Palm Beach County

Eligible Metropolitan Area (EMA)

COMPREHENSIVE PLAN

2012-2015

Palm Beach County Board of County Commissioners
301 N. Olive Avenue
West Palm Beach, FL 33401
(561) 355-2201

Prepared by
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Electronic copies of this document can be accessed at:
http://carecouncil.org/planningforcare/

Funded through the Ryan White HIV/AIDS Treatment Extension Act of 2009
Department of Community Services
Palm Beach County, Florida

April 30, 2012

C O N T E N T S

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

Department of Community Services

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West Palm Beach, FL 33401

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April 17, 2012

Dear Elected Officials and Concerned Citizens:

The Ryan White Comprehensive Plan 2012-2015 is a living document that serves as a roadmap to our community's vision on how best to deliver HIV/AIDS services based on identified needs and challenges.

This three year Plan for our Eligible Metropolitan Area (EMA), Palm Beach County, was developed with cooperation from various HIV/AIDS service funding streams, planning council members, and agencies involved in the care of individuals affected by and infected with HIV/AIDS.

I would like to express gratitude to all of the individuals involved in the completion of the Ryan White Comprehensive Plan 2012-2015. This Plan will allow our community to better address the needs of the people affected by HIV/AIDS in Palm Beach County, Florida.

Sincerely,

Channell Wilkins, Director
Community Services Department

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

FLORIDA DEPARTMENT OF HEALTH

Rick Scott
Governor

Steven L. Harris, M.D., M.Sc.
Interim State Surgeon General

April 24, 2012

Dear Palm Beach County Residents:

It is a pleasure to write this letter of support for the Comprehensive Plan 2012-2015 (Comp Plan) developed by the Palm Beach County HIV CARE Council. The members of this Council have shown commitment and dedication in creating a document that will serve as a guide for the implementation of HIV/AIDS services in Palm Beach County, Florida.

The Comp Plan will allow for our community to be pro-active 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. It will work to increase our community's knowledge of HIV services, enhance referrals to care, and support testing and prevention initiatives. As more of our residents learn their HIV status, it becomes increasingly important to be able to link these positive individuals with comprehensive, quality health care.

Now more than ever, in times of limited resources, we must continue to coordinate and participate in collaborative HIV prevention partnerships and patient care activities. This Comp Plan will help our community, including advocates, healthcare service providers and other partners within the HIV-positive community, to promote, protect and improve the health and lives of persons living with HIV/AIDS in Palm Beach County.

I encourage those involved in implementing our Comp 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 utilize the information in this Plan to the greatest extent possible to strengthen our system of care in Palm Beach County.

Sincerely,

Alina M. Alonso, M.D.

PALM BEACH COUNTY HEALTH DEPARTMENT
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Public Health
Prevent. Promote. Protect.

Letter of Concurrence from the Chair of the Planning Council

Palm Beach County HIV CARE Council

600 Sandtree Drive, Ste. 101
Palm Beach Gardens, Florida 33403

Mary Kannel
CARE Council Chair
Telephone- (561) 844-4220
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E-Mail- Mary_Kannel@doh.state.fl.us

Monday, April 23, 2012

Dear Friends and All Concerned Citizens;

It is with pride, on behalf of the Palm Beach County HIV CARE Council, that I present the Palm Beach County EMA's Comprehensive Plan 2012-2015.

This Plan has been the collaboration of multiple funding agencies, community volunteers, and involvement from individuals infected and affected with HIV/AIDS. It is the work product of those dedicated to decreasing the number of HIV/AIDS cases in Palm Beach County and increasing the number of persons living with HIV/AIDS in medical care.

On behalf of the Palm Beach County HIV CARE Council I encourage our elected officials and community leaders to become familiar with the Plan and use the information to determine funded polices in the future. By working together we will achieve an efficient continuum of care for all people living with HIV/AIDS in Palm Beach County, Florida.

Sincerely,

Mary Kannel
Chair
Palm Beach County HIV CARE Council

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

The development of the Comprehensive Plan 2012-2015 would not have been possible without the 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 Data Collection Team, Grantee Staff, and Planning Council Support Staff has enriched this Comprehensive Plan with invaluable insight.

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

The Palm Beach County HIV CARE Council has developed the Comprehensive Plan 2012-2015, a living document, that serves as a roadmap to our community's vision on how best to deliver HIV/AIDS services based on identified needs and challenges. The Plan will guide our Continuum of Care through 2015.

The Comprehensive Plan 2012-2015 is a work of collaboration amongst funded agencies and community volunteers. There is 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.

EXECUTIVE SUMMARY

The Comprehensive Plan 2012-2015 is to function as a guide to the community for the organization and delivery of health and support services in Palm Beach County, Florida. With the execution of the implementation chart in Section 3 of this Plan, our hope is that the continuum of care will:

- Increase people living with HIV/AIDS knowledge of HIV (services, prevention, medication).
- Increase collaboration with agencies and providers of HIV/AIDS services, as well as other social and medical services.
- Develop and implement a Quality Management Plan for the continuum of care of people living with HIV/AIDS including measuring client satisfaction.
- Ensure service cost effectiveness.
- Increase the number of PLWHA who are aware of their status and are in primary medical care by enhancing post-test counseling, referral, and linkage to care.
- Assess health outcomes of people living with HIV/AIDS in emerging special populations.

Where We Are Now: What Defines our Continuum of Care?

Our continuum of care has been established for people living in Palm Beach County, Florida who are affected or infected with HIV/AIDS. As of December 31, 2010 the number of people living with HIV (not AIDS) (PLWH) in Palm Beach County was 3,059. For the same time period, the number of people living with AIDS (PLWA) in Palm Beach County was 4,619. For both populations, PLWH and PLWA, the two highest exposure categories were Heterosexual followed by Men who have Sex with Men (MSM). The race/ethnicity groups with the highest prevalence of both HIV and AIDS in Palm Beach County include, Black, not Hispanic (60%, 64%, respectively), White, not Hispanic (26%, 22%, respectively), and Hispanic (13%, 13%, respectively). The 2010 Unmet Need Framework Table displays an estimated 3,567 individuals who were aware of their status, but did not receive specified primary medical care services. The estimated number of living HIV positive individuals in Palm Beach County who were unaware of their status in 2010 was 1,943.

The Coordinated Services Network (CSN) is a partnership of state and federal funding sources, planning authorities, medical and social support agencies, and people living with HIV/AIDS that provides the continuum of care for PWLHA of Palm Beach County. It is composed of the following four partnerships;

1. *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 needs, the priorities of these needs, the allocation of funding, and the plan for providing services to HIV/AIDS individuals.

2. *Funding Partners,* which includes government bodies responsible to administer state or federal funds for implementation of medical and support programs for the HIV infected.

3. *Quality Management,* 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, and collect summarized information on the demographic and service information.

4. *CSN Service Providers,* which provide medical and support services.

The Ryan White Part A Planning Council conducts a Comprehensive Needs Assessment every three years to identify the need and service priorities of PLWHA residing in Palm Beach County, Florida. Respondents of the needs assessment survey included Out of Care Respondents, Providers, and In Care Respondents. In Care and Out of Care Respondents most frequently selected financial assistance, food, and housing as the services in greatest need. Providers most frequently selected mental health, housing, case management, transportation substance abuse treatment and food as the services in greatest need.

The three highest ranked service gaps (need but can't get) by In Care and Out of Care Respondents were:

1. Food Bank/Home Delivered Meals
2. Emergency Financial Assistance
3. Transportation

The Comprehensive Needs Assessment also identified five special populations within PLWHA community which included: Haitians, African-American Women, African-American Men Incarcerated in Past 12 Months, Men Who Have Sex With Men, and Hispanics. All of these populations have expressed the same needs and gaps as mentioned above in varying ranking order.

The Comprehensive Needs Assessment gathered data regarding service barriers (needed but didn't know about).

The three most frequently chosen barriers by all PLWHA were:

1. Emergency Financial Assistance
2. Legal Services
3. Food

Three chosen barriers by providers were:

1. Funding
2. Case Management
3. Treatment Adherence

The three most frequently chosen barriers by all five special populations of PLWHA were:

1. Legal Services
2. Food
3. Oral/Dental Health

The Comprehensive Needs Assessment findings provide HIV planning groups, service providers, funders, and consumers a picture of the local HIV epidemic as well as our continuum of care. The findings are incorporated into our Comprehensive Plan enabling the community to make sound decisions about how to organize and maintain an effective and efficient continuum of care for the people who plan for, provide, and receive services in Palm Beach County, Florida.

The successes and challenges of the Comprehensive Plan of 2009 were evaluated. A few examples of the successes have been strong collaborations formed between consumers, providers, and community leaders, an efficient quality management system, and an increase in the knowledge of HIV/AIDS treatment and care. A few examples of the challenges have been wording used to outline activities have not always been measurable, review of the status of the Plan did not occur often enough, and incentive-based programs to foster adherence to medications and medical treatment was not implemented due to funding.

Where Do We Need To Go: What is Our Vision for an Ideal System of Care?

The system of care that Palm Beach County wants is one that provides the highest possible standards of care for all PLWHA in the EMA and conforms to all federal, state and local principles. The significant challenges, critical concerns, and areas of focus from the evaluation of the Comprehensive Plan of 2009 have prompted the development of strategies to overcome the same issues for the future. The strategies for the Comprehensive Plan of 2012-2015 involve; describing activities in a timely measurable fashion, reviewing the status of activities on a more frequent basis, and evaluating the overall Plan to ensure financial support needed to maintain detailed activities.

The Comprehensive Plan 2012-2015 will have the following proposed care goals for the future.

Goal 1: Increase Access to Care and Optimize Health Outcomes for People Living with HIV
Goal 2: Reduce the Number of People Who Become Infected with HIV
Goal 3: Reduce HIV-Related Health Disparities

The same goals will pertain to the care of individuals aware of their HIV status, but are not in care (Unmet Need). Goals regarding individuals unaware of their HIV status (EIIHA) will be the following:

Goal 1: Annually, through voluntary counseling and testing, increase the proportion of HIV-infected people in Palm Beach County who know they are infected.

Goal 2: Annually, increase the proportion of HIV-infected people in Palm Beach County who are linked to appropriate prevention, care and treatment services.

Goals in the Comprehensive Plan 2012-2015 will be evaluated by the CARE Council, along with gaps and overlaps in care for PLWHA in Palm Beach County, FL. The CARE Council will use a Priorities and Allocations process to fund many services in an attempt to close the gaps in care for PLWHA. The Grantee will review client files in CAREWare to determine how services have been utilized and to what extent. This will ensure that clients are receiving necessary assistance

and that overlaps in care are not occurring. The CARE Council will work with other funders such as; Part B, Part F, Private Providers (Non-Ryan White Funded), Prevention, Substance Abuse, STD, Medicare, Medicaid, Children's Health Insurance Program, and Community Programs to create optimal access to care for everyone.

How Will We Get There: What is the Strategy, Plan, Activities, and Timeline Associated with Achieving Specified Goals and Meeting Identified Challenges?

The CARE Council has developed a chart that lists activities which will improve the current system of care for PLWHA. The activities have been written to be measurable and to support all of HRSA's guiding principles. The chart will address the objectives of Healthy People 2020, will reflect the Statewide Coordinated Statement of Need (SCSN), it will adapt to changes within the Affordable Care Act (ACA), and will reflect the goals of the National HIV/AIDS strategy. Palm Beach County will be ready to respond to change including funding level fluctuations. A detailed implementation chart (with strategy, plan, activities and timeline) is included in Section 3.

How Will We Monitor Progress?

The CARE Council will serve as the mechanism for monitoring the environment and determining when and how each component of the evaluation will be completed. The information gathered by relevant committees in regards to the implementation of the Comprehensive Plan 2012-2015 will be evaluated on a quarterly basis and used in the decision making.

SECTION 1

S E C T I O N 1

Where Are We Now: What Defines our Continuum of Care?

A. Description of the Local HIV/AIDS Epidemic

The 2010 mid-year population estimate for Palm Beach County was 1,287,244. Of these, 48% were male and 52% female. The county is racially and ethnically diverse. In 2010, 63% of the population was White non-Hispanic, 16% were Black non-Hispanic, 19% were Hispanic, and 2% were other races/ethnicities. A large proportion of the county's population is senior retirees. The 2010 age distribution in years was as follows: 0-12, 15%; 13-19, 8%; 20-24, 6%; 25-29, 6%; 30-39, 11%; 40-49, 13%; 50-59, 13%; 60+, 28%.[1]

People Living with HIV (HIV [Not AIDS]) Prevalence)
As of December 31, 2010, the number of people living with HIV (not AIDS) (PLWH) in Palm Beach County was 3,059. This translates to an HIV prevalence rate of 238 per 100,000 (100,000 X 3,059/1,287,244). 60% of these people were non-Hispanic Blacks, 26% were non-Hispanic Whites, and 13% were Hispanics. 60% were males. 98% were adults age 20+, approximately evenly split between the younger adult age group (20-44 years; 50%) than the older adult age group (age 45+; 48%). Among adults and adolescents, the most frequent exposure categories were heterosexual (59%), followed by men having sex with men (MSM; 33%). Among the 26 pediatric cases (age 0-12), all were exposed due to a mother with/at risk for HIV infection.

People Living with AIDS (AIDS Prevalence)
As of December 31, 2010, the number of people living with AIDS (PLWA) in Palm Beach County were 4,619, representing an AIDS prevalence rate of 359 per 100,000 (100,000 X 4,619/1,287,244). Approximately two-thirds (64%) of these people were non-Hispanic Blacks, 22% were non-Hispanic Whites, and 13% were Hispanics. About two-thirds (63%) were males, and 98% were adults age 20+. In contrast to the HIV (not AIDS) adult prevalence, a greater proportion of the people living with AIDS were older adults aged 45+ (64%) than younger adults age 20-44 (34%). The exposure categories are similar to those of people living with HIV. Among adults and adolescents, the most frequent exposure categories were heterosexual (58%), followed by MSM (29%). All of the 9 pediatric cases (age 0-12) were exposed due to a mother with/at risk for HIV infection.

