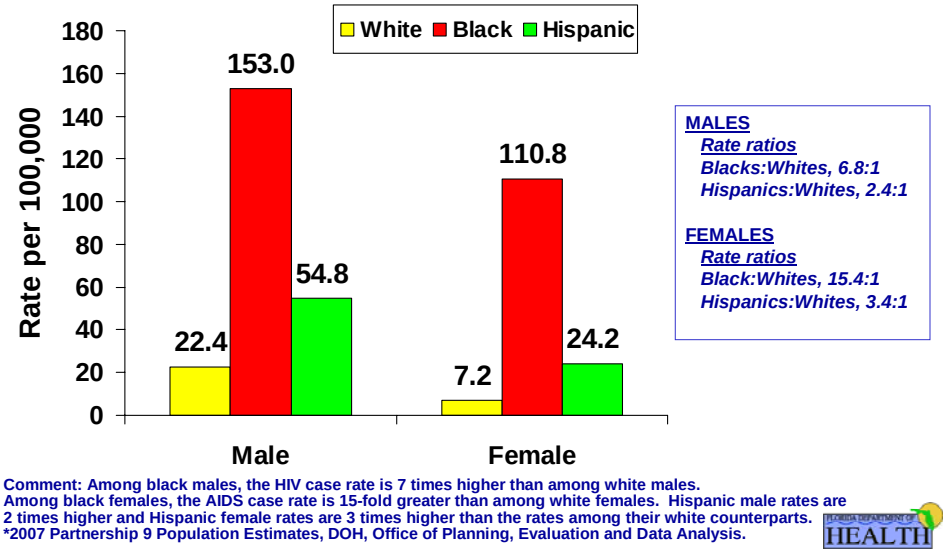
Reported AIDS Case Rates per 100,000 Population
By Sex and Race/Ethnicity, Partnership 9, 2007



Comment: Among black males, the AIDS case rate is 11 times higher than among white males. Among black females, the AIDS case rate is 15-fold greater than among white females. Hispanic male rates are 3 times higher and Hispanic female rates are 2 times higher than the rates among their white counterparts.
***2007 Partnership 9 Population Estimates, DOH, Office of Planning, Evaluation and Data Analysis.**

The distribution of HIV in the EMA is uneven across demographic categories. In Palm Beach County as of 2007, HIV case rates per 100,000 population among males is 22.4 White, 153 Black and 54.8 Hispanic. The HIV case rate per 100,000 population among females is 7.2 White, 110.8 Black, and 24.2 Hispanic. As displayed in the graph below, the Black male population has HIV case rates almost 7 times higher than the White male population. The Black female population has HIV case rates 15 times that of the White female population.

Reported HIV Case Rates per 100,000 Population By Sex and Race/Ethnicity, Partnership 9, 2007



Comment: Among black males, the HIV case rate is 7 times higher than among white males. Among black females, the AIDS case rate is 15-fold greater than among white females. Hispanic male rates are 2 times higher and Hispanic female rates are 3 times higher than the rates among their white counterparts.
*2007 Partnership 9 Population Estimates, DOH, Office of Planning, Evaluation and Data Analysis.

Services for the affected population are provided by the Palm Beach County Health Department and community-based organizations located in the areas most impacted by HIV/AIDS. The Continuum of Care provides a variety of services as detailed in Section 1.G. The EMA uses Part A funds for life sustaining treatment, as well as support services to ensure access to primary care/treatments and maintain quality of life throughout all geographic areas to serve all demographic categories. On-going analyses of trends and changes in epidemiologic data are used in all decision making processes.

C. Future Trends

As mentioned above, the epidemiological data from the Florida Department of Health, Bureau of HIV/AIDS suggest the following as possible future trends in Palm Beach County:

- The data suggest an overall decrease in AIDS incidence, as well as a decrease among all races/ethnicities, all ages, and gender.
- The data suggest an overall increase in HIV incidence as well as among all races/ethnicities and gender.
- The data suggest that HIV/AIDS case deaths are decreasing overall, as well as among all races/ethnicities and gender.
- The data indicate that HIV incidence is increasing among the MSM population.
- The data suggest there continues to be a decrease in HIV cases among Blacks and females.

- The data suggest there is an increase in HIV cases among Hispanics and Whites and males.
- The data suggest there continues to be a decrease in AIDS cases among Blacks, Whites and males.
- The data suggest there is an increase in AIDS cases among Hispanics and females.

D. Description of the History of Local, State and Regional Response to the Epidemic

Palm Beach County began receiving Part B (formerly Title II) funds in 1991. In 1994, because of growth in the number of AIDS cases, our area became eligible for Part A (formerly Title I) funding. Part A funds were used to create a local HIV Health Services Planning Council. In 1997, the Part B Consortia and the Part A planning bodies combined creating the Palm Beach County HIV CARE Council.

The Palm Beach County HIV CARE Council serves as the Part A HIV/AIDS Services Planning Council and Part B AIDS Consortium to provide a broad compendium of services, which form the Continuum of Care for county residents affected by HIV spectrum disease. The CARE Council produced the Palm Beach County 2007-2010 Comprehensive HIV CARE Needs Assessment.

The Council's purpose is to conduct a needs assessment, develop a comprehensive plan, establish medical and support service priorities, allocate funds for the services, and evaluate the effectiveness of those services. The Palm Beach County Board of County Commissioners directs the county's Department of Community Services, as the Grantee, to administer the Part A and MAI funds and evaluate the effectiveness of those services.

Starting in 1991, Housing Opportunities for People With AIDS (HOPWA) funds, administered by the City of West Palm Beach Department of Economic and Community Development, were utilized to assist PLWHA in Palm Beach County access critically-needed housing services.

Two additional state funding streams administered by the Palm Beach County Health Department through the Bureau of HIV/AIDS in Tallahassee are used to provide services in Palm Beach County. These funds, General Revenue AIDS Network and General Revenue Patient Care, predate funds provided by the Ryan White Act (commencing 1986 and 1989, respectively).

Currently, Palm Beach County does not receive Parts C or D support.

Finally, through funding under Ryan White Act Part F, AETC is the designated provider via the University of South Florida (USF), Department of Community Health, Tampa, Florida.

E. Assessment of Need

1. Highlights from the Comprehensive Needs Assessment 2007-2010

i. Service Utilization from the Comprehensive Needs Assessment 2007-2010

Survey respondents in care were asked to describe their level of utilization of the thirty service categories prioritized by the planning council. The 252 respondents in care described their utilization of each survey categories as one of the following:

- "need and use" if they utilize the service
- "do not need" if they do not utilize the service
- "need, can't get" to show possible gaps in services
- "can get, won't use" to show barriers in service utilization

The five most frequently utilized, "need and use", services for all respondents were:

- Case Management 74.6% (188)
- Laboratory/Diagnostic Testing 71.0% (179)
- Dental Care 57.5% (145)
- Ambulatory Primary Outpatient Medical Care 56.3% (142)
- HIV Prevention 51.6% (130)

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

Questions 59-88. Please check off how the following services apply to you:
Need and Use, Do not Need, Need/Can't Get, Can Get/Won't Use

Service Category	Utilization (Need and Use) n=252		
	rank	#	percent
Ambulatory/Primary Outpatient Medical Care	4	142	56.3%
Buddy Companion	18	70	27.8%
Case Management	1	188	74.6%
Clinical Trials	19	65	25.8%
Complementary Therapies	21	41	16.3%
Counseling Other	7	112	44.4%
Day and Respite Care	20	52	20.6%
Dental Care Services	3	145	57.5%
Direct Emergency Assistance	13	89	35.3%
Drug Reimbursement	17	78	31.0%
Food Bank/Home Delivered Meals	10	95	37.7%
Health Insurance Continuation	14	88	34.9%
HIV Prevention	5	130	51.6%
Home Health Care Services	22	40	15.9%
Hospice	27	14	5.6%
Housing	15	84	33.3%
Inpatient Hospital Coordination	22	40	15.9%
Laboratory Diagnostic Testing	2	179	71.0%
Legal Services/Permanency	12	88	34.9%
Mental Health	9	96	38.1%
Nurse Care Coordination	25	33	13.1%
Outreach	11	91	36.1%
Peer Advocacy	16	79	31.3%
Specialty Outpatient Medical Services	8	101	40.1%
Substance Abuse Outpatient	23	39	15.5%
Substance Abuse Residential	24	38	15.1%
Translation	26	31	12.3%
Transportation	6	115	45.6%
Treatment Adherence	12	90	35.7%
Vocational Rehabilitation	22	41	16.3%

ii. Service Utilization Trends 2000-2007

Needs assessments were conducted in 2000, 2003 and 2007. The tables below contain service utilization data from each respective study. In addition to data analyses for each year's needs assessment, analyses were conducted to identify trends from 2000 through 2007. Service categories used to analyze utilization have varied slightly in the three needs assessments. Therefore, some service categories included in past needs assessments were not included and could not be compared with the service categories in the 2007 needs assessment. For example Spiritual/Religious Counseling was a service that was included in past needs assessments, but was removed from the list of services used in the 2007 needs assessment. The list of service categories in the 2007 data collection instruments, include only the services in the current continuum of care that are prioritized and funded by the CARE Council. In some cases, this has resulted in non consecutive ranking in the tables below.

The following services *remained highly utilized* from 2000 through 2007. The following table lists the services from the highest to lowest rankings of utilization in 2007.

Service Categories that Remained Highly Utilized	2007 (n=252)			2003 (n=400)		2000 (n=271)	
	rank	#	percent	rank	percent	rank	percent
Case Management	1	188	74.6%	1	73.5%	2	68.0%
Laboratory Diagnostic Testing	2	179	71.0%	2	72.0%	1	75.0%
Dental Care Services	3	145	57.5%	5	61.5%	6	58.0%
Ambulatory/Primary Outpatient Medical Care	4	142	56.3%	8	52.8%	3	59.0%

The following services *significantly increased in utilization* from 2000 through 2007. The following table lists the services from the highest to lowest rankings of utilization in 2007.

Service Categories that Significantly Increased in Utilization	2007 (n=252)			2003 (n=400)		2000 (n=271)	
	rank	#	percent	rank	percent	rank	percent
HIV Prevention	5	130	51.6%	6	58.5%	13	43.0%
Transportation	6	115	45.6%	15	44.8%	24	27.0%
Counseling	7	112	44.4%	21	29.8%	27	23.0%
Direct Emergency Assistance	13	89	35.3%	18	36.5%	25	25.0%
Housing	15	84	33.3%	19	33.5%	28	21.0%
Buddy Companion	18	70	27.8%	40	6.3%	32	14.0%
Day and Respite Care	20	52	20.6%	36	9.0%	33	12.0%
Home Health Care Services	22	40	15.9%	42	5.5%	45	6.0%
Vocational Rehabilitation	22	41	16.3%	28	18.0%	41	10.0%

The following services (listed from the highest to lowest rankings of utilization in 2007) *significantly decreased in utilization* from 2000 through 2007.

Service Categories that Significantly Decreased in Utilization	2007 (n=252)			2003 (n=400)		2000 (n=271)	
	rank	#	percent	rank	percent	rank	percent
Food Bank/Home Delivered Meals	10	95	37.7%	15	44.8%	11	43.0%
Drug Reimbursement	17	78	31.0%	7	56.3%	8	53.0%
Hospice	27	14	5.6%	41	5.8%	35	11.0%

The following table summarizes all utilization data from the past three needs assessments. The top five categories for each year are highlighted for emphasis.

Utilization of Service Categories Across the 2007, 2003, 2000 Needs Assessments

Service Category	2007 (n=252)			2003 (n=400)		2000 (n=271)	
	rank	#	percent	rank	percent	rank	percent
Ambulatory/Primary Outpatient Medical Care	4	142	56.3%	8	52.8%	3	59.0%
Buddy Companion	18	70	27.8%	40	6.3%	32	14.0%
Case Management	1	188	74.6%	1	73.5%	2	68.0%
Clinical Trials	19	65	25.8%	30	16.0%	26	24.0%
Counseling	7	112	44.4%	21	29.8%	27	23.0%
Complementary Therapy- Acupuncture	not available			35	9.3%	44	7.0%
Complementary Therapy- Massage	21	41	16.3%	33	13.0%	30	19.0%
Day and Respite Care	20	52	20.6%	36	9.0%	33	12.0%
Dental Care Services	3	145	57.5%	5	61.5%	6	58.0%
Direct Emergency Assistance	13	89	35.3%	18	36.5%	25	25.0%
Drug Reimbursement	17	78	31.0%	7	56.3%	8	53.0%
Food Bank/Home Delivered Meals	10	95	37.7%	15	44.8%	11	43.0%
Health Insurance Continuation	14	88	34.9%	25	22.3%	23	27.0%
HIV Prevention	5	130	51.6%	6	58.5%	13	43.0%
Home Health Care Services	22	40	15.9%	42	5.5%	45	6.0%
Hospice	27	14	5.6%	41	5.8%	35	11.0%
Housing	15	84	33.3%	19	33.5%	28	21.0%
Inpatient Hospital Coordination	22	40	15.9%	n/a	n/a	n/a	n/a
Laboratory Diagnostic Testing	2	179	71.0%	2	72.0%	1	75.0%
Legal Services/Permanency	12	88	34.9%	20	34.3%	17	33.0%
Mental Health	9	96	38.1%	23	27.0%	16	35.0%
Nurse Care Coordination	25	33	13.1%	43	5.0%	n/a	n/a
Outreach	11	91	36.1%	n/a	n/a	n/a	n/a
Peer Advocacy	16	79	31.3%	26	20.3%	22	28.0%
Specialty Outpatient Medical Services	8	101	40.1%	n/a	n/a	n/a	n/a
Substance Abuse Outpatient	23	39	15.5%	24	22.8%	n/a	n/a
Substance Abuse Residential	24	38	15.1%	24	22.8%	n/a	n/a
Translation	26	31	12.3%	29	17.3%	40	10.0%
Transportation	6	115	45.6%	15	44.8%	24	27.0%
Treatment Adherence	12	90	35.7%	n/a	n/a	n/a	n/a
Vocational Rehabilitation	22	41	16.3%	28	18.0%	41	10.0%

Note: Data in black cells represent the services most frequently mentioned.

iii. Service Utilization Among Special Populations

Haitian Respondent's Service Needs and Utilization
The most frequently utilized services among Haitian in care respondents differed from those utilized by all in care respondents. Ambulatory/primary outpatient medical care, HIV prevention, and case management were among the five most frequently utilized services by both groups of respondents. Clinical trials, health insurance continuation, legal services, peer advocacy, and specialty medical services were among the most frequently utilized services among Haitian in care respondents

Latin/Hispanic Respondent's Service Needs and Utilization
Among Latin/Hispanic respondents in care, the most frequently utilized services include ambulatory/primary outpatient medical care, case management, counseling other, HIV prevention, laboratory diagnostic testing.

MSM Respondent's Service Needs and Utilization
Among MSM respondents in care, case management was identified as the most frequently utilized service, followed by laboratory diagnostic testing, ambulatory/primary outpatient medical care, counseling, and mental health therapy.

Black Heterosexual Respondent's Service Needs and Utilization
When asked to identify the services they need and use, in care Black heterosexuals and all in care respondents identified similar services. Case management was the most frequently mentioned service, followed by laboratory diagnostic testing and dental services.

WCBA Respondent's Service Needs and Utilization
When asked what services they need and use, WCBA in care most frequently identified the same five service categories as all in care respondents.

Recently Incarcerated Respondent's Service Needs and Utilization
Recently incarcerated respondents who are in care and all in care respondents identified similar services most frequently utilized. Both groups identified cases management and laboratory diagnostic testing as the most frequently utilized services.

Substance Using Women Respondent's Service Needs and Utilization
In care female respondents who have used drugs within the past 12 months and all in care respondents identified laboratory diagnostic testing, case management, and dental care services as the most frequently utilized services. In addition, food and specialty medical care were identified as highly utilized services.

The following table below summarizes the most highly utilized services for all respondents and seven special populations.

Survey Questions 59-88. Please check off how the following services apply to you: Need and Use, Do not Need, Need/Can't Get, Can Get/Won't Use

Utilizied Service Categories	All In Care Respondents n=252			Haitian In Care Respondents n=49			Hispanic/Latin In Care Respondents n=37			MSM In Care Respondents n=52			Heterosexual Black In Care Respondents n=130			WCBA In Care Respondents n=58			Jail/Prison Past 12 mos. In Care Respondents n=22			Substance Using Women In Care Respondents n=12		
	rank	#	%	rank	#	%	rank	#	%	rank	#	%	rank	#	%	rank	#	%	rank	#	%	rank	#	%
Ambulatory/Primary Outpatient Medical Care	4	142	56.3%	1	37	75.5%	2	30	81.1%	3	38	73.1%				4	32	55.2%	3	11	50.0%			
Case Management	1	188	74.6%	3	33	67.3%	1	33	89.2%	1	44	84.6%	2	94	72.3%	1	38	65.5%	1	15	68.2%	2	7	58.3%
Clinical Trials				5	31	63.3%																		
Counseling Other							4	16	43.2%	4	33	63.5%												
Dental Care Services	3	145	57.5%										3	80	61.5%	3	33	56.9%				3	6	50.0%
HIV Prevention	5	130	51.6%	2	34	69.4%	4	16	43.2%	2	41	78.8%	4	71	54.6%	5	31	53.4%						
Laboratory Diagnostic Testing	2	179	71.0%				3	18	48.6%				1	95	73.1%	2	35	60.3%	2	12	54.5%	1	10	83.3%
Legal Services/Permanency				5	31	63.3%																		
Peer Advocacy				3	33	67.3%																		
Specialty Outpatient Medical Services				4	32	65.3%																3	6	50.0%
Transportation													5	70	53.8%									
Health Insurance Continuation				5	31	63.3%																		
Mental Health										5	32	61.5%												
Food Bank																						3	6	50.0%

Note: The table above only displays data from the most frequently selected services; the remaining cells are blacked out.

iv. Problems While Trying to Access Needed Services

All respondents in care were asked to identify problems they have had trying to get needed services. 151 of 252 (60%) responded that they had problems trying to access needed services. Among the variety of problems mentioned, the most frequently mentioned included the following:

- Transportation (40.4%, 61)
- Not wanting people to know they have HIV (28.5%, 43)
- Not knowing how to apply (27.8%, 42)

The table to the right summarizes all responses to this question.

Survey Question 57. Have you had any of the following problems while trying to get needed services? (check any or all that apply)?

Problems While Trying to Get Needed Services	In Care Respondents n=151	
	number	percent
Transportation problems	61	40.4%
I don't want people to know I have HIV	43	28.5%
Didn't know how to apply	42	27.8%
Application process too complicated	38	25.2%
Didn't know where to apply	33	21.9%
Drug or alcohol addiction	25	16.6%
Turned down/not eligible	24	15.9%
Trouble communicating	22	14.6%
Had to wait too long for service	22	14.6%
Other health problems	20	13.2%
Needed evening appointment	13	8.6%
On waiting list	13	8.6%
Cost of service is too high	12	7.9%
Service sites located too far away	12	7.9%
Needed weekend appoint	8	5.3%
Too busy taking care of child	7	4.6%
Too busy taking care of partner	3	2.0%
Homeless	2	1.3%
Afraid of immigration issues	1	0.7%
Problems getting a case manager	1	0.7%

Most respondents (70.2%, 106) who cited problems, said they had more than one problem while trying to get needed services. The table to the right summarizes the number and percentage of respondents by the number of problems cited.

Number of Selected Problems While Trying to Get Needed Services	In Care Respondents	
	number	percent
1	45	29.8%
2 to 4	89	58.9%
More than 4	17	11.3%
Total	151	100.0%

v. Survey Respondents Who Are Out of Care

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

- viral load count
- CD4 lab work
- antiretroviral therapy within the last 12 months

The following table summarizes the demographic characteristics of the 148 survey respondents who were not in care.

Demographics Characteristics of Respondents Out of Primary Medical Care n=148

Race/Ethnicity	number	percent
Black	114	77%
White	26	18%
Hispanic	7	5%
Skipped Question	1	1%
Total	148	100%
Gender	**number**	**percent**
Male	67	45%
Female	81	55%
Transgender	0	0%
Total	148	100%
Age	**number**	**percent**
0-24	15	10%
25-29	18	12%
30-39	40	27%
40-44	31	21%
45-49	13	9%
50-59	26	18%
60+	4	3%
Skipped Question	1	1%
Total	148	100%
Special Populations	**number**	**percent**
MSM	23	16%
IDU	17	11%
Haitian	26	18%
WCBA	58	39%
Heterosexual	111	75%
Geographic Location	**number**	**percent**
East County	114	77%
West County	34	23%
Total	148	100%

Respondents were asked what best describes their situation regarding being out of care. Of the 148 out of care respondents, 35.1% (52) had never been in care, 37.2% (55) had been receiving care, but had stopped more than 12 months ago, and 21.6% (32) said they were recently diagnosed and had not entered primary care.

When asked about the reasons for not being in care, the six most frequent responses were:

- "I am afraid of being identified as HIV positive." 39.9% (59)
- "I am too embarrassed or ashamed to go." 36.5% (54)
- "I know where to go, but I do not want to go there." 36.5% (54)
- "I do not have medical insurance and couldn't afford care." 34.5% (51)
- "I have heard bad things about the medications and their side effects." 34.5% (51)
- "I am not ready to deal with my HIV status." 31.8% (47)

88.5% (137) identified more than one reason for being out of care.

When asked to "check all that apply" regarding why PLWHA were not in care, service providers and respondents not in care cited a wide range of reasons. Overall, providers cited each reason at a higher rate than PLWHA. Providers and PLWHA alike frequently identified the following reasons:

- Afraid of being identified as HIV-positive.
- Do not have medical insurance, cannot afford care.
- Heard bad things about medications and the side effects.
- Not ready to deal with HIV status.

Provider respondents selected the following reasons for PLWHA not being in medical care at higher rates than the PLWHA respondents did:

Reasons for not being in medical care	PLWHA Respondents n=252		Provider Respondents n=18	
	number	percent	number	percent
Using drugs and alcohol.	42	28.4%	11	61.1%
Have mental health problems.	7	4.7%	11	61.1%
Do not have transportation	39	26.4%	11	61.1%

When the respondents who are not in primary medical care were asked what services, other than medical care and medication, they need to get into primary medical care the three most frequently chosen responses were financial assistance, food and housing.

Out of care respondents frequently selected a number of supportive services needed. For example, 11.5% (17) said they needed only one service. Of all out of care respondents, 134 (90.5%) said they needed at least one service to get into care and 117 (79%) said they needed more than one.

Providers were asked the same question regarding the services, other than medical care and medications, which out of care PLWHA needed to get into primary medical care. The percentages were somewhat similar with a few notable exceptions.

Provider respondents indicated much more frequently than PLWHA that mental health services were needed, 66.7% and 18.9%, respectively. Likewise, providers indicated more frequently than PLWHA that substance abuse treatment was needed, 55.6% and 30.4%, respectively.

Respondents who are out of care were asked what would be some reasons they would enter primary medical care. The most frequently cited reasons were:

- "When I get sick and know I need care." 64.9% (96)
- "When I am ready to deal with my illness." 33.8% (50)
- "Someone else with HIV/AIDS reaches out to me." 30.4% (45)

More than two-thirds (67%, 99) of respondents not in care identified more than one reason that they would enter care.

Provider respondents were asked to identify the reasons that would prompt PLWHA to enter primary medical care. Providers and PLWHA alike most frequently cited the following two reasons:

- "Get sick and know they need care."
- "Ready to deal with illness."

Providers were more likely than PLWHA to attribute entering primary care to the potential influence of an outreach worker, a referral, or a culturally sensitive health care provider.

vi. Comparison of PLWHA Who Are In Care with PLWHA Who Are Out of Care

The data in this section highlight some of the socioeconomic differences between survey respondents who are in care and respondents who are out of care.

- Overall, out of care respondents reported a lower level of educational achievement than in care respondents.
- Respondents who are in care were more likely to report being "on disability" than respondents who are out of care.
- Similar percentages of both the in care and out of care respondents are employed, 35.4% and 34.5%, respectively.
- A higher percentage of respondents who are out of care indicated that they were not employed, 50%, compared to 34.5% of the in care respondents.
- When the respondents were asked where they currently reside, out of care respondents indicated that they were homeless at a much higher rate than the in care respondents, 17.6% and 1.6% respectively. Of the 30 respondents who said they are homeless, 4 (13.3%) said they were in care and 26 (86.7%) were out of

care. In addition, the out of care respondents indicated that they are "staying/living with family or friends" at a higher percentage than the in care respondents, 31.1% and 18.3%, respectively.

- Respondents' 2006 annual household size and income were compared to Federal Poverty Levels (FPL). A higher percentage of the out of care respondents were living at or below 100% of the FPL than the in care respondents, 85.1% and 66.3%, respectively.
- Respondents were asked if, during the past 12 months, they traded sex for money or drugs. 33.8% of the respondents who are out of care indicated that they had traded sex for money or drugs compared to only 9.5% of the respondents who are in care.

vii. PLWHA Who Are In Care, but Have Been Out of Care Within the Past Five Years

The 252 respondents who are currently in care were asked if there had been a period during the last 5 years during which they have been out of care for more than twelve months. Of the 252 respondents in care, 17.5% (44 out of 252), responded in the affirmative.

The 44 respondents who had been out of care for more than 12 months, anytime during the past five years were asked to describe their circumstances during that time. The most frequently reported situation was "I had been receiving medical care for HIV, but I stopped for more than 12 months." (54.4%); followed by "I had recently been diagnosed with HIV, and had not entered primary care." (13.6%)

The three most commonly mentioned reasons for being out of care are as follows:

- I was using drugs and alcohol (34.1%).
- I was afraid of being identified as HIV-positive (29.5%).
- I was too embarrassed or ashamed to go (22.7%)

Respondents were told to "check all that apply".70.5% selected more than one reason, suggesting that PLWHA who are out of care may need to overcome multiple problems in order to get into and stay in care.

The forty-four in care respondents who were out of care for more than 12 months within the past five years were asked what services, other than medical care and medications, they needed to get into primary medical care. The three most frequently identified services included financial assistance (direct emergency assistance), housing and food. The respondents were told to "check all that apply". Most respondents (68.1%) said they needed more than one service to get back into care.

The 44 respondents, who are currently in care but had been out of care for more than 12 months over the past five years, were asked to identify the reasons for returning to primary medical care. The most frequently identified reasons were:

- I got sick and knew I needed care.

- I was ready to deal with my illness.
- A family member or friend helped get me into care.

Respondents were told to "check all that apply". Slightly more than half of the respondents selected more than one reason that they returned to care. This suggests that PLWHA returning to care is a complex process.

When respondents were asked if someone had been involved in their care or if an outreach worker helped get them back into care, 41% (18 of the 44) responded in the affirmative and cited the following source of assistance:

- Comprehensive AIDS Program (9)
- Family and friends (3)
- Jay's Ministries (2)
- CARE Council (1)
- Legal Aid of Palm Beach County (1)
- Health Department (1)
- Regeneration Center (1)

Some focus group participants stated they were first diagnosed and/or had originally entered care in the following locations:

- Jail/prison
- Substance abuse treatment center
- Emergency room

viii. Special Populations Who Are Out of Care

The following is a summary from seven special populations who are out of care when asked "what best describes your situation?"

Haitian Out of Care Respondents
The rate of out of care respondents of Haitian descent who have recently been diagnosed with HIV was more than twice the rate of all out of care respondents in the same situation (46.2% compared to 21.6%). In contrast, the rate of out of care respondents of Haitian descent who have never been in care was less than half the rate of all out of care respondents in the same situation (15.4% compared to 35.1%).

Latin/Hispanic Out of Care Respondents
When asked, "What best describes your situation?" only one Latin/Hispanic out of care said, "I have recently diagnosed with HIV and have not entered primary care."

MSM Out of Care Respondents
When out of care MSM were asked to describe their situation, only 13% said they were recently diagnosed and had not entered primary care, compared to 21.6% among all out of care respondents. The rate of MSM who had been receiving medical care at one time was about the same as the rate among all out of care respondents (39.1% and 37.2%

respectively). The rate of out of care MSM who had never been in care was higher than the rate among all out of care respondents (43.5% compared to 35.1%).

Black Heterosexual Out of Care Respondents
Black heterosexual out of care respondents were asked to describe their current situation. As among all out of care respondents, the most frequently mentioned description was that they had been in care at one time but stopped more than 12 months ago. The second most frequently described situation was never having been in care at all.

WCBA Out of Care Respondents
When WCBA who are out of care were asked what their current situation is, their responses were similar to all out of care respondents. Most said they had never been in care or had stopped more than 12 months ago.

Recently Incarcerated Out of Care Respondents
The twenty respondents who are out of care were asked to describe their situation. As among all out of care respondents, out of care respondents who were recently incarcerated most frequently mentioned, "I had been receiving medical care for HIV, but I stopped more than 12 months ago."

Substance Using Women Out of Care Respondents
Of the 41 substance abusing out of care women, 41.5% (17) had never been in care and 31.7% (13) reported, "I had been receiving medical care for HIV, but I stopped more than 12 months ago". In comparison, only 35.1% (52) of all out of care respondents had never been in care and 37.2% (55) had been in care but stopped more than 12 months ago. Among respondents in both groups, approximately 22% said they were recently diagnosed and had not entered primary care.

The table below displays responses from all out of care respondents and seven special populations.

Survey Question 23. What best describes your situation?

Situation	All Out of Care Respondents n=148		Haitian Out of Care Respondents n=26		Latin/Hispanic Out of Care Respondents n=7		MSM Out of Care Respondents n=23		Black Heterosexual Out of Care Respondents n=86		WCBA Out of Care Respondents n=58		Jail/Prison Past 12 mos. Out of Care Respondents n=20		Substance Using Women Out of Care Respondents n=41	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
I have recently been diagnosed with HIV, and have not entered primary care.	32	21.6%	12	46.2%	1	14.3%	3	2.6%	21	18.4%	17	14.9%	4	3.5%	9	7.9%
I had been receiving medical care for HIV, but I stopped more than 12 months ago.	55	37.2%	10	38.5%	3	42.9%	9	7.9%	34	29.8%	19	16.7%	9	7.9%	13	11.4%
Never been in care	52	35.1%	4	15.4%	3	42.9%	10	8.8%	23	20.2%	19	16.7%	4	3.5%	17	14.9%
No Response	9	6.1%	0	0.0%	0	0.0%	1	0.9%	8	7.0%	3	2.6%	3	2.6%	2	1.8%
Total	148	100.0%	26	100.0%	7	100.0%	23	20.2%	86	75.4%	58	50.9%	20	17.5%	41	36.0%

The following is a summary from seven special populations who are out of care when asked "What are the reasons that you are not in primary medical care?" Respondents were asked to check all that apply.

Haitian Out of Care Respondents
The reasons for not being in primary medical care among Haitian out of care respondents differed when compared to the reasons of all out of care respondents. Fear associated with immigration or other legal issues was identified by 34.6% of the respondents of Haitian descent. Not knowing that they are eligible for free care, not wanting any bad news about their health, and preferring to use Voodoo were also significant reasons among the Haitian out of care respondents, with 19.2% identifying each of these reasons.

Latin/Hispanic Out of Care Respondents
Latin/Hispanics were more likely than all out of care respondents to cite shame, financial and transportation barriers, and medication side effects as reasons for not being in care.

MSM Out of Care Respondents
When out of care MSM were asked to identify the reasons that they are not in primary medical care, the most frequently identified reasons were the same as those most frequently mentioned by all out of care respondents. An additional reason given by MSM was, "I do not want any bad news about my health".

Black Heterosexual Out of Care Respondents
Respondents were asked to identify the reasons for being out of care. The most frequently cited reason in both groups was, "I am afraid of being identified as HIV-positive."

WCBA Out of Care Respondents
When WCBA who are out of care were asked why they are not in primary medical care, their responses were similar to all respondents who are not in care, i.e., fear and financial barriers.

Recently Incarcerated Out of Care Respondents
The most frequently cited reasons for being out of care were lack of transportation, lack of insurance or money to pay for care, and not wanting to go for care.

Substance Using Women Out of Care Respondents
Out of care female respondents who have used drugs within the past 12 months most frequently identified similar reasons for being out of care as those identified by all out of care respondents. The reasons most frequently mentioned by out of care women who had used drugs were, "I know where to go but I do not want to go there" (43.6%, 19), "I am afraid of being identified as HIV positive (39%, 16), and "I am using drugs and alcohol" (39%, 16).

The following table displays responses from all out of care populations and seven special populations who are out of care.

Survey Question 24. What are the reasons that you are not in primary medical care? (check all that apply)

Out of Care Reasons	All Out of Care Respondents n=148		Haitian Out of Care Respondents n=26		Latin/Hispanic Out of Care Respondents n=7		MSM Out of Care Respondents n=23		Black Heterosexual Out of Care Respondents n=86		WCBA Out of Care Respondents n=58		Jail/Prison Past 12 mos. Out of Care Respondents n=20		Substance Using Women Out of Care Respondents n=41	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
I am afraid of being identified as HIV-positive.	59	39.9%	6	23.1%			11	47.8%	31	36.0%	22	37.9%			16	39.0%
I am too embarrassed or ashamed to go.	54	36.5%			5	71.4%	12	52.2%							13	31.7%
I know where to go but I do not want to go there.	54	36.5%					9	39.1%	28	32.6%	22	37.9%	7	35.0%	19	46.3%
I do not have medical insurance and can not afford care.	51	34.5%	14	60.9%	5	71.4%			30	34.9%	21	36.2%	7	35.0%		
I have heard bad things about the medications and their side effects.	51	34.5%	6	26.1%	4	57.1%			30	34.9%					14	34.1%
I am not ready to deal with my HIV status.									27	31.4%						
I do not have transportation.					4	57.1%							8	40.0%		
I do not want any bad news about my health.			5	19.2%			9	39.1%								
I do not know that I am eligible for free care.			5	19.2%												
I am scared of immigration or other legal issues.			9	34.6%												
I prefer to use Santeria or Voodoo.			5	19.2%												
I am using drugs and alcohol.													6	30.0%	16	39.0%
I am in jail or prison and do not want to aske for care.													6	30.0%		

Note: The table above only displays data from the most frequently selected statements; the remaining cells are blacked out.

The following is a summary from seven special populations who are out of care when asked "What services, other that medical care and medications do you need to get into primary medical care?"

Haitian Out of Care Respondents
Overall, the services, other than medical care and medication, that Haitian out of care respondents indicated they need to get into primary medical care were very similar to all out of care respondents. Haitian out of care respondents selected legal services at nearly twice the rate of all out of care respondents (42.3% compared to 24.3%). In contrast, the rate of Haitian out of care respondents who selected financial services compared was less than half the rate of all out of care respondents who did so (55.4% compared to 26.9%).

Latin/Hispanic Out of Care Respondents
When asked what services, other than medical services and medication, do they need to get into primary medical care Latin/Hispanic respondents who are out of care most frequently identified financial assistance, food, transportation, and dental care.

MSM Out of Care Respondents
When out of care MSM respondents were asked to identify the services, other than medical care and medications, that they need in order to get into primary medical care, the four most frequently selected services were the same as those selected by all out of care respondents. Compared to all out of care respondents, a higher percentage of MSM selected case management, while a higher percentage of all out of care respondents selected food.

Black Heterosexual Out of Care Respondents
When asked what services they need to get into primary medical care, out of care respondents as a whole and Black heterosexual out of care respondents mentioned the same five service categories (with almost evenly distributed frequencies) as all out of care respondents.

WCBA Out of Care Respondents
When asked to select the services, other than medical care and medications, that they needed in order to get into primary medical care WCBA as well as all respondents who are out of care identified the same top five services at similar frequencies. The most frequently mentioned services were financial assistance, transportation, food, case management, and housing.

Recently Incarcerated Out of Care Respondents
As all out of care respondents, recently incarcerated out of care respondents most frequently cited financial assistance, food, housing, case management and transportation as the most needed services.

Substance Using Women Out of Care Respondents
The out of care female respondents who have used drugs within the past 12 months frequently selected financial assistance as a service, other than medical care and

medication, that they need to get into primary medical care. The most frequently selected services were very similar to those of all out of care respondents.

The following table displays responses from all out of care respondents and seven special populations who are out of care.

Survey Question 26. What services, other than medical care and medications, do you need to get into primary medical care? (check all that apply)

Needed Services	All Out of Care Respondents n=148		Haitian Out of Care Respondents n=26		Latin/Hispanic Out of Care Respondents n=7		MSM Out of Care Respondents n=23		Black Heterosexual Out of Care Respondents n=86		WCBA Out of Care Respondents n=58		Jail/Prison Past 12 mos. Out of Care Respondents n=20		Substance Using Women Out of Care Respondents n=41	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Financial Assistance	82	55.4%			4	57.1%	13	56.5%	45	52.3%	34	58.6%	11	55.0%	28	68.3%
Food	80	54.1%	8	30.8%	5	71.4%	10	43.5%	48	55.8%	32	55.2%	10	50.0%	25	61.0%
Housing	78	52.7%	8	30.8%			12	52.2%	48	55.8%	29	50.0%	10	50.0%	26	63.4%
Case Management	76	51.4%	13	50.0%			14	60.9%	45	52.3%	31	53.4%	9	45.0%		
Transporation	73	49.3%	8	30.8%	4	57.1%			46	53.5%	33	56.9%	9	45.0%	27	65.9%
Dental Care			8	30.8%	4	57.1%										
Legal Services			11	42.3%												

Note: The table above only displays data from the most frequently selected statements; the remaining cells are blacked out.

The following is a summary from seven special populations who are out of care when asked "What would be some reasons you enter primary medical care" (check all that apply.)

Haitian Out of Care Respondents
When asked "What would be some reasons you enter primary medical care?" the most frequently cited reason among all out of care respondents was "I get sick and know I need care". The second most frequently cited reason among Haitian out of care respondents was, "I am able to deal with the other problems in my life that are keeping me out of care."

Latin/Hispanic Out of Care Respondents
Latin/Hispanic respondents who are out of care most frequently select the following reasons they would enter primary medical care:

- I get sick and know I need care.
- I am ready to deal with my illness.
- I find a doctor or medical facility that ensures my confidentiality.
- I find a doctor or clinic that is culturally sensitive and speaks my language.

MSM Out of Care Respondents
When out of care MSM respondents were asked to identify reasons to enter care, they indicated that someone else with HIV/AIDS reaching out to them, as well as confidentiality within the medical facility would be important factors.

Black Heterosexual Out of Care Respondents
The reasons cited by out of care Black heterosexual respondents regarding the reasons they would enter primary medical care were similar to the reasons cited by all out of care respondents. The most frequently cited reasons were, "I get sick and know I need care," followed by "I am ready to deal with my illness."

WCBA Out of Care Respondents
WCBA and all respondents who are out of care selected similar reasons that they would enter primary medical care. The most frequently selected responses were, "I get sick and know I need care," and "I am ready to deal with my illness."

Recently Incarcerated Out of Care Respondents
Recently incarcerated and all out of care respondents cited the three reasons to enter primary medical care, i.e., "I get sick and know I need care", "I am ready to deal with my illness", "Someone else with HIV/AIDS reaches out to me."

Substance Using Women Out of Care Respondents
All out of care respondents as well as women who have used drugs in the past 12 months cited the same three reasons they would enter primary medical care. The most frequent response among both groups was "I get sick and know I need care" (75.6% of women who had used drugs in the past 12 months and 64.9% of all out of care respondents).

The following table displays responses from all out of care respondents as well as seven special populations.

Survey Question 27. What would be some reasons you enter primary medical care? (check all that apply)

Reasons to Enter Primary Medical Care	All Out of Care Respondents n=148		Haitian Out of Care Respondents n=26		Latin/Hispanic Out of Care Respondents n=7		MSM Out of Care Respondents n=23		Black Heterosexual Out of Care Respondents n=86		WCBA Out of Care Respondents n=58		Jail/Prison Past 12 mos. Out of Care Respondents n=20		Substance Using Women Out of Care Respondents n=41	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
I get sick and know I need care.	96	64.9%	15	57.7%	5	71.4%	12	52.2%	57	66.3%	41	70.7%	8	40.0%	31	75.6%
I am ready to deal with my illness.	50	33.8%	4	15.4%	6	85.7%			25	29.1%	21	36.2%	5	25.0%	13	31.7%
Someone else with HIV/AIDS reaches out to me.	45	30.4%					12	52.2%	21	24.4%	15	25.9%	6	30.0%	10	24.4%
I find a doctor or medical facility that ensures my confidentiality	38	25.7%			4	57.1%	9	39.1%	18	20.9%						
I find a doctor or medical facility I like.	31	20.9%							18	20.9%						
I am able to deal with other problems in my life that are keeping me out of care.			9	34.6%							15	25.9%				
I find a doctor or clinic that is culturally sensitive and speaks my language.					4	57.1%										
A family member or friend helps me get into care.													5	25.0%		

Note: The table above only displays data from the most frequently selected statements; the remaining cells are blacked out.

2. Unmet Need Estimates

i. Unmet Need Framework

Florida's methodology for obtaining the population and care pattern data To calculate and quantify the estimate of unmet need for HIV primary medical care AND the limitations of using these estimates

The Bureau of HIV/AIDS has estimated that 125,000 persons are living with HIV/AIDS in Florida. However, for the purpose of this narrative, the data analysis for demonstrating need will focus on those cases of HIV (not AIDS) and those with AIDS who were *reported* and alive through 2006. These data are generated from the HARS database, and also include those living and in care cases identified in the out of state (OOS) database (3% of total living cases). The combination of these two databases provides a more complete picture of the epidemic of "living" HIV/AIDS cases in need of care in Florida, than by just using HARS data alone.

Limitations:

Although the HIV/AIDS Reporting System (HARS) data was utilized as one of the primary tools for estimating unmet need, it must be noted that there are limitations to the data in HARS. HIV cases were not reportable in Florida until July 1, 1997. HIV reporting is not retroactive; the report is limited to HIV confirmatory tests performed in a confidential setting since that time and only via diagnostic HIV tests (i.e., Western Blot or IFA). Therefore, HIV (not AIDS) cases with diagnostic dates prior to 07/1997 were not reportable. Viral loads and CD4 counts officially became reportable November 20, 2006. Therefore, only the last 6 weeks of labs performed in 2006 were officially "reportable" and thus both the HIV data and all laboratory data (viral HIV tests and CD4s) for 2006 are incomplete and thus the data for HIV (not AIDS) will underestimate the true number of diagnosed and in care clients that are not yet reported. With the new reporting laws finally implemented, HIV and laboratory reporting will become more complete within a few years. On the other hand, AIDS case reporting is considered to be very timely and approximately 95% complete. Thus the data on living AIDS cases will be more reliable.

Staffing is a limitation to having all of the CD4 and viral HIV tests entered into HARS. Limited funds for data entry staff force the prioritizing of data entry of new cases or updates from HIV to AIDS into HARS over updating viral HIV tests or CD4s that have no impact on the HIV or AIDS diagnosis. Electronic lab reporting (ELR) to Florida began in 2006, but was limited to a few labs (including the State lab and Lab Corp). Full implementation of ELR will take several years. Additionally, funds were identified for a data entry operator to begin data entry of the paper lab results (those not sent electronically) received since the end of 2006. These paper labs were entered into a stand-alone Access data set, not connected with HARS. The databases will be matched with cases in care via Medicaid and ADAP, as well as with the lab databases. In care data for cases not in care via ADAP or Medicaid, and using a lab that has not yet reported, may not be counted, thus a factor of "those estimated in care via other sources" were used to capture those cases. These estimates were based on local chart reviews.

Compared with other states, Florida is a state with a lot of inward migration. Many PLWHAs come to Florida for the climate. Based on a recent migration study, as many as 5% of newly reported cases could have been reported from other states. Cases found to have previously been reported "out of state" (OOS) are subsequently deleted from the HARS registry, thus the true number of PLWHAs living in Florida is not realized by the HARS data alone. A separate database captures the OOS data from the cases deleted from Florida HARS. Although still in its infancy, this database allows the ability to "enhance" estimations of prevalence and in care patterns.

Improvements from last year:

Even though the HIV reporting database is not complete at the present time, Florida has further adjusted its methodology again this year to perform a match with HARS to the ELR and paper lab databases, along with Medicaid and ADAP databases to identify any living PLWHA in care as defined by the Framework in 2006. An additional set of matches was performed with the Out of State (OOS) database to identify any PLWHAs who were reported OOS but in care in Florida in 2006. Further adjustments to being "in care" were based on local chart reviews from top HIV providers. Although this methodology differs from what would be ideal according to MOSAICA [organization that provides Unmet Need technical assistance to EMAs], each year, it becomes closer to approaching that "gold standard" of estimating in care patterns of persons living and aware with HIV (not AIDS) (PLWH) and AIDS (PLWA). Furthermore, as requested by HRSA and MOSAICA, Florida's methodology identifies different in-care patterns by EMA and Title II consortia as well as by demographic and risk groups for those data "known to be in care".

Justification for utilizing Florida's methodology and data to estimate unmet need:

We acknowledge the limitations of these data on which these estimates are based. At present, the biggest assumption we are making is that those reported cases with a documented prescription, CD4 or viral HIV test (as defined by HRSA) in either HARS, Medicaid, ADAP, ELR or the paper lab database plus the local estimates of those in care via other sources are representative of those HIV/AIDS cases that are not yet reported in HARS. Nonetheless, we feel the balance of the data and assumptions are fairly robust to error and bias. Each year, Florida will strive to improve this methodology for calculating unmet need until more accurate in-care data is available via HARS and other matched databases.

Data used to generate the unmet need estimates (HARS, ADAP, & Medicaid) are usually generated by the state and disseminated to the 6 EMAs. The same formulas used to estimate prevalence and care patterns are applied to the state and each of the 6 EMAs to ensure uniformity in the data. Additionally, the methodology allows for local input to adjust the care patterns as needed. These data are area (EMA or Consortium) specific and tailored to the needs of the grantees. The incidence, prevalence and death data also include special population data, which further characterizes the local epidemic. Florida provides timely and comprehensive breakdowns of the HIV and AIDS cases by current age group for all of the prevalence data.

Protocol:

The following protocol describes the steps taken to identify the care patterns at the EMA and Consortia area levels. All data were generated at the county level. Then the county data were merged to calculate EMA and Consortia level data.

- AIDS *Case* Prevalence is defined as the number of reported AIDS cases alive and reported in the HARS or OOS databases through 12/31/06 as of 04/05/07.
- HIV *Case* Prevalence is defined as the number of reported HIV (not AIDS) cases alive and reported in the HARS or OOS databases through 12/31/06 as of 04/05/07.
- HIV/AIDS *Case* Prevalence is defined as the number of reported AIDS cases and HIV (not AIDS) alive and reported through 12/31/06 as of 04/05/07.
- The number of persons living with AIDS (PLWA) and ***aware: (letter A below)*** is defined as the number of reported AIDS cases alive and reported through 12/31/06, as of 04/05/07. Florida has a very timely and complete reporting system. It is assumed that ***all*** reported AIDS cases are aware of their diagnosis.
- The number of persons living with HIV (not AIDS) (PLWH) and ***aware: (letter B below)*** is defined as the number of reported HIV (not AIDS) cases alive and reported through 12/31/06, as of 04/05/07. Florida has a very timely and complete reporting system and there are systems in place to attempt to locate and inform all newly reported HIV positive cases of their status. It is assumed that 90% of all reported HIV (not AIDS) cases are aware of their diagnosis.
- PLWHA and ***Aware (letter C below).*** The total of PLWH and PLWA aware
- PLWA and PLWH that are estimated to be ***Aware and IN care.*** These data were calculated by a combination of several steps.
    1. HARS case data of HIV/AIDS cases living and reported through 2006 were matched with the ELR, paper labs, Medicaid and ADAP databases. One single database will be created from these matches that contains any HIV/AIDS case from HARS with at least one CD4, Viral HIV test or HIV prescription recorded in 2006, indicating that they received the specified HIV primary medical care service within a 12-month period as defined by HRSA. Geographic, demographic and risk data will also be incorporated into the database.
    2. Additionally, an out of state (OOS) database which tracks cases reported from other states, but in care in Florida will also be included in the numbers for estimating "in care".
    3. Utilizing local resources, **Each EMA will estimate in their application how their percent of persons accessing care besides Medicaid or ADAP are divided (private care, Medicare, VA, Ryan White, etc.) Chart reviews from top HIV providers will be conducted at the local level to provide these local data estimates.** Since names from these sources are not available for matching, the percent of the PLWHAs in care by these services will be added to the percent of those of those in care found via matches with Medicaid and ADAP.

Using the above input data and estimates, we are able to generate EMA and Consortia level data to estimate individual local care patterns using the HRSA formula.

A. PLWA, AIDS Prevalence (Living) and Aware for a recent time period:
(Data Source is HARS and OOS databases).
As define above.

B. PLWH, HIV (not AIDS) Prevalence (Living) and Aware for a recent time period:
(Data Source is HARS and OOS databases).
As define above.

C. PLWHA Prevalence (Living) and Aware for a recent time period:
(Data Source is HARS and OOS databases).
As define above.

D. Number of PLWA who received the specified HIV primary medical care services in a 12-month period.

E. Number of PLWH who received the specified HIV primary medical care services in a 12-month period. (For both steps D and E, the data source includes the HARS & OOS databases, along with the ADAP, Medicaid, ELR and paper lab databases & local primary care resources). This is calculated by identifying the documented prescription, CD4 or viral load as defined by HRSA from ADAP, Medicaid, ELR and paper lab databases and matching them with living cases from the HARS and the OOS databases. An additional "estimated" percent in care is added to the total to include those unreported labs, and/or persons receiving care outside of ADAP or Medicaid.

F. Number of PLWHA who received the specified HIV primary medical care services in a 12-month period. (D+E)

G. Number of PLWA who DID NOT receive the specified HIV primary medical care services in a 12-month period. These numbers were calculated by subtracting the PLWA aware and in care (D above) from the total PLWA aware (A above).

H. Number of PLWH who DID NOT receive the specified HIV primary medical care services in a 12-month period. These numbers were calculated by subtracting the PLWH aware and in care (E above) from the total PLWH aware (B above).

I. Total of PLWHA who DID NOT receive the specified HIV primary medical care services in a 12-month period. This total was calculated by adding the PLWA aware and NOT in care (G above) to the total of PLWH aware and NOT in care (H above).

Future plans include:

- Continuing to re-evaluate the entire step-by-step process of calculating the unmet need in order to provide the most accurate area-specific data.
- Continue to incorporate matched data between HARS and the OOS databases with the Medicaid, ADAP ELR and paper lab databases into the methodology to ensure the most complete in-care data.
- Identify any other databases, that may be beneficial for matching with HARS and OOS in order to identify additional sources of care, not captured elsewhere.
- Once E-HARS is implemented in Florida, and ELR is more complete we will evaluate the completion of HARS data for use in more steps of this process of calculating unmet need.

The table below displays the most recently available Unmet Need Framework Table for the Palm Beach EMA. Out of the total number of HIV+ aware population of 6,856, it is estimated that 4,952 (72%) PLWHA are receiving primary medical care services, and 1,904 (28%) are out of care.

PALM BEACH EMA
Unmet Need Framework Table

Column 1	Column 2	Column 3	Column 4	Column 5
Population Sizes		**Value**		**Data Source(s)**
Row A.	Number of persons living with AIDS (PLWA), aware for the period of 01/01/2006 - 12/31/2006	4,385		HARS and OOS data sets plus matches with ADAP, Medicaid, and Lab databases
Row B.	Number of persons living with HIV (PLWH)/non-AIDS/aware, for the period of 01/01/2006 - 12/31/2006	2,471		HARS and OOS data sets plus matches with ADAP, Medicaid, and Lab databases
Row C.	Total number of HIV+aware, for the period of 01/01/2006 - 12/31/2006	6,856		
Care Patterns		**Value**	**Percent**	**Data Source(s)**
Row D.	Number of PLWA who ***did*** receive the specified HIV primary medical care services in 12-month period	3,388	77%	HARS and OOS data sets plus matches with ADAP, Medicaid, and Lab databases
Row E.	Number of PLWH/non-AIDS/aware who ***did*** receive the specified HIV primary medical care services in 12-month period	1,564	63%	HARS and OOS data sets plus matches with ADAP, Medicaid, and Lab databases
Row F.	Total number of HIV+/aware who ***did*** receive the specified HIV primary medical care services in 12-month period	4,952	72%	
Calculated Results		**Value**	**Percent**	**Calculation**
Row G.	Number of PLWA who ***did NOT*** receive primary medical services	997	23%	Value: Value A - Value D. Percent: Value G/Value A.
Row H.	Number of PLWH/non-AIDS/aware who ***did NOT*** receive primary medical services	907	37%	Value: Value B - Value E. Percent: Value H/Value B.
Row I.	Total HIV+/aware who ***did NOT*** receive specified primary medical care services (quantified estimate of unmet need)	1,904	28%	Value: Value G + Value H. Percent: Value I/Value C

ii. CARE Systems Assessment Demonstration (CSAD)

In 2003, Palm Beach County EMA was the recipient of a Special Project of National Significance (SPNS) called the CARE Systems Assessment Demonstration Project (CSADP). CSADP sought:

1). To determine, by utilizing the Unmet Need framework relating to Special Populations and epidemiological data from HARS, which segment of our HIV-infected populace was the most disproportionately and egregiously affected by HIV-spectrum disease in Palm Beach County. By using our EMA's Unmet Need calculations in concert with the EMA's epidemiological profile we selected to focus our attention on HIV+

Black women who are aware of their status and either not receiving care or who have dropped out of care;

2) To identify and assess barriers which would inhibit/prohibit individuals belonging to that group from receiving medical care;

3) To evaluate the local CARE System from the perspective of the documents we produce relating to HIV/AIDS, from the perspective of the providers/administrators and key stakeholders in terms of delivering care to PLWHAs, and from the point of view of the consumers; and

4) To develop an implementation/action plan to design a system that could encourage those not in care to access care and then maintain care.

After examining the system in terms of the domains of comprehensiveness, capacity, integration, accessibility, acceptability, technical competencies, and client health seeking behaviors, the CSAD Project findings indicated that across all aspects of the research (i.e., Documents, Systems, and the RARE initiative) there were indicators of common impediments or barriers to care and common strengths in the system.

The common barriers to access to care were found to be:

- Inconvenience (i.e., transportation; location and hours of operation)
- Impersonality of staff and lack of respect by some staff particularly receptionists
- Impediments at the primary care providers (i.e., long waiting, long appointments) lack of follow-up; lack of insurance
- ER utilization
- Hopelessness/powerlessness
- Prioritization that places other obligations ahead of HIV+ primary medical care
- Abusive spouse
- Substance abuse
- Referral process
- Lack of confidentiality
- Lack of knowledge of available services
- Lack of knowledge about disease and treatment of disease
- Limited provision of services for non-English speaking clients
- Evidence of fragmentation of services (i.e., clients need to travel to get specialty medical care and labs and pharmaceuticals)
- Loss of social network
- Poor quality of care and provider
- Insufficient capacity
- Denial and fear

The common strengths across domains and aspects of the research were:

- A multiple provider mix
- Availability of primary medical care
- Availability of case management
- Some convenient provider locations
- Belief in services
- Some providers are in safe and secure locations

- Providers have appropriate credentials
- HIV training and knowledge
- Consumers report knowing where to go for health care

These collapsed findings were presented to approximately 100 individuals (providers, consumers, planners, community members, and other interested parties) who were invited to participate in a two day strategic planning session. They were given detailed accounts of the findings across the document review, the systems analysis and the RARE initiative. Findings were driven by the data collection that examined seven dimensions of the HIV Continuum of CARE as were referenced above (i.e., comprehensiveness; capacity; integration; accessibility; acceptability; technical competencies; and client health seeking behaviors).

According to the implementation/action plan that was developed during a two day strategic planning session six themes emerged as interventive goals that we have decided to incorporate into our system to address the Unmet Need of Black Women, the group we selected to focus our attention on. The six supra-themes presented here as goals were in order of importance to the CARE Council:

- Education
- Single Point of Access
- Treatment Adherence
- Stigma
- Confidentiality
- Cultural Beliefs, Attitudes and Practices

The Grantee as well as the CARE Council has used the results of the Unmet Need Framework in the planning for by allocating monies to Outreach in order to find the persons who are aware of their status and are not in primary medical care. In addition, monies have been increased in all Medical Services, Nurse Care Coordination, and Treatment Adherence in preparation for the increase in persons entering into Primary Medical Care.

3. Gaps in Care

i. Service Gaps from the Comprehensive Needs Assessment 2007-2010

Survey respondents in care were asked to describe their level of utilization of the thirty service categories prioritized by the planning council. The 252 respondents in care described their utilization of each survey categories as one of the following:

- "need and use" if they utilize the service
- "do not need" if they do not utilize the service
- "need, can't get" to show possible gaps in services
- "can get, won't use" to show barriers in service utilization

The five services most frequently described as "need, can't get", suggesting gaps in services were:

- Housing 33.7% (85)

- Direct Emergency Assistance 32.5% (82)
- Food 32.1% (81)
- Complementary Therapies 27.4% (69)
- Drug Reimbursement (prescriptions) 26.6% (67)

The table to the right displays all responses to the question.

In the Out of Care section of this report, data from respondents who are out of care suggests similar service gaps. When asked what supportive services the respondents who are out of care need in order to enter primary medical care, the most frequently named services included financial services (direct emergency assistance), housing, and food.

Questions 59-88. Please check off how the following services apply to you:
Need and Use, Do not Need, Need/Can't Get, Can Get/Won't Use

Service Category	Gaps (Need, Can't Get) n=252		
	rank	#	percent
Ambulatory/Primary Outpatient Medical Care	25	16	6.3%
Buddy Companion	6	63	25.0%
Case Management	21	27	10.7%
Clinical Trials	13	40	15.9%
Complementary Therapies	4	69	27.4%
Counseling Other	11	48	19.0%
Day and Respite Care	10	52	20.6%
Dental Care Services	7	60	23.8%
Direct Emergency Assistance	2	82	32.5%
Drug Reimbursement	5	67	26.6%
Food Bank/Home Delivered Meals	3	81	32.1%
Health Insurance Continuation	8	54	21.4%
HIV Prevention	20	28	11.1%
Home Health Care Services	12	41	16.3%
Hospice	18	31	12.3%
Housing	1	85	33.7%
Inpatient Hospital Coordination	17	33	13.1%
Laboratory Diagnostic Testing	22	23	9.1%
Legal Services/Permanency	17	33	13.1%
Mental Health	15	35	13.9%
Nurse Care Coordination	18	31	12.3%
Outreach	14	37	14.7%
Peer Advocacy	16	34	13.5%
Specialty Outpatient Medical Services	19	28	11.1%
Substance Abuse Outpatient	23	21	8.3%
Substance Abuse Residential	24	18	7.1%
Translation	19	29	11.5%
Transportation	9	54	21.4%
Treatment Adherence	14	36	14.3%
Vocational Rehabilitation	7	59	23.4%

ii. Service Gap Trends 2000-2007

Needs assessments were conducted in 2000, 2003 and 2007. The tables below contain service gaps data from each respective study. In addition to data analyses for each year's needs assessment, analyses were conducted to identify trends from 2000 through 2007. Service categories used to analyze gaps have varied slightly in the three needs assessments. Therefore, some service categories included in past needs assessments were not included and could not be compared with the service categories in the 2007 needs assessment. For example Spiritual/Religious Counseling was a service that was included in past needs assessments, but was removed from the list of services used in the 2007 needs assessment. The list of service categories in the 2007 data collection instruments, include only the services in the current continuum of care that are prioritized and funded by the CARE Council. In some cases, this has resulted in non consecutive ranking in the tables below.

This section includes data from the 2000, 2003 and 2007 needs assessments regarding services which respondents indicated they "need, can't get". The table below lists the service gaps that *remained fairly consistent* from 2000 through 2007. Services are listed from the highest to lowest rankings of utilization in 2007.

Service Category Gaps that Remained Fairly Consistant	2007 (n=252)			2003 (n=400)		2000 (n=271)	
	rank	#	percent	rank	percent	rank	percent
Housing	1	85	33.7%	1	33.8%	4	31.0%
Direct Emergency Assistance	2	82	32.5%	5	26.3%	2	34.0%
Complementary Therapy	4	69	27.4%	8	22.0%	6	29.0%
Dental Care Services	7	60	23.8%	9	20.0%	12	19.0%
Health Insurance Continuation	8	54	21.4%	7	23.8%	9	22.0%
Transportation	9	54	21.4%	17	13.5%	10	21.0%
Clinical Trials	13	40	15.9%	13	16.5%	16	12.0%
Mental Health	15	35	13.9%	23	10.8%	19	9.0%
Peer Advocacy	16	34	13.5%	15	14.8%	13	17.0%
Case Management	21	27	10.7%	24	10.0%	19	9.0%
Ambulatory/Primary Outpatient Medical Care	25	16	6.3%	26	9.5%	21	6.0%

The following table displays the services gaps that *significantly increased* from 2000 through 2007. Services are listed from the highest to lowest rankings of utilization in 2007.

Service Category Gaps that Significantly Increased	2007 (n=252)			2003 (n=400)		2000 (n=271)	
	rank	#	percent	rank	percent	rank	percent
Food Bank/Home Delivered Meals	3	81	32.1%	3	27.0%	12	19.0%
Drug Reimbursement	5	67	26.6%	20	11.5%	17	11.0%
Buddy Companion	6	63	25.0%	13	16.5%	18	10.0%
Day and Respite Care	10	52	20.6%	22	11.0%	20	8.0%
Counseling	11	48	19.0%	18	12.8%	18	10.0%
Home Health Care Services	12	41	16.3%	29	8.8%	23	4.0%
Hospice	18	31	12.3%	21	11.8%	23	4.0%
Translation	19	29	11.5%	33	6.8%	23	4.0%
Laboratory Diagnostic Testing	22	23	9.1%	31	7.8%	24	2.0%

"Legal Services/Permanency" is the only service category that *significantly decreased* in the percentage of respondents who "need, can't get" that service from 2000 through 2007. The following table displays the percentages of respondents who stated they "need, can't get" legal services from 2000 through 2007.

Service Category Gaps that Significantly Decreased	2007 (n=252)			2003 (n=400)		2000 (n=271)	
	rank	#	percent	rank	percent	rank	percent
Legal Services/Permanency	17	33	13.1%	19	12.3%	11	20.0%

The table below displays all service gap data across the past three needs assessments. The five most highly ranked gaps are highlighted for emphasis.

Gaps by Service Categories across the 2007, 2003, and 2000 Needs Assessments

Service Category	2007 (n=252)			2003 (n=400)		2000 (n=271)	
	rank	#	percent	rank	percent	rank	percent
Ambulatory/Primary Outpatient Medical Care	25	16	6.3%	26	9.5%	21	6.0%
Buddy Companion	6	63	25.0%	13	16.5%	18	10.0%
Case Management	21	27	10.7%	24	10.0%	19	9.0%
Clinical Trials	13	40	15.9%	13	16.5%	16	12.0%
Counseling	11	48	19.0%	18	12.8%	18	10.0%
Complementary Therapy- Acupuncture	not available			16	13.8%	11	20.0%
Complementary Therapy- Massage	4	69	27.4%	8	22.0%	6	29.0%
Day and Respite Care	10	52	20.6%	22	11.0%	20	8.0%
Dental Care Services	7	60	23.8%	9	20.0%	12	19.0%
Direct Emergency Assistance	2	82	32.5%	5	26.3%	2	34.0%
Drug Reimbursement	5	67	26.6%	20	11.5%	17	11.0%
Food Bank/Home Delivered Meals	3	81	32.1%	3	27.0%	12	19.0%
Health Insurance Continuation	8	54	21.4%	7	23.8%	9	22.0%
HIV Prevention	20	28	11.1%	n/a	n/a	22	5.0%
Home Health Care Services	12	41	16.3%	29	8.8%	23	4.0%
Hospice	18	31	12.3%	21	11.8%	23	4.0%
Housing	1	85	33.7%	1	33.8%	4	31.0%
Inpatient Hospital Coordination	17	33	13.1%	n/a	n/a	n/a	n/a
Laboratory Diagnostic Testing	22	23	9.1%	31	7.8%	24	2.0%
Legal Services/Permanency	17	33	13.1%	19	12.3%	11	20.0%
Mental Health	15	35	13.9%	23	10.8%	19	9.0%
Nurse Care Coordination	18	31	12.3%	25	9.8%	n/a	n/a
Outreach	14	37	14.7%	n/a	n/a	n/a	n/a
Peer Advocacy	16	34	13.5%	15	14.8%	13	17.0%
Specialty Outpatient Medical Services	19	28	11.1%	n/a	n/a	n/a	n/a
Substance Abuse Outpatient	23	21	8.3%	28	9.0%	n/a	n/a
Substance Abuse Residential	24	18	7.1%	28	9.0%	n/a	n/a
Translation	19	29	11.5%	33	6.8%	23	4.0%
Transportation	9	54	21.4%	17	13.5%	10	21.0%
Treatment Adherence	14	36	14.3%	n/a	n/a	n/a	n/a
Vocational Rehabilitation	7	59	23.4%	11	17.3%	n/a	n/a

Note: Data in black cells represent the services most frequently mentioned.

iii. Service Gaps Among Special Populations

Haitian Respondent's Service Gaps

Among Haitian respondents who are in care, the most frequently mentioned gaps in services were for drug reimbursement, food, and vocational rehabilitation. Unlike all in care respondents, Haitians in care identified health insurance continuation, treatment

adherence, and vocational rehabilitation more frequently as services they need, but can't get.

Latin/Hispanic Respondent's Service Gaps
Among the Latin/Hispanic respondents who are in care the most frequently identified service gaps include dental care, direct emergency assistance, food, home health care, housing, and transportation.

MSM Respondent's Service Gaps
MSM respondents in care, like all respondents in care, identified complementary therapies and direct emergency assistance as services they need, but cannot get. Buddy companion and dental care were also services that MSM in care respondents said they need but cannot get.

Black Heterosexual Respondent's Service Gaps
Both Black, heterosexual in care respondents and all in care respondents most frequently identified the same leading five service gaps.

WCBA Respondent's Service Gaps
The service gaps identified by WCBA who are in care, were similar to the gaps identified by all in care respondents. The gaps most frequently identified by WCBA in care were in housing, food bank/home delivered meals, direct emergency assistance, and transportation.

Recently Incarcerated Respondent's Service Gaps
Both the recently incarcerated respondents who are in care and all in care respondents most frequently mentioned direct emergency assistance and housing as service gaps. The recently incarcerated respondents also selected mental health therapy and counseling as services that they need but can not get.

Substance Using Women Respondent's Service Gaps
When respondents were asked to identify services they need but can't get, in care female respondents who have used drugs within the past 12 months and all in care respondents most frequently mentioned direct emergency assistance and housing. In addition, in care female respondents who have used drugs within the past 12 months identified transportation as a service gap.

The following table summarizes the most frequently mentioned gaps for all respondents and those of seven special populations.

Survey Questions 59-88. Please check off how the following services apply to you: Need and Use, Do not Need, Need/Can't Get, Can Get/Won't Use

Service Category Gaps	All In Care Respondents n=252			Haitian In Care Respondents n=49			Hispanic/Latin In Care Respondents n=37			MSM In Care Respondents n=52			Heterosexual Black In Care Respondents n=130			WCBA In Care Respondents n=58			Jail/Prison Past 12 mos. In Care Respondents n=22			Substance Using Women In Care Respondents n=12		
	rank	#	%	rank	#	%	rank	#	%	rank	#	%	rank	#	%	rank	#	%	rank	#	%	rank	#	%
Complementary Therapies	4	69	27.4%	4	10	20.4%				1	25	48.1%	5	28	21.5%									
Dental Care Services							1	23	62.2%	4	19	36.5%												
Direct Emergency Assistance	2	83	32.9%	3	11	22.4%	3	21	56.8%	2	22	42.3%	3	30	23.1%	3	18	31.0%	1	14	63.6%	2	6	50.0%
Drug Reimbursement	5	67	26.6%	1	17	34.7%							4	29	22.3%				2	13	59.1%			
Food Bank/Home Delivered Meals	3	81	32.1%	1	17	34.7%	3	21	56.8%				1	40	30.8%	2	20	34.5%						
Health Insurance Continuation				2	12	24.5%																		
Home Health Care Services							4	20	54.1%															
Housing	1	85	33.7%	4	10	20.4%	2	22	59.5%				2	34	26.2%	1	31	53.4%	2	13	59.1%	1	7	58.3%
Transportation							4	20	54.1%							4	16	27.6%				1	7	58.3%
Treatment Adherence				4	10	20.4%																		
Vocational Rehabilitation				1	17	34.7%							4	29	22.3%									
Buddy Companion										3	20	38.5%												
Mental Health																			2	13	59.1%			
Counseling																			1	14	63.6%			

Note: The table above only displays data from the most frequently selected services; the remaining cells are blacked out.

4. Prevention Needs

i. Florida and Palm Beach County's Top Seven HIV Prevention Target Populations

In an effort to maximize the efficiency, effectiveness and allocation of limited HIV prevention resources throughout the state, the PPG (Prevention Planning Group) decided to focus on seven priority populations. This will allow a concentrated statewide focus on the delivery of HIV prevention resources to the communities and target populations most in need of HIV prevention services in each area. The table below displays the State of Florida and Palm Beach County's top seven priority populations for HIV/AIDS prevention. The populations were determined through examination of the HIV case data.

Florida and Palm Beach County's Top Seven Target Populations	
Rank	**Target Populations**
1	HIV Positives
2	Black Heterosexual
3	White MSM
4	Black MSM
5	Hispanic MSM
6	Black IDU
7	Hispanic Heterosexual

ii. HIV Prevention Survey of PLWHAs in Palm Beach County

The following is a summary of the most recent prevention study conducted in Palm Beach County. Over the past several years the EMA has continued to experience reductions in HIV prevention monies while the need for additional prevention programs increases.

The HIV Prevention Survey of PLWHAs in Palm Beach County was conducted in April 2005. Surveys were conducted and data were compiled and analyzed by the Community Planning Partnership (CPP). This section, excerpted from the CPP's report, includes a brief description of the study and highlights of the findings.

In April 2003, the Centers for Disease Control and Prevention (CDC) announced that it was refocusing its HIV prevention efforts to address two nationwide trends, specifically, 1) an increase in behaviors that put people at risk of infection with HIV, and 2) an increase in the number of people diagnosed with syphilis and HIV.

To respond to these challenges, the CDC launched its *Advancing HIV Prevention (AHP) Initiative* which focuses efforts on counseling, testing, and referral for the estimated 180,000 to 280,000 persons who are unaware of their HIV infection as well as prevention services for people living with HIV/AIDS who are already receiving HIV related services.

AHP impacts HIV Prevention Community Planning because all HIV Prevention Community Planning Groups will be required to prioritize HIV-infected persons as its highest priority population for prevention services.

In order to keep its Partnership on the cutting edge of HIV prevention planning and maximize HIV prevention efforts in Palm Beach County, in December 2003, the Community Planning Partnership voted to amend its Prevention Plan to include the goals, objectives, and Procedural Guidance of CDC's CBO Program Announcement 04060 aimed at reducing HIV transmission by:

1. Increasing the proportion of individuals at high risk for HIV infection who receive appropriate prevention services.
2. Reducing barriers to early diagnosis of HIV infection.
3. Increasing the proportion of individuals at high risk for HIV infection who become aware of their serostatus.
4. Increasing access to quality HIV medical care and ongoing prevention services for individuals living with HIV.
5. Addressing high priorities identified by the state of local HIV prevention Community Planning Group (CPG).
6. Complementing HIV prevention activities and interventions supported by state and local health departments.

In response to an ITN issued by the Florida Department of Health, the Partnership (CPP) developed a proposal which would provide information needed to develop programs to meet the AHP strategy of reducing "HIV transmission by increasing access to quality HIV medical care and ongoing prevention services for individuals living with HIV". The Department approved the proposal and this report summarizes the findings of the study. It is hoped that the findings will help the EMA identify the HIV prevention needs of PLWH in Palm Beach County and develop programs and strategies to effectively meet these needs.

The Partnership is comprised of individuals who have knowledge of, or are interested in HIV prevention, and includes members of the affected communities, service providers, and community leaders. Although not formally combined with patient care planning, the Partnership has a close working relationship with Palm Beach County's HIV CARE Council. Treasure Coast Health Council provided planning and staff support for the CPP and the CARE Council and several members of the CPP were also members of the CARE Council and/or one of the CARE Council's many committees. CARE Council members and CPP members have collaborated on the RARE Project and the Special Populations Study of Blacks in Palm Beach County.

In addition to the Lead Chair and Co-Chair, the Executive Committee was comprised of the Secretary, the Regional Minority AIDS Coordinator (RMAC) and the PIR Task Force (which was comprised of the Chairs of the Special Populations Committees). As anticipated, the entire membership, which serves as a "Planning Committee of the Whole" was involved in developing and implementing this project. The Project Workgroup (comprised of the Lead Chair, Co-Chair, and all interested members) provided detailed input to the development and implementation of the Project Outline

(with tasks and timeframes). The Coordinator and Lead Chair (or Co-Chair, depending upon availability) modified the Outline as necessary to accommodate changing conditions, including an extraordinarily active and disruptive hurricane season.

The proposal for this project was developed during a meeting of CPP members on May 11, 2004. All CPP members were invited to participate and those who could not attend were encouraged to submit ideas via email. In light of CDC's commitment to prioritize HIV-infected persons as the highest priority population for prevention services and develop appropriate interventions for them, the Partnership proposed to conduct a study to improve its understanding of HIV prevention with PLWH in Palm Beach County.

The study consisted of 112 "exit interviews" with patients/clients of HIV/AIDS medical care and case management services in Palm Beach County (including the Health Department, Comprehensive AIDS Program (CAP), and Compass). The interviews solicited information related to HIV prevention issues and the sources of information regarding those messages. Also included were standard risk behavior questions.

Some of the planning and implementation highlights include the following:

- Experienced interviewers, including those who received extensive training in data collection through the RARE project and the Special Project of National Significance (SPNS) *Care System Assessment Demonstration Project* being conducted in Palm Beach County, and other qualified individuals were recruited and trained for this study.
- Careful site selection ensured that all areas of the county in which services are provided (i.e. Riviera Beach, West Palm Beach, Belle Glade, and Delray Beach) were equitably represented in the study.
- Interviewers coordinated scheduling with providers to ensure that a pool of informed and willing respondents would be available at specific locations on specific dates within specific time ranges.
- Interviewers were provided with appropriate meeting rooms to ensure client privacy.
- Respondents were identified by interviewers who were stationed at provider locations at predetermined dates and times; or, were recruited by data collectors as they exited their medical or case management appointments.
- The interviews were conducted by trained interviewers in English, Spanish, or Creole as needed.
- Each respondent was provided with a $10.00 gift card upon the completion of his or her interview.
- Staff compiled and analyzed the data and prepared this report of findings to be disseminated to the Partnership for use by the entire community.

It is hoped that the findings from this project will improve HIV prevention community planning by increasing knowledge and understanding of HIV Prevention needs of PLWH another step towards prioritizing PLWH as the highest priority population for prevention services in EMA.

The highlights of findings listed below will work to guide HIV prevention planning for

PLWHA in Palm Beach County.

1. 89% of respondents would prefer to receive prevention information in English, while 5.4% would prefer Spanish, and 5.4% would prefer Creole.