New AIDS Cases Reported Within the Past Three Years (AIDS Incidence)
The number of new AIDS cases reported in Palm Beach County in 2008, 2009, and 2010 was 887. 63% of these were non-Hispanic Blacks, 20% were non-Hispanic Whites, and 16% were Hispanics. 63% were males. Almost all (98%) of these cases were adults age 20+. 55% were age 20-44 and 43% were age 45+. Among adults and adolescents, the most frequent exposure categories were heterosexual (64%), followed by MSM (28%). The one pediatric case (age 0-

[1] Florida Department of Health, Bureau of HIV/AIDS Surveillance Section (2011). *Epidemiological Profile, Palm Beach County.*

12) was exposed due to a mother with/at risk for HIV infection. The number of newly reported AIDS cases per year has declined over the past decade from 452 in 2001 to 250 in 2010.[2]

HIV/AIDS Cases by Demographic Characteristics and Exposure Category
The number of cases in Palm Beach County classified as AIDS incidence, AIDS prevalence, and HIV (not AIDS) prevalence from data source eHARS are displayed below.

Of the 7,678 HIV/AIDS cases in Palm Beach County , the race/ethnicity groups with the highest prevalence of both HIV and AIDS include: Black, not Hispanic (4,783/62%), White, not Hispanic (1,821/24%) and Hispanic (971/13%). The majority of the cases are male (4,745/62%), and the age with the majority of cases at diagnosis is 45+ years (4,425/58%).

[2]Florida Department of Health, Bureau of HIV/AIDS Surveillance Section (2011). *HIV/AIDS Epidemiology, Palm Beach County.*

Demographic Group/ Exposure Category RISKS REDISTRIBUTED	Newly reported AIDS cases is defined as the number of new AIDS cases reported during the period specified, (excl DOC cases). Data from eHARS as of 12/31/2010		Living AIDS Cases is defined as the number of diagnosed cases of AIDS in eHARS, as of the date specified. These include cases whose current residence is Palm Beach County, regardless where diagnosed.		Living HIV (not AIDS) cases is defined as the number of diagnosed cases of HIV (not AIDS) in eHARS, as of the date specified. These include cases whose current residence is Palm Beach County, regardless where diagnosed.		Combined living HIV/AIDS cases is defined as the number of diagnosed cases of HIV/AIDS in eHARS, as of the date specified. These include cases whose current residence is Palm Beach County, regardless where diagnosed.	
Race/Ethnicity	**#**	**% of Total**	**#**	**% of Total**	**#**	**% of Total**	**#**	**% of Total**
White, not Hispanic	177	20%	1,030	22%	791	26%	1,821	24%
Black, not Hispanic	558	63%	2,944	64%	1,839	60%	4,783	62%
Hispanic	139	16%	579	13%	392	13%	971	13%
Asian/Pacific Islander	1	0%	9	0%	13	0%	22	0%
American Indian/Alaskan Native	0	0%	2	0%	1	0%	3	0%
Not Specified/Other	12	1%	55	1%	23	1%	78	1%
Total:	887	100%	4,619	100%	3,059	100%	7,678	100%
Gender	**#**	**% of Total**	**#**	**% of Total**	**#**	**% of Total**	**#**	**% of Total**
Male	562	63%	2,918	63%	1,827	60%	4,745	62%
Female	325	37%	1,701	37%	1,232	40%	2,933	38%
Total:	887	100%	4,691	100%	3,059	100%	7,678	100%
Age at Diagnosis (Incidence) / Current Age (Prevalence)	**#**	**% of Total**	**#**	**% of Total**	**#**	**% of Total**	**#**	**% of Total**
0-12 years	1	0%	9	0%	26	1%	35	0%
13-19 years	12	1%	55	1%	44	1%	99	1%
20-44 years	492	55%	1,586	34%	1,533	50%	3,119	41%
45+ years	382	43%	2,969	64%	1,456	48%	4,425	58%
Total:	887	100%	4,619	100%	3,059	100%	7,678	100%

The HIV/AIDS prevalence of 7,646 cases in the chart below, displays the three categories of exposure with the highest percentages which include: Heterosexual (4,472/58%), MSM (2,322/30%), and IDU (565/7%). There were 35 cases of Mothers with/at Risk for HIV infection, equating 100% of the HIV/AIDS prevalence totals for Pediatric AIDS Exposure Categories (ages 0-12). As the chart indicates, the percentages of Risk Not Reported or Other exposure category were at 0%, meaning no cases were recorded for this exposure category.

	Newly Reported AIDS Cases 2008-2010		AIDS Prevalence through 2010 as of 05/2011		HIV (not AIDS) Prevalence through 2010 as of 05/2011		Total HIV Prevalence through 2010 as of 05/2011	
Demographic Group/ Exposure Category RISKS REDISTRIBUTED	**Newly reported AIDS cases is defined as the number of new AIDS cases reported during the period specified, (excl DOC cases). Data from eHARS as of 12/31/2010**		**Living AIDS cases is defined as the number of diagnosed cases of AIDS in eHARS, as of the date specified. These include cases whose current residence is Palm Beach County, regardless where diagnosed.**		**Living HIV (not AIDS) cases is defined as the number of diagnosed cases of HIV (not AIDS) in eHARS, as of the date specified. These include cases whose current residence is Palm Beach County, regardless where diagnosed.**		**Combined living HIV/AIDS cases is defined as the number of diagnosed cases of HIV/AIDS in eHARS, as of the date specified. These include cases whose current residence is Palm Beach County, regardless where diagnosed.**	
Adult/Adolescent AIDS Exposure Category	**#**	**% of Total**	**#**	**% of Total**	**#**	**% of Total**	**#**	**% of Total**
MSM	249	28%	1,318	29%	1,004	33%	2,322	30%
IDU	56	6%	400	9%	165	5%	565	7%
MSM/IDU	14	2%	111	2%	41	1%	152	2%
Heterosexual	563	64%	2,684	58%	1,788	59%	4,472	58%
Other	4	0%	99	2%	36	1%	135	2%
Total:	886	100%	4,612	100%	3,034	100%	7,646	100%
Pediatric AIDS Exposure Categories (ages 0-12)	**#**	**% of Total**	**#**	**% of Total**	**#**	**% of Total**	**#**	**% of Total**
Mother with/at risk for HIV infection	1	100%	9	100%	26	100%	35	100%
Risk not reported/Other	0	0%	0	0%	0	0%	0	0%
Total:	1	100%	9	100%	26	100%	35	100%

Disproportionate Impact on Certain Populations

HIV/AIDS has a significant and disproportionate impact on Palm Beach County's minority communities, homeless, MSM, IDU, and formerly-incarcerated individuals, as indicated in the following table.

Based on the data in the table below, the HIV/AIDS prevalence rate in the general population of Palm Beach County is 596 per 100,000 populations (100,000 X 7,678/1,287,244). The prevalence rates in the table indicate that:

- Among non-Haitian Blacks, the HIV/AIDS prevalence rate is more than 3 times higher than among the general population.
- Among men who have sex with men (MSM), the HIV/AIDS prevalence rate is more than 10 times higher than among the general population.
- Among intravenous drug users (IDU), the HIV/AIDS prevalence rate is more than 8 times higher than among the general population.
- Among Haitian-born persons, the HIV/AIDS prevalence rate is almost 6 times higher than among the general population.
- Among homeless persons, the HIV/AIDS prevalence rate is 1.6 times higher than among the general population.
- Among formerly incarcerated individuals, the HIV/AIDS prevalence rate is almost 6 times higher than among the general population.

Thus, the above populations are clearly disproportionately impacted by HIV/AIDS. Disparities are further illustrated by the following trends over the past decade[3]:

- Hispanic AIDS cases increased from 10% in 2001 to 18% in 2010.
- From 2001 to 2010, the proportion of black HIV cases decreased by 10% while whites increased by 15% and Hispanics by 44%.
- From 2001 to 2010, the proportion of male HIV cases decreased by 17% among blacks while increasing by 120% for Hispanics.
- For the past ten years, black women represented 65% or more of the HIV cases each year. The percent of black female HIV cases increased by 6% from 2001 to 2010. In contrast, a decrease was observed among white female HIV cases (9%). The proportion of Hispanic female HIV cases shifted up and down over this same time period.
- The percent of newly reported HIV cases has shown increases among the 20-29 and 50+ age groups over the past several years.
- MSM remains as the primary mode of exposure among male HIV cases, followed by high risk heterosexual contact.
- The heterosexual risk continues to be the dominant mode of exposure to HIV among females.

[3]Florida Department of Health, Bureau of HIV/AIDS Surveillance Section (2011). *HIV/AIDS Epidemiology, Palm Beach County.*

PLWH/A Subpopulations in Palm Beach County through 2010

PLWH/A Subpopulations	(A) Number of PLWH/A (N=7,678)	(B) Percent of All PLWH/A (A/7,678)	(C) Number in Total County Population (N=1,287,244)	(D) Percent of Total County Population (C/1,287,244)	(E) HIV/AIDS Prevalence Rate per 100,000 (100,000XA/C)
Black (non-Haitian)	3,420 [4]	45%	169,437 [5]	13%	2,018
Hispanic	971 [3]	13%	241,999 [4]	19%	401
MSM	2,322 [3]	30%	36,595 [6]	3%	6,345
IDU	717 [3]	9%	14,158 [7]	1%	5,064
Haitian Born	1,363 [3]	18%	39,002 [8]	3%	3,495
Homeless	31 [9]	0.40%	3,228 [8]	0.30%	960
Formerly Incarcerated	43 [10]	0.60%	12269 [9]	0.10%	3,507

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[4] Florida Department of Health, Bureau of HIV/AIDS Surveillance Section (2011). Section 2 – Table 1b: Background Data Used for the Calculations of AIDS Prevalence, and HIV (not AIDS) Prevalence.

[5] Florida Department of Health, Bureau of HIV/AIDS Surveillance Section (2011). *Epidemiological Profile, Palm Beach County.*

[6] Estimate based on prevalence of 7.5% MSM among males age 18+ in Florida, Lieb, S., et al., (2009). Estimating Populations of Men Who Have Sex with Men in the Southern United States. *Journal of Urban Health*, November 13, 2009; Population data from U.S. Census (2009). *American Community Survey, 2009, Palm Beach County.*

[7] Estimate based on prevalence of 1.4% IDU among persons age 18+ in South Florida, Lieb, S., et al., (2004). An HIV Prevalence-based Model for Estimating Urban Risk Populations of Injection Drug Users and Men Who Have Sex with Men. *Journal of Urban Health, 81 (3);* Population data from U.S. Census (2009). *American Community Survey, 2009, Palm Beach County.*

[8] U.S. Census (2009). American Community Survey, 2009, Palm Beach County.

[9] Palm Beach County Continuum of Care (2011). *2011 Point in Time Count.*

[10] Florida Department of Health, Bureau of HIV/AIDS Surveillance Section (2011). *Co-Morbidities/Other Factors/Surrogate Markers.*

Populations Underrepresented in the Ryan White Program

Underrepresented populations may be identified by comparing demographic characteristics of the PLWH/A population in the county with the characteristics of PLWH/A served by the Ryan White Program-funded system in the county. The following table shows these comparisons in relation to race/ethnicity, gender, and age. As seen in the table, the demographic characteristics of the PLWH/A population in the county and the PLWH/A served by the Ryan White Program are nearly identical, suggesting that no populations are underserved.[5]

Comparison of all PLWH/A with PLWH/A Served, Palm Beach County, 2010

CATEGORIES	PLWH/A [11]	PLWH/A Served [12]
RACE/ETHNICITY		
White	24%	21%
Black	62%	64%
Hispanic	13%	14%
Asian/Pacific Islander	0%	0%
American Indian	0%	0%
Other/Unknown/Multiracial	1%	1%
GENDER		
Male	62%	59%
Female	38%	41%
AGE (years)		
0-12	0%	1%
13-44	42%	42%
45+	58%	57%

[11] Florida Department of Health, Bureau of HIV/AIDS Surveillance Section (2011). *Attachment 3: AIDS Incidence, AIDS Prevalence, and HIV (not AIDS) Prevalence.*

[12] Palm Beach County Department of Community Services (2011). *RDR Summary Units & Clients Counts, 1/1/10-12/31/10.*

Estimate of Unmet Need

An updated and refined estimate of unmet need in Palm Beach County was completed by using the HRSA/HAB Unmet Need Framework. Use of the Unmet Need Framework Table yields an estimate of 3,567 PLWH/A who were aware of their status, but did not receive the specified primary medical care services in 2010. This is 46% of the total estimated 7,678 PLWH/A who were aware of their status. Data from the Unmet Need Framework Table are generated from the HIV/AIDS Reporting System (eHARS) database which captures cases living and in care in Florida regardless of state reported. Although the eHARS dataset is utilized as the primary tool for estimating unmet need, it must be noted that there are limitations to the data in this database.

Limitations

HIV cases were not reportable in Florida until July 1, 1997. From 7/01/97 through 11/20/06, the HIV report was 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). Mandatory lab reporting of all viral test results and all CD4 counts went into law on November 20, 2006. Only detectable viral tests are reportable as a new case in eHARS, therefore those patients testing as "undetectable" will not be reported until they have a detectable viral load and/or develop AIDS; thus the data for HIV (not AIDS) will underestimate the true number of diagnosed and in care clients that are not yet reported. Paper labs (lab reports from labs not currently reporting electronically) received at the State Health Office were entered into a stand-alone-Access dataset, not connected with eHARS. With the reporting laws in place for over 4 years and the continued expansion of ELR, HIV and laboratory reporting has become more complete (but still only at about 75% complete).