2. The three topics and issues that were most frequently identified as "somewhat important" or "very important" were:

- Protecting yourself from infection with another strain of HI V (somewhat important 1, 0.9%; very important 111, 99.1 %)
- Protecting yourself from infection with another sexually transmitted disease (STD) (very important, 112, 100%)
- Protecting yourself from other infectious diseases (for example, tuberculosis, hepatitis C, etc.) (somewhat important, 2, 1.8%, very important 98.2%)

3. In addition to the three topics mentioned above, respondents indicated interest in a broad range of HIV prevention topics.

4. When respondents were asked about topics related to four specific HIV prevention methods, they indicated that "safer sex" was the most frequently discussed topic followed by "condoms", "abstinence", and "cleaning needles".

5. The three most frequently mentioned people from whom respondents receive and want to receive HIV prevention information were:

- Physician
- Case manager
- Nurse

6. The three most frequently mentioned methods or media by which respondents receive and want to receive HIV prevention information were:

- Individual face-to-face
- Brochures, pamphlets and other written materials
- Magazines

7. 35% of respondents indicated their physician discussed HIV prevention the day of the survey and 33% said their case manager did so.

8. 50% of respondents said they receive HIV prevention information and services from their physician during every visit, compared with only 33% who said they receive such information from their case managers during every visit.

9. Up to 15.2% of respondents reported engaging in some type of risk behavior during the past month; 17% of respondents had engaged in some type of risk behavior during the past six months.

10. Multivariate analyses (e.g., regarding particular populations, providers, prevention topics, etc.) may be conducted in the future depending on available resources.

F. Description of the Current Continuum of Care

The Coordinated Services Network (CSN) is a partnership of state and federal funding sources, planning authorities, medical and social support agencies, and people who are living with HIV/AIDS that provides a continuum of care for persons and families living with HIV Spectrum Disease and AIDS.

The CSN participating providers provide services to qualified individuals and families residing in Palm Beach County, Florida. Services are provided based on the medical and financial condition of the client and affected family members. This philosophy reflects congressional mandates to ensure medically needy individuals who have little or no financial resources with a level of medical care comparable to those with greater financial capacity.

There are four categories of partners in the CSN as follows:

Palm Beach County HIV CARE Council, which is comprised of a balanced number of HIV infected or affected individuals, service providers and community leaders working to identify the needs of HIV infected/affected individuals and families, establish the priorities of those needs, allocate potential funding to meet those needs, and develop a plan for providing services.

Funding Partners, which includes government bodies responsible to administer state or federal funds for implementation of medical and support programs for the HIV infected, listed as follows: PBC Board of County Commissioners, Ryan White Part A; Treasure Coast Health Council, Inc., Ryan White Part B; WPB Board of City Commissioners, Housing Opportunities for Persons With AIDS (HOPWA); Florida Department of Health, General Revenue Funds: Patient Care and Network.

The funding partners agree to develop service definitions for each of the services contracted, issue public Request(s) For Proposals "RFP" soliciting eligible non-profit and governmental agencies to provide the various services detailed in the HIV Comprehensive Plan, negotiate and enter into contracts with agencies selected through the competitive process, monitor the contracts, monitor the providers' ability and provision of services, make payments to the contracted providers for services, monitor distribution and use of services, ensure services are fairly provided across the county, prepare the official grant applications.

Program Support, which provides general supportive planning, management and system-wide support, to develop service standards, monitor service provision for quality improvement, measure effectiveness of the services provided, collect and provide summarized information on the demographic and service information.

CSN Service Providers are entrusted with providing medical and support services.

The overarching goal of the continuum of care is to improve, stabilize and maintain optimum health for persons living with HIV/AIDS. To this end, consumers and providers of HIV/AIDS services have partnered with others in our community to develop a system of care that meets the needs of a wide variety of individuals and families. The system of care operates within the constraints of low or no annual funding increases while serving an increasing population with more complex needs.

Early in the AIDS pandemic, it became clear that HIV infected individuals required more than medical care to make health maintenance effective. HIV generally infects individuals during early adulthood and AIDS often becomes a serious health condition during the most productive period of one's life. Often, HIV infected individuals have young families to support. When the HIV infected individual is the sole support of a family, loss of earning capacity has severe emotional and physical impact on an HIV infected individual, negatively affecting the person's health even more.

HIV and AIDS quickly made its way into the heterosexual community in Palm Beach County. In the earliest days of the AIDS pandemic, this was in contrast to other areas of the United States where HIV was evidenced among homosexuals. What was to become prevalent around the world was evidenced in Palm Beach County when HIV infection was first observed in the early 1980s. HIV was attacking women of childbearing age at alarming rates. A combination of factors caused this phenomenon, but in the early days of the pandemic these factors were not so clear. Fortunately, local Health Department leaders understood the community needed to come together to meet the challenge. Advocacy for treatment and supportive services funding resulted in some of the earliest state-funded assistance to Palm Beach County.

The resulting holistic approach to maintaining health focused on improving or maintaining a higher quality of life over what initially was a relatively short time span. This was based upon a philosophy of making the AIDS patient as comfortable as possible for the time he or she had left. A program of supportive services was developed to assist HIV/AIDS infected individuals in maintaining a medical regimen of often-unproven therapies. That meant providing all of the necessary resources that could effectively keep someone in care. A list of services including housing assistance, transportation assistance, health education, food and nutritional services, medications and other supports such as mental health counseling and case management was developed. Initially, the Florida legislature provided the bulk of the funding for these services, with the Palm Beach County Health Care District providing funds for Case Management, a service that coordinated the overall care plan for individuals. Much later, the federal government responded with both Ryan White and HOPWA funding. These programs expanded the number of persons who could receive these services and added additional resources.

As medical treatment and pharmaceuticals became ever more effective, it also became clear that individuals more often sought supportive services to maintain living conditions and were becoming less concerned about their health because on "the cocktail" they were feeling better, stronger, and were returning to a sense of normalcy. With the introduction

of multiple drug therapies and Protease Inhibitors, many individuals literally were given a new lease on life. Numerous individuals at highly advanced stages of HIV disease have seen remarkable improvement in health status, including restoration of their immune systems to near normal levels. Along with the new pharmaceuticals to slow disease progression, advances in the treatment of related illnesses have made significant progress toward improving overall health.

Suppression of HIV disease progression and battling opportunistic infections with these potent medications bring other medical complications to many. Over the long term, side effects can appear even though the patient initially responded well to the drugs. Combinations that initially worked well for the patient may fail, and/or cause damage to the kidneys, pancreas or other organs. This requires the attending physician to experiment with other combinations until a successful one is found. This often takes months of trial and error. During these periods, the patient often remains medically disabled, requiring the full assistance of the care system.

As stated above, the federal government responded slowly to the pandemic. Underestimating the severity of the disease or the extent it was infecting the population, Congress and the administration in power at the time believed it was the responsibility of individual states to address HIV at a local level. By the late 1980s, it became clear this philosophy was impractical. Congress did respond, and in a very big way. After years of advocating for a national response to AIDS, the Ryan White CARE Act was enacted in 1990. Pouring millions of dollars into the hardest hit regions of the U.S., the federal government quickly became the driving force in HIV/AIDS funding. Requiring that state and local funding resources remain at pre-Ryan White levels, Congress provided an opportunity not only to expand services but to expand the system providing those services.

Five years after enacting the Ryan White CARE Act, Congress acknowledged the necessity to focus on provision of quality services that document effectiveness. In the "Amendments to The CARE Act", enacted in 1996, 2000 and 2006 the Secretary of Health was directed to provide measurement of the program's quality and effectiveness and to develop mechanisms to demonstrate this. Also recognizing a change in the populations affected, the Amendments included additional requirements to ensure services were directed to populations most severely impacted by HIV/AIDS.

In addition, the Congressional Black Caucus and representatives of other racial minorities worked to legislate specific funding for minorities. These requirements challenge communities to demonstrate funding is directed to populations hardest hit by HIV/AIDS and that providers have the same cultural and racial characteristics as the individuals served.

Beginning in 1998, the Palm Beach County HIV CARE Council and Part A grantee sought assistance to effect responsible program management. As a result of the request, the HIV/AIDS Bureau (HAB), which oversees the Ryan White Program at a federal level, provided technical assistance over a twenty-month period. The goal was to assist

the community in addressing the ever-increasing challenges of providing effective health and supportive services to those in need. A core premise of this activity was not only to strengthen the mechanism of delivering care, but also to develop a means to document care delivery and effectiveness. The result of the technical assistance is as follows:

- Development of a better understanding of the responsibilities of each of the partners
- Development of standards of care for all provided services
- Development of minimum eligibility measures
- Development of a management information system
- Development of quality improvement activities

Efforts such as the Management Information System and Quality Improvement activities have brought the community even closer together as partners. Parts A and B conduct a joint RFP process. Joint program monitoring activities across funding sources resulted in a reduction of duplicative program monitoring visits.

A summary of how the system works is as follows:

- Outreach activities that raise public awareness of available HIV and AIDS services available to individuals who document HIV infection
- A wide variety of services are encompassed in the CSN
- The majority of clients enter the CSN through case management agencies. Currently, there are three agencies providing this service at locations across the entire county
- Individuals apply for services

In accordance with the adopted care standards, applicants must be presented with a choice of case management agencies. During the intake process, the interviewer must explain this right, must describe the agencies providing services, provide the client a list of service locations for each agency and ensure that the client signs a form indicating this choice has been explained and offered.

The primary case management agency is responsible for collecting the following information: a denial letters from Medicaid and our local taxing district, Health Care District; proof of HIV infection, AIDS and overall health status; proof of financial need, including federal tax forms, payroll data, social security records, etc.; proof of medical insurance, such as VA, Medicaid, Medicare, or private insurance if applicable; proof of living expenses, including all debt payments, lease or mortgage obligations, utility and child care costs; other appropriate information documenting the financial status of the client and immediate household.

Based upon the medical and psychosocial assessment for services are determined. If a client only needs one or two supportive services, he or she may be referred to the providing agency. If it is apparent the individual requires, and is eligible for, more comprehensive assistance, a care plan is developed and implemented. Depending on need, various levels of assistance are provided under the adopted plan of care. The case manager works with the client, family and service providers to ensure the overall plan of

care is effective. This includes consideration of culturally appropriate services based upon the client's ethnic background. On a regular basis, the plan is reviewed and updated to ensure appropriateness and effectiveness.

During the period of enrollment, case managers closely monitor all aspects of the client's well being. Regular contact is maintained not only with the client, but also with medical providers and providers of the client's support services. Each of the service providers involved in serving the client maintains its own care plan, closely monitoring and revising the plan to afford the most appropriate level of support. Coordination and communication between all parties is maintained through the case manager. Attention is also given to the client's family and living situation, ensuring the client's family is provided appropriate support. All of this attention is focused on maintaining the client's physical and mental health. The case manager tailors the plan of care to the client's needs and ability to independently manage his or her illness. As the client becomes increasingly capable of independently living with HIV, the Case Manager plays a smaller role in the client's situation.

To ensure responsible program management, all service providers are required to re-evaluate the client's medical and financial eligibility at specific intervals. The intervals are indicted in the Standards of Care established for each service. This ensures only the most needy clients receive services, and moves clients toward self-sufficiency as health status improves. Also, this process ensures there are adequate funds to provide the most crucial services to all in need.

As a client's health improves and is stabilized, focus is on providing support to move the client toward a life independent of the HIV/AIDS continuum of care. This includes directing clients toward resources that will enable the client to return to the workforce. Job training or retraining is often appropriate to ensure reasonable employment opportunities. A coordinated plan is developed and implemented to ensure optimum health is maintained and necessary supports remain in place over the long term.

G. Resource Inventory

The resource inventory describes the array of HIV/AIDS services available in the EMA. Due to recent policy changes which limit Ryan White spending on support services to 25% of the total Ryan White services budget, the EMA is in the process of adjusting the system to try to fill support service gaps. It has become a great challenge to maintain a collaborative and coordinated service delivery system.

The Resource Inventory was compiled from responses to the Provider Survey 2007. Similar to the inventory in the Part B grant application, this inventory summarizes information about HIV-related services currently available in Palm Beach County.

Caseload capacity data regarding these services are used for planning purposes by the CARE Council. According to these data, the current system of care is functioning near

full capacity. Current issues of concern related to caseload capacity include the following:

- Except for services provided by the Veterans Administration, all service categories will require the allocation of additional funds in order to increase the number of PLWHA served.
- Case management organizations recently reported waiting lists that continue to increase each week; they informed the CARE Council and the grantee that they would need an increase in funding in order to serve additional PLWHA.
- In accord with federal guidance, additional funds were recently allocated to outreach services. It is expected that this will result in an increase in the number of persons needing services during the current fiscal year.

In addition to the information in the Resource Inventory Table, the CARE Council produces the Redbook which contains a wider array of available services to PLWHA, but does not include capacity and utilization data. The Redbook can be viewed at www.carecouncil.org under Local HIV Services.

Resource Inventory

Contact Information	Service Area	Funding Source	Target Population	Referral Tracking Mechanism
Ambulatory Outpatient Medical Care Capacity: 4,426				
County Health Department Riviera Beach Health Center 7289 Garden Road Riviera Beach 33404 561-803-7360 Mitchell Durant, Ph.D	Central/North Eastern Palm Beach County	Medicaid, Healthcare District, RW Part A, Network, Patient Care, Private Insurance, Medicare	All Populations, Communities of Color, WICY	FACTORS
C.L. Brumback Health Center 38754 St Road 80 Belle Glade 33430 561-803-7360 Mitchell Durant, Ph.D	Western Palm Beach County	Medicaid, Healthcare District, RW Part A, Network, Patient Care, Private Insurance, Medicare	All Populations, Migrant Workers, Communities of Color, WICY	FACTORS
County Health Department West Palm Beach Clinic 1150 45th Street West Palm Beach 33407 561-803-7360 Mitchell Durant, Ph.D	Central/North Eastern Palm Beach County	Medicaid, Healthcare District, RW Part A, Network, Patient Care, Private Insurance, Medicare	All Populations, Migrant Workers, Communities of Color, WICY	FACTORS
County Health Department Delray Beach Health Center 225 South Congress Avenue Delray Beach 33444 561-803-7360 Mitchell Durant, Ph.D	Southern Eastern Palm Beach County	Medicaid, Healthcare District, RW Part A, Network, Patient Care, Private Insurance, Medicare	All Populations, Migrant Workers, Communities of Color, WICY	FACTORS

Kenneth Ness, MD 1411 North Flagler Drive, West Palm Beach 33407 561-655-8388	Central Palm Beach County	RW Part A, Private Insurance	All Populations	Paper Referral
Infectious Disease Consultants 5150 Linton Blvd Delray Beach 33484 561-499-1442	Southern Palm Beach County	RW Part A, Private Insurance	All Populations	Paper Referral
Infectious Disease Associates 2300 South Congress Ave Boynton Beach 33426 561-735-7531	Southern Palm Beach County	RW Part A, Private Insurance	All Populations	Paper Referral
Triple O Medical Services, MD 1515 North Flagler Drive, Ste 220 West Palm Beach 33401 561-832-6770 Olayemi O. Osiyemi	Central Palm Beach County	RW Part A, Private Insurance	All Populations	Paper Referral
Children's Medical Services 5101 Greenwood Ave West Palm Beach 33401 561-881-5040 Paula Dorhout	County-wide	Medicaid, Private Insurance, Health Care District, Kidcare	WICY	not available
VA Medical Center 7305 North Military Trail West Palm Beach 33410 561-422-7522 M. Chris Saslo	County-wide	Veterans Administration	Veterans	VA database
Comprehensive AIDS Program 2330 South Congress Ave. Palm Springs 33406 561-472-2466 Yolette Bonnet	Central Palm Beach County	RW Part A and B, Medicaid, Medicaid Managed Care, Private Insurance, Health Care District, Local funding	All Populations, Haitian, Latin	FACTORS

Case Management Capacity: 4,130				
Comprehensive AIDS Program 2222 W. Atlantic Avenue Delray Beach 33445 561-274-6400 Yolette Bonnet	Southern Palm Beach County	RW Part A and B, Medicaid, Medicaid Managed Care, Private Insurance, Health Care District, Local funding	All Populations, Haitian, Latin	FACTORS
Comprehensive AIDS Program 2001 West Blue Heron Blvd. Riviera Beach 33404 561-844-1266 Yolette Bonnet	Northern Palm Beach County	RW Part A and B, Medicaid, Medicaid Managed Care, Private Insurance, Health Care District, Local funding	All Populations, Haitian, Latin	FACTORS
Comprehensive AIDS Program 25 SE MLK Jr. Blvd. Belle Glade 33430 561-996-7059 Yolette Bonnet	Western Palm Beach County	RW Part A and B, Medicaid, Medicaid Managed Care, Private Insurance, Health Care District, Local funding	All Populations, Haitian, Latin	FACTORS
Comprehensive AIDS Program 2330 South Congress Ave. Palm Springs 33406 561-472-2466 Yolette Bonnet	Central Palm Beach County	RW Part A and B, Medicaid, Medicaid Managed Care, Private Insurance, Health Care District, Local funding	All Populations, Haitian, Latin	FACTORS
Compass 7600 South Dixie Hwy West Palm Beach 33405 561-533-9699 Chris Lacharite	Central Palm Beach County	RW Part A	LGBT, All Populations	FACTORS

County Health Department Riviera Beach Health Center 7289 Garden Road Riviera Beach 33404 561-803-7360 Mitchell Durant, Ph.D	Central/North Eastern Palm Beach County	Medicaid, Healthcare District, RW Part A, Network, Patient Care, Private Insurance, Medicare	All Populations, Migrant Workers, Communities of Color, WICY	FACTORS
County Health Department C.L. Brumback Health Center 38754 St Road 80 Belle Glade 33430 561-803-7360 Mitchell Durant, Ph.D	Western Palm Beach County	Medicaid, Healthcare District, RW Part A, Network, Patient Care, Private Insurance, Medicare	All Populations, Migrant Workers, Communities of Color, WICY	FACTORS
County Health Department West Palm Beach Clinic 1150 45th Street West Palm Beach 33407 561-803-7360 Mitchell Durant, Ph.D	Central/North Eastern Palm Beach County	Medicaid, Healthcare District, RW Part A, Network, Patient Care, Private Insurance, Medicare	All Populations, Migrant Workers, Communities of Color, WICY	FACTORS
County Health Department Delray Beach Health Center 225 South Congress Avenue Delray Beach 33444 561-803-7360 Mitchell Durant, Ph.D	Southern Palm Beach County	Medicaid, Healthcare District, RW Part A, Network, Patient Care, Private Insurance, Medicare	All Populations, Migrant Workers, Communities of Color, WICY	FACTORS
Minority Development and Empowerment, Inc. 3175 South Congress Ave Ste. 301 Palm Springs 33461 561-296-5722 Francois Leconte	County-wide	RW Part A and B	Haitian Population	FACTORS

Positive Healthcare 14000 North Military Trail Ste 104 Delray Beach 33435 561-279-7738 Ron Haberle	County-wide	Medicaid, Medicare	Medipass Recepients	not available
Children's Medical Services 5101 Greenwood Ave West Palm Beach 33401 561-881-5040 Paula Dorhout	County-wide	Medicaid, Private Insurance, Health Care District, Kidcare	WICY	not available
Dental Care Capacity: 2,000				
County Health Department Riviera Beach Health Center 7289 Garden Road Riviera Beach 33404 561-882-3126 Alan Lasch	Central/North Eastern Palm Beach County	Medicaid, Healthcare District, RW Part A, Network, Patient Care, Private Insurance, Medicare	All Populations	FACTORS
County Health Department C.L. Brumback Health Center 38754 St Road 80 Belle Glade 33430 561-996-1625 Alan Lasch	Western Palm Beach County	Medicaid, Healthcare District, RW Part A, Network, Patient Care, Private Insurance, Medicare	All Populations	FACTORS
County Health Department Delray Beach Health Center 225 South Congress Avenue Delray Beach 33444 561-274-3111 Alan Lasch	Southern Palm Beach County	Medicaid, Healthcare District, RW Part A, Network, Patient Care, Private Insurance, Medicare	All Populations	FACTORS

County Health Department West Palm Beach Clinic 1150 45th Street West Palm Beach 33407 561-803-7360 Mitchell Durant, Ph.D	Central Eastern Palm Beach County	Medicaid, Healthcare District, RW Part A, Network, Patient Care, Private Insurance, Medicare	All Populations	FACTORS
Pharmaceutical Capacity: 2,075				
Palm Beach County Health Care District 324 Datura Street, Suite 400 West Palm Beach 33401 561-655-8100 ext. 1202 Jose Rodriquiz	County-wide	RW Part A, Public Funding	All Populations	not available
Children's Medical Services 5101 Greenwood Ave West Palm Beach 33401 561-881-5040 Paula Dorhout	County-wide	Medicaid, Private Insurance, Health Care District, Kidcare	WICY	not available
County Health Department Riviera Beach Health Center 7289 Garden Road Riviera Beach 33404 561-803-7360 Mitchell Durant, Ph.D	Central/North Eastern Palm Beach County	Medicaid, Healthcare District, RW Part A, Network, Patient Care, Private Insurance, Medicare	All Populations	FACTORS
County Health Department C.L. Brumback Health Center 38754 St Road 80 Belle Glade 33430 561-803-7360 Mitchell Durant, Ph.D	Western Palm Beach County	Medicaid, Healthcare District, RW Part A, Network, Patient Care, Private Insurance, Medicare	All Populations	FACTORS

County Health Department Delray Beach Health Center 225 South Congress Avenue Delray Beach 33444 561-803-7360 Mitchell Durant, Ph.D	Southern Palm Beach County	Medicaid, Healthcare District, RW Part A, Network, Patient Care, Private Insurance, Medicare	All Populations	FACTORS
County Health Department West Palm Beach Clinic 1150 45th Street West Palm Beach 33407 561-803-7360 Mitchell Durant, Ph.D	Central Eastern Palm Beach County	Medicaid, Healthcare District, RW Part A, Network, Patient Care, Private Insurance, Medicare	All Populations	FACTORS
Mental Health Treatment Capacity: 624				
Comprehensive AIDS Program 2222 W. Atlantic Avenue Delray Beach 33445 561-274-6400 Yolette Bonnet	Southern Palm Beach County	RW Part A and B, Medicaid, Medicaid Managed Care, Private Insurance, Health Care District, Local funding	All Populations, Haitian, Latin	FACTORS
Comprehensive AIDS Program 2001 West Blue Heron Blvd. Riviera Beach 33404 561-844-1266 Yolette Bonnet	Northern Palm Beach County	RW Part A and B, Medicaid, Medicaid Managed Care, Private Insurance, Health Care District, Local funding	All Populations, Haitian, Latin	FACTORS
Comprehensive AIDS Program 25 SE MLK Jr. Blvd. Belle Glade 33430 561-996-7059 Yolette Bonnet	Western Palm Beach County	RW Part A and B, Medicaid, Medicaid Managed Care, Private Insurance, Health Care District, Local funding	All Populations, Haitian, Latin	FACTORS

Comprehensive AIDS Program 2330 South Congress Ave. Palm Springs 33406 561-472-2466 Yolette Bonnet	Central Palm Beach County	RW Part A and B, Medicaid, Medicaid Managed Care, Private Insurance, Health Care District, Local funding	All Populations, Haitian, Latin	FACTORS
Compass 7600 South Dixie Hwy West Palm Beach 33405 561-533-9699 Chris Lacharite	Central Palm Beach County	RW Part A	LGBT, All Populations	FACTORS
County Health Department Riviera Beach Health Center 7289 Garden Road Riviera Beach 33404 561-803-7360 Mitchell Durant, Ph.D	Central/North Eastern Palm Beach County	Medicaid, Healthcare District, RW Part A, Network, Patient Care, Private Insurance, Medicare	All Populations	FACTORS
County Health Department C.L. Brumback Health Center 38754 St Road 80 Belle Glade 33430 561-803-7360 Mitchell Durant, Ph.D	Western Palm Beach County	Medicaid, Healthcare District, RW Part A, Network, Patient Care, Private Insurance, Medicare	All Populations	FACTORS
County Health Department West Palm Beach Clinic 1150 45th Street West Palm Beach 33407 561-803-7360 Mitchell Durant, Ph.D	Central Palm Beach County	Medicaid, Healthcare District, RW Part A, Network, Patient Care, Private Insurance, Medicare	All Populations	FACTORS

County Health Department Delray Beach Health Center 225 South Congress Avenue Delray Beach 33444 561-803-7360 Mitchell Durant, Ph.D	Southern Palm Beach County	Medicaid, Healthcare District, RW Part A, Network, Patient Care, Private Insurance, Medicare	All Populations	FACTORS
Oakwood Center of the Palm Beaches, Inc 406/408 SE MLK Jr. Belle Glade 33430 561-383-5736 Pat Priola	All Palm Beach County	RW Part A, Medicaid, Private Funding	All Populations	Paper Referral
United Deliverance Community Resource Center, Inc. 821 Grant St West Palm Beach 33407 561-659-7988 Sandra White	Central Palm Beach County	CDC, Private Funding	All Populations	Paper Referral
Substance Abuse Treatment Outpatient Capacity: 30				
Gratitude House 1700 N. Dixie Highway West Palm Beach 33407 (561) 833-6826 Gail Dempsey	All Palm Beach County	RW Part A	WICY	Paper Referral
Substance Abuse Treatment Residential Capacity: 8				
Gratitude House 1700 N. Dixie Highway West Palm Beach 33407 (561) 833-6826 Gail Dempsey	All Palm Beach County	RW Part A	WICY	Paper Referral

Health Insurance Capacity: 30				
Comprehensive AIDS Program 2330 South Congress Ave. Palm Springs 33406 561-472-2466 Yolette Bonnet	Central Palm Beach County	RW Part A, Private Funding	All Populations, Haitian, Latin	FACTORS
Outreach Capacity: 945				
Positive Healthcare 14000 North Military Trail Ste 104 Delray Beach 33435 561-279-7738 Ron Haberle	County-wide	Medicaid, Medicare	Medipass Recepients	not available
Minority Development and Empowerment, Inc. 3175 South Congress Ave Ste. 301 Palm Springs 33461 561-296-5722 Francois Leconte	County-wide	RW Part A and B	Haitian Population	FACTORS
Treatment Adherence Capacity: 520				
Comprehensive AIDS Program 2330 South Congress Ave. Palm Springs 33406 561-472-2466 Yolette Bonnet	Central Palm Beach County	RW Part A	All Populations, Haitian, Latin	FACTORS
County Health Department Riviera Beach Health Center 7289 Garden Road Riviera Beach 33404 561-803-7360 Mitchell Durant, Ph.D	Central/North Eastern Palm Beach County	Medicaid, Healthcare District, RW Part A, Network, Patient Care, Private Insurance, Medicare	All Populations, Migrant Workers, Communities of Color, WICY	FACTORS

County Health Department Delray Beach Health Center 225 South Congress Avenue Delray Beach 33444 561-803-7360 Mitchell Durant, Ph.D	Southern Palm Beach County	Medicaid, Healthcare District, RW Part A, Network, Patient Care, Private Insurance, Medicare	All Populations	FACTORS
Emergency Financial Assistance	**Capacity: 374**			
Comprehensive AIDS Program 2222 W. Atlantic Avenue Delray Beach 33445 561-274-6400 Yolette Bonnet	Southern Palm Beach County	RW Part A, Medicaid, Medicaid Managed Care, Private Insurance, Health Care District, Local funding	All Populations, Haitian, Latin	FACTORS
Comprehensive AIDS Program 2001 West Blue Heron Blvd. Riviera Beach 33404 561-844-1266 Yolette Bonnet	Northern Palm Beach County	RW Part A, Medicaid, Medicaid Managed Care, Private Insurance, Health Care District, Local funding	All Populations, Haitian, Latin	FACTORS
Comprehensive AIDS Program 25 SE MLK Jr. Blvd. Belle Glade 33430 561-996-7059 Yolette Bonnet	Western Palm Beach County	RW Part A, Medicaid, Medicaid Managed Care, Private Insurance, Health Care District, Local funding	All Populations, Haitian, Latin	FACTORS
Comprehensive AIDS Program 2330 South Congress Ave. Palm Springs 33406 561-472-2466 Yolette Bonnet	Central Palm Beach County	RW Part A, Medicaid, Medicaid Managed Care, Private Insurance, Health Care District, Local funding	All Populations, Haitian, Latin	FACTORS

Compass 7600 South Dixie Hwy West Palm Beach 33405 561-533-9699 Chris Lacharite	Central Palm Beach County	RW Part A	LGBT, All Populations	FACTORS
Food Services Capacity: 1,415				
Comprehensive AIDS Program 2222 W. Atlantic Avenue Delray Beach 33445 561-274-6400 Yolette Bonnet	Southern Palm Beach County	RW Part A, Medicaid, Medicaid Managed Care, Private Insurance, Health Care District, Local funding	All Populations, Haitian, Latin	FACTORS
Comprehensive AIDS Program 2001 West Blue Heron Blvd. Riviera Beach 33404 561-844-1266 Yolette Bonnet	Northern Palm Beach County	RW Part A, Medicaid, Medicaid Managed Care, Private Insurance, Health Care District, Local funding	All Populations, Haitian, Latin	FACTORS
Comprehensive AIDS Program 25 SE MLK Jr. Blvd. Belle Glade 33430 561-996-7059 Yolette Bonnet	Western Palm Beach County	RW Part A, Medicaid, Medicaid Managed Care, Private Insurance, Health Care District, Local funding	All Populations, Haitian, Latin	FACTORS
Comprehensive AIDS Program 2330 South Congress Ave. Palm Springs 33406 561-472-2466 Yolette Bonnet	Central Palm Beach County	RW Part A, Medicaid, Medicaid Managed Care, Private Insurance, Health Care District, Local funding	All Populations, Haitian, Latin	FACTORS

Compass 7600 South Dixie Hwy West Palm Beach 33405 561-533-9699 Chris Lacharite	Central Palm Beach County	RW Part A	LGBT, All Populations	FACTORS
Legal Services Capacity: 386				
Legal Aid Society of Palm Beach County 423 Fern Street Ste 200 West Palm Beach 33401 561-655-8944 David Begley	County-wide	RW Part A	All Populations	FACTORS
Transportation Capacity: 878				
Comprehensive AIDS Program 2222 W. Atlantic Avenue Delray Beach 33445 561-274-6400 Yolette Bonnet	Southern Palm Beach County	RW Part A, Medicaid, Medicaid Managed Care, Private Insurance, Health Care District, Local funding	All Populations, Haitian, Latin	FACTORS
Comprehensive AIDS Program 2001 West Blue Heron Blvd. Riviera Beach 33404 561-844-1266 Yolette Bonnet	Northern Palm Beach County	RW Part A, Medicaid, Medicaid Managed Care, Private Insurance, Health Care District, Local funding	All Populations, Haitian, Latin	FACTORS
Comprehensive AIDS Program 25 SE MLK Jr. Blvd. Belle Glade 33430 561-996-7059 Yolette Bonnet	Western Palm Beach County	RW Part A, Medicaid, Medicaid Managed Care, Private Insurance, Health Care District, Local funding	All Populations, Haitian, Latin	FACTORS

Comprehensive AIDS Program 2330 South Congress Ave. Palm Springs 33406 561-472-2466 Yolette Bonnet	Central Palm Beach County	RW Part A, Medicaid, Medicaid Managed Care, Private Insurance, Health Care District, Local funding	All Populations, Haitian, Latin	FACTORS
Compass 7600 South Dixie Hwy West Palm Beach 33405 561-533-9699 Chris Lacharite	Central Palm Beach County	RW Part A	LGBT, All Populations	FACTORS
Home Healthcare Capacity: 47				
Comprehensive AIDS Program 2330 South Congress Ave. Palm Springs 33406 561-472-2466 Yolette Bonnet	Central Palm Beach County	RW Part A, Medicaid, Medicaid Managed Care, Private Insurance, Health Care District, Local funding	All Populations, Haitian, Latin	FACTORS
Florida Housing Corporation 534 Datura Street West Palm Beach 33401 561-659-9330 Susan Boone	Eastern/Central Palm Beach County	RW Part A	All Populations	FACTORS
Housing Capacity: 267				
Comprehensive Community Care Network, Inc. 2330 South Congress Ave. Palm Springs 33406 561-472-2466 Yolette Bonnet	County-wide	HOPWA	All Populations	FACTORS

Florida Housing Corporation 534 Datura Street West Palm Beach 33401 561-659-9330 Susan Boone	Eastern/Central Palm Beach County	HOPWA	All Populations	FACTORS
Gratitude House 1700 N. Dixie Highway West Palm Beach 33407 (561) 833-6826 Gail Dempsey	Eastern/Central Palm Beach County	HOPWA	All Populations	Paper Referral
Oakwood Center of the Palm Beaches, Inc 406/408 SE MLK Jr. Belle Glade 33430 561-383-5736 Pat Priola	Eastern/Central Palm Beach County	HOPWA	All Populations	Paper Referral
The Children's Place at Home Safe 2309 Ponce de Leon Ave. West Palm Beach, FL 33407 561-832-6185	Eastern/Central Palm Beach County	HOPWA	All Populations	Paper Referral

H. Profile for the Ryan White CARE Act Funded Providers by Service Category

1. RDR 2007

The RDR report provides the Chief Elected Official and HRSA with unduplicated client data from each individual service provider, but duplicated across providers, i.e. the report does not specify how many different providers served a particular client. The report does demonstrate that the demographic profile of clients served (i.e. gender, race/ethnicity, and age) which is similar to that of PLWHA in Palm Beach County.

2007 RDR REPORT											
PROVIDER	**Compass**	**CAP**	**Florida Housing Corp**	**Gratitude House**	**Legal Aid Society**	**Minority Development**	**Oakwood Center**	**PBC Health Dept**	**PBC Healthcare District**	**TCHC**	**Total**
GENDER											
Male	286	1060	39	2	244	239		1228	614	341	4053
Female	113	913	13	45	177	151	4	915	443	358	3132
Transgender						1					1
Unknown/unreported											
AGE											
Under 2 years				3				7			10
2-12 years		12			1	1		10	5	1	30
13-24 years	9	56		4	7	8		62	16	16	178
25-44 years	201	740	24	26	140	174	4	859	495	298	2961
45-64 years	184	1072	28	14	258	208		1100	517	362	3743
65 years or older	5	93			15			105	24	22	264
Unknown/unreported											
RACE/ETHNICITY											
White (not Hispanic)	201	429	13	18	164	32		360	188	248	1653
Black or African American	128	1270	35	25	237	223	4	1479	430	339	4170
(not Hispanic)											
Hispanic or Latino(a)	56	248	4	3	10	124		274	31	108	858
Asian	4	4			1			5		4	18
Native Hawaiian or Other	1							2			3
Pacific Islander											
American Indian or		4			2				1		7
Alaska Natice											
More than one race	9	18		1				18	1		47
Unknown/unreported					7	12		5	406		430

PROVIDER	Compass	CAP	Florida Housing Corp	Gratitude House	Legal Aid Society	Minority Development	Oakwood Center	PBC Health Dept	PBC Healthcare District	TCHC	Total
SERVICES PROVIDED/CLIENTS SERVED											
CORE SERVICES											
Outpatient/ambulatory medical care		33						1898			1931
AIDS Pharmaceutical Assistance (local)				3							3
Oral health care								738			738
Early intervention services (Parts A and B)											
Health Insurance Premium & Cost Sharing Assistance											
Home health care		53									53
Home and community-based health services			12								12
Hospice services											
Mental health services	101	108		44		26					279
Medical nutrition therapy											
Medical case mgmt (including treatment adherence)	387	1838								519	2744
Substance abuse services-outpatient				24							24

PROVIDER	Compass	CAP	Florida Housing Corp	Gratitude House	Legal Aid Society	Minority Development	Oakwood Center	PBC Health Dept	PBC Healthcare District	TCHC	Total
SUPPORT SERVICES											
Case mgmt (non-medical)				44		241				172	457
Child care services											
Pediatric dev. Assessment/early intervention services											
Emergency financial assistance	35	232									267
Food bank/home-delivered meals	137	763									900
Health education/risk reduction						76					76
Housing services		334	52								386
Legal services					421						421
Linguistics services						40					40
Medical transportation services	70	560									630
Outreach services		160		44		76					280
Permanency planning											
Psychosocial support services				44							44
Referral for health care/supportive services				22		76					98
Rehabilitation services											
Respite care											
Substance abuse services-residential		22		20			4			8	54
Treatment adherence counseling				44		48					92
	730	4103	64	289	421	583	4	2636	0	699	9529

2. Ryan White Providers including the Services Provided

The service locations in the table below include all Part A and B funded services, as well as State General Revenue funded services. Following the table each provider is marked on the following GIS maps. The Healthcare District provides pharmaceuticals at their four pharmacy locations, shown on the map. In addition, the Healthcare District Network includes all Walgreen, Wal-Mart, Albertson, Kmart, CVS, Publics and Winn Dixie locations which are not identified on the map. Only the most frequently utilized specialty medical service facilities are included in the table and are marked on the map as well.