The OOS database became obsolete in 2010 and is no longer being updated. All cases with a lab from Florida but reported out of state are now being entered into eHARS. Due to the sheer volume of these OOS cases, there currently is a back log of over 1,000 OOS cases to be entered into the eHARS system, thus, for this year, the total number of cases and their care status will be under-reported. Although not fully complete, it now replaces the need to conduct matches from the OOS database.

OOS data only represent a minimal amount of the prevalent cases that have migrated into Florida (3-4%), yet it is still valuable data to include in the analyses as it represents persons living and in care in Florida, regardless of where they were reported. It is expected that this data entry process will be up-to-date for next year's analysis.

As defined in the protocol below, cases from the eHARS database were matched with cases in care via Medicaid, ADAP and HMS (Health Management System, a County Health Department database for client based services), CAREware (an HIV/AIDS patient care dataset), as well as with the ELR and paper lab databases. Cases in care by some *other* source utilizing a lab that did NOT report via ELR or paper lab, will NOT be captured as "in-care" via all of these matches. This artificially deflates the percent of cases in care. Therefore a factor of "those estimated in care via other sources" is used to capture those cases. These estimates were based on local chart reviews and are edited each year per local feedback following local chart reviews. These adjustments can be fined tuned by the EMA to reflect the results of more recent chart reviews. Since laboratory reporting is still not fully complete from all labs, some local adjustment may be

needed to more closely reflect the percent in care for a given area. These adjusted estimates also help to account for those reported cases that have unknowingly migrated *out* of Florida and are no longer in care here.

Changes from last year:
Since the implementation of eHARS in January 2009, the ability to track and update current residence became available, as well as the ability to add cases to the database that were reported from another state, but in care in Florida. This year, the PLWHA data reflect the current county of resident, if in care, as opposed to the county of report as in previous years. This more accurately reflects where a case is living and if in FL, whether the case is in care or not. *As a result, this year's results by EMA are NOT directly comparable to previous years.*

Per guidance from the Centers for Disease Control, Florida re-assigned several thousand cases previously reported in Florida but identified as being reported elsewhere first. If those cases were identified as no longer living in Florida and were NOT in care in 2010, they were omitted in the TOTAL count of PLWHA. As a result, they will no longer negatively impact the in care data since they are no longer living in Florida. This will account for a smaller increase in PLWHA from the previous year.

Significant efforts have been made to eliminate duplicate cases in the system. Although less than 1%, in previous years, duplicate cases may have resulted in persons being counted for in care twice under two different names, thus artificially increasing the total number and the percent in care.

Electronic laboratory reports are now being imported into eHARS, thus simplifying the matching process. Paper labs were still being manually entered in a stand-alone database. Each year, more and more labs are now reporting via ELR. As these data become more complete and all labs are imported into eHARS, the percent estimated "in care but not reported with care" will lower each year.

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 who are living in Florida and are in care with a documented prescription, CD4 or viral HIV test (as defined by HRSA) in either eHARS, Medicaid, ADAP, HMS, CAREware, ELR or the paper lab database (plus the local estimates of those in care via other sources, if adequate) are representative of those HIV/AIDS cases that are not yet reported in eHARS. 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 in order to provide the most reflective analysis of HIV/AIDS care within the state.

Protocol:
In order to assure the most accurate statistics on living status, the state has ongoing matches with the Death Certificate database in the Office of Vital Statistics. We receive ongoing reports of death certificates on cases with a known HIV-related death. Additionally, we routinely match our living database with the death certificate database to receive notification on deaths to cases

with unrelated causes. Furthermore, on an annual basis, the state obtains the five most recent years of deaths from the Social Security Death Master File (SSDMF) to match with our data and update deaths accordingly. In the past year, we also matched our AIDS cases with the National Death Index and identified over 700 new deaths, not previously recorded.

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. eHARS case data of HIV/AIDS cases still presumed living in Florida (regardless of state of report) through 2010 were matched with Medicaid, ADAP, HMS, CAREware and the ELR and paper labs databases. One single database was created from results of these matches that contains any HIV/AIDS case from eHARS with at least one CD4, Viral HIV test or HIV prescription recorded in 2010, indicating that they received the specified HIV primary medical care service within a 12-month period as defined by HRSA and therefore in care. Geographic, demographic and risk data were also incorporated into the database. Cases reported from the department of Corrections (DOC) are included in the above match, but not accounted for in the local and state totals. They are treated as a "special population" and thus their data are shown in that category only.

Data used to generate the unmet need estimates are developed by the state and disseminated to the 6 EMAs. The same formulas used to estimate the 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.

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. **Living AIDS Cases (PLWA) through 2010, (as of 05/26/11):** (Data Sources for both A & B are from the eHARS database).
B. **Living HIV (not AIDS) Cases (PLWH) through 2010, (as of 05/26/11):**
C. **PLWHA through 2010, (as of 05/26/11): (A+B)**
D. **Number of PLWA who received the specified HIV primary medical care services in a 12-month period.** (Data Sources for both D and E include eHARS database, along with Medicaid, ADAP, HMS, CAREware and the ELR and paper labs databases).
E. **Number of PLWH who received the specified HIV primary medical care services in a 12-month period.**
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 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 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. (G+H)**

K.

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), for the period of 01/01/2010 - 12/31/2010	4,619		eHARS and OOS data sets plus matches with ADAP, Medicaid, HMS, Care and Electronic and Paper Lab databases
Row B.	Number of persons living with HIV (PLWH)/non-AIDS/, for the period of 01/01/2010 - 12/31/2010	3,059		eHARS and OOS data sets plus matches with ADAP, Medicaid, HMS, Care and Electronic and Paper Lab databases
Row C.	Total number of HIV+, for the period of 01/01/2010 - 12/31/2010	7,678		
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	2,879	62%	eHARS and OOS data sets plus matches with ADAP, Medicaid, HMS, Care and Electronic and Paper Lab databases
Row E.	Number of PLWH/non-AIDS/ who did receive the specified HIV primary medical care services in 12-month period	1,232	40%	eHARS and OOS data sets plus matches with ADAP, Medicaid, HMS, Care and Electronic and Paper Lab databases
Row F.	Total number of HIV+/ who did receive the specified HIV primary medical care services in 12-month period	4,111	54%	
Calculated Results		**Value**	**Percent**	**Calculation**
Row G.	Number of PLWA who ***did NOT*** receive primary medical services	1,740	38%	Value: Value A - Value D. Percent: Value G/Value A.
Row H.	Number of PLWH/non-AIDS/ who did NOT receive primary medical services	1,827	60%	Value: Value B - Value E. Percent: Value H/Value B.
Row I.	Total HIV+/ who did NOT receive specified primary medical care services (quantified estimate of unmet need)	3,567	46%	Value: Value G + Value H. Percent: Value I/Value C

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.
- Improve the calculation of in and out migration in eHARS and incorporate them with the population and estimates of who is in care:
- Identify any other available databases that may be beneficial for matching with eHARS in order to identify additional sources of care, not captured elsewhere.
- Continue to enhance the process of importing paper labs into eHARS, thus making the lab data in eHARS more complete and possibly reducing the need of utilizing other matching components.
- Importing paper lab data into eHARS.

Unmet Need Trends, 2008-2010

The following table shows the percent of unmet need for PLWA and PLWH for 2008, 2009, and 2010. As seen in the table, the percent of unmet need for both PLWA and PLWH increased over the three-year period despite significant efforts to get PLWHA into care. Possible reasons for this include that it may be an artifact of the increasing accuracy of the unmet need estimation methodology; more PLWHA may be out of care due to budget cuts; or more PLWHA may feel unable to afford care or lack insurance due to the economic recession and unemployment.

Percent of Unmet Need, 2007-2009

POPULATIONS	2007	2008	2009	2010
PLWH	33%	39%	52%	60%
PLWA	23%	25%	32%	38%
TOTAL PLWH/A	27%	30%	40%	46%

How Unmet Need Trends are Reflected in Planning and Decision Making

The CARE Council is committed to ensuring primary medical care to all PLWHA. Funding for Early Intervention Services (EIS) to find PLWHA, refer and link them into care has remained stable. Funding for medical case management and EIS to find PLWHA who have fallen out of care as well as for assisting clients to remain in care has remained stable. An increase in all medical care categories particularly for medications and health insurance continuation has been decided in order to accommodate the influx of PLWHA who will enter our system of care. A Peer Mentor program will be implemented to bring PLWHA into care and keep them in care. Further, our EIS efforts will specifically target the recently incarcerated population and the Haitian population since they have a high proportion of PLWHA out of care.

Early Identification of Individuals with HIV/AIDS (EIIHA)

The Palm Beach County HIV CARE Council has created a strategy for the Early Identification of Individuals with HIV/AIDS (EIIHA) which includes the following goals:

1. By 2012, through voluntary counseling and testing, increase by 10% the proportion of HIV- infected people in Palm Beach County who know they are infected.

2. By 2012, increase by 10% the proportion of HIV-infected people in Palm Beach County who are linked to appropriate prevention, care and treatment services.

Both of these goals are consistent with making individuals who are unaware of their HIV status, aware. Goal 1 aims to make more unaware PLWHA aware, and goal 2 aims to refer and link the newly aware to care.

The EIIHA strategy uses data from a number of data systems, including the Bureau of STD Prevention and Control's PRISM (Patient Reporting Investigating Surveillance Manager), ADAP data systems, CAREWare, AIDS Surveillance's Electronic Lab Reporting (ELR), and Florida's Health Clinic Management System (HMS), to track the provision of test results to both Ryan White and private providers in order to identify individuals unaware of their status.[6] With the use of the above systems the number of individuals diagnosed with HIV and living in Palm Beach County as of December 31, 2009 was 7,311. Applying the estimated back calculation methodology, the number of living HIV positive individuals who were unaware of their status was 1,943 (.21 x 7,311/.79).

B. Description of Current Continuum of Care

Coordination of Services and Funding Streams
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 in their overall systems.

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; Health Council of Southeast Florida, 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.

[13]Florida Department of Health Bureau of HIV/AIDS (2010). *FY2011 – PS10-1001 IOPR Guidance.*

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.

Quality Management, 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.

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 2010. 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.

In accord with federal guidance, funds were recently allocated to early intervention services. It is expected that this will result in an increase in the number of persons linking to services.

In addition to the information in the Resource Inventory Table found in appendix 1, below are definitions of services by category:

CORE MEDICAL SERVICES

1. Medical Care

a Outpatient/Ambulatory Medical Care

Provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, registered nurse, or nurse practitioner in an outpatient setting. Settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not outpatient settings. Services includes diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties). *Primary medical care* for the treatment of HIV infection includes the provision of care that is consistent with the Public Health Service's guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies.

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, IGRA, AFB, pap smear, toxoplasmosa, hepatitis B, & CMV serologies) & all other laboratory tests as clinically indicated (e.g. HCV serology) that are generally accepted to be medically necessary for the treatment of HIV disease & its complications and have an established Florida Medicaid or Medicare reimbursement rate, as well as new tests that may not have an established reimbursement rate.

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 Medical 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, registered nurse. Specialties may include, but are not limited to, outpatient rehabilitation, dermatology, oncology, obstetrics and gynecology, urology, podiatry, pediatrics, rheumatology, physical therapy, speech therapy, occupational therapy, developmental assessment, and psychiatry.

e Oral Health Care

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

Service caps approved by the CARE Council must be adhered to. Clinical decisions must be informed by the American Dental Association Dental Practice Parameters.

f Early Intervention Services (EIS)

Includes counseling individuals with respect to HIV/AIDS; testing (including tests to confirm the presence of the disease, tests to diagnose the extent of immune deficiency, tests to provide information on appropriate therapeutic measures); referrals to appropriate services based on HIV status; linkage to care and education and health literacy training for clients to help them navigate the HIV care system; other clinical and diagnostic services regarding HIV/AIDS; periodic medical evaluations for individuals with HIV/AIDS; and providing therapeutic measures.

Services shall be provided at specific points of entry. Coordination with HIV prevention efforts and programs as well as prevention providers is required. Referrals to care and treatment must be monitored. Grantee may modify targeted areas to include additional key points of entry.

g Nurse Care Coordination

A range of client-centered services provided by a registered nurse and coordinated with the client's primary outpatient healthcare provider, providing the Ryan White patient's main link with ongoing medical services.

Key activities include: 1)provides primary care as part of the clinical team, 2)triage for new problems, 3)provide health education and self-care education, 4) coordinate medical plan and specialty referrals, 5) implement and monitor home-based service plans, including home visits if necessary, 6) facilitate access to clinical trials, 7) guarantee patient access to clinical care five days per week, 8)coordinate in-patient and out-patient care, 9) conduct chart reviews for evaluation of services to Ryan White funded patients.

h Health Insurance Premium & Cost Sharing Assistance

Provision of financial assistance for eligible individuals living with HIV to maintain a continuity of health insurance or to receive medical benefits under a health insurance program. This includes premium payments, risk pools, co-payments, and deductibles.

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

i Home Health Care

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

j Home and Community-Based Health Services

Includes skilled health services furnished to the individual in the individual's home based on a written plan of care established by a case management team that includes appropriate health care professionals. Services include durable medical equipment; home health aide services and personal care services in the home; day treatment or other partial hospitalization services; home intravenous and aerosolized drug therapy (including prescription drugs administered as part of such therapy); routine diagnostics testing administered in the home; and appropriate mental health, developmental, and rehabilitation services. Inpatient hospitals services, nursing home and other long term care facilities are NOT included.

k Hospice Services

Includes end-of-life care provided to clients in the terminal stage of illness. Includes room, board, nursing care, counseling, physician services, and palliative therapeutics. Services may be provided in a residential setting, including a non-acute-care section of a hospital that has been designated and staffed to provide hospice services.

l Mental Health Services

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

m Medical Nutrition Therapy

Provided by a licensed registered dietitian outside of a primary care visit. The provision of food, nutritional services, and nutritional supplements may be provided pursuant to a physician's recommended and nutritional plan developed by a licensed, registered dietician.

n Medical Case management services (including treatment adherence)

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

Case Management providers must be PAC Waiver providers or demonstrate that they have begun the PAC Waiver application process.
Medical Case Management services exclude determining/re-determining clients' eligibility.

Peer Mentor Program

The goal of the Peer Mentor program is to improve HIV-related health outcomes and reduce health disparities for at risk communities through HIV peer education. Peers shall be persons living with HIV from the community, not working as licensed clinical professionals, who share key characteristics with target population which shall include: a. community membership, gender, race/ethnicity, b. disease status or risk factors, c. sexual orientation, d. salient experiences, e.g. former drug use, sex work, incarceration. The Peer Mentor will use shared characteristics/experiences to act effectively as a trusted educator, mentor for adopting health behavior, role model, and empathic source of social and emotional support.

The contributions of HIV-positive peers shall include: adherence to medical care (keeping appointments, responding to physician referrals, and picking up medications); linking to medical care and support services; self-management of disease; emotional support and reduced risk behaviors.

Treatment Adherence
Treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatment.

- Substance Abuse Services-Outpatient

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

SUPPORT SERVICES

Case Management (non-Medical)

Supportive Case Management
Includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatments, as medical case management does.

Excludes determining/re-determing clients' eligibility.

Determining Eligibility
Provision of eligibility screenings for clients.

Referral for Health Care/Supportive Services
The act of directing a client to a service in person or through telephone, written, or other type of communication. Referrals for health care/supportive services that were not part of Outpatient/Ambulatory services or case management services (medical or non-medical) should be reported under this item.

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

Substance Abuse Services- residential

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

Provides room and board, substance abuse treatment and counseling, including specific HIV counseling in a secure, drug-free state-licensed residential (non-hospital) substance abuse detoxification and treatment facility. This treatment shall be short term. Anyone providing direct counseling services must under the supervision of staff possessing postgraduate degree in the appropriate counseling-related field, or a Certified Addiction Professional (CAP). Part A funds may not be used for hospital inpatient detoxification.

Food Bank/Home Delivered Meals
Provision of actual food or meals. It does not include finances to purchase food or meals. The provision of essential household supplies such as hygiene items and household cleaning supplies should be included in this item. Includes vouchers to purchase food.

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

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

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

Outreach Services
Programs that have as their principal purpose identification of people with unknown HIV disease or those who know their status so that they may become aware of, and may be enrolled in care and treatment services (i.e., case finding). Outreach services does not include HIV counseling and testing or HIV prevention education. These services may target high-risk communities or individuals. Outreach programs must be planned and delivered in coordination with local HIV prevention outreach programs to avoid duplication of effort; be targeted to populations known through local epidemiologic data to be at disproportionate risk for HIV infection; be conducted at times and in places where there is a high probability that individuals with HIV infection will be reached; and be designed with quantified program reporting that will accommodate local effectiveness evaluation.

Legal Services
Provision of services to individuals with respect to powers of attorney, do-not-resuscitate orders and interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the Ryan White Program. It does not include any legal services that arrange for guardianship or adoption of children after the death of their normal caregiver.

Health Education/Risk Reduction
Provision of services that educate clients with HIV about HIV transmission and how to reduce the risk of HIV transmission. It includes the provision of information about medical and psychosocial support services and counseling to help clients living with HIV improve their health status.

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

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

Linguistics Services
Provision of interpretation and translation services. Types of linguistic services to be provided include oral interpretation and written translation as needed to facilitate communications and services delivery. Training and qualifications based on available State and local certifications are required.

Child Care Services
Provision of care for the children of clients who are HIV-positive while the clients attend medical or other appointments or Ryan White Program-related meetings, groups, or training.
NOTE: This does not include child care while a client is at work.

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

Redbook
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.

Budget Cuts
Our EMA has received a reduction of almost a million dollars, approximately 10%, in funding since 2005. Further cuts would likely lead to additional reductions or perhaps the elimination of some support services. The impact of reductions on the Continuum of Care has had a detrimental impact, and will continue to do so if our EMA experiences further funding cuts. The implementation of the 75%/25% medical/support category and the restructuring of core medical and support has severely impacted the provision of support services to the PLWH/A community.

Resources from the State of Florida such as the Florida State Part B Supplemental, ADAP and AICP have been reduced for our EMA. Both ADAP and AICP invoked waitlists over the last few years, which has led to Part A funds having to close the gap for some client services.

Due to all of the factors mentioned above the CARE Council annually prepares for cuts with the creation of a budget for an overall reduction in funding. This budget holds much of the medical services harmless and reduces funding for the support services. Additionally, the CARE Council is working with the Grantee on the cost savings measures described in more detail below, including the reduction in costs for medical and non-medical case management (supportive), implementation of a Peer Mentor Program, and revising the eligibility criteria.

Impact of Ryan White Funding Decline
In recent years we have had a decrease in overall funding. During those years support services have been heavily impacted. As more PLHWA come into care each year the cost for medical services increases. Accommodating the medical service needs is a top priority. In order to do so, funding for support services has been and will continue to be reduced or eliminated completely. The overall effect would be a financial downturn for this EMA.

In preparation of a possible reduction in funding, the Grantee is reviewing all services to explore where cost savings measures can be implemented. Some examples of this include the implementation of a financial cap of 400% FPL for all medical services effective June 30, 2011. This has not resulted in a great cost savings as there were only a small number of clients over 400% FPL and they were receiving minimal services; although the CARE Council and Grantee felt it was fiscally prudent to have a cap put in place. A standard unit cost for medical and non medical case management has been implemented. This will equate a cost savings of approximately $300,000. In March 2012, the EMA will implement a Peer Mentor Program. The hope is that this will be a support to case management services, and the reimbursement rate will be lower than case management leading to additional cost savings. The Grantee is also reviewing the administration and quality management costs to see where reductions can be made. In the past the Grantee had contracts with an outside agency for the CARE Council support tasks, but have now hired staff internally and provide the service at a much lower rate equating a savings of approximately $100,000.

Our EMA understands that many times the receipt of support services allows clients to remain in care, so we are looking at ways to reduce overall costs for services, so we can continue to provide minimal support services rather than eliminate them completely.

C. Description of Need

Every three years the Ryan White Part A CARE Council conducts a Comprehensive Needs Assessment. The findings in the Comprehensive Needs Assessment 2011-2014 are to be used by the CARE Council to help identify the needs and service priorities of PLWH/A residing in Palm Beach County. A 108-item survey was developed and administered to collect information from PLWH/A and providers regarding service priorities and needs.

Information was gathered from respondents who were in primary medical care, as well as respondents who were out of primary medical care. In this study, the definition of "in care" or "in primary care" is the definition adopted by Health Resources and Services Administration (HRSA) for being "in primary medical care" if the patient has been in…

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

Lab work for CD4 count
Lab work for viral load count
Prescription for Anti-Retroviral Therapy (ART)."

This definition is an "operational" or working definition of being "in care" and uses information likely to be available in most states and EMAs.

Survey respondents who were not in primary medical care were asked what services, other than medical care and medication did they need to get into primary medical care. The following chart displays the care needs.

The three most frequently chosen responses were financial assistance (49.3%, 34), food (46.4%, 32) and housing (44.9%, 31). Additional services in response to need were, case management, transportation, substance abuse treatment, mental health services, legal services, labs, dental care, and treatment adherence. There were 3 out of the 69 respondents that claimed there were no services needed to get into care. However, there were 2 out of the 69 respondents that claimed they were not sure of the services they needed to get into care. Respondents who claimed that other services, such as an 'employment', 'late appointments availability', and 'mental services later in treatment' made up 4.3% of the overall percentage, 3 out of 69.

Services Needed	Out of Care Respondents (n=69)	
	Number	Percent
Financial Assistance	34	49.30%
Food	32	46.40%
Housing	31	44.90%
Case Management	28	40.60%
Transportation	25	36.20%
Substance Abuse Treatment	15	21.70%
Mental Health Services	12	17.40%
Legal Services	11	15.90%
Labs	11	15.90%
Dental Care	6	8.70%
Treatment Adherence	5	7.20%
None	3	4.30%
Not Sure	2	2.90%
Other (e.g. job, late appointments, might need mental health services later)	3	4.30%

Providers were asked the same question regarding services, other than medical care and medications that PLWHA need to get into primary medical care. The following table shows what services providers believe are needed for PLWHA to obtain care.

The most frequently selected service needs for clients indicated by the 14 providers are mental health services (64.3%, 9), housing (57.1%, 8), case management (50.0%, 7), transportation (50.0%, 7), substance abuse treatment (50.0%, 7), and food (50.0%, 7). Both legal services and dental care were the least selected services by the providers, (29.0%, 4).

Services Needed	Provider Respondents (N=14)	
	Number	Percent
Financial Assistance	6	42.90%
Food	7	50.00%
Housing	8	57.10%
Case Management	7	50.00%
Transportation	7	50.00%
Substance Abuse Treatment	7	50.00%
Mental Health Services	9	64.30%
Legal Services	4	28.60%
Labs	6	42.90%
Dental Care	4	28.60%
Other (e.g. job, late appointments, might need mental health services later)	0	0.00%

Providers have cited capacity development needs to address disparities in the availability of HIV-related services for both historically underserved and rural communities. They have also cited needs in case management, medication, mental health/substance abuse, housing, transportation services, as well as basic resources which are highlighted below.

Case Management
Greater access to case managers is needed overall, with HIV providers needing more case managers to attend to clients. Case loads need to become smaller and more specialized. Housing resources are needed for people living with HIV.

Medication
Easier access to medication is needed and there is a need for more medication assistance programs. A reduction in the number of PLWH/A on ADAP & AICP wait lists are also needed.

Mental Health/Substance Abuse
There is a greater need for access to qualified mental health providers. More local facilities that offer residential substance abuse treatments of HIV+ pregnant women in hospital like settings, similar to Plantation General in Broward, are needed.

Housing
More housing options and resources are needed for PLWH/A. There needs to be specialized housing resource in the system.

Transportation
More transportation options are needed for clients so that they can attend their appointments.

Basic Resources
Clients at times move in and out of care. The Comprehensive Needs Assessment captured data from survey respondents now in care, but who had been out of care within the past five years. Clients were asked what services, other than medical care and medications, were needed when out of care.

The three most frequently identified services were food (63.3%, 31), financial assistance (51.0%, 25), and housing (42.9%, 21). Additional services in response to need were transportation, case management, substance abuse treatment, legal services, labs, dental care, treatment adherence, and mental health services. 7 out of the 49 respondents indicated that no services were needed when they were out of care. The following table displays the care needs.

Services Needed When Out of Care	In Care Respondents Who Were Out of Care (n=49)	
	Number	Percent
Food	31	63.30%
Financial Assistance	25	51.00%
Housing	21	42.90%
Transportation	18	36.70%
Case Management	17	34.70%
Substance Abuse Treatment	11	22.40%
Legal Services	11	22.40%
Labs	11	22.40%
Dental Care	10	20.40%
Treatment Adherence	7	14.30%
Other (Please Specify)	6	12.20%
Mental Health Services	7	14.30%
None/No response	7	14.30%

D. Description of priorities for the allocation of funds

The Priorities & Allocations (P&A) Committee follows a detailed work plan, which guides the annual P&A Process. The P&A Process begins in May and concludes in November with a verbal review and evaluation of the process. The CARE Council Support staff conducts an extensive orientation and review of the Part A (Title I Manual): Section V Technical Assistance Papers, and Priority Setting and Section VII Priority Setting and Resource Allocation. All CARE Council committees have an opportunity to make recommendations to the P&A Committee during this process.

a. The Priority Setting and Allocation (P&A) process is inclusive of the needs of PLWHA who are aware of their status but not in care through the review of epidemiological data from the Department of Health informing the CARE Council members of the number of PLWHA aware and not in care. Additionally, the Needs Assessment 2011-2014 includes extensive data from PLWHA who are aware but not in care, as well as PLWHA who are currently in care but have been out of care over the past 5 years. Allocations for EIS, as well as an increase in the allocations for medical core services were a result of these data.

b. The needs of PLWHA who are unaware of their HIV status are considered through a review of the epidemiological data from the Department of Health (DOH). While this is a fairly new data requirement of HRSA's, the local CARE Council has been reviewing these data for several years. One of the CARE Council's strategies for bringing people in to care was to go to the source of where and when PLWHA are becoming aware of their status and linking to care. A review of the disaggregated demographics of PLWHA testing positive and who is or is not linking to care within 30 days is reviewed. Through these data an allocation to EIS was approved. Based on the DOH data, there are specific target populations that this service will focus on making aware and linking to care.

c. The needs of PLWHA from historically underserved populations are considered through the review of unmet need, unaware, needs assessment, and epidemiological data sets, as well as public forums. These data display where the disparities are, as well as where the EMA needs to focus efforts to bring PLWHA into care. The P&A Committee, as well as the CARE Council, continued to follow the plan they developed during a 2006 workshop conducted by the Academy of Educational Development entitled, CARE Act Planning in a Changing Environment. The CARE Council chose to plan 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 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.

d. The CARE Council involves PLWHA in the P&A process to gather qualitative data through the following: community forums, PLWHA Surveys among in and out of care populations, Focus Groups among special populations, and a permanent representation of PLWHA membership on the CARE Council and its committees as defined by the Bylaws. Forty-six percent (46%) of the CARE Council members are PLWHA, and the majority of the P&A Committee members are PLWHA.