Organization	Location of Service Provision	Address of Service Provision	ZIP Code	Service/s Provided
COMPASS, Inc.	COMPASS, Inc.	7600 South Dixie Hwy., West Palm Beach	33405	Case Management, Transportation, Food Vouchers, Direct Emergency Assistance
COMPASS, Inc.	CHD Riviera Beach Health Center	7289 Garden Road, Riviera Beach	33404	Case Management, Transportation, Food Vouchers, Direct Emergency Assistance
COMPASS, Inc.	CHD Delray Beach Health Center	225 Congress Ave, Delray Beach	33462	Case Management, Transportation, Food Vouchers, Direct Emergency Assistance
CAP/CCCnet, Inc.	CAP/CCCnet, Inc.	25 SE Martin Luther King Blvd., Belle Glade	33430	Case Management and access to all services
CAP/CCCnet, Inc.	CAP/CCCnet, Inc.	2222 W. Atlantic Ave, Delray Beach	33445	Case Management and access to all services
CAP/CCCnet, Inc.	CAP/CCCnet, Inc.	2001 W. Blue Heron, Riviera Beach	33404	Case Management and access to all services
CAP/CCCnet, Inc.	CAP/CCCnet, Inc.	2330 South Congress Blvd. Palm Springs	33406	Case Management and access to all services
CAP/CCCnet, Inc.	Lakeside Quality Home Health Care	485 W. Main Street, Pahokee	33476	Home Health
CAP/CCCnet, Inc.	Vital Home Care of Fla, Inc.	5700 Lake Worth Rd #209-6, Lake Worth	33461	Home Health
CAP/CCCnet, Inc.	Caring for Seniors	1964 S Congress Ave, West Palm Beach	33406	Home Health
CAP/CCCnet, Inc.	Eastcare Services, Inc.	268 Swain Blvd, Greenacres	33463	Home Health
CAP/CCCnet, Inc.	Multilingual Psychotherapy Centers	1609 Forum Place #7, West Palm Beach	33401	Mental Health
CAP/CCCnet, Inc.	Banyan Institute	11388 Okeechobee Blvd, Royal Palm Beach	33411	Mental Health
CAP/CCCnet, Inc.	CARE, Inc.	321 Northlake Blvd #102, North Palm Beach	33408	Residential Substance Abuse Treatment

Organization	Location of Service Provision	Address of Service Provision	ZIP Code	Service/s Provided
CAP/CCCnet, Inc.	Comprehensive Alcohol Rehabilitation Program	PO Box 2507, West Palm Beach	33402	Residential Substance Abuse Treatment
CAP/CCCnet, Inc.	Drug Abuse Foundation	400 S Swinton Ave, Delray Beach	33444	Residential Substance Abuse Treatment
Florida Housing Corporation	Florida Housing Corporation	534 Datura St. West Palm Beach	33401	Home Health Care
Gratitude Guild	Gratitude Guild	1700 North Dixie Hwy West Palm Beach	33407	Substance Abuse Residential and Outpatient
Health Care District of Palm Beach County	CHD Riviera Beach Health Center	7289 Garden Road, Riviera Beach	33404	Prescriptions/Nutritional Supplements
Health Care District of Palm Beach County	CHD West Palm Beach Clinic	1150 45th Street, West Palm Beach	33407	Prescriptions/Nutritional Supplements
Health Care District of Palm Beach County	CHD CL Brumback Health Center	38754 State Road 80, Belle Glade	33430	Prescriptions/Nutritional Supplements
Health Care District of Palm Beach County	CHD Delray Beach Center/Annex	225 South Congress Ave, Delray Beach	33462	Prescriptions/Nutritional Supplements
Legal Aid Society of Palm Beach County, Inc.	Legal Aid Society of Palm Beach County, Inc.	423 Fern St., Ste 200, West Palm Beach	33401	Permanency Planning/Legal Services
Legal Aid Society of Palm Beach County, Inc.	CAP/CCCnet, Inc.	25 SE Martin Luther King Blvd., Belle Glade	33430	Permanency Planning/Legal Services
Legal Aid Society of Palm Beach County, Inc.	CAP/CCCnet, Inc.	2222 W. Atlantic Ave, Delray Beach	33445	Permanency Planning/Legal Services
Minority Development and Empowerment, Inc.	Minority Development and Empowerment, Inc.	3175 South Congress Ave. Suite 301, Palm Springs	33461	Case Management, Outreach

Organization	Location of Service Provision	Address of Service Provision	ZIP Code	Service/s Provided	
Oakwood Center of the Palm Beaches, Inc.	PANDA	816/824 NW Ave. D, Belle Glade	33430	Substance Abuse Residential and Outpatient	
Oakwood Center of the Palm Beaches, Inc.	Oakwood Center of the Palm Beaches, Inc.	406/408 SE MLK Jr. Blvd, Belle Glade	33430	Mental Health Therapy	
Palm Beach County Health Department	CHD Riviera Beach Health Center	7289 Garden Road, Riviera Beach	33404	Primary Ambulatory Outpatient Medical Care, Nurse Care Coordination, Dental, Treatment Adherence, Mental Health, Case Management, ADAP, Nutrition Counseling, Specialty Medical (Psychiatry & OBGYN), Lab/Diagnostic	
Palm Beach County Health Department	CHD Delray Beach Health Center/Annex	225 South Congress Ave, Delray Beach	33462	Primary Ambulatory Outpatient Medical Care, Nurse Care Coordination, Dental, Treatment Adherence, Mental Health, Case Management, ADAP, Nutrition Counseling, Specialty Medical (OBGYN), Lab/Diagnostic	
Palm Beach County Health Department	CHD CL Brumback (Belle Glade) Health Center	38754 State Road 80, Belle Glade	33430	Primary Ambulatory Outpatient Medical Care, Nurse Care Coordination, Dental, Mental Health, Case Management, ADAP, Nutrition Counseling, Specialty Medical (OBGYN), Lab/Diagnostic	
Palm Beach County Health Department	West Palm Beach Health Center	1150 45th Street, West Palm Beach	33407	Primary Ambulatory Outpatient Medical Care, Nurse Care Coordination, Dental, Mental Health, Case Management, Nutrition Counseling, Specialty Medical (OBGYN), Lab/Diagnostic	
Treasure Coast Health Council	Infectious Disease Consultants	5150 Linton Blvd. Ste. 230, Delray Beach	33484	Primary Ambulatory Outpatient Medical Care, Lab/Diagnostic	
Treasure Coast Health Council	Infectious Disease Consultants	2300 Congress Ave, Boynton Beach	33426	Primary Ambulatory Outpatient Medical Care, Lab/Diagnostic	
Treasure Coast Health Council	Triple O Medical Services	1515 N. Flagler Dr. Ste 220, West Palm Beach	33401	Primary Ambulatory Outpatient Medical Care, Lab/Diagnostic	
Treasure Coast Health Council	Kenneth Ness, M.D.	1411 North Flagler Dr., West Palm Beach	33407	Primary Ambulatory Outpatient Medical Care, Lab/Diagnostic	
Treasure Coast Health Council	JFK Memorial Hospital	7301 S. Congress Avenue Atlantis	33462	Specialty Outpatient Medical Care	Hospital
Treasure Coast Health Council	Allen H Bezner, M.D.	200 Knuth Road #200 Boynton Beach	33436	Specialty Outpatient Medical Care	Neurology & Psychology

Organization	Location of Service Provision	Address of Service Provision	ZIP Code	Service/s Provided	Organization
Treasure Coast Health Council	Bethesda Memorial Hospital, INC	3800 S Congress Ave #7 Boynton Beach	33437	Specialty Outpatient Medical Care	Hospital
Treasure Coast Health Council	Mark Paris, MD	7499 San Clemente Place Boca Raton	33433	Specialty Outpatient Medical Care	Ophthalmology
Treasure Coast Health Council	Cauvin Frett Psychiatry LLC	8177 Glades Road suite #204 Boca Raton	33434	Specialty Outpatient Medical Care	Psychiatry
Treasure Coast Health Council	J David Crowell, MD	170 So Barfield Highway Pahokee	33476	Specialty Outpatient Medical Care	Ophthalmology
Treasure Coast Health Council	Dennis Feinrider, MD	6801 Lake Worth Road #219 Lake Worth	33467	Specialty Outpatient Medical Care	Neurology
Treasure Coast Health Council	Glades General Hospital	1201 S Main Street Belle Glade	33430	Specialty Outpatient Medical Care	Hospital
Treasure Coast Health Council	Glenn Englander, MD	1411 N Flagler Dr. # 8700 West Palm Beach	33407	Specialty Outpatient Medical Care	Gastroenterology
Treasure Coast Health Council	Good Samaritan Hospital	1309 Flagler Drive West Palm Beach	33407	Specialty Outpatient Medical Care	Hospital
Treasure Coast Health Council	Hematology Oncology Associates	4685 S. Congress Ave #200 Lake Worth	33461	Specialty Outpatient Medical Care	Hematology/Oncology
Treasure Coast Health Council	Palm Beach Neurology	1200 S. Main St. Belle Glade	33430	Specialty Outpatient Medical Care	Neurology
Treasure Coast Health Council	Pulmonary Specialists of Palm Beach	13005 Southern Blvd, #235 Loxahatchee	33470	Specialty Outpatient Medical Care	Pulmonary
Treasure Coast Health Council	Raymond Henderson, MD	1717 N Flagler Dr # 3 West Palm Beach	33407	Specialty Outpatient Medical Care	Surgeon – General
Treasure Coast Health Council	St Mary's Hospital	901 - 45th Street West Palm Beach	33407	Specialty Outpatient Medical Care	Hospital
Treasure Coast Health Council	Thomas E Lipin, MD	210 Jupiter Lakes Blvd Building 3000 #202 Jupiter	33458	Specialty Outpatient Medical Care	Surgeon – ENT
Treasure Coast Health Council	Urology Ctr of Florida	1325 S Congress Avenue #111 Boynton Beach	33426	Specialty Outpatient Medical Care	Urology
Treasure Coast Health Council	Visual Health Center	2889 10th Avenue North Lake Worth	33461	Specialty Outpatient Medical Care	Ophthalmology

Organization	Location of Service Provision	Address of Service Provision	ZIP Code	Service/s Provided	Organization
Treasure Coast Health Council	William Gogan, MD	701 Northlake Blvd #208 N Palm Beach	33408	Specialty Outpatient Medical Care	Orthopedic
Treasure Coast Health Council	Waters Edge Dermatology	600 Village Square Crossings Palm Beach Gardens	33410	Specialty Outpatient Medical Care	Dermatology
Treasure Coast Health Council	Cardiology Partner - BG Ste. #102	12953 Palms West Dr Ste # 102 Loxahachee	33470	Specialty Outpatient Medical Care	Cardiology
Treasure Coast Health Council	Cardiology Partner - BG	1200 S Main St Belle Glade	33430	Specialty Outpatient Medical Care	Cardiology
Treasure Coast Health Council	Berto Lopez MD, PA	1501 Presidential Way #21 West Palm Beach	33401	Specialty Outpatient Medical Care	Gynecology
Treasure Coast Health Council	Palm Beach Gastro Consultants	1157 South State Rd. #7 Wellington	33414	Specialty Outpatient Medical Care	Gastroenterology
Treasure Coast Health Council	Catherine Lowe, MD	11380 Prosperity Farms Road, # 112-C Palm Beach Gardens	33410	Specialty Outpatient Medical Care	Ophthalmology
Treasure Coast Health Council	South Florida Gastroenterology Associates	5210 Linton Blvd #102 Delray Beach	33484	Specialty Outpatient Medical Care	Gastroenterology
Treasure Coast Health Council	Essie Tarr, ARNP, MSBC,CHT	7681 1ST Terrace Lake Worth	33463	Specialty Outpatient Medical Care	Psychotherapy
Treasure Coast Health Council	Sam F Wanis, DO	2925 10TH Ave N # 204 Lake Worth	33461	Specialty Outpatient Medical Care	Gynecology

3. Comparison of Service Locations with ZIP Codes of PLWHA

A comparison of service locations with ZIP Codes of PLWHA demonstrates that most medical and support services are available in the most heavily impacted ZIP Codes. In addition, routes of the public transportation system, Palm Tran, connects residents of most ZIP Codes with all service locations including case management and public health clinics.

ZIP Code data in the table to the right and on the maps in this section were provided by the Florida Department of Health (DOH), Bureau of HIV/AIDS with the following stipulation:

> "Department of Health (DOH) workers who release aggregate HIV/AIDS data outside the Department must comply with the policy of suppressing all non-zero tabulated cells for zip code data with <3 cases (i.e., all cells containing only 1 or 2 cases). All marginal totals shown in table form should routinely be inspected to ensure that values of internal cells expressed as <3 cannot be exactly determined. Consolidation with other data subgroups may be necessary to avoid such disclosure. ZIP Code areas are subject to geographic expansion or other changes over time. The ZIP Codes of residence at time of diagnosis may not correspond to the PLWHA's current ZIP Code."

All cells with <3, unless otherwise noted were counted as one.

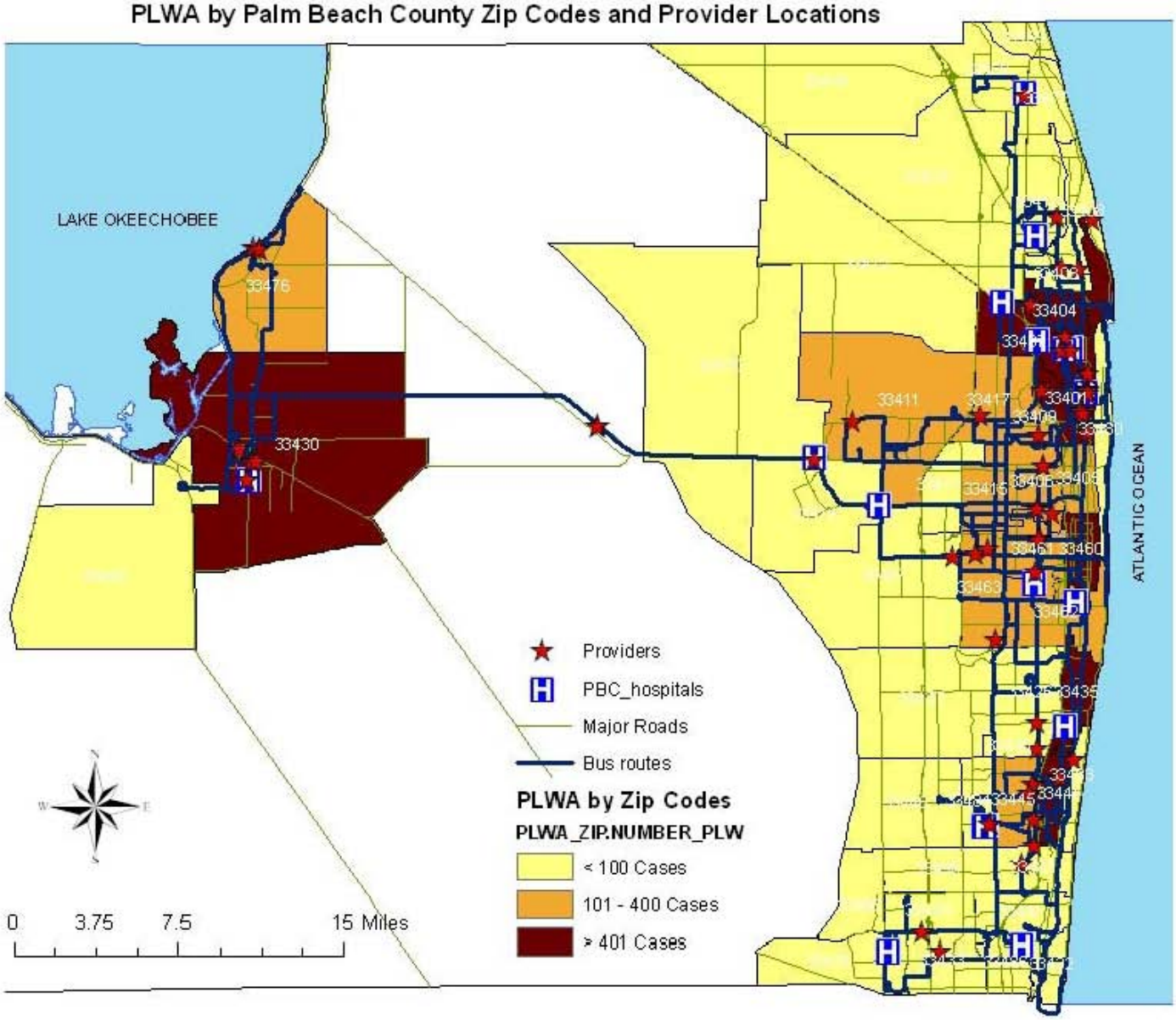
The following maps do not reflect the count of homeless PLWHA in the EMA.

Presumed Living HIV/AIDS Cases in Palm Beach County, excl Department of Corrections, through 2005

ZIP Code	Number of PLWHA		ZIP Code	Number of PLWHA
homeless	28		33440	2
33401	500		33441	1
33402	14		33442	2
33403	85		33444	732
33404	590		33445	126
33405	129		33446	11
33406	112		33447	4
33407	690		33448	1
33408	33		33449	1
33409	156		33454	1
33410	61		33455	1
33411	129		33458	66
33412	11		33459	3
33413	23		33460	472
33414	47		33461	144
33415	160		33462	143
33416	16		33463	150
33417	130		33464	2
33418	25		33465	2
33419	3		33466	3
33420	2		33467	36
33421	2		33468	4
33422	1		33469	12
33424	3		33470	38
33425	2		33476	133
33426	41		33477	8
33427	3		33478	7
33428	73		33480	23
33429	2		33481	1
33430	638		33482	3
33431	50		33483	56
33432	62		33484	18
33433	56		33486	60
33434	28		33487	35
33435	415		33489	1
33436	79		33493	51
33437	35		33496	18
33438	8		33498	2
33439	1		33784	1
			Total	6817

Note: The shaded cells in the table above indicate zip codes that are post office boxes.

PLWA by Palm Beach County Zip Codes and Provider Locations



Presumed HIV/AIDS cases excludes DOH through 2005

Data presented complies with Bureau of HIV/AIDS policy

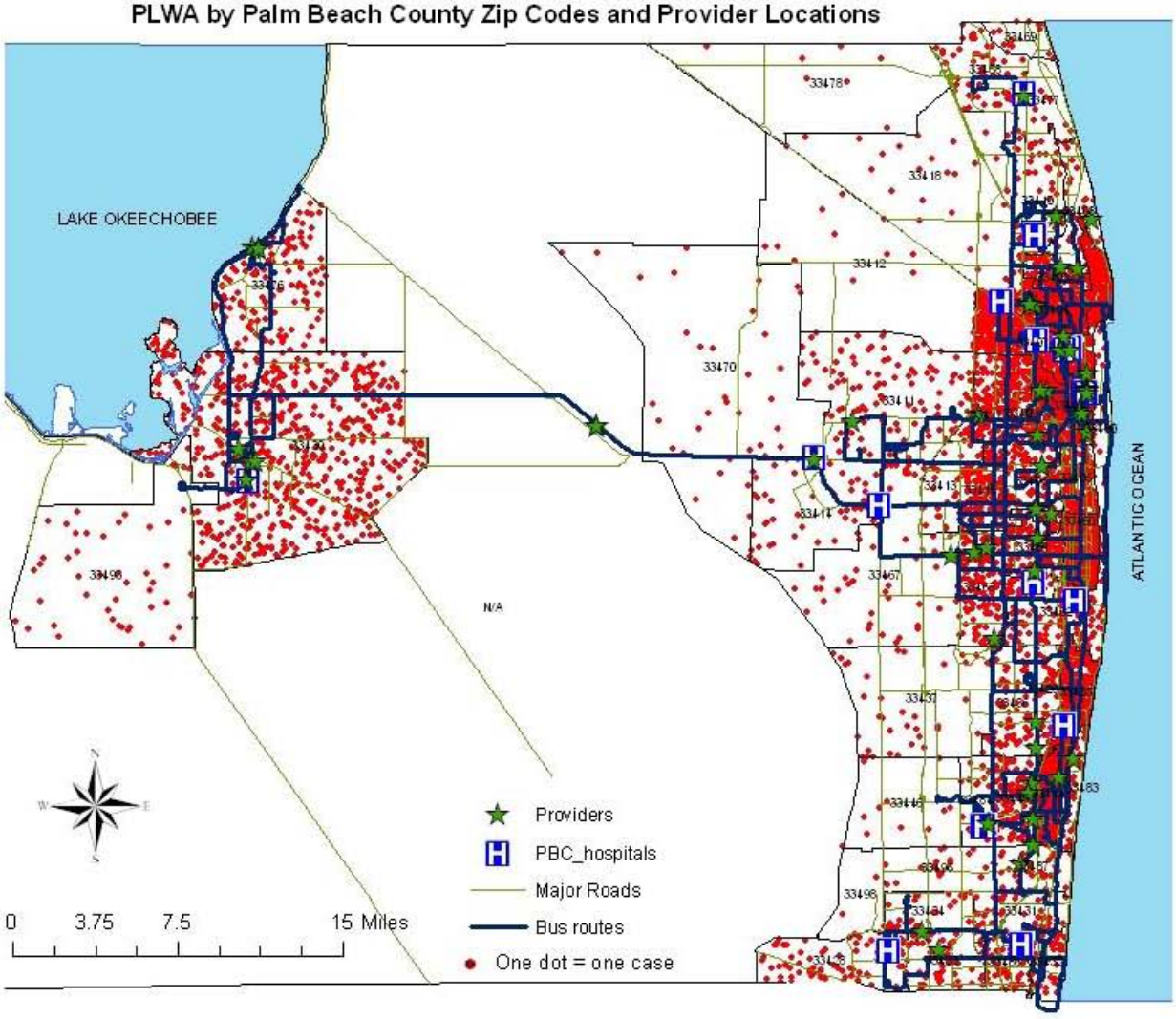
Zip code of residence at time of diagnosis may not correspond to the current zip codes

Homeless count and non-palm Beach County Zip codes are not reflected on map

Metadata
PCS:NAD_1983_HARN_StatePlane_Florida_East_FIPS_0901_Feet
Source: Shape files from Palm Beach County GIS

Created by Michael B. Greene, HCD, Planning Dept., 7/31/07

PLWA by Palm Beach County Zip Codes and Provider Locations



Presumed HIV/AIDS cases excludes DOH through 2005

Data presented complies with Bureau of HIV/AIDS policy

Zip code of residence at time of diagnosis may not correspond to the current zip codes

Homeless count and non-palm Beach County Zip codes are not reflected on map

Metadata
PCS:NAD_1983_HARN_StatePlane_Florida_East_FIPS_0901_Feet
Source: Shape files from Palm Beach County GIS

Created by Michael B. Greene, HCD, Planning Dept., 7/31/07

4. Provider Survey from the Needs Assessment 2007-2010

Provider Survey responses included information about providers' efforts to:

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

Racial, Gender, and Geographic Disparities

Most of the organizations that participated in the Provider Survey report that they are working to address racial, gender, and geographic disparities in health outcomes for PLWHA. Ryan White funded organizations comply with the Cultural Competency and Linguistic Standards of Care implemented in 2003. The following is a list of the providers' responses to Provider Survey Question 10 "How is your organization working to address racial, gender, and geographic disparities health outcomes for PLWHA?"

- Work cooperatively with other private and public organizations, religious groups, and neighborhood leaders who are respectful of the beliefs, values and traditions of the Haitian community.
- Located in highest prevalence areas in the county. Employ a culturally and linguistically diverse staff.
- Staff is multicultural.
- Provide services in county-wide by offering home visits.
- All clients undergo assessment and develop care plans to maximize potential for positive health outcomes. At risk clients are followed closely to assure adherence.
- Follow professional, ethical standards of practices.
- Access to health care is one area needing greater emphasis as it relates to reducing disparities among population groups most at risk. Ethnicity, age, gender, and disability have been identified as major contributing factors in determining the overall health status of our population.
- The PBCHD is committed to providing an integrated, interdisciplinary approach to care and support services. In addition, the PBCHD continues to advocate for and ensure improved health and health care access in disparate populations. The health department has been able to improve the quality, capacity, service capability and coordination of HIV care by:
    - Optimizing HIV care resources;
    - Enhancing linkages among community based and AIDS service organizations;
    - Integrating Medicaid, Health Care District, general revenue, CARE act and other funding streams;
    - Offering comprehensive health care and social support services;
    - Providing one-stop shopping where feasible and
    - Exploring best practices and models from other disciplines that may lead to the development of a plan to eliminate disparities in accessing services for affected subpopulations and underserved communities.

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. The frequency of the response is in parenthesis.

Improving Services
Providers responded to the question "What is the single most important change you would suggest to improve services for individuals or families infected with HIV?" as follows:

Increase in Support Service Capacity & Availability

- Early intervention to improve long-term adherence and identify those gaps early (1)
- Housing (3)
- Medication and Medical Care (2)
- Case Management (1)
- Health Insurance Coverage (1)
- Medicaid that would be non-interrupted; maybe through a waiver program. (1)
- Stable funding over time in specific service categories to prevent constant changes in client eligibility and required changes based on availability of funds. (3)
- Transportation (1) "We have seen that cab vouchers are a costly solution. They do not ensure that clients will use them to go to their scheduled appointments. Bus passes do not open access to many of our clients if they are too sick/weak or have young children which need to accompany them to the appointments. The most efficient transportation service is provided by case managers. If we could make a change, it would be to fund liability insurance for service providers OR to invest in a van that would be shared by the Ryan White providers. Gas cards have been used successfully in other counties to help with cost of gas for those clients who have a car or access to a car."

Systematic Changes

- Single point of entry (1)

Cultural Sensitivity/Stigma

- Strong stigma among the Haitian community that keeps them from seeking professional help. "We need to incorporate the clients' worldviews in the helping process congruent with behavior and expectations normative for a given community and adapted to suit the specific needs of the client." (1)

Enhance efforts to collaborate and coordinate with other organizations
Sixty-one percent (11) of the organizations responded in the affirmative when asked "Does your agency have any HIV-specific verbal agreements, commitment letters, letters of collaboration, binding agreements, or signed Memoranda of Understanding (MOUs) with other agencies in the area?" The majority of the providers have MOUs with the organizations that function as the point of entry into care (i.e. case management). The following are the responses and frequencies from the providers regarding how the CARE Council could help the agencies better coordinate services with other providers in the area:

Training and Meeting Facilitation (12)

- Training in working with people from other cultures
- Training to learn other languages

- Training to gain additional experience/knowledge about providing HIV care, such as antiretroviral treatments, dealing with opportunistic infections, and monitoring and explaining a patient's health status
- Training on how to better advocate for clients/patients
- Opportunities for networking among providers to share information and HIV/AIDS care and available resources
- Make sure providers like substance abuse, etc. are responsive and can mobilize to meet clients needs
- Coordinate interagency/inter-provider gatherings to discuss the importance of referral process
- Create coalition to include care providers to improve community services

Provide Information (2)

- Update Redbook
- Maximize available Title I (Part A) funding through the utilization of supportive facts/finding on local population (numbers, utilized needs)

Increase Planning Council Representation (1)

- Have more Glades representation on the CARE Council

Increase Funding (2)

- Should access more funding from CARE Council (easier access/areas of medication/transportation/respite care)

Improve Access to Services (3)

- Referrals
- Countywide transportation services
- Providing services in a more convenient manner (such as better office hours, quicker appointments, less waiting, in a location that is easier to get to)

Plan for Expansion

A few of the organizations that participated in the Provider Survey responded that they have had to reduce the number of clients served due to funding cuts and/or are not planning to provide additional services and/or expand capacity. Three organizations are planning to provide additional services to PLWHA. The following are the responses describing the areas of expansion:

- Initiated an outreach program, recently funded by the Part A program
- Expanding HOPWA services to the western communities of Belle Glade and Pahokee
- Expanding primary medical care through a new Federally Qualified Healthcare Center (FQHC)
- Planning to expand medical services for women and children and early intervention services
- Initiated a client advocacy/peer navigation program this year

I. Barriers to Care

1. Service Barriers Identified by PLWHA

Survey respondents in care were asked to describe their level of utilization of the thirty service categories prioritized by the planning council. The 252 respondents in care described their utilization of each survey categories as one of the following:

- "need and use" if they utilize the service
- "do not need" if they do not utilize the service
- "need, can't get" to show possible gaps in services
- "can get, won't use" to show barriers in service utilization

Overall, there was a very low number of respondents who said they "can get, won't use" the services, which suggests there may be few barriers to services. The five services most frequently selected by respondents as "can get, won't use", were:

- Clinical Trials 8.7% (22)
- Peer Advocacy 6.7% (17)
- Specialty Outpatient Medical Services 6.7% (17)
- Substance Abuse Treatment-Residential 6.0% (15)
- Complementary Therapies 5.6% (14)
- Day Respite Care 4.8% (12)
- Nurse Care Coordination 4.8% (12)
- Outreach 4.8% (12)
- Substance Abuse Treatment-Outpatient 4.8% (12)
- Translation 4.8% (12)

2. Service Barrier Trends 2000-2007

Needs assessments were conducted in 2000, 2003 and 2007. The table below contain service barrier data from each respective study. In addition to data analyses for each year's needs assessment, analyses were conducted to identify trends from 2000 through 2007. Service categories used to analyze service barriers have varied slightly in the three needs assessments. Therefore, some service categories included in past needs assessments were not included and could not be compared with the service categories in the 2007 needs assessment. For example Spiritual/Religious Counseling was a service that was included in past needs assessments, but was removed from the list of services used in the 2007 needs assessment. The list of service categories in the 2007 data collection instruments, include only the services in the current continuum of care that are prioritized and funded by the CARE Council. In some cases, this has resulted in non consecutive ranking in the table below.

Overall, the percentages of respondents indicating that they "can get, but won't use" particular services has *remained very low and fairly consistent* in the last three needs assessments. The table below displays service barrier data across the past three needs assessments. The five most highly services with barriers are highlighted for emphasis.

Barriers by Service Categories across the 2007, 2003, and 2000 Needs Assessments

Service Category	2007 (n=252)			2003 (n=400)		2000 (n=271)	
	rank	#	percent	rank	percent	rank	percent
Ambulatory/Primary Outpatient Medical Care	9	7	2.8%	18	1.0%	13	1.0%
Buddy Companion	10	6	2.4%	16	1.5%	3	6.0%
Case Management	9	7	2.8%	15	1.8%	9	3.0%
Clinical Trials	1	22	8.7%	11	2.8%	3	6.0%
Counseling	8	8	3.2%	15	1.8%	3	6.0%
Complementary Therapy- Acupuncture	not available			7	4.0%	5	5.0%
Complementary Therapy- Massage	4	14	5.6%	5	5.0%	7	4.0%
Day and Respite Care	5	12	4.8%	19	0.8%	6	4.0%
Dental Care Services	9	7	2.8%	14	2.0%	4	6.0%
Direct Emergency Assistance	11	5	2.0%	17	1.3%	11	3.0%
Drug Reimbursement	9	7	2.8%	10	3.0%	8	4.0%
Food Bank/Home Delivered Meals	9	7	2.8%	16	1.5%	8	4.0%
Health Insurance Continuation	6	10	4.0%	17	1.3%	9	3.0%
HIV Prevention	7	9	3.6%	11	2.8%	7	4.0%
Home Health Care Services	10	6	2.4%	16	1.5%	6	4.0%
Hospice	7	9	3.6%	14	2.0%	10	3.0%
Housing	12	4	1.6%	21	0.3%	12	2.0%
Inpatient Hospital Coordination	9	7	2.8%	n/a	n/a	n/a	n/a
Laboratory Diagnostic Testing	10	6	2.4%	19	0.8%	12	2.0%
Legal Services/Permanency	6	10	4.0%	15	1.8%	10	3.0%
Mental Health	7	9	3.6%	13	2.3%	5	5.0%
Nurse Care Coordination	5	12	4.8%	11	2.8%	n/a	n/a
Outreach	5	12	4.8%	n/a	n/a	n/a	n/a
Peer Advocacy	2	17	6.7%	6	4.3%	10	3.0%
Specialty Outpatient Medical Services	2	17	6.7%	n/a	n/a	n/a	n/a
Substance Abuse Outpatient	5	12	4.8%	9	3.3%	1	7.0%
Substance Abuse Residential	3	15	6.0%	9	3.3%	1	7.0%
Translation	5	12	4.8%	18	1.0%	12	2.0%
Transportation	12	4	1.6%	20	0.5%	13	1.0%
Treatment Adherence	11	5	2.0%	n/a	n/a	n/a	n/a
Vocational Rehabilitation	7	9	3.6%	12	2.5%	7	4.0%

Note: Data in black cells represent the services most frequently mentioned.

3. Service Barriers Identified by Special Populations

Haitian Respondent Barriers to Services

The most frequently mentioned services that Haitian respondents said they can get, but won't use (i.e. suggesting barriers to services) include nurse care coordination and peer advocacy while the most frequently mentioned barriers by all respondents in care were for clinical trials, peer advocacy, and specialty outpatient services.

Latin/Hispanic Respondents Barriers to Services
Clinical trials, specialty outpatient medical services, and substance abuse treatment were the most frequently selected services barriers, i.e. services that respondents "can get, but won't use".

MSM Respondent Barriers to Services
Vocational rehabilitation and specialty outpatient medical care were the two most frequently mentioned services which MSM in care said they can get, but won't use.

Black Heterosexual Respondent's Barriers to Services
The service barriers, indicated by selecting "can get, won't use" were relatively low.

WCBA Respondent's Barriers to Services
WCBA in care most frequently identified clinical trials, substance abuse residential, and substance abuse outpatient as services they can get but won't use.

Recently Incarcerated Respondent's Barriers to Services
Recently incarcerated respondents who are in care and all in care respondents identified similar services that they can get, but won't use (i.e. services to which there are barriers). The services most frequently mentioned by both groups were specialty outpatient services and clinical trials.

Substance Using Women Respondent's Barriers to Services
When asked about service barriers, women who have used drugs within the past 12 months had very few responses. The most frequently selected services included clinical trials and substance abuse treatment.

The following table displays identified service barriers for all respondents as well as seven special populations.

Survey Questions 59-88. Please check off how the following services apply to you: Need and Use, Do not Need, Need/Can't Get, Can Get/Won't Use

Service Category Barriers	All In Care Respondents n=252			Haitian In Care Respondents n=49			Hispanic/Latin In Care Respondents n=37			MSM In Care Respondents n=52			Heterosexual Black In Care Respondents n=130			WCBA In Care Respondents n=58			Jail/Prison Past 12 mos. In Care Respondents n=22		
	rank	#	%	rank	#	%	rank	#	%	rank	#	%	rank	#	%	rank	#	%	rank	#	%
Clinical Trials	1	22	8.7%				1	12	32.4%							1	7	12.1%	2	4	18.2%
Complementary Therapies	4	14	5.6%	2	5	10.2%							3	8	6.2%						
Counseling Other																					
Day and Respite Care	5	12	4.8%	2	5	10.2%															
Dental Care Services				2	5	10.2%															
Health Insurance Continuation													3	8	6.2%						
Hospice				2	5	10.2%															
Mental Health				2	5	10.2%															
Nurse Care Coordination	5	12	4.8%	1	6	12.2%							2	9	6.9%						
Outreach	5	12	4.8%										3	8	6.2%						
Peer Advocacy	2	17	6.7%	1	6	12.2%							1	12	9.2%						
Specialty Outpatient Medical Services	2	17	6.7%				2	6	16.2%	2	4	7.7%							1	6	27.3%
Substance Abuse Outpatient	5	12	4.8%				2	6	16.2%							2	6	10.3%			
Substance Abuse Residential	3	15	6.0%				2	6	16.2%							1	7	12.1%			
Translation	5	12	4.8%																		
Vocational Rehabilitation										1	5	9.6%									

Note: The table above only displays data from the most frequently selected services; the remaining cells are blacked out.

4. Service Barriers Identified by Service Providers

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. The frequency of the response is in parenthesis.

When providers were asked to, "List three barriers that their organization has faced when providing care to people living with HIV/AIDS," they responded as follows:

Systematic Issues

- HUD regulations and cost to maintain compliance
- Fixed hours
- Limited parking
- Lack of referrals from other agencies
- Coordination of care (planning, integrating, implementing)
- Location
- Limited daytime hours for ADAP clinic
- Lack of alcohol and drug referrals

Service Capacity & Availability

- Housing (7)
- Transportation (3) "Clients do not like the current systems which are difficult to navigate and may include long wait periods and possibly not showing up for scheduled pick-up."
- Dental
- Locating clients
- Clients' refusal to apply/follow through with required documentation
- Accessibility to Medicaid and HCD denial letters
- Insurance coverage: This is to include insurance issues (insurance authorization to treat), inpatient procedures, and income level for insurances targeting indigent is too low.

Legal Issues

- Immigration status

Cultural Sensitivity

- Level of stress related to acculturation
- Language

Education

- Level of education

Treatment Adherence

- Poor compliance with treatment (3)

Familial Issues

- Lack of family support
- Non-compliance with caregivers

Substance Use

- Drug and alcohol problems (3)

Confidentiality

- Confidentiality- laws made to protect the client are getting in the way of providing services.

Funding

- Funding cuts and shifts (4)

Mental Health

- Services for client with co-occurring psychiatric disorders

S E C T I O N 2

Where Do We Need To Go: What System of Care Do We Want?

The current Continuum of Care is a partnership of state and federal funding sources, planning authorities, medical and social support agencies, and people who are living with HIV/AIDS that provides a system of care for persons living with HIV/AIDS. The goal of the Continuum of Care is to improve and maintain optimal health for persons living with HIV/AIDS.

The system of care that Palm Beach County wants is one that provides the highest possible standard of care for all PLWHAs in the EMA and conforms to all federal, state and local principles. The significant issues, critical concerns, areas of focus from Health Resources and Services Administration (HRSA), Centers for Disease Control and Prevention (CDC), Florida Bureau of HIV/AIDS, and the Palm Beach County HIV CARE Council are included below. Our Continuum of Care within the EMA has adopted these concepts and has built the Comprehensive Plan 2009-2012 to support and implement them all.

A. Key Changes of the Ryan White HIV/AIDS Treatment Modernization Act of 2006

The Ryan White HIV/AIDS Treatment Modernization Act of 2006 provides the Federal HIV/AIDS programs in the Public Health Service (PHS) Act under Title XXVI flexibility to respond effectively to the changing epidemic.

The new law changed how Ryan White funds can be used, with an emphasis on providing life-saving and life-extending services for people living with HIV/AIDS across this country.