Public forums are held in areas disproportionately impacted by HIV/AIDS, including Belle Glade (western, rural area), West Palm Beach (north/central eastern area), and Delray Beach (south/central eastern area). Demographics of the attendees are collected and reviewed by the P&A Committee. In FY 2011 there were forty-one (41) attendees. Forty-eight percent (48%, 19 of 40 respondents) of the participants identified themselves as being HIV positive. Black and Hispanic/Latin/Multi-racial persons accounted for 63% (25 of 40 respondents) of the participants, and 61% (25 of 41 respondents) of the participants were female. When asked to rank the service categories public forum participants selected outpatient primary medical care and HIV medications both as the #1 priority, followed by medical case management, laboratory, mental health and specialty medical care. Recommendations from the forums and the committees included the need for additional funding for supportive services (i.e. medical case management, food, and housing).

e. In order to increase access to the core medical services and reduce disparities in access to the Continuum of Care, and address the unmet need and gaps found in the needs assessment, the CARE Council allocates significantly more money to all medical services. The West Palm Beach EMA anticipates an increase in persons utilizing all medical services over the next fiscal year through efforts that are made in increasing access to underserved and special populations in the EMA. According to the Needs Assessment data from PLWHA who are out of care, these survey respondents were poorer and less educated than PLWHA who are in care. PLWHA survey respondents who are out of care were more likely to be homeless, have substance abuse and mental health issues, and be without disability benefits. The allocations reflect an increase across all services for PLWHA coming into care as it is anticipated they will likely need and use most of the available services. Additionally, a significant allocation was made to Early Intervention Services to bring aware and unaware PLWHA in to care. This will lead to a reduction in disparities in access to the continuum. The Needs Assessment 2011-2014 was reviewed including the EMA's epidemiological profile, out of care responses, in care respondents' service priorities, utilization, gaps and barriers, and GIS maps discussed below. The Implementation Plan in the Comprehensive Plan 2012-2015 is also reviewed to ensure that monies would be allocated in order to meet our set goals, objectives and activities.

f. Changes and trends in HIV/AIDS epidemiology data are used in the P&A Process to ensure our service delivery system is meeting the changing needs of the HIV/AIDS community. Epidemiological data from the Department of Health is reviewed. The data displayed data trends for the entire PLHWA population as well as disaggregated data for sub-populations (e.g. MSM, Heterosexual, IDU, male, female, age groups). The data also displays GIS maps for all of the special populations. These data allowed the CARE Council to make informed decisions. Allocations particularly for medical services increased as well as early intervention services as more persons are expected to be brought into care.

The GIS map (found in Appendix 2) was prepared for the Comprehensive Needs Assessment 2011-2014. The map displays PLWHA cases by zip code through 2009, HIV/AIDS service locations, and the public transportation route. A comparison of service locations with ZIP Codes of PLWHA demonstrates that services are available in the most heavily impacted ZIP Codes and

that Palm Tran, the public transportation system, connects residents of most ZIP Codes with all service locations including all case management and public health clinics.

ZIP Code data were provided by the Department of Health, 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.

g. Cost data are used by the CARE Council in making funding allocation decisions. These data included the following sources: Unit Costs; Expenditure Trends FY 2002-FY 2011; FY 2011 Part A, Part B, HOPWA, General Revenue Patient Care and Network [Florida state matching funds] allocations; Number of PLWHA Served FY 04 through FY10; Service Utilization (RSR); and Service Category Definitions and Priorities FY 2012. The CARE Council's allocations are based on a demonstrated need funding worksheet that attempts to estimate costs for services over the next fiscal year by displaying the following information for each service category: estimated annual cost per patient currently in care + estimated cost for a 6% increase of PLWHA in care + estimated cost to fill service gaps found in the Needs Assessment 2011-2014.

h. The Unmet Need Framework is used in the P&A Process to identify and demonstrate how expenditures, particularly for medical services, may increase in the upcoming years as more persons are brought into care through increased early intervention service efforts for the estimated 3,567 (46%) of the 7,678 PLWHA who are aware and out of care, as well as the 1,943 unaware PLWHA. Data from Florida Department of Health, HIV and AIDS Reporting System (HARS) 2009 including Unmet Need Framework was reviewed.

i. The CARE Council will prospectively address potential funding fluctuations, increases or decreases, in the Part A award by discussing and planning for three circumstances including an increase, level or decrease in Part A funding. The P&A Committee work plan includes an annual meeting in November to develop and vote on budgets for all three scenarios. The committee will then meet after receipt of the award to amend the allocations, if necessary.

j. The CARE Council historically has allocated most if not all of the MAI funds to case management services. The philosophy is that medical case management services work to decrease the health disparities for disproportionately impacted minority populations by getting people in to care sooner and increasing the likelihood of clients staying in care. The CARE Council has arrived at this assessment through the review of data including unmet need, needs assessment, client level health outcome data.

k. Data related to Persons Unaware of their HIV Status is reviewed and discussed leading to a significant allocation to the Early Intervention Services line item. The EMA has a close working relationship with the prevention planning group. In addition, the EMA has a robust testing and counseling program. There are gaps when attempting to reach the EIIHA subgroups. The EMA is committed to filling the gaps.

l. Demonstrated need worksheets were created to show the overall impact of services to budget. Below you will find demonstrated worksheets for both Medical and Support Services.

Medical Services and Support Services

A	B	C	D	E	F	G	H	I	J	K	L
Priority	Service Category	FY 10-11*	# Expected to be Served	Gaps	Increase % PLWHA in Care by 6%	Total PLWHA Need	Estimated Avg. Cost/Person/ Year	Total PLWHA Need	% of Total Services	FY 12-13 Application	% of Total Services (Application)
						D+E+F=G	C/D=H	GxH=I			
ASSUMPTIONS:			#1	#2	#3	#4	#5				
Medical Subtotal		*$6,694,969*							*87%*	*$7,725,000*	*80%*
1a	Ambulatory/Primary Outpatient Medical Care	$849,066	1228	45	74	1347	$691	$931,425	10.83%	$935,000	9.65%
1b	Laboratory Diagnostic Testing	$1,071,119	1386	57	83	1526	$773	$1,179,302	13.72%	$1,180,000	12.18%
1c	Drug Reimbursement										
	Local Supplemental	$760,782	945	28	57	1030	$805	$829,252	9.65%	$900,000	9.29%
	ADAP Supplemental	$0	-	-	-	0	$0	$0	0.00%	-	0.00%
	Nutritional Supplement	$20,752	-	-	-	0	$0	$0	0.00%	$24,000	0.25%
	Pediatric AZT	$0	-	-	-	0	$0	$6,000	0.07%	$6,000	0.06%
1d	Specialty Outpatient Medical Services	$437,888	275	15	17	306	$1,592	$487,807	5.67%	$485,000	5.01%
1e	Oral Health	$405,112	824	69	49	943	$492	$463,448	5.39%	$500,000	5.16%
1f	Early Intervention Services	$0	0	-	-	0	-	$0	0.00%	$500,000	5.16%
1g	Nurse Care Coordination	$117,019	571	11	34	617	$205	$126,381	1.47%	$150,000	1.55%
1h	Health Insurance Premium & Cost Sharing Assistance	$209,000	138	15	8	162	$1,514	$244,739	2.85%	$250,000	2.58%
1i	Home Health Care	$100,925	54	2	3	59	$1,869	$110,715	1.29%	$115,000	1.19%
1j	Hospice	$0	-	-	-	0	-	$0	0.00%	$0	0.00%
1k	Mental Health	$87,029	124	9	7	140	$702	$98,430	1.14%	$115,000	1.19%
1l	Medical Nutrition Therapy	$0	-	-	-	0	$0	$0	0.00%	$0	0.00%
1m	Medical Case Management Total:	$2,612,314	2419	179	145	2743	$1,080	$2,962,364	34%	$2,520,000	26%
1m	Medical Case Management Services (including Treatment Adherence)	$2,612,314	2419	179	145	2743	$1,080	$2,962,364	34.46%	$2,270,000	23.43%
	Peer Mentor	$0	-	-	-	-	-	-	-	$250,000	2.58%
1n	Substance Abuse Outpatient	$23,963	23	1	1	25	$1,042	$26,287	0.31%	$45,000	0.46%

Support Subtotal		***$952,665***							***13%***	***$1,965,000***	***20%***
2	**Case Management (non-medical)**	$98,910	349	26	21	396	$283	$112,164	1.30%	$925,000	9.55%
3	**Referral for Health Care/Supportive Services**	$0	-	-	-	0	$0	$0	0.00%	$0	0.00%
4	**Housing**	$0	-	-	-	0	$0	$0	0.00%	$0	0.00%
5	**Substance Abuse Residental**	$8,206	3	0	0	3	$2,735	$9,289	0.11%	$100,000	1.03%
6	**Food Bank/Home Delivered Meals**	$201,727	462	122	28	612	$437	$267,087	3.11%	$275,000	2.84%
7	**Emergency Financial Assistance**	$86,047	150	32	9	191	$574	$109,538	1.27%	$175,000	1.81%
8	**Medical Transportation Services**	$107,810	717	102	43	862	$150	$129,588	1.51%	$190,000	1.96%
9	**Treatment Adherence Counseling**	$0	-	-	-	0	$0	$0	0.00%	$0	0.00%
10	**Outreach**	$196,311	84	3	5	92	$2,337	$213,979	2.49%	$0	0.00%
11	**Legal Services**	$253,654	329	27	20	375	$771	$289,419	3.37%	$300,000	3.10%
12	**Health Education/Risk Reduction**	$0	-	-	-	-	$0	$0	0.00%	$0	0.00%
13	**Psychosocial Support Services**	$0	-	-	-	-	$0	$0	0.00%	$0	0.00%
14	**Rehabilitation Services**	$0	-	-	-	-	$0	$0	0.00%	$0	0.00%
15	**Linguistics Services**	$0	-	-	-	-	$0	$0	0.00%	$0	0.00%
16	**Child Care Services**	$0	-	-	-	-	$0	$0	0.00%	$0	0.00%
17	**Respite Care**	$0	-	-	-	-	$0	$0	0.00%	$0	0.00%
Total Service		**$7,647,634**					**$18,053**	**$8,597,214**	**100.00%**	**$9,690,000**	**100.00%**
Total inc. Grantee (10%) and QM (5%)		**$8,997,216**						**$10,114,369**		**$11,400,000**	

*Column C: FY 10-11: Formula+Supplemental+MAI and Carry Over.

ASSUMPTIONS:

1. Column D: FY 10-11 Implementation Plan (Final #s Served)
2. Column E (Gaps): Increase in # Served from Needs Assesment 11-14: # Estimated to be Served FY 10-11 x % PLWHA; Survey Respondents Who Were at or Below 300% of the FPL Who Said They Need But Can't Get Service.
3. Column F: In 2010, 41% (3,183) of PLWHA Were Out of Care. A Plausible Goal of 6% Increase of PLWHA Entering Into Care is Used Here. The Anticipation is that PLWHA Entering Care Will Utilize Ryan White Medical and Support Services While They Apply For Other Medical Payer Sources
4. Column G (Total PLWHA Need): Column D+E+F+G: Total # Estimated to be Served FY 10-11 + In Care Gaps + 6% PLWHA Entering Care
5. Column H: Ryan White Part A (Formula + Supplemental + MAI + Carry Over) / # Estimated to be Served FY 10-11

E. Description of gaps in care

The Comprehensive Needs Assessment 2011-2014 displayed the responses of those PLWH/A who were "in" and "out" of care. Service gaps were defined as, 'need but can't get.' The following table displays both core and support services by rank, number and percentage for each service.

The five highest ranked "Need But Can't Get" services were: food bank/home delivered meals (26.4%, 78), emergency financial assistance (21.3%, 63), transportation (14.2%, 42), health insurance (11.1%, 33), and both legal services/permanency (8.1%, 24) with rehabilitation services (8.1%, 24).

Respondents of PLWH/A out of care indicated similar gaps for the following services:

Gaps Needed But Can't Get

Service Categories	Rank	#	%
CORE SERVICES			
Medical Care			
Primary Medical Care		11	3.70%
Lab Diagnostic Testing		12	4.10%
Medical Specialist		16	5.40%
Nurse Care Coordination		6	2.00%
Case Management		22	7.40%
Medications		9	3.00%
Oral/Dental Health		25	8.40%
Health Insurance	4	33	11.10%
Mental Health Services		21	7.10%
Substance Abuse Treatment			
Substance Abuse Residential		11	3.70%
Substance Abuse Outpatient		11	3.70%
Nutrition Counseling		21	7.10%
Early Intervention Services (HIV testing & counseling, medical evaluation)		11	3.70%
Home Health Care		11	3.70%
Hospice		9	3.00%
Food Bank/Home Delivered Meals	1	78	26.40%
Transportation	3	42	14.20%
Outreach		9	3.00%
Health Education/Risk Reduction		14	4.70%
Treatment Adherence		10	3.40%
Legal Services/Permanency	5	24	8.10%
Rehabilitation Services	5	24	8.10%
Emergency Financial Assistance (help paying for utilities, appliances, etc.)	2	63	21.30%
Linguistics Services (interpretation & translation services)		19	6.40%
Support groups		22	7.40%
Other (housing, app't. reminders)		5	1.70%

Trends of Service Gaps

The Comprehensive Need Assessments administrated in 2000, 2003, 2007, and most recently 2010 indicated service gaps remained somewhat consistent from 2000-2010. The service gaps that were consistently ranked over the years have been emergency financial assistance, food, transportation, case management, and mental health services. The table below displays the service gaps, and the five most "consistent" categories.

Service Gaps that Remained Somewhat Consistent
Across the 2000, 2003, 2007, and 2010 Needs Assessments

Service Categories	2000 (n=271)		2003 (n=400)		2007 (n=252)		2010 (n=296)	
	Rank	%	Rank	%	Rank	%	Rank	%
CORE SERVICES								
Medical Care								
Primary Medical Care	21	6.00%	26	9.50%	25	6.30%	13	3.70%
LaboratoryDiagnostic Testing	24	2.00%	31	7.80%	22	9.10%	12	4.10%
Case Management	19	9.00%	24	10.00%	21	10.70%	7	7.40%
Mental Health Services	19	9.00%	23	10.80%	15	13.90%	8	7.10%
SUPPORT SERVICES								
Food Bank/Home Delivered Meals	12	19.00%	3	27.00%	3	32.10%	1	26.40%
Transportation	10	21.00%	17	13.50%	9	21.40%	3	14.20%
Health Education/Risk Reduction*	n/a	n/a	n/a	n/a		n/a	11	4.70%
Emergency Financial Assistance	2	34.00%	5	26.30%	2	32.50%	2	21.30%
Linguistics Services	23	4.00%	33	6.80%	19	11.50%	9	6.40%

*Only HRSA service categories and "Support groups" were used in the 2010 survey. Therefore, the category "HIV Prevention" was not used (as in previous years) and "Health Education/Risk Reduction" was added to the 2010 survey.

Although the above services have been consistent, there have been services for which gaps significantly decreased from 2000-2010. The following table displays the decrease in service gaps.

Service Gaps that Somewhat Decreased Across the 2000, 2003, 2007, and 2010 Needs Assessments

Service Categories	2000 (n=271)		2003 (n=400)		2007 (n=252)		2010 (n=296)	
	Rank	%	Rank	%	Rank	%	Rank	%
CORE SERVICES								
Nurse Care Coordination	n/a	n/a	25	9.80%	18	12.30%	16	2.00%
Medications*	17	11.00%	20	11.50%	5	26.60%	15	3.00%
Oral/Dental Health	12	19.00%	9	20.00%	7	23.80%	6	8.40%
Health Insurance	9	22.00%	7	23.80%	8	21.40%	4	11.10%
Substance Abuse Treatment								
Substance Abuse Residential	n/a	n/a	28	9.00%	24	7.10%	13	3.70%
Substance Abuse Outpatient	n/a	n/a	28	9.00%	23	8.10%	13	3.70%
Early Intervention Services	18	10.00%	18	12.80%	11	19.00%	13	3.70%
Home Health Care	23	4.00%	29	8.80%	12	16.30%	13	3.70%
Hospice	23	4.00%	21	11.80%	18	12.30%	15	3.00%
SUPPORT SERVICES								
Outreach	n/a	n/a	n/a	n/a	14	14.70%	15	3.00%
Treatment Adherence	n/a	n/a	n/a	n/a	14	14.30%	14	3.40%
Rehabilitation Services*	n/a	n/a	n/a	n/a	n/a	n/a	5	8.10%

*The category ”Medications” was called "Drug Reimbursement" or “Drug/Medicine” or “Drug Prescription Program” in previous Needs Assessments.

**Only HRSA service categories and “Support groups” were used in the 2010 survey. Therefore, the category “Vocational Rehabilitation” was not used and the data were not included (as they were in previous years) and “Rehabilitation Services” was added to the 2010 survey.

The table below displays all 26 service gaps across the past four needs assessments. The five most highly ranked gaps for each year are highlighted for emphasis.

Gaps in Service Categories Across the 2000, 2003, 2007, and 2010 Needs Assessments

Service Categories	2000 (n=271)		2003 (n=400)		2007 (n=252)		2010 (n=296)		
	Rank	%	Rank	%	Rank	%	Rank	#	%
CORE SERVICES									
Medical Care									
Primary Medical Care	21	6.00%	26	9.50%	25	6.30%	13	11	3.70%
Laboratory Diagnostic Testing	24	2.00%	31	7.80%	22	9.10%	12	12	4.10%
Medical Specialist	n/a	n/a	n/a	n/a	19	11.10%	10	16	5.40%
Nurse Care Coordination	n/a	n/a	25	9.80%	18	12.30%	16	6	2.00%
Case Management	19	9.00%	24	10.00%	21	10.70%	7	22	7.40%
Medications*	17	11.00%	20	11.50%	5	26.60%	15	9	3.00%
Oral/Dental Health	12	19.00%	9	20.00%	7	23.80%	6	25	8.40%
Health Insurance	9	22.00%	7	23.80%	8	21.40%	4	33	11.10%
Mental Health Services	19	9.00%	23	10.80%	15	13.90%	8	21	7.10%
Substance Abuse Treatment									
Substance Abuse Residential	n/a	n/a	28	9.00%	24	7.10%	13	11	3.70%
Substance Abuse Outpatient	n/a	n/a	28	9.00%	23	8.10%	13	11	3.70%
Nutrition Counseling	n/a	n/a	n/a	n/a	n/a	n/a	8	21	7.10%
Early Intervention Services	18	10.00%	18	12.80%	11	19.00%	13	11	3.70%
Home Health Care	23	4.00%	29	8.80%	12	16.30%	13	11	3.70%
Hospice	23	4.00%	21	11.80%	18	12.30%	15	9	3.00%
SUPPORT SERVICES									
Food Bank/Home Delivered Meals	12	19.00%	3	27.00%	3	32.10%	1	78	26.40%
Transportation	10	21.00%	17	13.50%	9	21.40%	3	42	14.20%
Outreach	n/a	n/a	n/a	n/a	14	14.70%	15	9	3.00%
Health Education/Risk Reduction**	n/a	n/a	n/a	n/a	n/a	n/a%	11	14	4.70%
Treatment Adherence	n/a	n/a	n/a	n/a	14	14.30%	14	10	3.40%
Legal Services/Permanency	11	20.00%	19	23.30%	17	13.10%	5	24	8.10%
Rehabilitation Services**	n/a	n/a	n/a	n/a	n/a	n/a	5	24	8.10%
Emergency Financial Assistance	2	34.00%	5	26.30%	2	32.50%	2	63	21.30%
Interpretation & Translation Services	23	4.00%	33	6.80%	19	11.50%	9	19	6.40%
Support Groups	n/a	n/a	n/a	n/a	n/a	n/a	7	22	7.40%

*The category ”Medications” was called "Drug Reimbursement" or “Drug/Medicine” or “Drug Prescription Program” in previous Needs Assessments.

**Only HRSA service categories and “Support groups” were used in the 2010 survey. Therefore, the categories “HIV Prevention” and “Vocational Rehabilitation” were not used and the data were not included (as in previous years) and “Health Education/Risk Reduction” and “Rehabilitation Services” were added to the 2010 survey.

Service Gaps of Emerging Populations within PLWH/A

The Comprehensive Needs Assessment 2010 identified five emerging populations within PLWHA including: (1) Haitians; (2) African American women; (3) African American men incarcerated in the past 12 months; (4) Men who have sex with men (MSM); and (5) Hispanics.[7]

The table below displays each emerging population as a percentage of all PLWH/A.

Emerging Special Populations	Percent of ALL PLWH/A
Haitian	18%
African-American Women	21%
African-American Men Incarcerated in the Past 12 Months	1%
MSM	30%
Hispanic	13%

The 2010 Needs Assessment examined the survey responses of each of these special populations separately. Additionally, the Needs Assessment included focus groups with members of each of these populations.

The following table shows the service gaps in primary medical care within each special population, based on the Comprehensive Needs Assessment survey findings. The service gap is the percentage of respondents who were in care (based on the definition provided earlier) who indicated that they either "need but can't get" or "needed but didn't know about" primary outpatient medical care. African-American men incarcerated in the past 12 months, MSM, and Hispanics all reported greater service gaps in primary medical care compared to the total sample of all survey respondents.

Service Gaps Special Populations

Emerging Special Populations	Number of Survey Respondents	Percentage of Those in Care Indicating Service Gaps in Primary Medical Care
Haitians	67	4%
African-American women	128	3%
African-American men incarcerated in past 12 months	26	31%
MSM	90	7%
Hispanics	27	17%
All respondents	365	5%

[14] Palm Beach County Department of Community Services (2010). *Needs Assessment 2011-2014.*

The following narrative describes each special population in terms of unique challenges that it presents to the service delivery system, and service gaps. Subsequently, the estimated costs of delivering services to each population are addressed.

Haitians

Unique Challenges

Providing services to PLWHA of Haitian descent can be extremely complicated, given the community's mistrust of government activities and apprehension in accessing the medical care system. A persistent feeling of stigma about HIV/AIDS in this population, a sense of vulnerability to deportation and/or incarceration, and a complex non-western system of beliefs about health behavior all make treatment of HIV/AIDS difficult. Further complicating factors include a low educational level, a low level of English ability, and illiteracy in either Creole or English. All of this translates into late entry into care and difficulty in keeping appointments and following treatment instructions. Most Haitians are diagnosed in the public hospital inpatient or emergency room units where they present with serious illness. A significant number of older persons of this population use non-traditional healing methods such as Haitian herbalists and spiritual healers before seeking western medical care, and then only when their symptoms have seriously progressed.[8]

Additional challenges arise from immigration status. In Florida, only people with an AIDS-defining diagnosis plus a documented disability are eligible for Medicaid. This policy excludes a significant number of legal immigrants living with AIDS who are not disabled and thousands of HIV positive clients. Many immigrants are not connected to care and lack basic knowledge of the American health care system. Undocumented immigrants are ineligible for most public assistance programs. This places additional pressure on the Ryan White program and creates challenges forgetting people tested and into treatment. In addition, undocumented immigrants are often reluctant to seek care largely because they fear deportation. When they do seek care, they are likely to be late presenters who are sicker and thus more costly to treat.[9]

Service Gaps

The 2010 Needs Assessment survey included 67 Haitian respondents. 72% of the respondents were in care and 28% were out of care. Almost one-half were unemployed, about one-quarter had either no schooling or an education level of grade 8 or less, and 82% lived at or below the poverty level. Almost all (97%) indicated they were heterosexual.

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

Among survey respondents, the rate of Haitian out of care respondents was higher than the out of care rate of all respondents (28% compared to 19%). The rate of Haitian out of care respondents who have never been in care was nearly twice the rate of all out of care respondents (42% compared to 23%). When asked why they did not get HIV/AIDS related medical year during the past year, Haitian out of care respondents cited the following reasons at notably higher rates than all out of care respondents: I could not pay for services; I was depressed; and I missed my appointment. Overall, the services, other than medical care and medication, that Haitian out of

[15] *Miami-Dade HIV/AIDS Partnership (2009). Comprehensive Plan for HIV/AIDS 2009-2011.*
[16] *Miami-Dade HIV/AIDS Partnership (2009). Comprehensive Plan for HIV/AIDS 2009-2011.*

care respondents indicated they need to get into primary medical care were very similar to those needed by all out of care respondents. Respondents in both groups most frequently mentioned the same five services (financial assistance, food, housing, case management, and transportation), although larger percentages of Haitian out of care respondents indicated that they needed the services.

In Care Haitian Respondents

Like all in care respondents, Haitian respondents who are in care most frequently mentioned gaps in services ("need but can't get") were for Emergency Financial Assistance, Food Bank/Home Delivery Meals, and Rehabilitation Services. Unlike all in care respondents, Haitian in care respondents also indicated gaps in Linguistic Services and Support Services. Like all respondents in care, Haitian in care respondents most frequently reported barriers ("needed but didn't know about") in regard to Support Services rather than to Core Services. The services most frequently mentioned by Haitian respondents in care that they needed but didn't know about were Rehabilitation Services, Legal Services/Permanency, Emergency Financial Assistance, and Health Education/Risk Reduction.

Haitian Focus Group Findings

Recurrent themes of continued reliance on case management, medical care, medications, and transportation were discussed throughout the group session. Participants also expressed their ongoing fears and anxieties regarding immigration status and financial and housing insecurities exacerbated by HIV. When asked about what it would take to persuade PLWH/A who are not in care to get back into care, respondents again expressed the need to help people overcome fear. When asked what helped them to get into care and stay in care, participants noted the importance of case management. When asked about what services are needed to help get back in care, participants expressed the inextricable link between clinical and support services. When asked about services they need but can't get, the only specific services mentioned was financial assistance for housing. However, participants expressed their need for continued help with services.

African-American Women

Unique Challenges

African-American women face many barriers to care and experience many factors that complicate their care. Poverty, limited education, lack of health insurance, immigration status, and lack of transportation continue to be significant problems for these women. Many African-American PLWH/A women feel disempowered in their relationships with men, are not well informed about HIV/AIDS, or do not feel the need for testing until well after they have been infected and become symptomatic. There are high rates of reported stigma attached to HIV/AIDS, creating a culture of denial that results in low-income African-American women not learning they are HIV positive until they become pregnant. African-American women who are of childbearing age are also at high risk for dropping out of care despite the high need for pre- and post-natal care, preventive care, screening, and other services, as well as HIV-related adherence counseling. Many African-American women struggle with family rejection and the stigma of HIV, which affects adherence to medical regimens as well as their ability to disclose

their HIV status to family, friends, or sexual partners. Additional factors such as partner domestic violence compound safety, security, and preventive health behaviors.[10]

Service Gaps

The 2010 Needs Assessment survey included 128 African American female respondents. 86% reported they were in care. 17% had either no schooling or an education level of 8th grade less, almost three-fourths were unemployed, and 82% were living at or below the poverty level. 89% indicated they were heterosexual.