The Ryan White HIV/AIDS Program was enacted in 1990 and, in addition to 2006, was reauthorized in 1996 and 2000.

Key Changes include:

- *New method for determining eligibility for Part A (formerly called Title I) funds* gives priority to urban areas with the highest number of people living with AIDS while also helping mid-size cities and areas with emerging needs.
- *New method for distributing Part A funds directs money to metropolitan areas with the highest number of people who are HIV-positive.* It also encourages outreach and testing, which will get people into treatment sooner and save more lives.
- *More money will be spent on direct health care for Ryan White clients.* Under the new law, grantees receiving funds under Parts A, B, and C (formerly called Titles I, II and III) must spend at least 75 percent of funds on "core medical services."
- *The new law recognizes that HIV/AIDS has had a devastating impact on racial/ethnic minorities in the U.S.* African Americans accounted for 49 percent of all HIV/AIDS cases diagnosed in 2005. The new law codifies the Minority AIDS Initiative for HRSA's Ryan White programs.

The Ryan White CARE Act Reauthorization Key Changes can be found at http://hab.hrsa.gov

B. Fact Sheet for the Ryan White HIV/AIDS Treatment Modernization Act of 2006

Today [December, 19, 2006], President Bush Signed the Ryan White HIV/AIDS Treatment Modernization Act of 2006. The President and Mrs. Bush appreciate Congress responding to the President's call to reauthorize the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act. This bill focuses on life-saving and life-extending services and increased accountability for funding. It will also provide more flexibility to the Secretary of Health and Human Services to direct funding to the areas of greatest need.

- *The President Is Committed To Addressing The Needs Of The 1 Million Americans Living With HIV/AIDS And To Preventing New HIV Infections Within The United States.* Since 2001, the Administration has devoted more than $74 billion [worldwide] to HIV/AIDS treatment and care, increasing annual treatment funding by 37 percent. The Administration has also devoted more than $15 billion to HIV/AIDS research to help develop new methods of treatment and prevention, increasing annual research funding by 20 percent.

- *The Ryan White CARE Act Is An Important Tool In Turning The Tide Against HIV/AIDS In America***.** For 16 years, the Ryan White CARE Act has provided medical care, antiretroviral treatments, and counseling to people living with HIV who would otherwise have little or no access to care. It also supports HIV testing to prevent this disease from spreading further.

Revising And Extending HIV/AIDS-Related Services

The Ryan White HIV/AIDS Treatment Modernization Act Revises And Extends Services Under The Ryan White Care Act (RWCA) Program. This Act will:

- Provide More Flexibility To Direct Funding To Areas Of Greatest Need. New supplemental grants will be provided to States with an increasing need for HIV/AIDS-related services due to limited access to health care, high prevalence of HIV/AIDS, and other relevant factors. The program's formula for awarding funds will also be updated to consider the number of HIV and AIDS cases – the previous formula considered only the number of AIDS cases.

- Target Money To Core Life-Saving Medical Services For Those In Need. Grantees under Titles I, II, and III of the program will use no less than 75 percent of funds to provide core medical services. In addition, the reauthorization calls for the Early Intervention Services grant program to provide core medical services for individuals with HIV/AIDS in underserved populations.

- Require More Aggressive Oversight Of RWCA Programs. For example, the Secretary of Health and Human Services will be required to submit biennial reports describing barriers to HIV program integration. In addition, the Government Accountability Office (GAO) will be required to conduct an evaluation concerning how funds are used to provide family-centered care involving outpatient or ambulatory care services under Title IV of the RWCA Program.

- Standardize Minimum Requirements For The AIDS Drug Assistance Program (ADAP). The Secretary of Health and Human Services will develop and maintain a list of core ADAP medications needed to manage symptoms associated with HIV infection. States will be required to ensure that their programs, at a minimum, provide these core medications.

Addressing HIV/AIDS In Women, Children, And Minorities

The Ryan White HIV/AIDS Treatment Modernization Act Authorizes Programs To Address HIV/AIDS In Women, Children, And Minorities. This Act will:

- Expand Resources For Women, Infants, And Children. The reauthorization provides for grants to States for the universal testing of newborns for HIV/AIDS. It also supports the provision of family-centered care for women and children with HIV/AIDS, including the provision of support services such as referrals for inpatient hospital services, treatment for substance abuse, mental health services, and other social services.

- Codify The Minority AIDS Initiative. HIV/AIDS has had a devastating impact on minorities in the United States – African-Americans accounted for 49 percent of all HIV/AIDS cases diagnosed in 2005. The Minority AIDS Initiative provides funding for activities to evaluate and address the disproportionate impact of HIV/AIDS and disparities in access, treatment, care, and outcome on racial and ethnic minorities.

This Fact Sheet can be located at: http://www.whitehouse.gov/news/releases/2006

C. Health Resources and Services Administration's Four Factors of Significant Implications

Health Resources and Services Administration has identified four factors with significant implications for HIV/AIDS care, services and treatment as follows:

1. The HIV/AIDS epidemic is growing among traditionally underserved and hard-to-reach populations.
2. The quality of emerging HIV/AIDS therapies can make a difference in the lives of people living with HIV.
3. Changes in the economics of health care are affecting the HIV/AIDS care network.
4. Policy and funding increasingly are determined by outcomes.

These factors can be found at: http://hab.hrsa.gov/aboutus.htm

D. Statewide Coordinated Statement of Need's "Identified Statewide Concerns: Unmet Needs, Emerging Trends, Cross-cutting Issues, Challenges, and Critical Gaps"

The 2006-2009 Statewide Coordinated Statement of Need is based on findings from the statewide needs assessments, local needs assessments conducted in the 14 regional planning areas, standardized consumer needs assessment, and SCSN survey. A number of concerns in the areas of unmet needs, emerging trends, cross-cutting issues, challenges, and critical gaps have been identified in the HIV/AIDS service delivery

systems throughout Florida. Goals and strategies have been developed to address these issues in the 2006-2009 Florida Comprehensive Plan and are listed below. The goals and strategies should be considered in a statewide context and may not apply to all regions and locales.

Unmet Needs

1.1 There is a need to improve on methods to assess the shifting HIV/AIDS demographics throughout the state and regional areas to better allow those care systems to respond to needs of emerging communities and populations as well as to identify people living with HIV who know their status but are not receiving regular HIV-related primary health care.

1.2 Trends in the epidemic show that disparities still exist with respect to race/ethnicity, economic status, and in geographic areas of the state.

1.3 There is an increase in the number of men and women who are in the jail or corrections system, which impacts their levels of care. There is a need to continue to improve transition to primary medical care for this population in some areas of the state.

Emerging Trends

2.1 Shifts in co-morbidities influence care and treatment, which impacts the HIV/AIDS systems of care by creating the need for integrated and interdisciplinary team approaches. These shifts include, but are not limited to, the following:

- The increase and impact of Hepatitis (i.e. HAV, HBV, HCV; STDs, and tuberculosis on HIV/AIDS systems of care.
- The increase and impact of substance abuse and mental health concerns. There is an inadequate number of treatment providers available around the state.
- The rise in patients using crystal methamphetamine who are not receiving treatment is causing disruptions in the healthcare of these patients. This issue does not appear to have reached a sufficient level of awareness by physicians and dentists. There is a need for improved coordination with SAMHSA funded mental health/substance abuse treatment providers
- There is a need for improved specialty care provider coordination.

2.2 An increase in the number of people who are negotiating for sexual encounters via the internet enables them to remain anonymous. This makes it difficult to reduce transmission and bring them into care.

2.3 Shifts in the populations affected by the disease influence care and treatment and impact the HIV/AIDS systems of care. There is an increasing need for integrated and interdisciplinary team approached, including the following:

- The increase in MSM and heterosexual transmissions.
- The increase in emerging populations such as seniors, migrating populations (farm workers and tourists), teens, women, minorities, and the incarcerated.
- Florida is a major refugee relocation center. There are increasing numbers of new residents who are coming from countries that are heavily impacted with HIV/AIDS or are victims of human trafficking which places a greater burden on the system.

Cross-Cutting Issues and Challenges

3.1 Transportation issues present challenges in both rural and urban areas of the state.

3.2 Major Medicaid reform in Florida will lead to new challenges to care and drug coverage systems as the changes take effect.

3.3 The coordination of services across funding sources and providers continues to present challenges throughout the state.

3.4 Staff turnover and related need for continual training and education.

3.5 Data management is a continual challenge within the state and regional areas. Challenges related to this issue include:

- Education regarding the sharing of clients' information to improve coordination of care across providers.
- Additional requirements for quality and performance measures place stress on staff and systems of care.
- Multiple data bases and the need for consistent, standardized methods for managing, collecting, and reporting of data.
- A need for better information systems to track people who drop out of care, follow-up on referrals, or who cross county lines in order to receive duplicated services.

3.6 There continues to be misunderstanding on the part of some clients related to their eligibility for services, which indicates a need for greater client education regarding the services.

3.7 There is a need to strengthen the planning, delivery and integration of prevention and patient care services across the continuum of care so that service gaps can be more easily addressed.

Critical Gaps

4.1 There is a limited availability of specialty providers, including dental providers, in some areas of the state.

4.2 Improved collaboration at the federal level and state level among mental health and substance abuse agencies, would help with providing integrated services to address the needs of some clients dealing with issues related substance use.

4.3 Decreasing numbers of providers who accept Medicaid reimbursement.

4.4 Limited availability of childcare options for women with children that may need residential treatment or may require regular medical care visits.

4.5 Limited availability of a continuum of care for HIV-infected adolescents in some areas of the state.

4.6 Continued stigma associated with HIV/AIDS status, which impedes access to care and/or services for some clients.

4.7 There is a need for coordinated mental health services to be integrated as a standard part of HIV care.

The SCSN states that while progress has been made in the state in reaching many of the goals and objectives, the HIV/AIDS epidemic is shifting to new populations which is posing a challenge. Women, persons with low socioeconomic class, minority populations, incarcerated and other marginalized groups are inequitably becoming

infected. These are people who have more pressing needs, making their ability to follow complex medical treatments less of a priority.

Ryan White planners, administrators, service providers, and consumers continue to be actively engaged in ongoing work within the various collaborative partnerships established in Florida. Collaboration between different service providers by coordinating direct care produces synergistic effects, reduces duplication of services and is both effective and efficient. Collaboration is also occurring with respect to quality management, fiscal and administrative tasks of the respective grants. This type of collaboration is becoming more necessary as the HIV/AIDS epidemic grows; the needs of the clients increase and become more complex, and reductions are made in HIV funding.

In 2006, when this report was released, a great effort was and continues to be made in the collaborative planning efforts between grantees within the state of Florida. The networks of care developed as a result of the Ryan White CARE Act, while comprehensive in scope, have not eliminated all the barriers and gaps within the service delivery systems. It is the intent of SCSN that barriers and gaps identified may be reduced through a sincere application of the recommended goals and strategies.

For the full report visit:
www.doh.state.fl.us/disease_ctrl/aids/care/SCSN_06_09_012505.pdf.

The 2009-2012 SCSN is currently being developed.

E. Palm Beach County HIV CARE Council's Paradigms and Values

In August 2006 consultants from the Academy for Educational Development (AED) conducted an all day workshop for all persons involved with the Palm Beach County HIV CARE Council entitled, *CARE Act Planning in a Changing Environment.* The workshop included modules such as changes in the HIV/AIDS environment, using information for decision making, and roles as decision makers. These modules assist the members in making recommendations for the Priorities and Allocations of Ryan White Funds in the EMA.

During the workshop, the Planning Council chose to plan for the Ryan White program based on the Justice Paradigm of Utilitarianism (greatest good for the greatest number) and secondly with the Justice Paradigm of Compassion (assisting the neediest first).

The Planning Council also developed three main values that their decision making is based on.
These values include:

1) Access to services for all who need services;
2) Compassion & Respect – treating all clients with respect and care; and
3) Accountability.

F. Palm Beach County HIV CARE Council's Priorities and Allocations Process

The priority setting and allocation (P&A) process begins in May and concludes upon receipt of the grant award, typically in early March. A variety of data sources, listed below, are used to assist the Planning Council in determining the priorities and allocations.

Epidemiological Data

- Trends/changes in HIV incidence and prevalence
- Trends/changes in AIDS incidence and prevalence
- Changes in the demographics of the EMA's HIV/AIDS cases in relation to the total population as a measure of disproportionate impact on specific populations
- Co-morbidity, poverty, and insurance status data

Service Utilization Data

- Numbers of unduplicated clients; numbers of units of service provided
- Demographic information regarding who is accessing care

Service Cost Data

- Unit costs for each service, known or estimated
- Cost effectiveness data
- Percentage of Ryan White funds spent on women, infants, children and youth (WICY)
- History of expenditure data by category
- History of encumbrance data by category

Qualitative and Quantitative Needs Assessment Data

- Quantitative data regarding persons living in the EMA who know they have HIV but are not receiving HIV/AIDS primary medical care
- Focus group findings
- Client Survey findings
- Provider Survey findings
- Special Population findings (Haitians, Latin/Hispanic, Black Heterosexuals, Women of Child Bearing Age, Women with a History of Substance Abuse, Recently Incarcerated, and MSM).
- Estimates of unmet need among clients in the service area's continuum of HIV/AIDS care
- Estimates of unmet need among clients not in the service area's continuum of HIV/AIDS care
- Information regarding populations with special needs, including barriers to care and other access issues

Other Relevant Data

- List of service categories, including definitions
- Information on other Ryan White Modernization Act of 2006

- Information on Medicaid data
- Information on Substance Abuse treatment programs
- Other governmental and non-governmental programs
- Comprehensive Plan – goals and strategies
- Capacity development needs
- Current local data on women, infants, children and youth (WICY)
- Funding stream data from Part A, Part B, General Revenue (Patient Care & Network), HOPWA, and prevention programs
- Gap analysis
- P&A Committee Work Plan
- Part A (Title I Manual): Section V Technical Assistance Papers, Priority Setting and Section VII Priority Setting and Resource Allocation
- P&A Committee members' evaluation of the P&A Process
- GIS Map displaying level of impact of PLWHA cases by zip code, HIV/AIDS service locations, and public transportation route

The Planning Council involves PLWHA in the planning process to gather qualitative data through the following:

- Community forums
- Needs Assessment 2007-2010 through PLWHA Survey and Focus Groups
- Permanent representation of PLWHAs as members on the Planning Council and its committees including the P&A Process as defined by the Bylaws

G. Prioritization

1. Priorities of the CARE Council FY 2008-2009

Priority	Service Category
1	Medical
1a	Ambulatory/Primary Outpatient Medical Care
1b	Laboratory Diagnostic Testing
1c	Drug Reimbursement
	Local Supplemental
	ADAP Supplemental
	Nutritional Supplement
	Pediatric AZT
1d	Specialty Outpatient Medical Services
1e	Oral Health
1f	Early Intervention Services
1g	Nurse Care Coordination
1h	Health Insurance Premium & Cost Sharing Assistance
1i	Home Health Care
1j	Hospice
1k	Mental Health
1l	Medical Nutrition Therapy
1m	Medical Case Management services (including Treatment Adherence)
1n	Substance Abuse Outpatient
2	Case Management (non-medical)
3	Referral for Health Care/Supportive Services
4	Housing
5	Substance Abuse Residential
6	Food Bank/Home Delivered Meals
7	Emergency Financial Assistance
8	Medical Transportation Services
9	Treatment Adherence Counseling
10	Outreach
11	Legal Services/Permanency
12	Health Education/Risk Reduction
13	Psychosocial Support Services
14	Rehabilitation Services
15	Linguistics Services
16	Child Care Services
17	Respite Care

2. Priorities of PLWHA & Providers from the Comprehensive Needs Assessment 2007-2010

Respondents who are in care were asked to prioritize the following service categories by identifying the seven services most important to them. The following responses suggest that respondents thought support and social services were more important than medical services. The seven most frequently selected service categories include the following:

- Case Management (71.8%, 181)
- Housing (64.3%, 162)
- Food Bank (59.9%, 151)
- Dental Care (53.2%, 134)
- Transportation (47.6%, 120)
- Counseling Other (34.9%, 88)
- HIV Prevention (34.9%, 88)

The table to the right summarizes all responses to this question.

> Case management functions as the EMA's single point of entry, providing primary access to the EMA's continuum of care. Clients' initial eligibility must be determined by case managers, necessitating high utilization and prioritization of case management services. Once eligibility is established, case managers assist clients in navigating the continuum of care, or clients may choose to access some services (e.g. primary medical care) independently.

Survey Question 58. If we have limited funding, what are the seven (7) most important services to you.

Service Category	Prioritization by In Care Respondents n=252	
	number	percent
Case Management	181	71.8%
Housing	162	64.3%
Food Bank/Home Delivered Meals	151	59.9%
Dental Care Services	134	53.2%
Transportation	120	47.6%
Counseling Other	88	34.9%
HIV Prevention	88	34.9%
Laboratory Diagnostic Testing	79	31.3%
Health Insurance Continuation	55	21.8%
Mental Health	55	21.8%
Direct Emergency Assistance	53	21.0%
Drug Reimbursement	52	20.6%
Legal Services/Permanency	50	19.8%
Ambulatory/Primary Outpatient Medical Care	48	19.0%
Buddy Companion	41	16.3%
Outreach	40	15.9%
Home Health Care Services	33	13.1%
Clinical Trials	32	12.7%
Specialty Outpatient Medical Services	29	11.5%
Substance Abuse Outpatient	28	11.1%
Complementary Therapies	26	10.3%
Substance Abuse Residential	22	8.7%
Translation	22	8.7%
Peer Advocacy	20	7.9%
Hospice	17	6.7%
Treatment Adherence	17	6.7%
Inpatient Hospital Coordination	15	6.0%
Day and Respite Care	14	5.6%
Vocational Rehabilitation	12	4.8%
Nurse Care Coordination	11	4.4%

Providers and PLWHA identified case management and housing were the most highly prioritized service categories. Other than those two categories, providers said that medical services were more important than support or social services while PLWHA food and dental care were more important than medical care.

Another difference between providers and PLWHA is that 38.9% of providers identified substance abuse residential treatment as a priority while only 8.7% of PLWH/A did so.

The table to the right summarizes the prioritization of services by respondents in care and providers. The most frequently prioritized services are highlighted for emphasis.

Survey Question. If we have limited funding, what are the seven (7) most important services to you.

Service Category	PLWHA Prioritization n=252		Provider Prioritization n=18	
	number	percent	number	percent
Ambulatory/Primary Outpatient Medical Care	48	19.0%	8	44.4%
Buddy Companion	41	16.3%	0	0.0%
Case Management	181	71.8%	9	50.0%
Clinical Trials	32	12.7%	1	5.6%
Complementary Therapies	26	10.3%	0	0.0%
Counseling Other	88	34.9%	0	0.0%
Day and Respite Care	14	5.6%	0	0.0%
Dental Care Services	134	53.2%	4	22.2%
Direct Emergency Assistance	53	21.0%	3	16.7%
Drug Reimbursement	52	20.6%	8	44.4%
Food Bank/Home Delivered Meals	151	59.9%	2	11.1%
Health Insurance Continuation	55	21.8%	4	22.2%
HIV Prevention	88	34.9%	5	27.8%
Home Health Care Services	33	13.1%	1	5.6%
Hospice	17	6.7%	1	5.6%
Housing	162	64.3%	9	50.0%
Inpatient Hospital Coordination	15	6.0%	0	0.0%
Laboratory Diagnostic Testing	79	31.3%	8	44.4%
Legal Services/Permanency	50	19.8%	1	5.6%
Mental Health	55	21.8%	5	27.8%
Nurse Care Coordination	11	4.4%	3	16.7%
Outreach	40	15.9%	4	22.2%
Peer Advocacy	20	7.9%	0	0.0%
Specialty Outpatient Medical Services	29	11.5%	5	27.8%
Substance Abuse Outpatient	28	11.1%	1	5.6%
Substance Abuse Residential	22	8.7%	7	38.9%
Translation	22	8.7%	1	5.6%
Transportation	120	47.6%	3	16.7%
Treatment Adherence	17	6.7%	4	22.2%
Vocational Rehabilitation	12	4.8%	1	5.6%

Note: Data in black cells represent the services most frequently mentioned by providers and in care respondents.

3. Priorities of Special Populations

The following is a summary from seven special populations who are in care when asked, "If we have limited funding what are the 7 most important services to you?"

Haitian Respondent's Prioritization of Service Categories
Haitian respondents who are in care, as well as all in care respondents selected case management as the service with the highest priority. Unlike all in care respondents, Haitian in care respondents did not identify transportation among the highest prioritized services. Haitian respondents who are in care selected legal services and drug reimbursement as high priorities.

Latin/Hispanic Respondent's Prioritization of Service Categories
The most highly prioritized services identified by Latin/Hispanic respondents in care were similar as all respondents in care with the exception of Health Insurance Continuation.

MSM Respondent's Prioritization of Service Categories
When asked to identify the seven most important services, MSM in care gave top priority to the same four services as all respondents in care as follows: case management, housing, food bank/ home delivered meals, and dental care services. MSM in care respondents ranked counseling (other) as the fifth priority while all respondents in care ranked transportation as the fifth priority. MSM respondents did not select HIV prevention as a high priority, but did select mental health services.

Black Heterosexual Respondent's Prioritization of Service Categories
Black, heterosexual in care respondents and all in care respondents selected the same six service categories as the top priorities. Both groups identified case management as the highest priority followed by housing, food bank/home delivered meals, dental care services, transportation and HIV prevention. Black, heterosexual in care respondents selected laboratory/diagnostic services in the top seven prioritized services

WCBA Respondent's Prioritization of Service Categories
WCBA and all in care respondents identified the same six services as the most important services, i.e., housing, case management, food, dental care, transportation, HIV prevention. WCBA did not select counseling as a top priority, but did select laboratory/diagnostic.

Recently Incarcerated Respondent's Prioritization of Service Categories
Recently incarcerated respondents who are in care and all in care respondents identified the same six services as the most important services, including case management, housing, food, dental, transportation, and counseling. Recently incarcerated respondents also selected laboratory/diagnostic and direct emergency assistance as top priorities, but did not select HIV prevention.

Substance Using Women Respondent's Prioritization of Service Categories

In care female respondents who have used drugs within the past 12 months and all in care respondents identified similar service priorities, including food, transportation, dental, housing, and case management. Notably, substance using women in care did not select counseling and HIV prevention as one of their top seven priorities, but did select laboratory/diagnostic services.

The following table summarizes the top five priorities of each special population.

Survey Question 58. If we have limited funding, what are the seven (7) most important services to you.

Service Category Priorities	All In Care Respondents n=252		Haitian In Care Respondents n=49		Latin/Hispanic In Care Respondents n=37		MSM In Care Respondents n=52		Black Heterosexual In Care Respondents n=130		WCBA In Care Respondents n=58		Jail/Prison Past 12 mos. In Care Respondents n=22		Substance Using Women In Care Respondents n=12	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Case Management	181	71.8%	37	75.5%	16	43.2%	38	73.1%	103	79.2%	36	62.1%	12	54.5%	6	50.0%
Housing	162	64.3%	18	36.7%	25	67.6%	29	55.8%	87	66.9%	41	70.7%	18	81.8%	7	58.3%
Food Bank/Home Delivered Meals	151	59.9%	19	38.8%	18	48.6%	26	50.0%	87	66.9%	34	58.6%	17	77.3%	11	91.7%
Dental Care	134	53.2%	24	49.0%	22	59.5%	24	46.2%	64	49.2%	33	56.9%	11	50.0%	8	66.7%
Transportation	120	47.6%			23	62.2%	20	38.5%	55	42.3%	31	53.4%	18	81.8%	9	75.0%
HIV Prevention			23	46.9%	13	35.1%			48	36.9%	27	46.6%				
Drug Reimbursement			20	40.8%												
Counseling			17	34.7%			22	42.3%					7	31.8%		
Legal Services			17	34.7%												
Health Insurance Continuation					11	29.7%										
Mental Health							18	34.6%								
Laboratory/Diagnostic									47	36.2%	22	37.9%	8	36.4%	8	66.7%
Direct Emergency Assistance													7	31.8%		

H. Centers for Disease Control's HIV Prevention Strategic Plan: Extended Through 2010

Below are segments of the CDC's report entitled "HIV Prevention Strategic Plan: Extended Through 2010".

Preface

We are now in the third decade of the HIV/AIDS epidemic and although HIV prevention efforts have grown substantially over time and we have made important progress, major unmet needs remain. HIV continues to pose a significant threat to Americans' health and well-being, with African Americans and men who have sex with men (MSM) of all races most severely affected. While African Americans account for 13 percent of the population, they account for nearly half of HIV diagnoses in 2005 (49% in 33 states with longstanding confidential name-based reporting) and nearly half of the people estimated to be living with HIV (47%). MSM also account for half of new HIV diagnoses in 2005 (49% in the 33 states with confidential name-based reporting) and nearly half of people estimated to be living with HIV (45%).

Reducing the toll of HIV among these groups requires a collaborative and intensive effort by government, partners, and the private and public sectors. The Centers for Disease Control and Prevention (CDC) is intensifying its own efforts to address the epidemic among African Americans and MSM. Targeted initiatives are underway, new HIV testing recommendations have been published, and new partnerships with community leaders have been established. CDC will continue to direct the majority of its resources to strategies, programs, and research for groups disproportionately affected by the epidemic and is working to expand the use of proven interventions and develop new approaches for reaching these populations.

There is no simple solution for eliminating HIV in the U.S. A complex set of historical, structural, environmental, and cultural factors – including racism, discrimination, poverty, denial, stigma, homophobia, and limited access to health care address the HIV/AIDS epidemic among disproportionately affected populations such as MSM and communities of color. Addressing these factors can have an important impact on the HIV epidemic.

CDC's *HIV Prevention Strategic Plan Through 2005* (*2001 Plan*) has served as a valuable guide for CDC action. CDC has used the 2001 Plan to identify needs for new and expanded prevention programs and initiatives, establish priorities, and direct and target resources. Importantly, the *2001 Plan* established a vision not only for CDC, but for the nation as a whole. It set forth an overarching public health goal of cutting new HIV infections in half—providing a vision of what could be accomplished with a significantly expanded investment in HIV prevention in the United States and with the full implementation of the activities outlined. While the *2001 Plan* was never fully implemented and progress did not accelerate at the desired rate through 2005, CDC remains committed to the aspirational goal of major reductions in HIV infection. CDC will therefore work with a range of partners to update the 2001 Plan and its overarching goals and develop a new long-range plan to guide the nation through 2020.

In the interim, CDC has developed the *HIV Prevention Strategic Plan: Extended Through 2010 (Extended Plan)* to guide the agency's efforts for the next 3 years and to define a realistic, short-

term goal at a time when challenges have increased and resources for prevention are not commensurate with prevention needs. Since 2001, HIV diagnoses and risk behaviors have increased among MSM; syphilis rates have increased nationally; and more people are living with HIV than ever before – many of whom are unaware of their infection – which increases the potential for continued HIV transmission. While prevention needs have actually increased, treatment advances have unfortunately contributed to a sense of complacency about the seriousness of HIV/AIDS. An extended strategic plan to address these challenges is essential. The short-term goal and milestones in this Extended Plan were endorsed by the CDC /HRSA Advisory Committee on HIV and STD Prevention and Treatment (CHAC).

This *Extended Plan* maintains the focus on core prevention priorities expressed in the 2001 Plan: reducing the number of new infections, increasing knowledge of HIV status, and promoting linkages to care, treatment, and prevention services. In addition, new objectives have been added to make urgent priorities more explicit, including: preventing new HIV infections among MSM and African Americans; addressing stigma and discrimination; promoting the use of rapid HIV tests; addressing the role of acute infection in HIV transmission; and increasing routine HIV testing in medical settings.

CDC is dedicated to helping people live longer, healthier lives by preventing new HIV infections and protecting the health of those already infected. While continuing to challenge us as a nation, CDC believes the short-term goal and milestones outlined in this *Extended Plan* can be achieved through the implementation of refined and targeted approaches.

Introduction to the HIV Prevention Strategic Plan: Extended Through 2010

This plan extends the *HIV Prevention Strategic Plan Through 2005 (2001 Plan)* published by the Centers for Disease Control and Prevention (CDC) in January 2001. The short-term goal, milestones, and accompanying objectives are based on general and specific recommendations from the CDC and HRSA Advisory Committee on HIV and STD Prevention and Treatment (CHAC), formerly known as the Advisory Committee for HIV and STD Prevention. The *HIV Prevention Strategic Plan: Extended Through 2010 (Extended Plan)*, which will serve as CDC's strategic guide for HIV prevention through 2010, includes a short-term goal of reducing new HIV infections by 5 percent per year or at least 10 percent by the end of 2010. To achieve this goal, the *Extended Plan* includes an expanded set of objectives and performance indicators that make priorities more explicit and ensure that key issues are effectively addressed. Twelve new objectives have been added, 20 existing objectives have been modified, and one objective was deleted (42 objectives total, compared to 27 in the 2001 *Plan*). The *Extended Plan* also incorporates 17 additional performance indicators (25 total, compared to 11 previously).

CDC Activities to Implement the 2001-2005 HIV Prevention Strategic Plan

While the *2001 Plan* was never fully implemented and HIV prevention resources in the United States declined slightly through 2005, the *2001 Plan* has been a valuable tool for directing efforts at CDC. Each fiscal year, the Division of HIV/AIDS Prevention (DHAP) in the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention holds a retreat to review and discuss the plan's goals and objectives. DHAP agrees on ten priority objectives that guide funding for new projects with a particular focus on populations and risk groups disproportionately affected by HIV/AIDS.

Although progress has not accelerated at the desired rate, there has been significant progress and movement in HIV prevention and hope for the future. Many people – both infected and uninfected – are being reached by prevention programs and engaging in safer behaviors:

- One of the most obvious achievements in HIV prevention is the dramatic decline in mother-to-child HIV transmission. While there were 1,650 documented cases of mother-to-child transmission in 1991, today there are estimated to be fewer than 150 cases each year.
- There have been declines in risk behavior among youth. From 1991-2005, the proportion of youth who reported engaging in sexual intercourse decreased from 54 percent to 47 percent. During the same time period, the proportion of youth who reported using condoms increased from 46 percent to 63 percent.
- In September 2006, CDC published "*Revised Recommendations for HIV Testing of Adults, Adolescents and Pregnant Women in Health-Care Settings*" to make voluntary HIV testing a routine part of medical care for Americans aged 13-64. These Revised Recommendations are a major step forward in reducing HIV acquisition and transmission and allowing people to know their HIV status.
- Rapid HIV testing technology, combined with innovative approaches, is showing promising results. Several rapid testing demonstration projects funded by CDC as part of the 2003 initiative, "Advancing HIV Prevention: New Strategies for a Changing Epidemic," report increased numbers of tests and increased proportions of persons receiving their test results, and a high percentage of persons knowing their HIV infection. This is a sign of significant progress in increasing Americans' knowledge of their HIV status.
- There has been a strong commitment among men who have sex with men (MSM) to address threats to HIV prevention, such as methamphetamine use.
- Studies repeatedly show that the majority of HIV-infected persons take steps to protect partners and prevent HIV transmission, once they know they are infected.

In addition, the focus on eliminating racial and ethnic disparities in new HIV infection rates has led CDC to better target prevention approaches. For example, through the Minority AIDS Initiative (MAI) CDC has continued to directly fund minority- serving community-based organizations (CBOs) for HIV prevention in communities of color. MAI funding has greatly enhanced CDC's ability to provide resources directly to CBOs located in and serving minority communities, and has enhanced CDC's ability to provide a range of services to disproportionately affected racial and ethnic communities.

CDC also realigned prevention programs that focus on persons at highest risk for transmitting HIV; conducted applied research to identify and evaluate evidence-based prevention interventions that have been shown to reduce risk behaviors; supported dissemination of effective interventions; implemented population-based behavioral surveillance and an HIV incidence surveillance system to supplement HIV/AIDS case surveillance; established strong linkages for prevention and quality medical care services; promoted rapid HIV testing in both clinical and non-clinical settings; and launched new efforts to enhance prevention services for

persons living with HIV and to develop new strategies to diagnose HIV infection. Most recently, CDC directed $45 million of 2007 agency funds to expand access to HIV testing among disproportionately affected populations, particularly African-Americans.

Looking Ahead: The Future of HIV Prevention Strategic Planning at CDC

While advances in HIV treatment have greatly improved the lives of HIV-infected people, HIV remains a serious and fatal disease. In 2005, over 16,000 Americans with AIDS died. As a nation, we must continue to invest in prevention. As with many other diseases, Americans tend to focus more on treating than preventing HIV. For example, in FY 2006, only 5 percent of the domestic HIV/AIDS budget went to prevention, including prevention research and programs. While treatment and care for those already infected remains critical, we must intensify our collective efforts to prevent people from becoming infected in the first place. The scale of our response must be commensurate with the challenges.

CDC remains committed to a strong prevention response. However, government support alone will not be sufficient. The support of the public and private sectors, as well as community organizations, is essential.

The CDC HIV Prevention Strategic Plan: Extended Through 2010 consists of a carefully considered set of short-term milestones and objectives for the nation's prevention priorities that will guide CDC's efforts for the next 3 years. CDC does not anticipate a significant expansion of HIV prevention funding during that time. This Extended Plan remains rooted in the best available science and builds on important progress already made in recent years. The plan refines objectives to ensure a focus on populations now at greatest risk and application of new technology and the latest science. We believe the short-term milestones can be achieved through refined, targeted approaches. These milestones challenge us to accelerate progress with available resources.

CDC will begin an in-depth, comprehensive, and inclusive process to develop a new long-range strategic plan. That plan, when completed, will provide a blueprint for HIV prevention activities through 2020 that is aligned with CDC's Health Protection Goals and integrated with other infectious diseases such as viral hepatitis, STD, and TB. As with the development of the original HIV Prevention Strategic Plan goals (2001-2005), the plan will be based on input from many sectors, including advocates from affected and at-risk communities, public health officials, academics, health-care providers, and others. CDC plans to identify the most important outcomes in surveillance, research, program, and evaluation and will develop indicators to closely monitor progress.

For more information and/or to obtain a copy of the full report visit www.cdc.gov/hiv/resources/reports.

I. Recent and Future Initiatives for the MSM in Florida

The Florida Department of Health, Bureau of HIV/AIDS and county health departments implement various HIV prevention strategies targeting gay men/MSM. Rejuvenation of HIV prevention efforts after 26 years of the epidemic among MSM is needed now. Community

mobilization can help open the door to comprehensive prevention efforts and a rethinking of public health strategies. Much is being done already. The following is a description of several recent and future HIV/AIDS initiatives for MSM in Florida.

Social Marketing (2006-2007)

MSM Media and Public Relations Campaign

This campaign includes both media and public relations for an integrated approach to reaching MSM. Media activities include interior bus transit and bus shelter advertising; internet banner ads on several gay-related sites as well as text ads on popular search engines like Google, Yahoo and MSN; ads in notable gay publications; and event sponsorships within the African-American and Hispanic MSM communities.

Palabras Sabias (Words of Wisdom)

Words of Wisdom is a Latino HIV/AIDS social marketing campaign that was produced through the Bureau of HIV/AIDS Latino Initiatives. Commonly used Spanish phrases are combined with HIV prevention messages. Cards are distributed to Latino gay men, created to promote HIV prevention and testing. They are used in outreach efforts in bars, clubs and the HIV prevention education project.

Latino MSM Public Service Announcements

MSM Latino, as part of the Bureau's Latino initiative, created a public service announcement targeted towards Latino MSM. The *MSM Latino* PSA addresses gay-identified men and non-gay identified men who have sex with other men, providing a risk reduction and HIV testing message.

Community-Based Organizations (2006-2008)

Twenty agencies have been funded through the Florida Department of Health or CDC to provide HIV prevention-related services to MSM. All 20 agencies address the needs of black MSM, 18 address Hispanic MSM, and 15 address white MSM. Many organizations were funded to serve multiple populations. The total funding was $3.3 million, allocated 42% to black MSM, 36% to Hispanic MSM, and 22% to white MSM.

HIV/AIDS Prevention Activities with MSM (2007-2008)

The Bureau of HIV/AIDS designated funding for four MSM projects beginning September 2007. The projects are to promote HIV awareness, prevention, and testing activities among MSM groups. Three programs were awarded to provide prevention interventions and one program to provide a social marketing awareness campaign.

Prevention Interventions

COMPASS (Palm Beach County) will implement the Popular Opinion Leader (POL) intervention to reach white MSM. The program will recruit trainers to educate white MSM on HIV/AIDS facts, myths and risk reduction activities.

South Beach AIDS Project (SoBAP) (Miami-Dade County) will promote testing among African-American MSM and recruit them to participate in the Many Men Many Voices (3MV) intervention.

Jacksonville Area Sexual Minority Youth Network (JASMYN) (Duval County) will implement Street Smart intervention to provide HIV prevention services for homeless and runaway black MSM between the ages of 15-23.

Social Marketing

The Miami-Dade County Health Department will implement a 16-month participatory social marketing and community mobilization effort targeted at gay men (both HIV-positive and HIV-negative). The specific purpose and focus of this effort is to find practical, effective ways to combat HIV/AIDS-related stigma and homophobia within communities and individuals.

Technology Transfer, Capacity Building and Community Mobilization (2006-2007)

Over the last two years, in response to the National HIV Behavioral Surveillance data and increases in HIV incidence among MSM in Florida during 1999-2004, the Miami-Dade County Health Department Office of HIV/AIDS sponsored two Gay Men's Health Summits and provided leadership and guidance to the Bureau of HIV/AIDS in organizing two Statewide Black and Latino MSM Consultations. The purposes of these meetings were to share key findings, disseminate theory-based HIV prevention strategies and share HIV prevention literature on gay men and other MSM with community constituents. These efforts have resulted in the creation of the Miami-Dade County MSM Taskforce and the Black and Latino MSM workgroup that are supported through the Statewide HIV/AIDS Minority Network. These groups have provided extensive recommendations to the health department on creating and sustaining an effective HIV prevention social marketing campaign for gay men and other men who have sex with men.

MSM Initiative, Broward County (2006-2007)

The Broward County Health Department implemented a prevention condom distribution campaign targeting MSM. The project consists of distributing condoms and HIV prevention information at gay businesses through a combination of social marketing campaigns and community events. The campaign includes the following media components: palm cards, print ads, mobile billboards and interactive/educational bar events called "Condom Mania".

East Side Specialty Clinic, Broward County (2006 onward)

Funded by the Bureau of HIV/AIDS, this MSM-friendly community facility caters to the health needs of gay men/MSM and other men. The clinic offers free counseling and testing services for chlamydia, gonorrhea, syphilis, HIV and hepatitis to over 40 clients and their partners every week.

inSpot STD Prevention Program (2007 onward)

In May 2007, the Bureau of STD launched www.inSpot.org as an additional option for those clients who wish to confidentially or anonymously notify on-line partners of an STD exposure. Statewide, during the first 6 weeks of the operation, there were 481 website home page hits, with 71 senders emailing 97 cards, including 10 specifically for syphilis. Approximately 83% were anonymous. InSpot posters are displayed in STD clinics.

MSM Coordinator Positions (Broward County, est. 2006; Miami-Dade, est. 2007)

These two recently established positions are responsible for coordinating and implementing HIV prevention, early intervention and linkage to care strategies for gay men/MSM in Broward and

Miami-Dade counties. Strategies include working with DOH-funded providers to support community mobilization efforts, build community capacity, and develop HIV prevention and linkage to care initiatives. This also includes implementing comprehensive HIV prevention and early intervention approaches in collaboration with local gay leaders, businesses, bars, clubs and venues where gay men/MSM congregate. The MSM Coordinator in Miami-Dade and Broward counties both facilitate Gay Men's HIV Prevention Task Forces and implement community-level interventions.

Statewide Black MSM Coordinator Position (est. 2007)
In an effort to further address HIV/AIDS disparities among Florida's black MSM and at the request of the Black Leaders Advisory Committee, the Bureau of HIV/AIDS designated a Statewide Black MSM Coordinator to help reduce HIV/AIDS among black MSM. The position is located at the Palm Beach County Health Department and reports to the Statewide Minority AIDS Coordinator located in Tallahassee. This position is responsible for planning and coordinating HIV/AIDS activities in Florida's black MSM communities.

Jacksonville Area Sexual Minority Youth Network (JASMYN) (2007)
JASMYN has received a CDC grant for implementing the initiative Advancing HIV Prevention to provide the Street Smart intervention to black MSM aged 18-23 years.

North Florida AIDS Network (NFAN) (2007-2009)
NFAN (Jacksonville area) is working on the first year of a three-year grant from Pfizer to provide Healthy Relationships to HIV-positive MSM, with technical assistance from the Duval County Health Department.

Duval County Health Department (2007)
The AIDS Program Office of the Duval CHD is implementing Partnership for Health, which includes but is not limited to MSM. The Jacksonville Area Sexual Minority Youth Network (JASMYN) has a CDC grant to provide Street Smart to African American MSM, aged 18-23. The CHD is planning to adapt and implement VOICES for MSM in 2008. Area Four provides an ongoing HIV and STD testing/counseling mobile unit outreach venue at an MSM bathhouse. The CHD performs about 200 rapid tests annually at MSM clubs, and approximately 4,000 tests annually to the public at large, all from the mobile unit outreach.

Alachua County Health Department (2007)
The Alachua CHD conducts MSM outreach and education via the internet. Planned Parenthood of North Florida does HIV testing at PRIDE Community Center two evenings per month on a walk in basis.

Orange County (2007)
Currently, there are two Mpowerment projects. One focuses on minority MSM, and the other includes white MSM, as well.

Area 14 (Polk, Hardee and Highlands counties) (2007)

The Polk CHD provide HIV Prevention services two Gay Bars and the PGLA (Polk Gay, Lesbian, Association), as well as the MCC Church, including HIV testing. A volunteer organization does HIV counseling and testing and educational programs in gay bars, as well.

Area 1 (Escambia, Santa Rosa, Okaloosa and Walton counties) (2007)
OASIS has implemented an Mpowerment Project for gay/bisexual men aged 18-29 years. The Project mobilizes young gay/bisexual men to shape a healthy community for themselves, build positive social connections, and support their friends to have safer sex.

Collier County (2007)
The Collier CHD has implemented the Popular Opinion Leader project for MSM. The CHD also conducts testing and outreach in the local gay bar and provides free testing cards to the patrons who do not want to test there. This is complemented with hepatitis vaccines and services.

Area 14 (Polk, Hardee and Highlands counties) (2007)
Basic HIV Prevention services are provided through the two Area 14 gay bars and PGLA (Polk Gay, Lesbian Association), as well as the Metropolitan Community Church. A volunteer organization conducts counseling and testing and educational programs in the gay bars as well.

Monroe County (2007)
AIDS Help, Inc. located in Key West, Monroe County, has been fighting HIV transmission for two years using Community PROMISE and a singular adaptation which interfaces with the internet to reach these higher risk target populations. Comprehensive Risk Counseling Services (CRCS) is a client-centered HIV prevention activity that combines HIV risk-reduction counseling and case management to provide intensive, ongoing, individualized prevention counseling and support. The Monroe CHD has established an adjunct outreach program through their CRCS clients to recruit persons with similar high risk behaviors for other educational programs such as Voices/Voces.

Area 5 (Pinellas and Pasco counties) (2007)
The AIDS Service Association of Pinellas County (ASAP) Suncoast prevention project, to include: rapid testing and the ASAP mobile van going to high risk MSM bars and the Sawmill gay camp ground in Pasco. ASAP also has a Prevention for Positives project. The CHD reaches out to MSM through the homeless shelters, detox facilities, and community rehabilitation centers.

Hillsborough County (2007)
Metropolitan Charities is funded by the Florida Department of Health for a Counseling, Testing, and Linkage (CTL) grant that targets Black, Hispanic, and White MSM in Hillsborough and Pinellas Counties utilizing rapid testing. Tampa Hillsborough Action Plan (THAP) receives CDC direct-funding for Many Men, Many Voices (3MV) in Hillsborough County. The 3MV program addresses factors that influence behavior, including cultural, social, and religious norms, among young Black and Hispanic MSM. The Hillsborough County Health Department's Specialty Care Clinic is implementing Partnership for Health, which includes, but is not limited to, MSM.

The information above can be found at http://www.doh.state.fl.us/Disease_Ctrl/aids

S E C T I O N 3

How Will We Get There: How Does Our System Need to Change to Assure Availability of and Accessibility to Core Services?

Based on the goals of Healthy People 2010 as well as the findings from the Comprehensive Needs Assessment 2007-2010 completed in October 2007 the following goals were created in order to improve the current system of care, and enhance the planning for the system of care. The objectives and activities build on the current evaluation process and provide measures by which our performance and progress can be evaluated. Achieving these goals will ensure the provision of high quality care and treatment services to all PLWHAs in our EMA.

As shown in the following table, the goals developed during the planning process relate to and support all of HRSA's guiding principles. A detailed description of each goal (with objectives and activities) is included in this section.

Implementation Plan

Goal 1: Improve Access to Health Care					
Activity		**Time**	**Responsible Party**	**Progress Reporting**	**Status**
Objective 1.1: Increase post-hospitalization follow up with PLWHA.					
1.1.a	Annually contact nurse case managers at public hospitals to ensure they have updated HIV service information.	FY 2009-2012	Health Planner	Planning Committee	
1.1.b	Update Redbook on www.carecouncil.org.	FY 2009-2012	CARE Council Secretary	CARE Council	
Objective 1.2: Enhance capacity of housing services to accommodate all PLWHAs who are aware of their status.					
1.2.a	Discuss with the City of West Palm Beach, regarding the possibility of the City applying for additional housing grants.	FY 2009-2012	Health Planner	Planning Committee	
1.2.b	Discuss with the City of West Palm Beach, regarding the creation of a task force of agencies interested in applying for housing grants.	FY 2009-2012	Health Planner	Planning Committee	
Objective 1.3: Enhance capacity of substance abuse and mental health services to accommodate all PLWHA.					
1.3.a	Discuss with local agencies, the possibility of applying for SAMHSA grants.	FY 2009-2012	Health Planner	Planning Committee	
1.3.b	Coordinate with the Palm Beach County Substance Abuse Coalition on efforts to raise awareness of substance abuse and increase HIV testing.	FY 2009-2012	Health Planner	Planning Committee	
1.3.c	Encourage the Priorities and Allocations committee to maintain level or increase funding for mental health services.	FY 2009-2012	Health Planner	CARE Council	
Objective 1.4: Enhance capacity and access to jobs and vocational training services to accommodate all PLWHA.					
1.4.a	Identify and disseminate information regarding resources for small businesses, continuing education, job training, etc. for PLWHA.	FY 2009-2012	EPICC	CARE Council	
Objective 1.5: Enhance access to HIV medications for PLWHA who are aware of their status.					
1.5.a	Review and consider revising the eligibility process for HIV medications.	FY 2009-2012	Medical Services Committee	CARE Council	
1.5.b	Investigate possible reasons that Part A monies have not been spent down in the drug reimbursement service category.	FY 2009-2012	Health Planner	Planning Committee	
Objective 1.6: Ensure continuity of care for PLWHA upon release from jail and prison.					

1.6.a	Increase collaboration with jails/prisons and the Ryan White Providers.	FY 2009-2012	Health Planner	CARE Council	
1.6.b	Contact DOC Pre-Release Planner for data and program successes.	FY 2009-2012	Health Planner	Planning Committee	
1.6.c	Conduct a study on the needs of this special population.	FY 2010	Health Planner	Planning Committee	
Objective 1.7: Enhance collaborations with non-Ryan White organizations and links to other funding sources.					
1.7.a	Increase client awareness of non-Ryan White funded services.	FY 2009-2012	Case Management Agencies	Grantee	
Objective 1.8: Enhance collaborations with HIV Outreach Programs.					
1.8.a	Contact the State for ARTAS program outcomes.	FY 2009-2012	Health Planner	CARE Council	
1.8.b	Continue to fund Outreach services with Ryan White monies.	FY 2009-2012	Priorities and Allocations Committee & CARE Council	Grantee & Health Planner	
Goal 2: Eliminate Health Disparities					
Activity		**Time**	**Responsible Party**	**Progress Reporting**	**Status**
Objective 2.1: Increase the number of PLWHA underserved and marginalized populations in primary medical care.					
2.1.a	Ensure that all Ryan White provider agencies receive training on cultural competence and confidentiality.	FY 2009-2012	Grantee	CARE Council	
2.1.b	Encourage Ryan White funded agencies to expand the Peer Navigation and ARTAS programs.	FY 2009-2012	Ryan White Funded Programs	CARE Council	
2.1.c	Maintain and increase PLWHA support groups countywide.	FY 2009-2012	Ryan White Funded Programs	CARE Council	
Objective 2.2: Remove existing barriers to care particularly for hard-to-reach and marginalized populations.					
2.2.a	Identify incentive-based healthcare programs, and consider implementing a local plan.	FY 2010	Health Planner	Planning Committee	
2.2.b	Support marketing campaigns that increase awareness of available services including support groups i.e. EPICC, Out in the Open, Silence is Death.	FY 2009-2012	Grantee, Ryan White Funded Programs, CARE Council	CARE Council	
2.2.c	Develop a fact sheet for consumers on provider confidentiality.	FY 2009	Support & Medical Services Committees	CARE Council	
2.2.d	Require adherence of the confidentiality standards and trainings for all Ryan White providers.	FY 2009-2012	Grantee	CARE Council	

Goal 3: Improve Quality of Care					
Activity		**Time**	**Responsible Party**	**Progress Reporting**	**Status**
Objective 3.1: Develop and implement a Quality Management (QM) Plan.					
3.1.a	Conduct assessment of the goals and objectives of the current QM Plan.	FY 2009-2012	Quality Management (QM) Committees and QM Program	Grantee and CARE Council	
3.1.b	Review and revise the QM Plan according to assessment results.	FY 2009-2012	QM Committees and QM Program	Grantee and CARE Council	
Objective 3.2: Ensure Ryan White funded agencies adhere to the Standards of Care.					
3.2.a	Update Social and Medical Standards of Care.	FY 2009-2010	QM Committees and QM Program	Grantee and CARE Council	
3.2.b	Require that adherence to the Standards of Care is included in contracts with agencies.	FY 2009-2012	QM Committees and QM Program	Grantee and CARE Council	
3.2.c	Monitor compliance with Standards of Care and quality indicators.	FY 2009-2012	QM Committees and QM Program	Grantee and CARE Council	
3.2.d	Report all QM/CQI findings to the CARE Council.	FY 2009-2012	QM Committees and QM Program	Grantee and CARE Council	
Objective 3.3: Ensure cost effectiveness.					
3.3.a	Assess cost effectiveness of each provider and service category.	FY 2009-2012	Grantee	CARE Council	
3.3.b	Monitor cost effectiveness of each provider and service category.	FY 2009-2012	Grantee	CARE Council	
Objective 3.4: Ensure client satisfaction.					
3.4.a	Standardize client satisfaction surveys for all Ryan White providers.	FY 2009	Grantee	CARE Council	
3.4.b	Monitor and assess tabulated responses, and implement corrective action if needed.	FY 2009-2012	Grantee	CARE Council	
Goal 4: Improve Health Outcomes					
Activity		**Time**	**Responsible Party**	**Progress Reporting**	**Status**
Objective 4.1: Increase the number of PLWHA who are aware of their HIV status who are in primary medical care.					
4.1.a	Conduct a study on the local unmet need estimate.	FY 2010	Health Planner	Planning Committee	
4.1.b	Ensure Case Managers accurately document the Ryan White clients in the client database that are in/not in primary medical care as well as the medical care payor source.	FY 2009-2012	Ryan White Funded Programs	Grantee	

4.1.c	Monitor the RW clients in the database that are in/not in primary medical care.	FY 2009-2012	Health Planner & MIS staff	Grantee and CARE Council	
4.1.d	Continue to conduct Unmet Need Mini Surveys	FY 2009-2012	Participating Organizations	Health Planner	
Objective 4.2: Raise community awareness of HIV/AIDS services within the EMA.					
4.2.a	Provide HIV/AIDS service information by participating in health fairs, public speaking engagements, and public awareness campaigns.	FY 2009-2012	Grantee, Ryan White Funded Programs, CARE Council	CARE Council	
Objective 4.3: Maintain PLWHA adherence to HIV medical care and treatment.					
4.3.a	Appropriate funding according to local and state Needs Assessment findings and other available data.	FY 2009-2012	Priorities and Allocations Committee & CARE Council	Grantee	
4.3.b	Increase and improve follow-up with recently diagnosed PLWHA by enhancing coordination between early intervention, counseling and testing and case management providers.	FY 2009-2012	Ryan White Funded Programs	CARE Council	
4.3.c	Increase and improve efforts to educate recently diagnosed PLWHA on the importance of being in care.	FY 2009-2012	Ryan White Funded Programs	CARE Council	
4.3.d	Encourage medical professionals and case managers to appropriately refer recently diagnosed PLWHA to counseling and mental health services.	FY 2009-2012	Grantee	CARE Council	
4.3.e	Contractually require medical providers to attempt to contact patients after appointments have been missed and/or medications have not been picked up.	FY 2009-2012	Grantee	CARE Council	
Objective 4.4: Assess health outcomes of PLWHA in the client database.					
4.4.a	Identify measurable health outcome and process indicators.	FY 2009-2010	Medical Services Committee & QM Program	CARE Council	
4.4.b	Develop health outcomes and process indicators evaluation methodology.	FY 2009-2010	Medical Services Committee & QM Program	CARE Council	
4.4.c	Collect client health outcome and process data.	FY 2010-2012	QM Staff	CARE Council	
4.4.d	Analyze health outcome and process data.	FY 2010-2012	QM Staff	CARE Council	
4.4.e	Develop and implement strategies to improve health outcomes and processes as needed.	FY 2010-2012	CARE Council	Grantee	
Objective 4.5: Increase Prevention for Positive efforts within the EMA.					

4.5.a	Support funding for health education, early intervention services, and ARTAS programs for PLWHA.	FY 2007-2009	Grantee, Ryan White Funded Programs, CARE Council	CARE Council	
Objective 4.6: Involve individual clients with monitoring their quality of care.					
4.6.a	Provide Train the Trainer Workshop on Consumer QA (HRSA-National Quality Assurance Institute)	FY 2009	Client Education Series	Grantee	
4.6.b	Support continuation of this program.	FY 2010-2012	Grantee, Ryan White Funded Programs	CARE Council	

S E C T I O N 4

How Will We Monitor Our Progress: How Will We Evaluate Our Progress in Meeting Our Short and Long Term Goals?

A. Implementation

Described above in Section 3 are the goals, objectives and activities that will be in effect FY 2009-2012. The CARE Council will monitor the progress of the Implementation Plan at the beginning of each fiscal year to ensure the accomplishment of the goals discussed in Section 3. This will work toward improving the evolving HIV Coordinated System of Care and allow the Planning Council to evaluate and monitor the progress year by year. Appropriate use of systems and organizational theories will enable planners and quality management evaluators to create outcome measures that are relevant to the lives of people with HIV Spectrum Disease. Contract monitoring, quality assurance, evaluation studies, and technical assistance will be used to monitor progress toward achieving the goals, objectives, activities and tasks presented in this plan.

The first step in implementing the plan was the acceptance of the plan by the HIV community. The development of the Palm Beach County CARE Council was based upon the epidemiological ratios and descriptions provided by the Florida Department of Health Bureau of HIV/AIDS. By predicating CARE Council membership to appropriately represent the HIV virus in our EMA, we have ensured that all Palm Beach County HIV stakeholders were represented and fully participated in the planning process and are in agreement with the idea of the comprehensive plan and are committed to its success.

The comprehensive planning process included the diverse population represented by the CARE Council and its staff. The community will share the responsibility and work for the success of the plan. The plan must be promoted within traditional and non-traditional communities so that all stakeholders have a better understanding of how the system works. The CARE Council will be the venue for this endeavor.

The planning bodies and funding streams however, will have to move beyond mere acceptance of this plan. They will need to use their resources to ensure that programs and activities are moving the community towards the goals and objectives presented in the comprehensive plan. The CARE Council will serve to promote collaboration, help inform planning bodies of potential areas of need, and improve decision-making about expanding, reducing, adding, eliminating, or refining services.

The comprehensive planning process provides HIV planning groups, service providers, funders

and consumers a picture of the local HIV epidemic and the continuum of care that is in place to meet the challenges of the epidemic for people and families at risk for and living with HIV. It enables the community to make sound decisions about how to organize and maintain an effective and efficient continuum of care by showing where we are now, where we need to go, how we intend to get there, and how we will monitor our progress.

Comprehensive planning does not end with the construction of the plan. It is important to note that planning is a journey and not a destination. It is only worth the time, effort and expense invested if it helps ensure that a comprehensive system of prevention and care are in place, and are maintained and refined over time to meet the essential health needs in a rapidly changing environment.

The Planning Council engages in the comprehensive planning process as a cooperative effort between the various funding streams and planning bodies. This planning document is intended to embody the goals of, and for, the entire HIV community. This includes the people who plan for, provide, and receive services in Palm Beach County, Florida. The complexity of the HIV disease and the people it affects, in addition to the complexity of funding and administration of HIV prevention and care programs, has produced a diverse system that is often fragmented. Service providers and planning groups are bound by different funding and legislative requirements and therefore, focus their efforts on separate pieces of the continuum of care (e.g., prevention funded primarily by CDC vs. primary care financed nearly entirely by HRSA). Added to the decision-making process are individuals who may or may not share cultural or social backgrounds, sexual orientation, HIV status, or work styles. Furthermore, the planning process is a demanding process that requires a great amount of time and effort. By accepting the comprehensive plan, all parties involved committed to a collaborative effort to implement the plan through the resources available through the various funding streams. This plan hopes to bring all pieces together and address the challenges of a coordinated, collaborative approach to monitoring and evaluating the system of care.

The Palm Beach County CARE Council and its various committees have a role in monitoring the progress toward achieving the Goals, Objectives, and Activities of this Plan. The CARE Council and the Executive Committee will oversee and direct all activities relating to the CARE Council. Over the next three fiscal years they will assure the fulfillment of the activities stated in Section 3. They will be responsible for identifying the appropriate composition for each task force and work group and determine the expertise needed to accomplish all activities. Each committee will make reports to the CARE Council at each meeting. The CARE Council will monitor the progress of each group and report back to the designated committees or groups. Because of the many work groups and committees, the CARE Council will need to periodically review the progress made by each entity. As goals are met, the CARE Council will need to establish priorities through the Executive and Priorities and Allocations Committees for the work of each subsequent group. This is necessary because fiscal constraints do not support work for all the working groups to operate simultaneously. In addition, the CARE Council will maintain representation in the SCSN process.

The Planning Committee is the arm of the CARE Council that has specific responsibility for the development and implementation of the goals contained within this document. This committee will focus on working toward coordinating a strong collaboration of consumers, providers, and

community leaders.

The Priorities and Allocations Committee will hold several public forums annually in order to obtain feedback from the community. The forums also include opportunities for networking, and educational opportunities for the public on issues such as stigma, HIV/AIDS treatment and care, as well as CARE Council activities. All information gathered is forwarded to the CARE Council.

The Community Awareness Committee (CAC) will be critical over the next 3 years in the implementation of the Comprehensive Plan 2009-2012. The CAC will educate the community on advocacy, treatment advances, HIV prevention. This committee will work toward building a network with CPP, EPICC, consumers, and providers.

The Membership Committee will continue to recruit members that are reflective of the epidemic and assure the training of members. Applications will be distributed to each contracted agency so that they might have an opportunity to submit an application for a committee member to represent their constituency, as well as to help promote membership to the clients they serve. The Membership Committee will establish the composition of the CARE Council, taking into consideration expertise and representation of diverse interests. This committee also has the option of recruiting participation from outside sources, when the group requires specific expertise. The CARE Council can benefit from the expertise available in the community at large in the development and implementation of many of its new programs, particularly those involving the use of advanced computer technologies.

A task of the Palm Beach County HIV CARE Council's Quality Assurance Committee will be to develop monitoring factors, baseline data, monitoring tools, and time frames. When the framework is complete, the Grantee and CARE Council staff can begin to monitor progress and identify barriers in reaching goals and objectives of the plan. The Quality Assurance Committee will then report their findings to the respective committees. In addition to monitoring the progress of the comprehensive plan the CARE Council will collect information that will assist the planning bodies in maintaining a clear picture of the changing face of the HIV virus the people we serve and the services available to these constituents.

Grantee and CARE Council support staff have a critical role to play in monitoring the progress of the Comprehensive Plan 2009-2012. The staff will provide consultation and support to each of the committees. Staff will continue to conduct and publicize research such as needs assessments and special studies. Staff will update the website (www.carecouncil.org), promote all CARE Council activities, and publicize all meetings.

B. Monitoring

Perhaps the biggest motivation behind comprehensive planning is the aim of organizing and delivering services within an ideal continuum of care. The core of the final plan is the implementation plan which includes goals and objectives developed to meet that ideal. Implementation of the plan requires monitoring the progress made in achieving stated goals and objectives. Monitoring allows for early recognition of problems so that barriers to progress can be identified and reported to planning bodies so that adjustments and modifications can be made

in programs and services to remedy the problems.

Contract monitoring is performed by the Part A grantee. This process includes monitoring of all programs receiving Ryan White Part A funds. It retains a comprehensive annual review of all contracted programs. The purpose of this process is contract oversight. The methods of the monitoring process focus on accessing the performance of service providers in meeting goals and objectives of their contracts and of the larger HIV Service System. These methods include the review of monthly invoices to compare actual units of service provided with budgeted funding; review of narrative program reports, submitted quarterly, wherein the providers themselves describe their progress in meeting stated goals and objectives and time line completions; and annual contract monitoring.

The monitoring process includes the following reporting requirements which apply to all contractors: 1) monthly invoicing; 2) tracking and reporting deliverables; 3) reporting unduplicated numbers of clients served; 4) administrative and fiscal reporting; 5) annual program, administrative, and fiscal reporting; and 6) quality review and program evaluation reporting. Reports are obtained from contractors monthly, quarterly, and annually.

In order to comply with HRSA's data report (RDR) requirements, all contracting agencies also must submit annual program reports which are to include: 1) aggregate information on units of services provided; 2) information relevant to the unduplicated clients served (number, gender, age, ethnicity, living situation, income, employment status, medical insurance status, HIV status, and primary health source; and 3) a narrative description of program progress.

For fiscal accounting purposes, contractors must submit monthly invoices that list actual expenditures for each program. Units of service provided must accompany each monthly invoice. Contractors also need to submit an annual agency audit report within 90 days of the end of the contractor's fiscal year.

In addition to the contractual monitoring, the Part A grantee coordinates Standards of Care (SOC) Assessments. The SOC are designed to guide service provision and set minimum expectations in the respective service categories and serve as the basis for indicators and performance measures. These assessments are designed to focus on the adherence and implementation of the SOC specific to the various services categories currently funded under the Ryan White Part A Program.

The Planning Council Committees created the SOC with the aim/approach of developing comprehensive standards that incorporated the full range of operational and clinical factors. A joint effort by the Planning Council support staff, the Quality Management Committee, and the Quality Management Coordinator is working to ensure that this ongoing approach will result in the SOC with defined and measurable outcomes that align with our Continuum of Care.

C. Evaluation

Because a comprehensive plan only makes sense only if it improves the quality of life for people and families at risk for and living with HIV, it is important that the plan keep pace with

the changing dynamics of the HIV Spectrum Disease. Examples of factors that fluctuate and change over time include the epidemiology of the disease, legislative and funding requirements, treatment protocols and the current health care delivery system. In addition to monitoring the progress made in achieving goals, a comprehensive plan must also address evaluation strategies to assess the continued relevance of the goals and objectives. Such strategies will provide an ongoing process for ensuring that the plan remains a viable working document.

The CARE Council will serve as the mechanism for tracking changes in the environment and determining when and how each component of the evaluation will be completed. The information gathered by relevant committees will be evaluated and used in decision making. Below are some examples of information to be collected:

- Changes in the epidemiology include the distribution of AIDS cases and people living with HIV in the EMA Factors such as age, gender, race/ethnicity, mode of transmission, stage of illness, employment and health insurance status, housing status and other socio-economic variables must also be considered. All planning bodies regularly update epidemiological information. The CARE Council will serve to integrate this data and present it to the community.

- Information on service needs is collected through needs assessments activities, including consumer and provider surveys, focus groups, interviews, and public forums. A comprehensive needs assessment is conducted every three years and special studies are produced every subsequent year to examine, explore and describe issues as they emerge from the environment. Much of the HIV community already participates in these endeavors yet, it is hoped that in the future, the CARE Council will be able to encourage more community members to engage in the process.

- Client-and system-level outcome tracking is conducted throughout the EMA. The EMA is in the process of implementing the CAREWare Data System and require all Part A -funded agencies to enter information such as viral load and CD4 counts, among other important biological and clinical indicators. These data can then be extracted into the software module to assist with the unduplication of client and will allow data base queries by client, provider, and service category. The collection of data was previously done through the FACTORS data system. Outcomes have been developed to measure the impact for each of the service categories as part of the Standards of Care (SOC). The HAB Performance Measures will be used to measure medical outcomes. These include:
    - **CD4 T-cell count-** percentage of clients with HIV infection who had 2 or more CD4 T-cell counts performed in the measurement year
    - **HAART-** percentage of clients with AIDS who are prescribed HAART
    - **Medical Visits-** percentage of clients with HIV infection who had 2 or more medical visits in an HIV care setting in the measurement year
    - **PCP Prophylaxis-** percentage of clients with HIV infection and a CD4 T-cell count below 200 cells/mm3 who were prescribed PCP prophylaxis
    - **ARV Therapy for Pregnant Women-** percentage of pregnant women with HIV infection who are prescribed antiretroviral therapy

A P P E N D I X

A. Glossary

Accountability: A framework that has been created to determine how a group and its members will be responsive and responsible to itself and the community.

ACTG (AIDS Clinical Trials Group): A network of medical centers around the country in which federally-funded clinical trials are conducted to test the safety and efficacy of experimental treatments for AIDS and HIV infection. These studies are funded by the National Institute of Allergy and Infectious Diseases (NIAID).

Acute: Reaching a crisis quickly; very sharp or severe.

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

Administrative Agent or Fiscal Agent: An organization, agent, or other entity (i.e., public health department or community based organization) which assists a grantee in carrying out administrative activities (e.g., disbursing program funds, developing reimbursement and accounting systems, developing Requests for Proposals (RFPs), monitoring contracts). Not all grantees use a separate administrative or fiscal agent.

Advocacy: Representation of the needs of a particular community. This can involve education of health and social service providers, local policy makers, elected officials and the media.

AETC: (AIDS Education and Training Center): Regional centers providing education and training for primary care professionals and other AIDS-related personnel. AETCs are authorized under Part F of the Ryan White Act and administered by HRSA's HIV/AIDS Bureau's Division of Training and Technical Assistance (DTTA).

Affected Communities: Groups of people who are either infected with the HIV virus or who are family members/significant others of infected individuals.

Aggregate Data: Combined data, composed of multiple elements, often from multiple sources; for example, combining demographic data about clients from all primary care providers in a service area generates aggregate data about client characteristics.

AIDS (Acquired Immunodeficiency Syndrome): A severe immunological disorder caused by a retrovirus and resulting in susceptibility of opportunistic infections and certain rare cancers. This disease is caused by the human immunodeficiency virus (HIV).

AIDS Network: The AIDS Network were established to plan, develop and deliver comprehensive health and support services to meet the identified needs of individuals with HIV/AIDS in a cost effective manner. The Florida Legislature funds the Network. The department is ultimately responsible and accountable to the legislature for the network's appropriate utilization of the funds as established.

Allocation: Total dollar amount that may be expended for a service category.

Antibody: A substance in the blood formed in response to invading disease agents such as viruses, bacteria, fungi and parasites. Antibodies defend the body against invading disease agents. Most HIV tests are antibody test including ELISA, Synthetic Peptide, Western Blot.

Antiretroviral: A substance that fights against a retrovirus, such as HIV.

ASO (AIDS Service Organization): An organization which provides medical or support services primarily or exclusively to populations infected with and affected by HIV disease.

At-Risk Communities: Specific groups of people in a defined area who have a greater chance of becoming HIV-infected due to behaviors of actions common to the group (i.e., injection drug users, men who have sex with men).

Attitude: A state of mind or feeling regarding a particular subject.

Average: A way of describing the typical value or central tendency among a group of numbers, such as average age or average income.

Bar Graph or Bar Chart: A visual way to show and compare scores or values for different categories of variables; for example, a bar chart might be used to show the number of reported AIDS cases who are from each major racial/ethnic group; the taller the bar, the larger the number of AIDS cases.

Behavioral Risk Factor Surveillance System (BRFSS): A telephone survey conducted by most states which provides information about a variety of health risk behaviors from smoking and alcohol use to seat belt use and knowledge of HIV transmission.

Behavioral Science: A science, such as psychology of sociology, that seeks to survey and predict responses (behaviors and actions) of individuals or groups of people to a given situation (i.e. why people do what they do).

BHRD (Bureau of Health Resources Development): Bureau within the Health Resources and Services Administration (HRSA, [her-sa]), U.S. Department of Health and Human Services, which is responsible for administering the Ryan White Part A, Part B and SPNS (Special Projects of National Significance), among other programs.

Bylaws: Standing rules written by a group to govern their internal function; address issues of voting, quorums, attendance, etc.

Capacity Development: Building the abilities and knowledge of individuals or groups so they may fully participate in a process or organization**.***

Casual Contact: Normal day-to-day contact (i.e. shaking hands among people at home, school, work or in the community).

CBO (Community Based Organization): An organization which provides services to locally-defined populations, which may or may not include populations infected with or affected by HIV disease.

CDC (Centers for Disease Control and Prevention): The Department of Health and Human Services (DHHS) agency that administers HIV/AIDS prevention programs, including the HIV Prevention Community Planning process, among other programs. The CDC is responsible for monitoring and reporting infectious diseases, administers AIDS surveillance grants and publishes epidemiologic reports such as the HIV/AIDS *Surveillance Report*.

CD4 or CD4+Cells: Also known as "helper" T-cells, these cells are responsible for coordinating much of the immune response. HIV's preferred targets are cells that have a docking molecule called "cluster designation 4" (CD4) on their surfaces. Cells with this molecule are known as CD4-positive (CD4+) cells. Destruction of CD4+ lymphocytes is the major cause of the immunodeficiency observed in AIDS, and increasing CD4 levels appear to be the best indicator for developing opportunistic infections.

CD4 Cell Count: The number of T-helper lymphocytes per cubic millimeter of blood. The CD4 count is a good predictor of immunity. As CD4 cell count declines, the risk of developing opportunistic infections increases. The normal range for CD4 cell counts is 500 to 1500 per cubic millimeter of blood. CD4 counts should be rechecked at least every 6 to 12 months if CD4 counts are greater than 500/mm3. If the count is lower, testing every 3 months is advised. A CD4 count of 200 or less indicates AIDS.

CEO: (Chief Elected Official): The official recipient of the Ryan White Part A funds within the EMA, usually a city mayor, county executive, or chair of the county board of supervisors. The CEO is ultimately responsible for administering all aspects of the Ryan White Act in the EMA and ensuring that all legal requirements are met. In EMAs with more than one political jurisdiction, the recipient of Ryan White Part A funds is the CEO of the city or urban county that administers the public health agency that provides out patient and ambulatory services to the greatest number of people with AIDS in the EMA. In Palm Beach County the CEO is the Palm Beach County Board of County Commissioners.

Chronic: A prolonged, lingering or recurring state of disease.

Closed- Ended Questions: Questions in an interview or survey format that provide a limited set of predefined alternative responses; for example, a survey might ask PLWH/A respondents if they are receiving case management services, and if they say yes, ask "About how often have you been in contact with your case manager for services during the past six months, either in

person or by telephone?" and provide the following response options: Once a week or more, 2-3 times a month, about once a month, 3-5 times, 1-2 times, not at all.

Coalesce: To grow together in order to form one whole unit.

Coalition: An alliance of community groups, organizations or individuals to meet a goal or purpose.

Coding: The process of "translating" data from one format to another, usually so the information can be entered into a computer to be tabulated and analyzed; often, coding involves assigning numbers to all the possible responses to a question, such as Yes=1, No=2, Not Sure =3, No Response=0.

Collaboration: A group of people or organizations working together to solve a problem in a process where individual views are shared and discussed and may be changed as the group progresses toward its goals.

Community: A group of people living in a defined area who share a common language, ethnicity, geographic area, behavior or belief.

Co-Morbidity: A disease or condition, such as mental illness or substance abuse, co-existing with HIV disease.

Comprehensive Planning: The process of determining the organization and delivery of HIV services. This strategy is used by planning bodies to improve decision making about services and maintain a continuum of care for PLWH/As.

Compromise: A "give and take" process where all points of view are considered and weighed in order to reach a common plan or goal.

Conflict: A disagreement among two or more parties.

Conflict of Interest: A conflict between one's obligation to the public good and one's self-interest. For example, if the board of a community-based organization is deciding whether to receive services from Company A, and one of the board members also owns stock in Company A, that person would have a *conflict of interest.*

Confidentiality: Keeping information private or secret.

Consortium/HIV Care Consortium: A regional or statewide planning entity established by many State grantees under Ryan White Part B to plan and sometimes administer Part B services. An association of health care and support service providers that develops and delivers services for PLWH/A under Ryan White Part B.

Continuity: Having the same or a similar situation, person or group over a period of time.

Continuum of Care: An approach that helps communities plan for and provide a full range of emergency and long-term service resources to address the various needs of PLWH/A.

Cost Effective: Economical and beneficial in terms of the goods or services received for the money spent.

County Health Department AIDS Patient Care: This funding is used for patient care services. An allocation is received by 29 of the 67 County Health Departments (CHD). The CHDs send Annual Plans to the Bureau of HIV/AIDS and report regularly as to the spending by category of these funds.

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

Data: Information that is used for a particular purpose.

Data Analysis: Careful, rigorous study of data; usually involves studying various elements of information and their relationships.

DCBP (Division of Community Based Programs): The division within HRSA's HIV/AIDS Bureau that is responsible for administering Ryan White Part C and Part D, and the HIV/AIDS Dental Reimbursement Program.

Decimal Places: Number of digits to the right of the decimal point, which separates numbers with a value greater than one from numbers with a value of less than one; the more numbers or decimal places used, the more precise the number; for example, 34.03 has two decimal places.

Defined Populations: People grouped together by gender, ethnicity, age, or other social factors.*

Dementia: The loss of metal capacity that affects a person's ability to function.

Department of Health and Human Services (DHHS): The U.S. government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves. DHHS includes more than 300 programs, covering a wide spectrum of activities. The Department's programs are administered by 11 operating divisions such as the Centers for Disease Control and Prevention, the Food and Drug Administration and the National Institutes of Health (see the entries for these agencies). DHHS works closely with state and local governments, and many DHHS-funded services are provided at the local level by state or county agencies, or through private-sector grantees. **Internet address:** **http://www.hhs.gov/**.

DHS (Division of HIV Services): The entity within Bureau of Health Resources Development (BHRD) responsible for administering Ryan White Part A and B.

Diagnosis: Confirmation of illness based on an evaluation of a patient's medical history.

Dispute: A conflict in which the parties involved have brought an internal disagreement.

Diverse/Diversity: Made up of all kinds; a variety of people and perspectives in one organization, process, etc.