Out of Care African-American Women Respondents

All out of care respondents were asked to describe their current situation regarding being out of care. As with all out of care respondents, the most frequently mentioned description by African American females was, "I have recently been diagnosed with HIV, and have not entered primary care." The second most frequently described situation for African American females was "I have not been recently diagnosed but have never been in care." Respondents were asked to identify the reasons for being out of care. In each group (all out of care respondents and African American female out of care respondents), the most frequently cited reason in was, "I am afraid of being identified as HIV-positive." When asked what services they needed to get into primary medical care, out of care respondents as a whole and African- American female out of care respondents mentioned the same top service categories (financial assistance, food, housing, case management, and transportation) as all out of care respondents. In nearly every category (except financial assistance), a larger percentage of African American females indicated the need for the services.

In Care African-American Women Respondents

African American female in care respondents and all in care respondents most frequently identified the leading service gaps ("need but can't get") to be Food Bank/Home Delivered Meals, Emergency Financial Assistance, Transportation, Health Insurance, and Legal Services. African American females also reported a gap in Oral/Dental Health. All in care respondents and African American female respondents reported similarly low levels of barriers to services ("needed but didn't know about"). The barriers most frequently cited by African American females were Rehabilitative Services and Legal Services/Permanency Planning.

African-American Women Focus Group Findings

When participants were asked why they or others they knew were out of care, their discussion focused on various combinations of fear, lack of knowledge about the disease and available treatment, denial, addiction, and barriers to accessing care due to lack of knowledge or financial resources. Participants discussed what they think it would take to persuade a person to get into care for the first time or to return to care after being out of care. Their responses focused on providing support and education. There was extensive discussion among participants regarding the importance of assuring their access to medical care, especially prescription medications. Several participants discussed fear and worry regarding funding cuts, wait lists, and barriers. As participants discussed the complex maze of access to prescription medications, they mentioned a wide assortment of funding jargon and resources. In addition to issues related to access, participants also discussed complications with medications and problems with side-effects.

[17] Miami-Dade HIV/AIDS Partnership (2009). *Comprehensive Plan for HIV/AIDS 2009-2011.*

African-American Men Incarcerated in Past 12 Months

Unique Challenges

HIV/AIDS service provision to the African-American community is complicated; the documented "down low" phenomenon among African-American men that contributes to increased STI and HIV infections in the community for both men and women. The economic and social ramifications of poverty in this community contribute to high levels of substance abuse, diagnosis at a later stage of illness, and other collateral problems. Stigma and lack of insurance are additional complicating factors that often result in late entry into care. African-Americans are also significantly more likely to drop out of care than other racial/ethnic groups.[11] Further, unique challenges to service delivery for recently incarcerated African-American men include substance abuse, lack of transportation, not being ready to deal with one's HIV status, and homelessness.[12]

Service Gaps

The 2010 Needs Assessment survey included 26 African American males who had been incarcerated in the past 12 months. 10 of these were out of care, and 23 lived at or below 100% of the federal poverty level.

Out of Care African-American Incarcerated Men Respondents

The ten 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." Like all out of care respondents, the most frequently cited reasons for being out of care were "I did not feel sick" and "I did not want people to know that I have HIV."As all out of care respondents, recently incarcerated out of care respondents most frequently cited food, financial assistance, transportation, and housing as the most needed services.

In Care African-American Incarcerated Men Respondents

Recently incarcerated in care African American males and all in care respondents most frequently reported a service gap ("need but can't get) regarding food/home delivered meals. Respondents in this special population mentioned transportation just as frequently as they mentioned food, followed by primary medical care. Generally, this population reported gaps regarding a fewer number of services, but at higher rates than among all in care respondents. The most frequently mentioned barriers ("needed but didn't know about") reported by recently incarcerated in care African American males were for food bank/home delivered meals and transportation.

African-American Incarcerated Men Focus Group Findings

Recently incarcerated African American men identified depression, stigma, and dislike of medication as barriers to care. They identified service gaps in housing, food, and ADAP (i.e. the recently-instituted waiting list). In regard to what helped them get into care, the respondents mentioned case management and having a support system.

[18]Miami-Dade HIV/AIDS Partnership (2009). *Comprehensive Plan for HIV/AIDS 2009-2011.*

[19] Treasure Coast Health Council (2010). PLWH/A Released from Jail/Prison in last 12 months.

Men Who Have Sex with Men (MSM)

Unique Challenges

The unique challenges of serving the MSM population include stigma and denial, including fear of learning one's HIV status or disclosing one's HIV-positive status; discrimination and homophobia, including fear of disclosure of being a MSM; and rejection by family, church, or loss of employment. Psychosocial health issues, such as depression, partner violence, and low self-esteem can contribute to neglect of HIV care.[13]

Service Gaps

The 2010 Needs Assessment included 90 respondents who identified themselves as MSM.79% of these were in care, 43% were at or below 100% of the federal poverty level, and about half had been unemployed during the past 12 months.

Out of Care MSM Respondents

When out of care MSM were asked to describe their situation, 63% said they had been recently diagnosed and had not entered primary care, compared to 45% among all out of care respondents. The rate of MSM who had not been recently diagnosed but had never been in care was about the same rate as among all out of care respondents (26% and 23% respectively). When out of care MSM were asked to identify the reasons that they are not in primary medical care, the most frequently identified reason was the same as those most frequently mentioned by all out of care respondents, specifically, "I did not feel sick". Among out of care MSM, the second most frequently mentioned reason was "I did not know where to go" (53%) while this response given at half that rate (26%) by all 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 (financial assistance, food, housing, and case management). Compared to all out of care respondents, a higher percentage of MSM selected financial assistance and labs.

In Care MSM Respondents

MSM respondents in care most frequently identified service gaps ("need but can't get") in case management, food bank/home delivered meals, oral/dental health, transportation, and emergency financial assistance. As with all in care respondents, emergency financial assistance was the most frequently mentioned service that in care MSM "needed but didn't know about"(service barrier). The next most frequently mentioned services in this category were mental health services, nutrition counseling, legal services/permanency, oral/dental health, and food bank/home delivered meals.

MSM Focus Group Findings

Respondents identified the following reasons for not being in primary care: lack of knowledge about appropriate care and treatment services; depression and stress; lack of information about treatment and availability of services; adverse reactions to medications; high cost of medication; having to take time off from work to pick up medications every month instead of every three months due to cutbacks in ADAP funding; drug and alcohol abuse/addiction; difficulties

[20]Florida Department of Health Bureau of HIV/AIDS (2007). Out in the Open: The Continuing Crisis of HIV/AIDS Among Florida's Men Who Have Sex with Men.

qualifying for services due to means testing; and stigma/embarrassment. When asked what would help MSM get back into care or stay in care, respondents identified facing a life or death illness; billboards; case management; support groups; learning to make taking care of oneself a priority; reducing or eliminating alcohol and drugs; exercise; having sympathetic and caring physicians; developing coping skills; psychotherapy; and concern for others. Participants said they were receiving the services they need (especially case management, medical care, medications, lab tests, and mental health counseling) and were generally very satisfied with those services. Some identified service gaps and barriers were the difficult and time-consuming eligibility process; ineligibility for food stamps and need for a food bank; the ADAP waiting list and change in medication distribution from every three months to every month; and unmet needs or difficulty accessing emergency financial assistance, dental health care, legal services (especially regarding immigration status), and transportation.

Hispanics

Unique Challenges

The challenges of serving Hispanic PLWH/A are similar to those for the Haitian population, such as stigma about both HIV/AIDS and homosexuality, immigration issues, and linguistic barriers. Also, similar to Haitians, there is a reliance on folk medicines and healers (botanicas and curanderas) as a means of treatment and there is substantial misinformation concerning the transmission of HIV/AIDS along with a high incidence of "no symptom, no problem" thinking in this population. Some Hispanic immigrants travel back and forth from the United States to their homeland, and some are seasonal migrant workers, complicating care and follow-up to treatment, thereby increasing the cost of care.[14]

Service Gaps

27 Hispanic respondents participated in the 2010 Needs Assessment survey. 18 of these were in care and 9 were out of care. The most frequently mentioned country of origin was the United States (10) followed by Puerto Rico (6) and Mexico (6). Other countries of origin include the Dominican Republic, Columbia, and Nicaragua. Over one-half were not working during the past year, over one-third had less than a high school education, and nearly two-thirds lived at or below the poverty level.

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

The most frequent circumstance cited by out of care Hispanic respondents was "I have recently been diagnosed with HIV, and have not entered primary care." As with all out of care respondents, out of care Hispanics most frequently said that the reason they did not get HIV/AIDS medical care during the past year was because they "did not feel sick." Both groups also cited financial barriers and not being "ready to deal with having HIV." Hispanics were more than twice as likely as all out of care respondents to report not knowing where to go for care. When asked what services, other than medical services and medication, they need to get into primary medical care, Hispanic respondents, like all out of care respondents, most frequently mentioned financial assistance. Other services needed by both groups included housing, food, and transportation.

[21]Miami-Dade HIV/AIDS Partnership (2009). *Comprehensive Plan for HIV/AIDS 2009-2011.*

In Care Hispanic Respondents

As with all out of care respondents, Hispanic in care respondents reported service gaps ("need but can't get") in food bank/home delivered meals, transportation, and emergency financial assistance. Unlike all in care respondents, Hispanics also reported gaps in case management and mental health services. Like all in care respondents, Hispanics most frequently reported barriers regarding food bank/home delivered meals and emergency financial assistance. Hispanics also identified nutrition counseling, oral/dental health, and health education/risk reduction among the top five services they needed but didn't know about.

Hispanic Focus Group Findings

Although all the Hispanic focus group participants said they were satisfied with their medical care and had access to medications, they complained about the pharmacy staff and about excessive waiting time and inconvenient hours of service at the pharmacy. Among the support the participant needed help accessing were financial assistance; transportation (gas cards, bus passes), food, housing, legal assistance, and work and job training.

F. Description of Prevention and Service Needs

Florida and Palm Beach County's HIV Prevention Target Populations

In an effort to maximize the efficiency, effectiveness, and allocation of limited HIV prevention resources throughout the state, the CPP (Community Prevention Partnership) decided to rank specific target populations of PLWH/A by taking into account HIV Case Data and Living Cases Data. The chart below displays the ranked targeted populations:

THREE FOLD PATH METHODOLOGY and Advancing HIV Prevention (AHP) Tool

Populations	40% of Weight HIV Case Data Rank	40% of Weight Living Cases Data Rank	20% of Weight CPP Palm Beach County Rank	Sum of each Rank Weighted	Final Rank for Florida
B-Hetero	1	1	1	1	1
B-IDU	8	5	8	7	8
B-MSM	3	3	2	3	3
H-Hetero	4	4	4	4	4
H-IDU	9	9	9	9	9
H-MSM	6	7	5	6	6
W-Hetero	5	6	6	6	5
W-IDU	7	8	7	7	7
W-MSM	2	2	3	2	2

The resulting ranking of the chart is as follows for Palm Beach County and the state of Florida:

PALM BEACH COUNTY
1- Black Hetero
2- Black MSM
3- White MSM
4- Hispanic Hetero
5- Hispanic MSM
6- White Hetero
7- White IDU
8- Black IDU
9- Hispanic IDU

FLORIDA
1- Black Hetero
2- White MSM
3- Black MSM
4- Hispanic Hetero
5- White Hetero
6- Hispanic MSM
7- White IDU
8- Black IDU
9- Hispanic IDU

The prevention and service needs for Palm Beach County, Florida lie in focusing attention to the population with the greatest number of HIV/AIDS cases. As seen in the chart above, the need for prevention will be in Black Heterosexual, followed by prevention for the MSM population. Prevention funding will support the populations with the most reported number of cases in an effort to reduce the incidence of HIV/AIDS among these individuals.

G. Description of barriers to care

Despite over twenty years of providing vital patient care services to the PLWHA communities, consumer surveys and focus groups conducted indicate barriers still exist that can limit or prevent PLWHAs from receiving available services that are essential to improving or maintaining their health. Addressing and overcoming these barriers to care is an ongoing challenge.

Routine Testing (including any state or local legislation barriers)
A barrier to routine testing that continues to exist is the fear that the results of the test will be available for people to see. However, there is a rule in place that requires the person conducting the test to obtain informed consent, which includes;

"an explanation that the information identifying the test subject and the results of the test are confidential and protected against further disclosure to the extent provided by law."

Despite this barrier, Florida leads the nation in the total number of HIV tests conducted in a 12 month period. The tables below show the number of tests administered in 2 consecutive 12 month periods, 2009 and 2010, in Palm Beach County, Florida.

In 2009 the number of tests administered totaled 33,359. In 2010 the number of tests administered increased by approximately 4.1% with a total of 34,751 tests. Both years, as seen in the table below, administered the highest number of tests to females, and heterosexuals.