Double blind Study: A clinical trial design in which neither the participating individuals nor the study staff know which patients are receiving the experimental drug and which are receiving a placebo or another therapy. Double-blind trials are thought to produce objective results, since the expectations of the doctor and the patient about the experimental drug do not affect the outcome. See Blinded Study.

Drug Resistance: The ability of some disease-causing microorganisms, such as bacteria, viruses, and mycoplasma, to adapt themselves, to grow, and to multiply even in the presence of drugs that usually kill them. See Cross-Resistance.

DSS (Division of Service Systems): The division within HRSA's HIV/AIDS Bureau that is responsible for administering Part A and B (including the AIDS Drug Assistance Program, ADAP).

DTTA (Division of Training and Technical Assistance): The division within HRSA's HIV/AIDS Bureau that is responsible for administering the AIDS Education and Training Centers (AETC) Program and technical assistance and training activities of the HIV/AIDS Bureau.

Efficacy: Power or capacity to produce a desired effect. If a prevention program has efficacy, it has been successful in achieving what it was intended to do.

ELISA (Enzymes-Linked Immunosorbent Assay): The most common test used to detect the presence of HIV infection. A positive ELISA test result must be confirmed by another test called a Western Blot.

EMA (Eligible Metropolitan Area): The geographic area eligible to receive Ryan White Part A funds. The boundaries of the eligible metropolitan area are defined by the Census Bureau. Eligibility is determined by AIDS cases reported to the Centers for Disease Control and Prevention (CDC). Some EMAs include just one city and others are composed of several cities and/or counties. Some EMAs extend over more than one state.

Encephalitis: A brain inflammation of viral or other microbial origin. Symptoms include headaches, neck pain, fever, nausea, vomiting, and nervous system problems. Several types of opportunistic infections can cause encephalitis.

Epidemic: A disease that occurs clearly in excess of normal expectation and spreads rapidly through a demographic segment of the human population. Epidemic disease can be spread from person to person or from a contaminated source such as food or water.

Epidemiologic Profile: A description of the current status and projected future spread of an infectious disease (an epidemic) in a specified geographic area; one of the required components of a needs assessment.

Epidemiology: The branch of medical science that studies the incidence, distribution, and control of disease in a population.

EPICC (Education, Prevention, Intervention, Care Coalition): EPICC is an organization located in Palm Beach County, Florida, which provides a venue for organizations to meet, discuss and plan for common interest issues regarding HIV/AIDS.

Ethnicity: A group of people who share the same place or origin, language, race, behaviors, or beliefs.

Etiquette: Different groups who have certain norms for acceptable and unacceptable behavior that is important when conflict arises.

Evidence-based: In prevention planning, evidence is based on scientific data, such as AIDS cases reported to health departments and needs assessments conducted in a scientific manner.

Exposure Category: In describing HIV/AIDS cases, same as transmission categories; how an individual may have been exposed to HIV, such as injecting drug use, men who have sex with men, and heterosexual contact.

Family Centered Care: A model in which systems of care under Ryan White Title IV are designed to address the needs of PLWH/As and affected family members as a unit, providing or arranging for a full range of services. The family structures may range from the traditional, biological family unit to non-traditional family units with partners, significant others, and unrelated care givers.

Fiscal Year: A twelve-month period set up for accounting purposes. For example, the federal government's fiscal year runs from October 1st to September 30th of the following year.

FDA (Food and Drug Administration): The DHHS agency responsible for ensuring the safety and effectiveness of drugs, biologic, vaccines, and medical devices used (among others) in the diagnosis, treatment, and prevention of HIV infection, AIDS, and AIDS-related opportunistic infections. The FDA also works with the blood-banking industry to safeguard the nation's blood supply.

Financial Status Report (Form 269): A report that is required to be submitted within 90 days after the end of the budget period that serves as documentation of the financial status of grants according to the official accounting records of the grantee organization.

Focus Group: A method of information collection involving a carefully planned discussion among a small group led by a trained moderator.

Formula Grant Application: The application used by EMAs and States each year to request an amount of Ryan White funding which is determined by a formula based on the number of reported AIDS cases in their location and other factors; the application includes guidance from DHS on program requirements and expectations.

Forum: A meeting or other outlets that provides an opportunity to share ideas and concerns on a particular topic in order to resolve disputes.

Frequency Distribution: A tally of the number of times each score or response occurs in a group of scores or response; for example, if 20 women with HIV provided information about how they were infected with the virus, the frequency distribution might be 8=injection drug use, 5= heterosexual contact with an injection drug user, 3=other heterosexual contact, 1= blood transfusion, and 3=don't know.

Gender: A person's sex (i.e. male or female)

Generalizability: The extent to which findings or conclusions from a sample can be assumed to be true of the entire population from which the sample was drawn.

Genotypic Assay: A test which analyzes a sample of the HIV virus from the patient's blood to identify actual mutations in the virus that are associated with resistance to specific drugs.

Grant: The money received from an outside group for a specific program or purpose. A grant application is a competitive process that involves detailed explanations about why there is a need for the money and how it will be spent.

Grantee: The recipient of Ryan White funds responsible for administering the funds. (for a full listing of definitions of grants management terms, see the PHS Grants Policy Statement, which can be accessed at http://www.nih.gov/grants/policy/gps/.). The West Palm Beach EMA's Grantee is the Palm Beach County Department of Community Services.

Guidelines: Rules and structures for creating a program.

HAART (Highly Active Antiretroviral Therapy): An aggressive anti-HIV treatment usually including a combination of two or more drugs with activity against HIV whose purpose is to reduce viral load to undetectable levels in the blood. There is a question about the virus "hiding out" in lymph glands, sperm, etc.

HCFA (Health Care Financing Administration): The DHHS agency that is responsible for administering the Medicaid, Medicare, and Child Health Insurance Programs.

Hepatitis: An inflammation of the live, which may be caused by bacterial or viral infection, parasitic infestation, alcohol, drugs, toxins, or transfusion of incompatible blood. Although many cases of hepatitis are not a serious threat to health, the disease can become chronic and can sometimes lead to liver failure and death. There are four major types of viral hepatitis: (1) hepatitis A, caused by infection with the hepatitis A virus, which is spread by fecal-oral contact;

(2) hepatitis B, caused by infection with the hepatitis B virus (HBV), which is most commonly passed on to a partner during intercourse, especially during anal sex, as well as through sharing of drug needles; (3) non-A, non-B hepatitis, caused by the hepatitis C virus, which appears to be spread through sexual contact as well as through sharing of drug needles (another type of non-A, non-B hepatitis is caused by the hepatitis E virus, principally spread through contaminated water); (4) delta hepatitis, which occurs only in persons who are already infected with HBV and is caused by the HDV virus; most cases of delta hepatitis occur among people who are frequently exposed to blood and blood products such as persons with hemophilia.

HICP (Health Insurance Continuation Program): A program authorized and primarily funded under Ryan White Part B that makes premium payments, co-payments, deductibles, or risk pool payments on behalf of a client to maintain his/her health insurance coverage.

High-Risk Behavior: Actions or choices that may allow HIV to pass from one person to another, especially through activities such as sexual intercourse and injecting drug use.

HIV (Human Immunodeficiency Virus): The virus that causes AIDS.

HIV/AIDS Bureau (HAB): The bureau within the Health Resources and Service Administration (HRSA) of the DHHS that is responsible for administering the Ryan White funding. Within HAB, the Division of Service Systems administers Part A, Part B, and the AIDS Drug Assistance Program (ADAP); the Division of Community Based Programs administers Part C, Part D, and the HIV/AIDS Dental Reimbursement Program; and the Division of Training and Technical Assistance administers the AIDS Education and Training Centers (AETC) Program. The Bureau's Office of Science and Epidemiology administers the Special Projects of National Significance (SPNS) Program.

HIV/EIS (HIV Early Intervention Services/Primary Care): Applied in the outpatient setting, HIV/EIS assures a continuum of care which include: (1) identifying persons at risk for HIV infection and offering them counseling, testing, and referral services, and (2) providing lifelong comprehensive primary care for those living with HIV/AIDS.

HIV/AIDS Dental Reimbursement Program: The program within HRSA's HIV/AIDS Bureau Division of Community Based Programs that assists accredited dental schools and post-doctoral dental programs with uncompensated costs incurred in providing oral health treatment to HIV positive patients.

HIV-Related Mortality Data: Statistics that represent deaths caused by HIV infection.

Home- and Community-Based Care: A category of eligible services that States may fund under Ryan White Part B.

Homophobia: An aversion to gay, transgender or homosexual person(s).

HOPWA (Housing Opportunities for Persons With AIDS): A program administered by the U.S. Department of Housing and Urban Development (HUD) which provides funding to support housing for PLWH/A and their families.

HRSA (Health Resources and Services Administration): The DHHS agency that is responsible for administering the Ryan White Act.

HUD (Department of Housing and Urban Development): The federal agency responsible for administering community development, affordable housing, and other programs including Housing Opportunities for Persons with HIV/AIDS (HOPWA).

IDU/IVDU (Injecting Drug User/Intravenous Drug User): A term used to refer to people who inject drugs directly into their blood streams by using a needle and syringe.

IGA (Intergovernmental Agreement): A written agreement between a governmental agency and an outside agency that provides HIV services.

Immune System: An integrated body system of organs, tissues, and cells within the body that protect it from viruses, bacteria, parasites, and fungi.

Incidence: The number of new cases of a disease that occur during a specified time period.

Incidence Rate: The number of new cases of a disease or condition that occur in a defined population during a specified time period, often expressed per 100,000 population. AIDS rates are often expressed this way.

Inclusion: An assurance that all affected communities are represented in the community planning process.

Key Informant Interview: A non-survey information collection method involving in-depth interviews with a small number of individuals carefully selected because of their experiences and/or knowledge related to the topic of interest. An interview guide or checklist is used to guide the discussion. Also called a “key person interview”.

KS (Kaposi's Sarcoma): A cancer that can involve the skin, mucous membranes, and lymph nodes; appears as grayish purple spots.

Lead Agency: The agency responsible for contract administration; also called a fiscal agent. An incorporated consortium sometimes serves as the lead agency. The lead agency for HOPWA is the City of West Palm Beach, the lead agency for Part B is Treasure Coast Health Council, the lead agency for Florida Department of Health Patient Care and AIDS Network is the Palm Beach County Health Department.

Leadership: The ability or skills needed to conduct, influence or guide community groups and individuals in any effort, or the process of developing these abilities and skills.

Lipodystrophy: A disturbance in the way the body produces, uses, and distributes fat. Lipodystrophy is also referred to as "buffalo hump," "protease paunch," or "Crixivan potbelly." In HIV disease, lipodystrophy has come to refer to a group of symptoms that seem to be related to the use of protease inhibitor drugs. How protease inhibitors may cause or trigger lipodystrophy is not yet known. Lipodystrophy symptoms involve the loss of the thin layer of fat under the skin, making veins seem to protrude; wasting of the face and limbs; and the accumulation of fat on the abdomen (both under the skin and within the abdominal cavity) or between the shoulder blades. Women may also experience narrowing of the hips and enlargement of the breasts.

Macrophage: A type of white blood cell that surrounds and consumes infected cells, disease agents, and dead material.

Maintenance of Effort: The Part A and Part B requirement to maintain expenditures for HIV-related services/activities at a level equal to or exceeding that of the preceding year.

Mandate: A directive or command that can be used to refer to a call for change as authorized by a government agency.

Mean: Arithmetic average calculated by adding up all the values or the responses to a particular question and dividing by the number of cases; for example, to determine the mean age of 12 children in a pediatric AIDS program, add up their individual ages and divide by 12.

Measurable Objective: An intended goal that can be proved or evaluated.

Median: A type of average which calculates the central value, the one that falls in the middle of all the values when they are listed in order from highest to lowest; for example, if the annual incomes of seven families were $37,231, $35,554, $30,896, $ 27,432, $24,334, $19,766, and $18,564, the median would be $27,432.

Medicaid: Medicaid is the United States health program for individuals and families with low incomes and resources. It is an entitlement program that is jointly funded by the states and federal government, and is managed by the states.

Medicare: Medicare is a social insurance program administered by the United States government, providing health insurance coverage to people who are either age 65 and over, or who meet other special criteria. The "Original Medicare" program has two parts: Part A (Hospital Insurance), and Part B (Medical Insurance). Only a few special cases exist where prescription drugs are covered by Original Medicare, but as of January 2006, Medicare Part D provides more comprehensive drug coverage.

Minority: A racial, religious, political, national or other group regarded as different from the larger group of which it is a part.

Mode: A type of average which identifies the most frequently occurring value; for example, suppose a prevention project included 13 youth of the following ages: 16,16,15,14,14,14,14,13,13,12,12,11,10; the mode would be 14, which occurs four times.

Monogamy: The practice of being married to one person, or being in an intimate relationship with a single individual.

Mutation: In biology, a sudden change in a gene or unit of hereditary material that results in a new inheritable characteristic. In higher animals and many higher plants, a mutation may be transmitted to future generations only if it occurs in germ -- or sex cell -- tissue; body cell mutations cannot be inherited. Changes within the chemical structure of single genes may be induced by exposure to radiation, temperature extremes, and certain chemicals. The term mutation may also be used to include losses or rearrangements of segments of chromosomes, the long strands of genes. Mutation, which can establish new traits in a population, is important in evolution. As related to HIV: During the course of HIV disease, HIV strains may emerge in an infected individual that differ widely in their ability to infect and kill different cell types, as well as in their rate of replication. Of course, HIV does not mutate into another type of virus.

Myopathy: Progressive muscle weakness. Myopathy may arise as a toxic reaction to AZT or as a consequence of the HIV infection itself.

Needs Assessment: A process of obtaining and analyzing findings about the needs of the community. Needs assessments may use several methods of information and data collection to determine the type and extent of unmet needs in a particular population or community. For example studying the needs of persons with HIV (PLWH) (both those receiving care and those not in care), identifying current resources (Ryan White Act and other) available to meet those needs, and determining what gaps in care exist.

Networking: Establishing links among agencies and individuals that may not have existed previously, which strengthens links that are used infrequently. Working relationships can be established to share information and resources on HIV prevention and other areas.

NIH (National Institute of Health): The federal agency that includes 24 separate research institutes and centers, among them the National Institute of Allergy and Infectious Diseases, National Institute of Mental Health, and National Institute of Drug Abuse. Within the Office of the NIH Director is the Office of AIDS Research, which is responsible for planning, coordinating, evaluating, and funding all NIH AIDS research.

NGO (Non-Governmental Organization): A private group that is not associated with federal, state, or local agencies; however, they often have programs or services that are similar to those offered by government agencies.

NIH (National Institute of Health): A division of the federal Health and Human Services agency which conducts medical research and offers the AIDS Clinical Trials Program.

NNRTI (Non-Nucleoside Reverse Transcriptase Inhibitor): The newest class of antiretroviral agents (e.g., delavirdine, nevirapine). NNRTIs stop HIV production by binding directly onto an enzyme (reverse transcriptase) in a CD4+ cell and preventing the conversion of the HIV virus' RNA to DNA.

Nucleoside Analog: Also called NRTI (Nucleoside Reverse Transcriptase Inhibitor) is the first effective class of antiviral drugs (e.g., AZT, ddl, ddC, d4T). NRTIs act by incorporating themselves into the HIV DNA, thereby stopping the building process. The resulting HIV DNA is incomplete and unable to create new virus.

OMB (Office of Management and Budget): The office within the executive branch of the Federal government which prepares the President's annual budget, develops the Federal government's fiscal program, oversees administration of the budget, and reviews government regulations.

Open-Ended Questions: Questions in an interview or survey format that allow those responding to answer as they choose, rather than having to select one of a limited set of predefined alternative responses.

Opportunistic Infection (OI): An infection or cancer that occurs in persons with weak immune systems to fight off bacteria, viruses and microbes due to AIDS, cancer, or immunosuppressive drugs such as corticosteroids or chemotherapy. Karposi's Sarcoma (KS), pneumocystis pneumonia (PCP), toxoplasmosis, and cytomegalovirus are all examples of opportunistic infections.

OSE (Office of Science and Epidemiology): The office within HRSA's HIV/AIDS Bureau that administers the SPNS Program, HIV/AIDS evaluation studies, and the Annual Administrative Report (AAR).

Over-representation/Under-representation: Term often used to indicate that a particular sub-population makes up a larger proportion- or a smaller proportion - of a particular group than would be expected, given its representation in the total population; for example, Hispanics and African Americans are both over represented among AIDS cases, compared to their percentage in the U.S. population, while Asians/Pacific Islanders are under-represented.

Over-sampling: A procedure in stratified random sampling in which a larger number of individuals from a particular group (or stratum) are selected than would be expected given their representation in the total population being sampled; this is done in order to have enough subjects to permit separate tabulation and analysis of that group; for example, minorities are often over sampled to permit separate analyses of data by racial/ethnic group as well as comparisons among racial/ethnic groups.

Palm Beach County Board of County Commissioners: The PBC Board of County Commissioners is the CEO (grantee) of Ryan White Part A funds.

Palm Beach County Department of Community Services (DCS): The DCS acts as fiscal agent for the PBC Board of County Commissioners and is responsible for the disbursement of Ryan White Part A funds.

Pandemic: An epidemic that occurs in a large area or globally, such as with HIV and AIDS.

Parity: A situation in which all members have an equal voice, vote and input into a decision making process.

Partner Notification: The confidential process of informing the sexual and needle sharing partners of an HIV infected person that they may also be infected.

Part A: The part of the Ryan White Act that provides emergency assistance to localities (EMAs) disproportionately affected by the HIV epidemic.

Part B: The part of the Ryan White Act that enables States and Territories to improve the quality, availability, and organization of health care and support services to individuals with HIV and their families.

Part C: The part of the Ryan White Act that supports outpatient primary medical care and early intervention services to people living with HIV disease through grants to public and private non-profit organizations.

Part D: The part of the Ryan White Act that supports coordinated services and access to research for children, youth, and women with HIV disease and their families.

Part F: The part of the CARE Act that includes the AETC Program, the SPNS Project, and the HIV/AIDS Dental Reimbursement Program.

PCP (Pneumocystis Carinii Pneumonia): A form of pneumonia caused by a parasite that does not usually cause infection in people with fully functioning immune systems; the leading cause of death in people with AIDS.

Percent: Literally, per hundred; a proportion of the whole, where the whole is 100; the percent is calculated by dividing the part of interest by the whole, and then multiplying by 100; for example, if you want to know what percent of recently reported AIDS cases are women, take the number of women AIDS cases (the part of interest), divide by the number of total AIDS cases (the whole), and multiply by 100; if your community has a total of 70 recently reported AIDS cases and 14 are women, divide 14 by 70 (=.2) and multiply by 100, and you get 20%.

Percentage Point: One one-hundredth; term used to describe numerical differences between two percent without comparing relative size; for example, if 16% of AIDS cases are Hispanic and 32% are African American, the difference is 16 percentage points (32 minus 16).

Perinatal: of, involving, or occurring during the period closely surrounding the time of birth.

Phenotypic Assay: A procedure whereby a sample DNA of a patient's HIV is tested against various antiretroviral drugs to see if the virus is susceptible or resistant to these drugs.

Public Health Service (PHS): The federal agency that addresses all issues of public health in the United States (the CDC is part of the Public Health Services).

Planning Council/HIV Health Services Planning Council: A planning body appointed or established by the Chief Elected Official of an EMA whose basic function is to establish a plan for the delivery of HIV care services in the EMA and establish priorities for the use of Ryan White Part A funds.

Planning Process: Steps taken and methods used to collect information, analyze and interpret it, set priorities, and prepare a plan for rational decision-making.

Population Count: Data which describe an entire population and were obtained from that entire population without sampling; the U.S. Census conducted every ten years is a population count since it attempts to obtain information from everyone living in the United States.

Prevalence: The total number of persons living with a specific disease of condition in a defined population at a given time (compared to the incidence, which refers to the number of new cases).

Prevalence Rate: The proportion of a population living at a given time with a condition or disease (compared to the incidence rate, which refers to new cases).

Primary Source Data: Original data that you collect and analyze yourself.

Priority Setting: The process used by a planning council or consortium to establish numerical priorities among service categories, to ensure consistency with locally identified needs, and to address how best to meet each priority.

Probability: The likelihood that a particular event or relationship will occur.

Probability Value: The probability that a statistical result- an observed difference or relationship- would have occurred by chance alone, rather than reflecting a real difference or relationship; statistical results are often considered to be significant if the probability, or **p value,** is less than .05, which means that there is less than a 5 % chance - 5 out of 100- that the result would have occurred by chance alone.

Profile of Provider Capability/Capability: A description of the extent to which the various services offered by a network of providers in the service area are available, accessible, and appropriate for PLWH/A, including particular populations.

Procurement: The process of selecting and contracting with providers, often through a competitive RFP process. For Part A, a responsibility of the grantee, not the planning council; for Part B, consortia are sometimes involved.

Prophylaxis: Treatment to prevent the onset of a particular disease (primary prophylaxis) or recurrence of symptoms in an existing infection that has been brought under control (secondary prophylaxis).

Proportion: A number smaller than one, which is calculated by dividing the number of subjects having a certain characteristic by the total number of subjects; for example, if 35 new AIDS cases have been reported in the community in the past year and 7 of them are women, the proportion of female AIDS cases is 7 divided by 35 or 1/5 (.2).

Protease: An enzyme breaks apart long strands of viral protein into separate proteins constituting the viral core and the enzymes it contains. HIV protease acts as new virus particles are budding off a cell membrane.

Protease Inhibitor: A drug that binds to and blocks HIV protease from working, thus preventing the production of new functional viral particles.

Public Health Service (PHS): An administrative entity of the U.S. Department of Health and Human Services; until October 1, 1995, HRSA was a division of the PHS.

Public Health Surveillance: An ongoing, systematic process of collecting, analyzing, and using data on specific health conditions and diseases, in order to monitor these health problems, such as the Centers for Disease Control and Prevention surveillance system for AIDS cases.

QA (Quality Assurance): A system of establishing standards and measuring performance in the attainment of those standards and with feedback of results in order to better meet those standards.

QI (Quality Improvement): A system of repetitive analysis of areas of potential improvement, ever increasing standards of performance, measurement of performance, and systems change to improve performance.

Ratio: A combination of two numbers that shows their relative size; the ratio of one number to another is simply the first number divided by the other, with the relation between the two numbers expressed as a fraction (x/y) or decimal (x:y/1), or simply the two numbers separated by a colon (x:y); for example, the ratio of minority to white pediatric AIDS cases in a community with 75 total cases, 45 among Hispanic and Black children and 30 among white children, would be 45/30 (45:30), 3/2 (3:2), or 1.5:1.

Raw Data: Data that are in their original form, as collected, and have not been coded or analyzed; for example, if a woman participating in an HIV nutrition workshop is tested to determine her knowledge of nutrition need and gets a score of 11, that is her raw score; if the score represented 11 correct answers out of 20, then the score could be converted to 11 divided by 20 times 100 or 55%, which is not a raw score.

Reliability: The consistency of a measure or question, in obtaining very similar of identical results when used repeatedly; for example, if you repeated a blood test three times of the same

blood sample, it would be reliable if it generated the same results each time. For example, a positive HIV test result is reliable because there are three tests on the blood sample.

Representative: Term used to indicate that a sample is similar to the population from which it was drawn, and therefore can be used to make inferences about that population.

Resource Allocation: The legislatively mandated responsibility of planning councils to assign the Ryan White Act funding amounts or percentages to established priorities across specific service categories, geographic areas, populations, or sub-populations.

Retrovirus: A type of virus that, when not infecting a cell, stores its genetic information on a single stranded RNA molecule instead of the more usual double stranded DNA. HIV is an example of a retrovirus. After a retrovirus penetrates a cell, it constructs a DNA version of its genes using a special enzyme, reverse transcriptase. This DNA then becomes part of the cell's genetic material.

Reverse Transcriptase (RT): A uniquely viral enzyme that constructs DNA from an RNA template, which is an essential step in the life cycle of a retrovirus such as HIV. The RNA-based genes of HIV and other retro viruses must be converted to DNA if they are to integrate into the cellular genome.

RFP (Request for Proposal): An open and competitive process for selecting providers of services (sometimes called RFP or Request for Proposal).

Rounding: Presenting numbers in more convenient units; rounding is usually done so that all numbers being compared have the same level of precision (one decimal place, for example); usually numbers under 5 are rounded down while 5 and over are rounded up; for example, you would round 3.08 to 3.1 and 4.14 to 4.1.

Ryan White HIV/AIDS Treatment and Modernization Act: The Federal legislation created to address the health care and service needs of people living with HIV/AIDS (PLWH/As) disease and their families in the United States and its Territories. The Act was enacted in 1990 (Pub. L. 101-381) and reauthorized in 1996, 2001 and 2006.

Salvage Therapy: A treatment effort for people who are not responding to, or cannot tolerate the preferred, recommended treatments for a particular condition. In the context of HIV infection, drug treatments that are used or studied in individuals who have failed one or more HIV drug regimens, including protease inhibitors. In this case failed refers to the inability to achieve or sustain low viral load levels.

SAMs (Self Assessment Modules): Self-assessment tools for planning bodies.

SAMHSA (Substance Abuse and Mental Health Services Administration): The DHHS agency that administers programs in alcohol abuse, substance abuse, and mental health.

Sample: A group of subjects selected from a total population or universe with the expectation that studying the group will provide important information about the total population.

SCSN (Statewide Coordinated Statement of Need): A written statement of need for the entire State developed through a process designed to collaboratively identify significant HIV issues and maximize CARE Act program coordination. The SCSN is legislatively mandated and the process is convened by the Part B grantee, with equal responsibility and input by all programs. Representatives must include all Ryan White Part A, B, C, D and Part F managers, providers, PLWH/As, and public health agency(s).

Secondary Source Data: Information that was collected by someone else, which can be analyze or re-analyze.

Secondary Analysis: Re-analysis of data or other information collected by someone else; for example, you might obtain data on AIDS cases in your metro area from the Centers for Disease Control and Prevention, and carry out some additional analyses of those data.

Serology: The study of blood serum and its component parts; blood serum is the fluid that separates from clotted or blood plasma that is allowed to stand. HIV testing is conducted using blood serum from the person being tested.

Seroconversion: The development of detectable antibodies of HIV in the blood as a result of infection. It normally takes several weeks to several months for antibodies to the virus to develop after HIV transmission. When antibodies of HIV appear in the blood, a person will test positive in the standard ELISA test for HIV. This is also referred to as the "window period".

Seroprevalence: The number of persons in a defined population who test HIV-population based on HIV testing of blood specimens. (Seroprevalence is often presented as a percent of the total specimens tested or as a rate per 100,000 persons tested.)

Seroprevalence Report: A report that provides information about the percent or rate of people in specific testing groups and populations who have tested positive for HIV.

SPNS (Special Projects of National Significance): A health services demonstration, research, and evaluation program funded under Part F of the Ryan White Act. SPNS projects are awarded competitively.

Statistical Significance: A measure of whether an observed difference or relationship is larger or smaller than would be expected to occur by chance alone; statistical results are often considered to be significant if there is less than a 5% chance -5 out of 100- that they would have occurred by chance alone.

Statistics: Information or data presented in numerical terms; quantitative data; often refers to numerical summaries of data obtained through surveys or analysis.

STD (Sexually Transmitted Disease): Infections spread by the transfer of organisms from person to person during sexual contact. Some examples are Chlamydia, Syphilis, Gonorrhea, Pubic Lice, Herpes, Human Papilloma virus (warts).

Stratified Random Sample: A random sample selected after dividing the population being studied into several subgroups or strata based on specific characteristics. Subsamples are then drawn separately from each of the strata. For example, the population of a community might be stratified by race/ethnicity before random sampling.

Supplemental Grant Application: An application for funding to supplement the Part A formula grant, and is awarded to EMAs on a competitive basis dependent upon demonstrated need and ability to use and manage the resources.

Surrogate Measures: Substitute measures, used to help understand a situation where adequate direct measures are not available; for example, it may be difficult to obtain good HIV surveillance data on teenagers, but incidence rates of sexually transmitted diseases (STDs) among teenagers can be used as surrogate measures of high-risk sexual behavior, since HIV is an STD, and people get STDs when they engage in unprotected sex.

Surveillance: An ongoing, systematic process of collecting, analyzing, and using data on specific health conditions and diseases (e.g. Centers for Disease Control and Prevention surveillance system for AIDS cases).

Surveillance Reports: Reports providing information on the number of reported cases of a disease such as AIDS, nationally and for specific locations and subpopulations; the Centers for Disease Control and Prevention issues such reports, providing both cumulative cases and new cases reported during a specific reporting period, such as each of the last two years.

Survey: Data collection method in which a number of individuals (often a probability sample) are asked the same set of questions, which are usually largely multiple choice or short-answer, and their responses are tabulated, analyzed, and compared to provide quantitative data about the population surveyed..

Survey Research: Research in which a sample of subjects is selected from a population and then interviewed or otherwise studied in order to gain information about the total population from which the sample was drawn.

T-cell: A type of white blood cell essential to the body's immune system; helps regulate the immune system and control B-cell and macrophage functions.

Tabulation of Data: Ordering and counting of quantitative data to determine the frequency of responses, usually the first step in data analysis; typically involves entering data into a computer for manipulation through some form of data analyses program.

Target Population: Populations to be reached through some action or intervention; may refer to groups with specific characteristics (e.g., race/ethnicity, age, gender, socioeconomic status) or to specific geographic areas.

TA (Technical Assistance): Training and skills development, which allows people and groups to perform their jobs better. This includes education and knowledge development in areas that range from leadership and communication to creating an effective needs assessment tool and understanding statistical data.

TOPWA: (Targeted Outreach for Pregnant Women Act): A Florida General Revenue funded HIV prevention intervention project.

Transmission Category: A grouping of disease exposure and infection routes; in relation to HIV disease, exposure groupings include injection drug use, men who have sex with men, heterosexual contact, perinatal transmission, etc.

Trend: Movement in a particular direction in the value of variables over times.

Trend Charts: Line charts which show changes or movement in the values of a particular variable over time; usually, values are recorded periodically as points on a graph, and then connected to show how the values are changing; often used to provide comparisons, such as separate lines showing reported AIDS cases among different population groups over time.

Tuberculosis (TB): A bacterial infection caused by *Mycobacterium tuberculosis*. TB bacteria are spread by airborne droplets expelled from the lungs when a person with active TB coughs, sneezes, or speaks. Exposure to these droplets can lead to infection in the air sacs of the lungs. The immune defenses of healthy people usually prevent TB infection from spreading beyond a very small area of the lungs. If the body's immune system is impaired because of infection with HIV, aging, malnutrition, or other factors, the TB bacterium may begin to spread more widely in the lungs or to other tissues. TB is seen with increasing frequency among persons infected with HIV. Most cases of TB occur in the lungs (pulmonary TB). However, the disease may also occur in the larynx, lymph nodes, brain, kidneys, or bones (extrapulmonary TB). Extrapulmonary TB infections are more common among persons living with HIV. See Multidrug Resistant TB.

Universe: The total population from which a sample is drawn.

Unmet Needs: Service needs of those individuals not currently in care as well as those in care whose needs are only partially met or not being met. Needs might be unmet because available services are either inappropriate for or inaccessible to the target population.

URS (Uniform Reporting System): Data collection system designed by HRSA to document the use of Title I and Title II funds.

Vaccine: A liquid made from modified or denatured viruses or bacteria that is injected in to the body and produces or increases immunity and protection against a particular disease.

Validity: The extent to which a survey question or other measurement instrument actually measures what it is supposed to measure; for example, a question which asks PLWH/A with TB whether they are taking their medication every day is valid if it accurately measures their actual level of medication use (as with directly observed therapy programs in which they are observed taking the medication), and it is not valid if they are not giving honest answers, and the question is really measuring the extent to which they realize that they should take their medication.

Value: Individual response or score; for example, if people responding to a survey are asked to state their age, each age is a value.

Variable: A characteristic or finding that can change or vary among different people or in the same person over time; for example, race/ethnicity varies among individuals, and income varies for the same individual over time.

Viral Load Test: In relation to HIV: Test that measures the quantity of HIV RNA in the blood. Results are expressed as the number of copies per milliliter of blood plasma. This test is employed as a predictor of disease progression and later remission.

Viremia: The presence of virus in blood or blood plasma. Plasma viremia is a quantitative measurement of HIV levels similar to viral load but is accomplished by seeing how much of a patient's plasma is required to spark an HIV infection in a laboratory cell culture.

Virus: Organism composed mainly of nucleic acid within a protein coat, ranging in size from 100 to 2,000 angstroms (unit of length; 1 angstrom is equal to 10-10 meters). When viruses enter a living plant, animal, or bacterial cell, they make use of the host cell's chemical energy and protein -- and nucleic acid -- synthesizing ability to replicate themselves. Nucleic acids in viruses are single stranded or double stranded, and may be DNA (deoxyribonucleic acid; see) or RNA (ribonucleic acid; see). After the infected host cell makes viral components and virus particles are released, the host cell is often dissolved. Some viruses do not kill cells but transform them into a cancerous state; some cause illness and then seem to disappear, while remaining latent and later causing another, sometimes much more severe, form of disease. In humans, viruses cause -- among others -- measles, mumps, yellow fever, poliomyelitis, influenza, and the common cold. Some viral infections can be treated with drugs.

Wasting: Severe loss of weight and muscle, or lean body mass, common among AIDS patients. Leads to muscle weakness, organ failure, tissue swelling, muscle and joint pain and contributes to fatal outcomes.

WCBA: Women of Child Bearing Age

Weighting: A procedure for adjusting the values of data to reflect each group's percent in the total population; for example, race/ethnicity and over-sampled minorities so you could compare findings for each group; in order to combine your findings to describe the entire population, you would weight the data to reflect the percentage of the whole population that comes from each racial/ethnic group.

Western Blot: A test for detecting the specific antibodies to HIV in a person's blood. It is commonly used to verify positive ELISA tests. A Western Blot test is more reliable than the ELISA, but it is harder and more costly to perform. All positive HIV antibody tests should be confirmed with a Western Blot test. Synthetic Peptide test has increased the accuracy of the Western Blot test, inconclusive results are rare.

Wild Type Virus: HIV that has not been exposed to antiviral drugs and therefore has not accumulated mutations conferring drug resistance.

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B. Palm Beach County HIV CARE Council Ryan White HIV/AIDS Treatment Modernization Act Part A March 1, 2008 - February 28, 2009 Service Category Definitions

1. MEDICAL CARE

a. Ambulatory/Outpatient Primary Care
Provision of comprehensive professional diagnostic and therapeutic services including comprehensive management of acute and chronic physical and mental conditions and prevention of such conditions through: initial visit and intake; complete medical history and physical examination; completion of lab tests necessary for evaluation and treatment; nutritional counseling; immunizations; referrals to other medical specialists; follow-up visits and maintenance appointments as indicated on the basis of a patients clinical status.

b. Laboratory Diagnostic Testing
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, tuberculin skin-tests, 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 reimbursement rate.

c. Drug Reimbursement Program/Local Supplemental Drug Program
Provision of injectable and non-injectable prescription drugs, at or below Public Health Service (PHS) price, and/or related supplies prescribed or ordered by a physician to prolong life, improve health, or prevent deterioration of health for HIV+ persons who do not have prescription drug coverage and who are not eligible for Medicaid, Health Care District, or other public sector funding, nor have any other means to pay. This service area also includes assistance for the acquisition of non-Medicaid reimbursable drugs.

ADAP Supplemental Drug Program
Program to expand Florida AIDS Drug Assistance Program (ADAP) locally by paying for FDA approved medications on the State of Florida ADAP formulary when the Florida ADAP is unable to pay for such medications for patients enrolled in the Florida ADAP program & patients are ineligible for other local health care programs which pay for these medications. Medications purchased under this program must be purchased at Public Health Services prices or less.

Nutritional Supplements
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.

d. Specialty Outpatient Health Care
Short term treatment of specialty medical conditions and associated diagnostic procedures for HIV positive patients based upon referral from a primary care provider, physician, physician assistant, clinical nurse specialist. 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.

e. Clinical Trials Outreach
A range of services used to support, enhance and enable patient participation in clinical trials, such as screening of medial charts for patient eligibility for inclusion in clinical trials and research studies.

f. Dental Care
Routine dental care examinations and prophylaxis, X-rays, treatment of gum disease, oral surgery, and medically necessary dentures.

g. Nurse Care Coordination
A range of client-centered services provided by a registered nurse specialist and coordinated with the client's primary outpatient healthcare provider, providing the Ryan White patient's main link with ongoing medical services.

h. Outreach Services
Programs which have as their principal purpose identifying people with HIV disease, particularly those who know their HIV status so that they shall become aware of and be linked to ongoing HIV primary care and treatment. Outreach activities must be planned and delivered in coordination with State and local HIV-prevention outreach activities to avoid duplication of effort and to address a specific service need category identified through State and local needs assessment processes. Activities must be conducted in such a manner as to reach those known to have delayed seeking care. Outreach services should be continually reviewed and evaluated in order to maximize the probability of reaching individuals who know their HIV status but are not actively in treatment. Broad activities that market the availability of health-care services for PLWH are not considered appropriate Title I outreach services.

i. Treatment Adherence Services
Provision of counseling or targeted interventions to specifically address barriers to treatment adherence to ensure readiness for and adherence to complex HIV/AIDS treatments for those in ambulatory outpatient medical care.

j. Inpatient Hospital Coordination

k. Health Insurance Continuation

Financial assistance for eligible individuals with HIV disease to maintain continuation of health insurance.

l. Hospice (Home Based Resid.)

m. Complementary Therapies (Other)
Complementary therapies delivered in a cost effective manner that is prescribed as part of a treatment program for HIV related neuropathy or myopathy.

n. Substance Abuse Treatment/counseling
a. Residential Substance Abuse Treatment
Provision of residential substance abuse treatment counseling, including specific HIV counseling in secure, drug-free state licensed residential (non-hospital) substance abuse detoxification and treatment facility, not to exceed 90 days.

b. Individual, Group Outpatient Counseling
Provision for regular, ongoing substance abuse monitoring and counseling, including specific HIV counseling, on an individual and group basis in a state licensed outpatient setting.

o. Mental Health Therapy/counseling
Psychological & psychiatric counseling services, including individual counseling, group counseling, & facilitation of support groups, provided by a mental health professional licensed or authorized to practice within the State, including psychiatrists, psychologists, clinical nurse specialists, social workers & counselors.

p. Home Health Care
Therapeutic, nursing, supportive and/or compensatory health services provided by a licensed/certified home health agency in a home/residential setting in accordance with a written individualized plan of care ordered by a Physician. Provides eligible patients with durable medical equipment (prosthetics, devices & equipment used by clients in a home/residential setting, wheelchairs, inhalation therapy equipment or hospital beds). Also, provide skilled & unskilled nursing care to eligible patients.

2. <u>CASE MANAGEMENT</u>
a. Case Management
A range of client-centered services that link clients with primary medical care, psychosocial and other services to insure timely, coordinated access to medically-appropriate levels of health and support services, continuity of care, ongoing assessment of the client's and other family members' needs and personal support systems, and inpatient case-management services that prevent unnecessary hospitalization or that expedite discharge, as medically appropriate, from inpatient facilities. Key activities include initial and ongoing assessment of eligibility for Ryan White and non-Ryan White services, initial comprehensive assessment of

the client's needs and personal support systems; development of a comprehensive, initialized service plan; coordination of the services required to implement the plan; client monitoring to assess the efficacy of the plan; periodic reevaluation and revision of the plan as necessary over the life of the client, prevention education, and identification of barriers to medical care. May include client-specific advocacy, and/or review of utilization of services.

b. Peer Advocacy

Staff by peers, preferably living with HIV disease, who interact, both within the case management system and in the community itself, with newly diagnosed clients who are resistant to entering the HIV continuum of care. Primary goal of this program is to assure that hard to reach patients have every opportunity to enter and remain in primary medical care.

3. HOUSING SERVICES

Suitable emergency, short term, or transitional housing and housing referral services. The purpose of short-term, emergency and transitional housing is to move or maintain an individual or family into a long-term, stable living situation. Thus, such assistance cannot be permanent and must be accompanied by a strategy to identify, relocate, and/or ensure the individual or family is moved to, or capable of maintaining a long-term living situation. Transitional housing cannot exceed a twenty-four month period (2 year) in accordance with the HIV CARE Council Housing Standards of Care. Housing referral services is defined as assessment, search, placement, and advocacy services and must be provided by case managers or other professionals who possess and advocacy services and must be provided by case managers or other professionals who possess a comprehensive knowledge of local, State, and Federal housing programs and how they can be accessed.

4. FOOD BANK/HOME DELIVERED MEALS

Provision of actual food, meals or grocery vouchers to enhance the nutritional health of Ryan White eligible clients & their families.

5. TRANSPORTATION

Conveyance services provided to a client in order to access health care or psycho-social support services. May be provided routinely or on an emergency basis. Transportation services shall be appropriate to the client's level of disability & priority shall be given to transportation services that link the client with health care services.

6. OTHER SUPPORT SERVICES

Legal Services

Assessment of individual need, provision of legal advice and assistance by an individual authorized to render such advice and assistance in the State of Florida in obtaining medical, social, community, legal, financial, or other needed services.

Permanency Planning

Assistance in placing children (whose age is less than 20) because their parents are unable to care for them due to HIV related illness or death, in temporary (foster care) or permanent (adoption) homes.

7 SUPPORT SERVICES, DIRECT EMERGENCY FINANCIAL ASSISTANCE
Provision of short-term payments to agencies, or establishment of voucher programs, to assist with emergency expenses related to food, utilities, medications, insurance co-pay or other critical needs to prevent homelessness or institutionalization.

8. VOCATIONAL REHABILITATION

9. HIV PREVENTION

10. COMPLEMENTARY THERAPIES
a. Massage Therapy
Complementary massage therapy delivered in a cost effective manner that is prescribed as part of a treatment program for HIV related neuropathy or myopathy.

11. COUNSELING (OTHER) (DROP IN & PEERS)
Services provided by a licensed or authorized professional or volunteer or peer under the supervision of a licensed or authorized professional in accordance with an individualized plan of care which is intended to improve or maintain a patient's quality of life & optimal capacity for self-care

12. BUDDY/COMPANION SERVICES
Activities provided by volunteers & peers to assist the client in performing household or personal tasks & providing mental & social support. Individual & group counseling services other than mental health, nutritional, or legal which is provided to clients, family and/or friends by non-licensed peer counselors.

13. DAY OR RESPITE CARE

13. TRANSLATION/INTERPRETATION SERVICES

15. CARE COUNCIL SUPPORT
Provision of support for the planning council, including the following:
a. Cost associated with conducting a needs assessment and other methods for obtaining input on community needs and priorities, such as public meetings, focus groups, and ad hoc panels, for the purpose of assisting the planning council in setting service priorities.
b. Staff support (clerical and professional expenses required by the planning council for performance of required planning council activities, including routine planning council administrative activities.
c. Cost incurred buy planning council members as a result of their participation of the planning council and in the conduct of their required planning council activities, in accordance with Chapter 7, Generally Allowable/Unallowable Costs, pp 7-6 to 7-7 of the

Public Health Service (PHS) Grants Policy Statement, which covers such items as reimbursement of reasonable and actual out-of-pocket costs incurred solely as a result of attending a scheduled meeting, including transportation, meals, babysitting fees, and lost wages.

d. Cost associated with the development of the comprehensive plan for the organization and delivery of HIV related services.

e. Costs associated with assessing the efficiency of the administrative mechanism in rapidly allocating funds within the EMA.

f. Cost associated with participation and coordinating with other sources of funding providing services for PLWH/As [Statewide Coordinated Statement of Need (SCNS)].

g. Marketing activities associated with publicizing the planning council's activities and programs for HIV-affected/infected populations and sub-populations, and efforts to substantively enhance community participation in planning council activities.

h. Development and implementation of planning council grievance procedures for decisions related to priorities and allocations.

16. PROGRAM SUPPORT

Activities that are not service oriented or administrative in nature but contribute to improved service delivery, including:

a. Continuous Quality Improvement & Evaluation
b. Standards of Care
c. Outcomes and Measures
d. Management Information System
e. Capacity Building

17. CAPACITY DEVELOPMENT

These funds will be utilized to fill gaps in service that were identified by the Rapid Assessment Response Evaluation Project (RARE) that was completed in Palm Beach County during FY 2001. The specific geographic areas identified in this report are 33404, 33460, 33444, and 33430. Capacity development will be used to help add new providers to the continuum of care and/or help current providers improve or expand their service delivery or management capacity in the above mentioned Palm Beach County locations.

C. HIV/AIDS Incidence, Prevalence, Deaths, Co-morbidities, and Trends

EPIDEMIOLGICAL PROFILE
Target Area
Partnership 9
PALM BEACH COUNTY

Mid-Year Population Estimates

2006

Sex	Total Pop	
Males	628,955	48%
Females	670,898	52%
Total	1,299,853	100%

Race/Ethnicity	Total Pop	
White, non-Hispanic	862,921	66%
Black, non-Hispanic	209,029	16%
Hispanic	198,959	15%
Other*	28,944	2%
Total	1,299,853	100%

Age Groups	Total Pop	
0 - 12	197,807	15%
13 - 19	111,116	9%
20 - 24	69,618	5%
25 - 29	67,065	5%
30 - 39	153,277	12%
40 - 49	188,400	14%
50 - 59	166,426	13%
60+	346,144	27%
Total	1,299,853	100%

2007

Sex	Total Pop	
Males	628,581	48.4%
Females	670,760	51.6%
Total	1,299,341	100.0%

Race/Ethnicity	Total Pop	
White, non-Hispanic	854,314	66%
Black, non-Hispanic	207,979	16%
Hispanic	207,978	16%
Other*	29,070	2%
Total	1,299,341	100%

Age Groups	Total Pop	
0 - 12	195,748	15%
13 - 19	109,478	8%
20 - 24	69,784	5%
25 - 29	69,317	5%
30 - 39	151,429	12%
40 - 49	181,857	14%
50 - 59	168,835	13%
60+	352,893	27%
Total	1,299,341	100%

Note: Other includes American Indian/Alaskan Native, Asian Pacific Islander, and all other race groups
Florida Department of Health, Bureau of HIV/AIDS

"Section 2617 (B)(2) states that the application for Title II funds shall contain a determination of the size and demographics of the population of people living with HIV in the State." [CARE Act]

Section 2 – Table 1a: HIV and AIDS Incidence, HIV/AIDS Deaths (excl DOC).

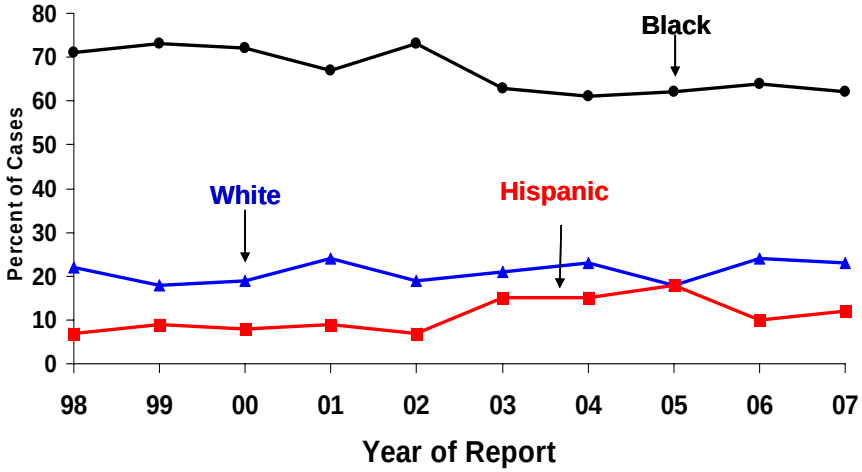
Demographic Group/ Exposure Category RISKS REDISTRIBUTED	AIDS Incidence in 2006 & 2007 AIDS incidence is defined as the number of new AIDS cases diagnosed during the period specified, data as of 01/08/08.					HIV Cases (regardless of current AIDS Status) Reported in 2006 & 2007 HIV Cases (regardless of current AIDS Status) Reported: is defined as the number of new HIV cases reported during the period specified, data as of 01/08/08.					HIV/AIDS Case Deaths in 2006 & 2007 HIV or AIDS cases that died (regardless of cause) in 2007, data as of 03/31/08.				
Race/Ethnicity	2006	% of Total	2007	% of Total	% change	2006	% of Total	2007	% of Total	% change	2006	% of Total	2007	% of Total	% change
White, not Hispanic	89	24%	65	23%	-27.0%	92	26%	112	27%	21.7%	56	23%	53	25%	-5.4%
Black, not Hispanic	235	64%	176	62%	-25.1%	203	57%	229	55%	12.8%	159	64%	138	65%	-13.2%
Hispanic	37	10%	34	12%	-8.1%	58	16%	67	16%	15.5%	21	9%	13	6%	-38.1%
Asian/Pacific Islander	1	0%	2	1%	100.0%	0	0%	3	1%	#DIV/0!	1	0%	0	0%	-100.0%
American Indian/Alaskan Native	0	0%	0	0%	#DIV/0!	0	0%	2	0%	#DIV/0!	0	0%	0	0%	#DIV/0!
Not Specified/Other	8	2%	7	2%	-12.5%	4	1%	2	0%	-50.0%	10	4%	7	3%	-30.0%
Total:	370	100%	284	100%	-23.2%	357	100%	415	100%	16.2%	247	100%	211	100%	-14.6%
Gender	2006	% of Total	2007	% of Total	% change	2006	% of Total	2007	% of Total	% change	2006	% of Total	2007	% of Total	% change
Male	212	57.3%	162	57.0%	-23.6%	211	59.1%	261	62.9%	23.7%	153	61.9%	122	57.8%	-20.3%
Female	158	42.7%	122	43.0%	-22.8%	146	40.9%	154	37.1%	5.5%	94	38.1%	89	42.2%	-5.3%
Total:	370	100.0%	284	100.0%	-23.2%	357	100.0%	415	100.0%	16.2%	247	100.0%	211	100.0%	-14.6%
Age at Diagnosis (Years)	2006	% of Total	2007	% of Total	% change	2006	% of Total	2007	% of Total	% change	2006	% of Total	2007	% of Total	% change
0- 2 years	0	0.0%	0	0.0%	#DIV/0!	2	0.6%	13	3.1%	550.0%	1	0.4%	1	0.5%	0.0%
3-12 years	0	0.0%	0	0.0%	#DIV/0!	1	0.3%	11	2.7%	1000.0%	0	0.0%	2	0.9%	#DIV/0!
13-19 years	4	1.1%	2	0.7%	-50.0%	19	5.3%	22	5.3%	15.8%	3	1.2%	1	0.5%	-66.7%
20-24 years	7	1.9%	5	1.8%	-28.6%	31	8.7%	35	8.4%	12.9%	11	4.5%	11	5.2%	0.0%
25-29 years	34	9.2%	26	9.2%	-23.5%	41	11.5%	50	12.0%	22.0%	22	8.9%	21	10.0%	-4.5%
30-39 years	106	28.6%	82	28.9%	-22.6%	88	24.6%	99	23.9%	12.5%	71	28.7%	71	33.6%	0.0%
40-44 years	81	21.9%	55	19.4%	-32.1%	56	15.7%	57	13.7%	1.8%	38	15.4%	29	13.7%	-23.7%
45-49 years	60	16.2%	54	19.0%	-10.0%	56	15.7%	44	10.6%	-21.4%	28	11.3%	24	11.4%	-14.3%
50-59 years	58	15.7%	45	15.8%	-22.4%	46	12.9%	58	14.0%	26.1%	51	20.6%	35	16.6%	-31.4%
60+ years	20	5.4%	15	5.3%	-25.0%	17	4.8%	26	6.3%	52.9%	22	8.9%	16	7.6%	-27.3%
Total:	370	100.0%	284	100.0%	-23.2%	357	100.0%	415	100.0%	16.2%	247	100.0%	211	100.0%	-14.6%

HIV data (for 2007) includes those cases that have converted to AIDS. These HIV cases cannot be added with AIDS cases to get combined totals since the categories are not mutually

Demographic Group/ Exposure Category RISKS REDISTRIBUTED	AIDS Incidence in 2006 & 2007 AIDS incidence is defined as the number of new AIDS cases diagnosed during the period specified, data as of 01/08/08.					HIV Cases (regardless of current AIDS Status) Reported in 2006 & 2007 HIV Cases (regardless of current AIDS Status) Reported: is defined as the number of new HIV cases reported during the period specified, data as of 01/08/08.					HIV/AIDS Case Deaths in 2006 & 2007 HIV or AIDS cases that died (regardless of cause) in 2007, data as of 03/31/08.				
Male Adult/Adolescent AIDS Exposure Category	2006	% of Total	2007	% of Total	% change	2006	% of Total	2007	% of Total	% change	2006	% of Total	2007	% of Total	% change
MSM	92	43.6%	78	47.8%	-16.2%	97	46.6%	131	52.9%	34.6%	59	38.7%	48	39.7%	-18.9%
IDU	12	5.8%	6	3.7%	-51.2%	9	4.3%	9	3.6%	-1.9%	15	9.8%	12	10.0%	-19.8%
MSM/IDU	10	4.5%	2	1.2%	-79.3%	10	4.8%	9	3.6%	-11.7%	8	5.4%	2	1.7%	-75.5%
Heterosexual	98	46.0%	76	46.6%	-22.6%	93	44.3%	99	40.0%	7.2%	70	46.1%	58	48.6%	-16.8%
Other	0	0.0%	1	0.6%	#DIV/0!	0	0.0%	0	0.0%	#DIV/0!	0	0.0%	0	0.0%	#DIV/0!
Total:	212	100.0%	162	100.0%	-23.6%	209	100.0%	248	100.0%	18.7%	152	100.0%	120	100.0%	-21.1%
Female Adult/Adolescent AIDS Exposure Category	2006	% of Total	2007	% of Total	% change	2006	% of Total	2007	% of Total	% change	2006	% of Total	2007	% of Total	% change
IDU	14	8.8%	14	11.3%	-0.9%	15	10.5%	16	11.0%	2.8%	15	15.5%	11	12.1%	-26.9%
Heterosexual	141	89.2%	107	87.9%	-23.9%	130	89.5%	127	89.0%	-1.9%	79	84.5%	77	87.9%	-2.6%
Other	3	2.0%	1	0.8%	-68.5%	0	0.0%	0	0.0%	#DIV/0!	0	0.0%	0	0.0%	#DIV/0!
Total:	158	100.0%	122	100.0%	-22.8%	145	100.0%	143	100.0%	-1.4%	94	100.0%	88	100.0%	-6.4%
Pediatric AIDS Exposure Categories (ages 0-12)	2006	% of Total	2007	% of Total	% change	2006	% of Total	2007	% of Total	% change	2006	% of Total	2007	% of Total	% change
Mother with/at risk for HIV infection	0	#DIV/0!	0	#DIV/0!	#DIV/0!	2	67%	23	96%	1050.0%	1	100%	2	67%	100.0%
Risk not reported/Other	0	#DIV/0!	0	#DIV/0!	#DIV/0!	1	33%	1	4%	0.0%	0	0%	1	33%	#DIV/0!
Total:	0	#DIV/0!	0	#DIV/0!	#DIV/0!	3	100%	24	100%	700.0%	1	100%	3	100%	200.0%

HIV data (for 2007) includes those cases that have converted to AIDS. These HIV cases cannot be added with AIDS cases to get combined totals since the categories are not mutually

Adult AIDS Cases
by Race/Ethnicity and Year of Report
Partnership 9, 1998-2007



Factors Affecting Disparities

-Late diagnosis of HIV.

-Access to/acceptance of care.

-Delayed prevention messages.

-Stigma.

-Non-HIV STD's in the community.

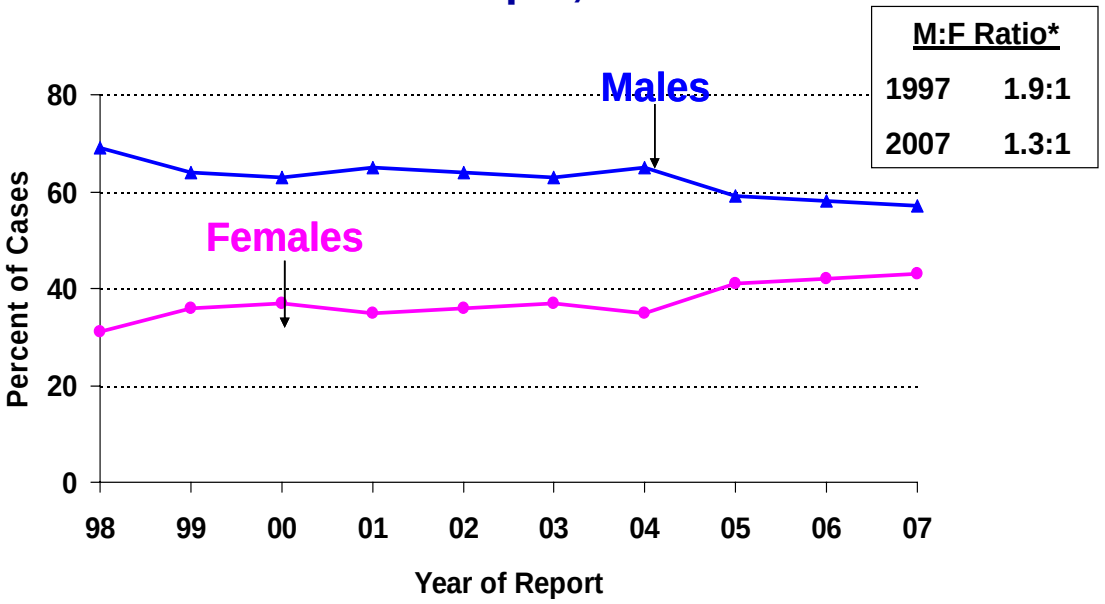
-Prevalence of injection drug use.

-Complex matrix of factors related to socioeconomic status

Comment: In 2007, blacks accounted for 62% of reported AIDS cases, but only 14% of the population. Hispanic cases increased from 7% in 1998 to 12% in 2007. Disparities are even more evident among women: Annually, more than 70% of female AIDS cases have been reported among black women since 1988. *HIV case reporting,* implemented in mid-1997, has shown a very similar distribution of cases by race/ethnicity and sex.

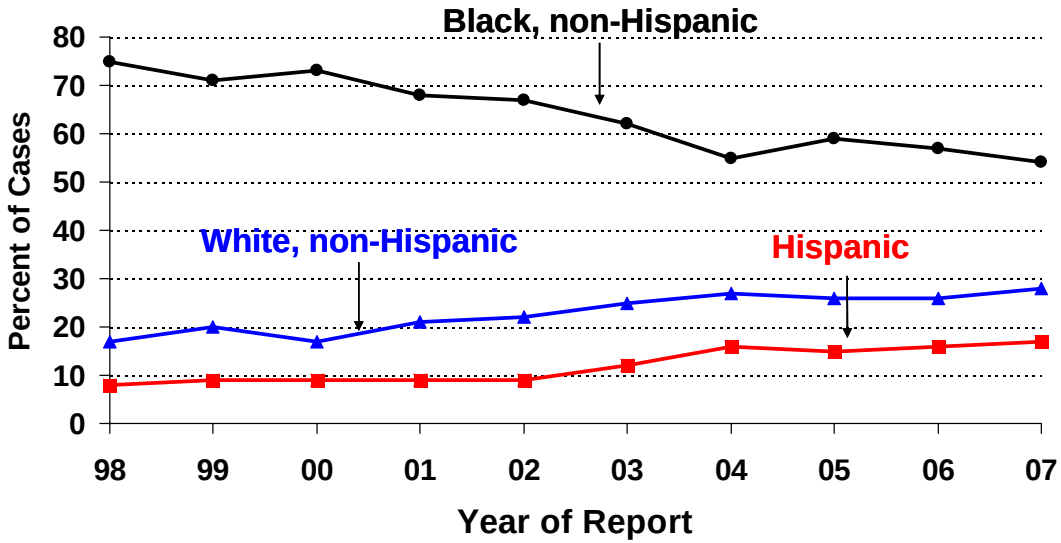
***Other includes American Indian/Alaska Native, Asian/Pacific Islander, and Multi-racial.**

Adult AIDS Cases
by Sex and Year of Report
Partnership 9, 1998-2007



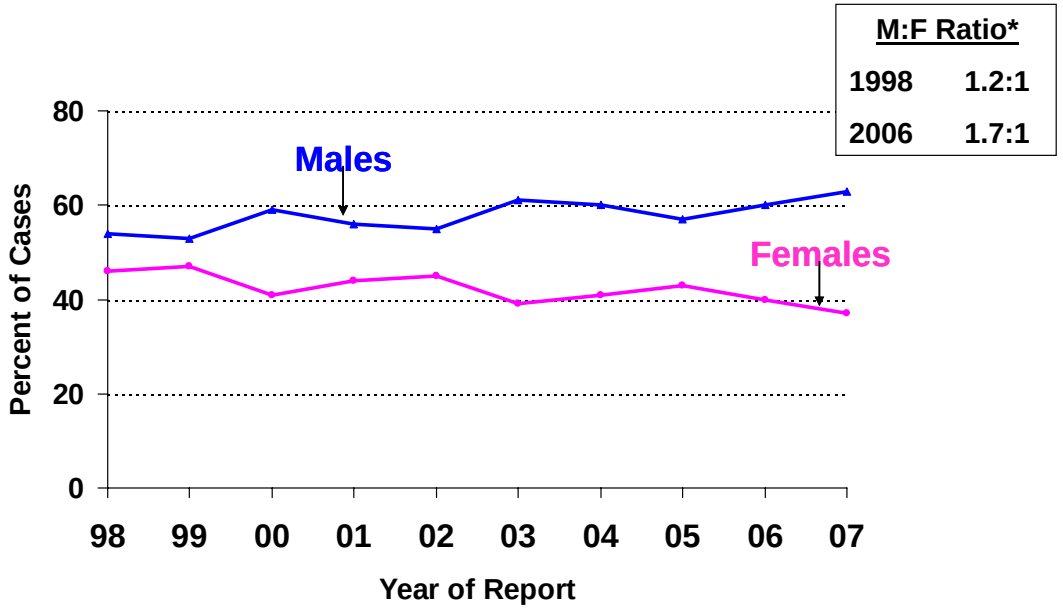
Comment: AIDS cases tend to represent HIV transmission that occurred many years ago. The relative increases in female cases reflect the changing face of the AIDS epidemic over time. *The male-to-female ratio is the number or percent of cases among males divided by the number or percent of female cases.

Adult HIV Cases
by Race/Ethnicity and Year of Report
Partnership 9, 1998-2007



Comment: In absolute numbers, from 2000-2007, HIV cases among blacks decreased by 30%, while increasing by 20% among whites. The decreases among blacks may correspond to some extent with recent targeted prevention, while the increases among whites may be associated with recent increases in HIV transmission among white MSM.

Adult HIV Cases by Sex and Year of Report
Partnership 9, 1998-2007



Comment: The trend for HIV cases by sex is the same of that for AIDS cases. Recent trends in HIV transmission are best described by the HIV case data. The relative increases in male HIV cases might be attributed to proportional increases in HIV transmission among men who have sex with men (MSM), which may influence future AIDS trends.

Section 2 – Table 1b: Background Data Used for the Calculations of AIDS Prevalence, and HIV (not AIDS) Prevalence (excl DOC).

Demographic Group/ Exposure Category RISKS REDISTRIBUTED	AIDS Case Prevalence (excl DOC) through 2007 as of 04/15/08 AIDS Case Prevalence is defined as the number of reported AIDS Cases as of the date specified.		HIV (not AIDS) Case Prevalence (excl DOC) through 2007 as of 04/15/08 HIV Case Prevalence is defined as the number of reported living HIV (not AIDS) cases as of the date specified.		HIV/AIDS Case Prevalence PLWHA (excl DOC) through 2007 as of 04/15/08 HIV/AIDS Case Prevalence is defined as the number of reported living HIV (not AIDS) and AIDS cases as of the date specified.	
Race/Ethnicity	# number	% of Total	# number	% of Total	# number	% of Total
White, not Hispanic	1,019	23.1%	710	25.4%	1,729	24.0%
Black, not Hispanic	2,855	64.7%	1,722	61.5%	4,577	63.5%
Hispanic	488	11.1%	329	11.8%	817	11.3%
Asian/Pacific Islander	5	0.1%	11	0.4%	16	0.2%
American Indian/Alaskan Native	0	0.0%	2	0.1%	2	0.0%
Not Specified/Other	47	1.1%	24	0.9%	71	1.0%
Total:	4,414	100.0%	2,798	100.0%	7,212	100.0%
Gender	# number	% of Total	# number	% of Total	# number	% of Total
Male	2,798	63.4%	1,582	56.5%	4,380	60.7%
Female	1,616	36.6%	1,216	43.5%	2,832	39.3%
Total:	4,414	100.0%	2,798	100.0%	7,212	100.0%
Current Age on 12/31/05 (Years)	# number	% of Total	# number	% of Total	# number	% of Total
0- 2 years	0	0.0%	6	0.2%	6	0.1%
3-12 years	23	0.5%	16	0.6%	39	0.5%
13-19 years	68	1.5%	53	1.9%	121	1.7%
20-24 years	40	0.9%	109	3.9%	149	2.1%
25-29 years	120	2.7%	266	9.5%	386	5.4%
30-39 years	838	19.0%	711	25.4%	1,549	21.5%
40-44 years	827	18.7%	468	16.7%	1,295	18.0%
45-49 years	867	19.6%	463	16.5%	1,330	18.4%
50-59 years	1,143	25.9%	481	17.2%	1,624	22.5%
60+ years	488	11.1%	225	8.0%	713	9.9%
Total:	4,414	100.0%	2,798	100.0%	7,212	100.0%

Demographic Group/ Exposure Category RISKS REDISTRIBUTED	AIDS Case Prevalence (excl DOC) through 2007 as of 04/15/08 AIDS Case Prevalence is defined as the number of reported AIDS Cases as of the date specified.		HIV (not AIDS) Case Prevalence (excl DOC) through 2007 as of 04/15/08 HIV Case Prevalence is defined as the number of reported living HIV (not AIDS) cases as of the date specified.		HIV/AIDS Case Prevalence PLWHA (excl DOC) through 2007 as of 04/15/08 HIV/AIDS Case Prevalence is defined as the number of reported living HIV (not AIDS) and AIDS cases as of the date specified.	
Male Adult/Adolescent AIDS Exposure Category	# number	% of Total	# number	% of Total	# number	% of Total
MSM	1,255	45.0%	776	49.4%	2,031	46.6%
IDU	210	7.5%	101	6.4%	311	7.1%
MSM/IDU	125	4.5%	46	2.9%	171	3.9%
Heterosexual	1,156	41.5%	636	40.5%	1,793	41.1%
Other	42	1.5%	13	0.8%	55	1.3%
Total:	2,788	100.0%	1,572	100.0%	4,360	100.0%
Female Adult/Adolescent AIDS Exposure Category	# number	% of Total	# number	% of Total	# number	% of Total
IDU	204	12.7%	121	10.0%	324	11.6%
Heterosexual	1,346	84.0%	1,068	88.7%	2,414	86.0%
Other	53	3.3%	15	1.3%	68	2.4%
Total:	1,603	100.0%	1,204	100.0%	2,807	100.0%
Pediatric AIDS Exposure Categories (current ages 0-12)	# number	% of Total	# number	% of Total	# number	% of Total
Mother with/at risk for HIV infection	23	100.0%	21	95.5%	44	97.8%
Risk not reported/Other	0	0.0%	1	4.5%	1	2.2%
Total:	23	100.0%	22	100.0%	45	100.0%

Demographic Group/ Exposure Category	AIDS Case Prevalence (excl DOC) through 2007 as of 04/15/08 AIDS Case Prevalence is defined as the number of reported AIDS Cases as of the date specified.		HIV (not AIDS) Case Prevalence (excl DOC) through 2007 as of 04/15/08 HIV Case Prevalence is defined as the number of reported living HIV (not AIDS) cases as of the date specified.		HIV/AIDS Case Prevalence PLWHA (excl DOC) through 2007 as of 04/15/08 HIV/AIDS Case Prevalence is defined as the number of reported living HIV (not AIDS) and AIDS cases as of the date specified.	
Special Populations	# number	% of Total	# number	% of Total	# number	% of Total
White MSM	667	N/A	397	N/A	1,064	N/A
Black MSM	410	N/A	209	N/A	619	N/A
Hispanic MSM	181	N/A	124	N/A	305	N/A
Whte Male IDU	80	N/A	43	N/A	123	N/A
Black Male IDU	172	N/A	60	N/A	232	N/A
Hispanic Male IDU	52	N/A	22	N/A	74	N/A
Whte Female IDU	60	N/A	49	N/A	109	N/A
Black Female IDU	102	N/A	43	N/A	145	N/A
Hispanic Female IDU	21	N/A	9	N/A	30	N/A
Whte Male Homeless	3	N/A	1	N/A	4	N/A
Black Male Homeless	10	N/A	2	N/A	12	N/A
Hispanic Male Homeless	2	N/A	0	N/A	2	N/A
Whte Female Homeless	0	N/A	1	N/A	1	N/A
Black Female Homeless	3	N/A	3	N/A	6	N/A
Hispanic Female Homeless	0	N/A	1	N/A	1	N/A
Male Haitian Born	568	N/A	189	N/A	757	N/A
Female Haitian Born	328	N/A	217	N/A	545	N/A
Whte Male Youth (current ages 13-24)	1	N/A	10	N/A	11	N/A
Black Male Youth (curent ages 13-24)	43	N/A	53	N/A	96	N/A
Hispanic Male Youth (current ages 13-24)	6	N/A	11	N/A	17	N/A
Whte Female Youth (current ages 13-24)	4	N/A	15	N/A	19	N/A
Black Female Youth (current ages 13-24)	47	N/A	64	N/A	111	N/A
Hispanic Female Youth (current ages 13-24)	5	N/A	9	N/A	14	N/A
White WCBA* (current ages 15-44)	108	N/A	119	N/A	227	N/A
Black WCBA* (current ages 15-44)	638	N/A	600	N/A	1,238	N/A
Hiapanic WCBA* (current ages 15-44)	85	N/A	75	N/A	160	N/A
White Ped Cases (current current ages 0-12)	1	N/A	4	N/A	5	N/A
Black Ped Cases (current ages 0-12)	21	N/A	14	N/A	35	N/A
Hispanic Ped Cases (current ages 0-12)	1	N/A	4	N/A	5	N/A
DOC Cases	41	N/A	23	N/A	64	N/A

*WCBA=Women of Child Bearing Age

MSM includes MSM & MSM/IDU

Male IDU includes IDU & MSM/IDU

Attachment 6 Co-Morbidities / Other Factors / Surrogate Markers

Documented Co-morbidity cases in 2007	Prevalence of the HIV/AIDS Population in this Area	Prevalence Rate of this Indicator per 100,000 living HIV/AIDS Cases from this Area	Data Source	Date of Data	Prevalence Rate of this Co-morbidity within the general population of this Disease in this Area
	N= 7,212				
AIDS Cases diagnosed through 2007 with Tuberculosis diagnosed in 2007	4	55.5	HARS	Data through 2007 (as of 03/08)	5.5
Infectious Syphilis reported in 2007 among HIV/AIDS patients by the County Health Department (minimal estimate, based on STD client data only)	5	69.3	STDMIS	Data through 2007 (as of 03/08)	1.9
Gonorrhea reported in 2007 among HIV/AIDS patients by the County Health Department (minimal estimate, based on STD client data only)	30	416.0	STDMIS	Data through 2007 (as of 03/08)	68.8
Chlamydia reported in 2007 among HIV/AIDS patients by the County Health Department (minimal estimate, based on STD client data only)	25	346.6	STDMIS	Data through 2007 (as of 03/08)	186.9
Hepatitis C (defined as ***any*** HIV/AIDS case noted with a history of acute and/or chronic viral Hepatitis C and documented in HARS and/or MERLIN)	266	3,688.3	HARS (local use variable) and/or matched with reported cases in the Hepatitis database	Data through 2007 (as of 03/08)	

Other Factors / Surrogate Markers Documented in 2007	Prevalence of the HIV/AIDS Population in this Area	Prevalence Rate of this Indicator per 100,000 living HIV/AIDS Cases from this Area	Data Source	Date of Data	
Homelessness (defined as any living HIV/AIDS case who was homeless at diagnosis of HIV or AIDS and documented in HARS)	26	360.5	HARS (address variable)	Data through 2007 (as of 03/08)	
Substance Abuse (defined as any living HIV/AIDS case noted with a history of substance abuse, e.g.. alcohol, methamphetamine, cocaine, inhalants, etc, and documented in HARS)	255	3,535.8	HARS (local use variable)	Data through 2007 (as of 03/08)	
Chronic Mental Illness (defined as any living HIV/AIDS case noted with a history of mental illness and documented in HARS)	366	5,074.9	HARS (local use variable)	Data through 2007 (as of 03/08)	
MSM (estimated seroprevalance of males with HIV/AIDS who have an MSM or MSM/IDU risk)	2,202	30,532.0	(Determined by PLWHA data)	Data through 2007 (as of 03/08)	
IDU (estimated seroprevalance of persons with HIV/AIDS who have and IDU or MSM/IDU risk)	806	11,178.9	(Determined by PLWHA data)	Data through 2007 (as of 03/08)	

Release of FL Department of Corrections Cases into the Local Area	Total Offenders Released	HIV-infected Offenders Released		Data Source	Date of Data
		Number	% HIV+		
Offenders who returned to the Area in 2007	1,035	69	6.7%	Dept. of Corrections Offender-based Information System	CY 2007, data as of 02/08
Offenders who returned to the Area in 2006	1,037	65	6.3%	Dept. of Corrections Offender-based Information System	CY 2006, data as of 01/07
Offenders who returned to the Area in 2005	1,108	87	7.9%	Dept. of Corrections Offender-based Information System	CY 2005, data as of 04/06

Section 2 – Table IV: Socio-Economic Data of the General Population

Data on Unemployment, Poverty levels and Insurance coverage are not readily available for the PLWHA cases

Race/ Ethnicity	**Civilian Labor Force Unemployed**			Population Living Below 100% Poverty			Without insurance coverage including without Medicaid.		
	Partnership		FLORIDA	Partnership		FLORIDA	Partnership		FLORIDA
	Number	Percent	Percent	Number	Percent	Percent	Number	Percent	Percent
White	15,697	55.9%	4.7%	71,375	47.9%	9.6%	357	73.2%	14.7%
Black	6,695	23.8%	9.1%	41,503	27.7%	23.4%	68	13.9%	26.0%
Hispanic	5,176	18.4%	5.4%	33,319	22.4%	16.5%	63	12.9%	33.2%
Other*	516	1.9%	6.5%	2,683	2.0%	18.2%	N/A	N/A	18.0%
Total	**28,084**	**100.0%**	**6.4%**	**148,880**	**100.0%**	**16.9%**	**488**	**100.0%**	**23.0%**

Selected Socioeconomic Indicators, Florida (U.S. Census 2000)

**Other race includes Asian/Hawaiian, Native American/Alaska Native, Other and multiple races.*

*** Numbers and percentages may not reflect all counties associated with the partnership because data was not available*

*** Due to the sample population, the insurance coverage data may not actually depict the true percentage of persons without health insurance*