Palm Beach County EMA Testing Data Years 2009 and 2010
Includes Total Number of Tests Performed at the State Laboratories From all Testing Sites

2009 Exposure Category	Number of Tests	Number Positive	Percent Positive	Gender	Number of Tests	Number Positive	Percent Positive
Male Sex With Male/IDU	127	14	11	Male	13,435	259	1.9
Male Sex With Male	1,316	93	7.1	Female	19,501	157	0.8
Injecting Drug User	1,265	23	1.8	Unknown	423	1	0.2
Sex Partner at Risk	842	81	9.6	**Total**	**33,359**	**417**	**1.3**
Child of Woman with HIV/AIDS	134	8	6	**Race/Ethnicity**	**Number of Tests**	**Number Positive**	**Percent Positive**
STD Diagnosis	2,788	33	1.2				
Sex for Drugs or Money	547	10	1.8	White	6,315	64	1
Hemophilia/Blood Recipient	0	0	#DIV/0!	Black	15,270	272	1.8
Victim of Sexual Assault	721	12	1.7	Hispanic	9,318	59	0.6
Health Care Exposure	460	1	0.2	Asian	273	1	0.4
Heterosexual	23,265	154	0.7	Am. Native	45	0	0
No Acknowledged Risk	409	2	0.5	Other	141	3	2.1
Unknown	1,485	99	6.7	Unknown	1,997	18	0.9
Total	**33,359**	**530**	**1.6**	**Total**	**33,359**	**417**	**1.3**

2010 Exposure Category	Number of Tests	Number Positive	Percent Positive	Gender	Number of Tests	Number Positive	Percent Positive
Male Sex With Male/IDU	125	8	6.4	Male	13,708	246	1.8
Male Sex With Male	1,345	114	8.5	Female	20,768	116	0.6
Injecting Drug User	1,466	13	0.9	Unknown	275	0	0
Sex Partner at Risk	809	26	3.2	**Total**	**34,751**	**362**	**1**
Child of Woman with HIV/AIDS	85	1	1.2	**Race/Ethnicity**	**Number of Tests**	**Number Positive**	**Percent Positive**
STD Diagnosis	2,807	18	0.6				
Sex for Drugs or Money	502	5	1	White	6,691	66	1
Hemophilia/Blood Recipient	0	0	0	Black	16,167	237	1.5
Victim of Sexual Assault	657	7	1.8	Hispanic	10,278	39	0.4
Health Care Exposure	395	0	0	Asian	330	4	1.2
Heterosexual	24,541	149	0.6	Am. Native	44	0	0
No Acknowledged Risk	427	2	0.5	Other	156	1	0.6
Unknown	1,592	19	1.2	Unknown	1,085	15	1.4
Total	**34,751**	**362**	**1**	**Total**	**34,751**	**362**	**1**

Program related barriers

The Comprehensive Needs Assessment 2011-2014 had respondents indicate program related barriers to care. Barriers to care were defined as "needed but didn't know about service." The table below displays the most frequently selected service barriers.

The most frequently selected barriers to care indicated by PLWHA are emergency financial assistance (11.1%, 33), legal services (11.1%, 33), food (9.5%, 28), support groups (7.4%, 22), outreach (7.1%, 21), transportation (6.4%, 19), and health education/risk reduction (6.4%, 19).

Barriers Needed But Didn't Know About Service

Service Categories	Rank	#	%
Medical Care			
Primary Medical Care		3	1.00%
Lab Diagnostic Testing		5	1.70%
Medical Specialist		7	2.40%
Nurse Care Coordination		9	3.00%
Case Management		11	3.70%
Medications		3	1.00%
Oral/Dental Health		18	6.10%
Health Insurance		15	5.10%
Mental Health Services		19	6.40%
Substance Abuse Treatment			
Substance Abuse Residential		10	3.40%
Substance Abuse Outpatient		7	2.40%
Nutrition Counseling		17	5.70%
Early Intervention Services (HIV testing & counseling, medical evaluation)		5	1.70%
Home Health Care		12	4.10%
Hospice		10	3.40%
Food Bank/Home Delivered Meals	2	28	9.50%
Transportation	5	19	6.40%
Outreach	4	21	7.10%
Health Education/Risk Reduction	5	19	6.40%
Treatment Adherence		15	5.10%
Legal Services/Permanency	1	33	11.10%
Rehabilitation Services		17	5.70%
Emergency Financial Assistance (help paying for utilities, etc.)	1	33	11.10%
Linguistics Services (interpretation & translation)		7	2.40%
Support Groups	3	22	7.40%
Other (housing, app't. reminders)			

Providers were asked to list barriers their organizations have faced when providing care to people living with HIV/AIDS. A summary of their responses is below:

Systematic Issues

- Contracting process
  - Complex and cumbersome contracting process.
  - Long delays and unfair placement of burden of financing services while the HRSA/Grantee contracting process produces long delays in obtaining initial reimbursement each year.
  - Single year contracts, rather than contracts that can easily be renewed.
- Funding
  - State & Federal funding cuts
  - There is no funding to help with rental assistance

Service Capacity & Availability

- Case Management
  - Access to case manager
  - HIV providers do not have enough case managers
  - Case loads too large
  - specialized housing resources for people living with HIV
- Medication
  - Access to medication
  - Medications Assistance Programs and ADAP & AICP wait list
- Mental Health and Substance Abuse
  - Access to qualified mental health provider
  - More local facilities that offer residential substance abuse treatment of HIV+ pregnant women in hospital setting like Plantation General in Broward
- Housing
  - Lack of housing options/resources
  - Specialized housing resources for people living with HIV
- Transportation
  - Lack of transportation to get to appointments;
- Basic resources
  - Clients' lack of basic resources (i.e. $$) prevents them from seeking medical services

Psychological and Cultural Issues

- Fear and Denial
  - Sense of hopelessness, general distrust of government and/or organizations, lacking belief that medicine can help you.
  - Denial of the disease- women don't believe they are positive
  - Denial that they are sick or at risk due to the disease
  - Confidentiality
    - Fear of others finding out their status
- Treatment Adherence

- Clients not taking responsibility for their own care (no shows for appointments, not picking up medications on time, not following through with specialty medical appointments or social service visits). This is referring to clients who have access to transportation, don't have mental health or substance abuse issues and speak English.
- Non-compliance
- Lack of applicants who want treatment

- Language barriers

Client Barriers

The Needs Assessments 2010 identified five special populations, those are: (1) Haitians; (2) African American women; (3) African American men incarcerated in the past 12 months; (4) Men who have sex with men (MSM); and (5) Hispanics.[15] Each of these special populations has stated barriers to care specific to their populations.

Haitians

Like all respondents in care, Haitian in care respondents most frequently reported barriers ("needed but didn't know about") in Support Services rather than to Core Services. The services most frequently selected by Haitian respondents in care that they needed but didn't know about were Rehabilitation Services, Legal Services/Permanency, Emergency Financial Assistance, and Health Education/Risk Reduction.

African-American Women

All in care respondents and African American female respondents reported similarly low levels of barriers to services ("needed but didn't know about"). The barriers most frequently cited by African American females were Rehabilitative Services and Legal Services/Permanency Planning.

African-American Men Incarcerated in Past 12 Months

The most frequently mentioned barriers ("needed but didn't know about") reported by recently incarcerated in care African American males were for food bank/home delivered meals and transportation.

Men Who Have Sex with Men (MSM)

As with all in care respondents, emergency financial assistance was the most frequently selected service that in care MSM "needed but didn't know about"(service barrier). The next most frequently selected services in this category were mental health services, nutrition counseling, legal services/permanency, oral/dental health, and food bank/home delivered meals.

Hispanics

Like all in care respondents, Hispanics most frequently reported barriers regarding food bank/home delivered meals and emergency financial assistance. Hispanics also identified nutrition counseling, oral/dental health, and health education/risk reduction among the top five services they needed but didn't know about.

[22] Palm Beach County Department of Community Services (2010). *Needs Assessment 2011-2014.*

H. Evaluation of 2009 Comprehensive Plan

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. Planning enables the community to make sound decisions about how to organize and maintain an effective and efficient continuum of care for the people who plan for, provide, and receive services in Palm Beach County, Florida. It has detailed the successes and has met the challenges of the epidemic for people and families at risk for and living with HIV.

Successes

The CARE Council and its various committees have a role in monitoring the progress toward achieving the Goals, Objectives, and Activities of the Comprehensive Plan. The CARE Council and the Executive Committee oversee and direct all activities relating to the CARE Council. Over the three fiscal years (2009-2012) they have successfully assured the fulfillment of all the activities pertaining to the plan. They have identified the appropriate committee to oversee and/or complete each activity and have determined the expertise needed to accomplish all activities.

The Planning Committee is the arm of the CARE Council that has specific responsibility for overseeing the development and implementation of the goals contained within the document. This committee, through the Comprehensive Plan, has diligently established strong work collaborations between consumers, providers, and community leaders.

The Priorities and Allocations Committee holds several public forums annually in order to obtain feedback from the task assigned to them in the Comprehensive Plan. These forums have created 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.

The Community Awareness Committee (CAC) is critical over the 3 years of the implementation of the Comprehensive Plan 2009-2012. The CAC has successfully educated the community on advocacy, treatment advances, HIV prevention. This committee has worked toward building a network with CPP, EPICC, consumers, and providers.

The Membership Committee recruits members that are reflective of the epidemic and assures the training of members. Through the Comprehensive Plan, applications have been distributed to each contracted agency and has successfully been accepted to gain a committee member that represents the agency's constituency, as well as having successfully promoted membership to the clients they serve. The Membership Committee has established the composition of the CARE Council, taking into consideration expertise and representation of diverse interests. The committee has recruited the participation from outside sources, when the group required specific expertise. The CARE Council has benefited from the expertise available in the community at large in the development and implementation of many of its new programs, particularly those that involve the use of advanced computer technologies.

A task of the CARE Council's Quality Management Committee is to develop monitoring

factors, baseline data, monitoring tools, and project time frames. When the framework was complete, as assigned by the Comprehensive Plan, the Grantee and CARE Council Support staff began to successfully monitor the progress and identify the barriers in reaching goals and objectives of the plan.

Grantee and CARE Council Support staffs have had a critical role monitoring the progress of the Comprehensive Plan 2009-2012. The staff has successfully provided consultation and support to each of the committees. In addition, the Staff continued to conduct and publicize research such as needs assessments and special studies. Staff, via the tasks listed in the Comprehensive Plan, have updated the website (www.carecouncil.org), promoted all CARE Council activities, and publicized all meetings.

Challenges

The complexity of the HIV disease and the people it affects, in addition to the complexity of funding and evaluation of HIV prevention and care program activities under the Comprehensive Plan 2009-2012, has produced a diverse system that offers various challenges.

The following challenges were highlighted in the CARE Council's final review of the progress made in implementing the Comprehensive Plan 2009-2012. The Council found that the wording used to outline activities was not always measureable. For example, one activity within the plan was written so that a particular action would be "encouraged." It was determined that this is a challenge to measure. Additionally, differences of opinion on the most accurate method of measurement caused this challenge to be identified.

Another challenge in the evaluation of the implementation plan written in the Comprehensive Plan 2009-2012 lies in the status review of the activities in the plan. Review of the progress of the implementation plan only occurred on an annual basis. This was viewed by the CARE Council to not be often enough. Additionally, there was little detail as to the progress reporting. During the annual reporting on the progress of the activities some CARE Council members felt more efforts could be made to describe how the activities in our objectives were met.

Also posing a challenge were fiscal constraints during the execution of the Comprehensive Plan 2009-2012 which did not allow support for all of the activities listed in the implementation plan. For example, the implementation of an incentive-based program to foster adherence to medications and medical treatment was not implemented due to funding.

SECTION 2

S E C T I O N 2

Where Do We Need To Go: What is our vision for an ideal system of care?

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.

A. Plan to meet challenges identified in the 2009 Comprehensive Plan

The Comprehensive Plan 2009-2012 detailed an implementation plan with goals, objectives and activities that would be in effect FY 2009-2012. The Palm Beach County HIV CARE Council (CARE Council) monitored the progress of the implementation plan at the beginning of each fiscal year to ensure the accomplishment of each goal. This plan worked to improve the evolving HIV Coordinated System of Care and allowed the Planning Council to identify challenges throughout the three years.

A number of challenges that have been identified throughout the life span of the Comprehensive Plan 2009-2012 include, wording that was used to outline an activity was not measurable, review on the status of the Comprehensive Plan did on occur often enough, and fiscal constraints did not allow for support of all activities listed in the implementation plan.

To meet the challenge of not having accurately worded measurable activities, the Planning Committee has agreed to describe activities in a timely fashion. Included in the implementation plan is a timeline for each activity and a progress reporting tab so that an activity can be accounted for and measurable.

To review the status of the Comprehensive Plan on a more frequent basis, the CARE Council has decided to evaluate the activities in the plan on a quarterly basis. Progress of the activities will be reported to the CARE Council and evaluated by the CARE Council every 3 months to meet the challenge of not having enough reviews throughout the three years.

To fiscally support the work of all committees, an evaluation will be made by the CARE Council to ensure financial support maintains the activities in the Comprehensive Plan.

B. 2012 proposed care goals

Goal 1: Increase Access to Care and Optimize Health Outcomes for People Living with HIV
Goal 2: Reduce the Number of People Who Become Infected with HIV
Goal 3: Reduce HIV-Related Health Disparities

C. Goals regarding individuals aware of their HIV status, but are not in care (Unmet Need)

Goal 1: Increase Access to Care and Optimize Health Outcomes for People Living with HIV
Goal 2: Reduce the Number of People Who Become Infected with HIV
Goal 3: Reduce HIV-Related Health Disparities

D. Goals regarding individuals unaware of their HIV status (EIIHA)

The following goals are adopted by the CARE Council to address early identification of individuals with HIV/AIDS (EIIHA):

> Annually, through voluntary counseling and testing, increase the proportion of HIV-infected people in Palm Beach County who know they are infected.
>
> Annually, increase the proportion of HIV-infected people in Palm Beach County who are linked to appropriate prevention, care and treatment services.

Both of these goals are consistent in making individuals who were unaware of their HIV status aware of their status; goal 1 aims to make more unaware PLWHA aware, and goal 2 aims to refer and link the newly aware to care.

The goals are consistent with the National HIV/AIDS Strategy (NHAS) goals of increasing access to care and optimizing health outcomes for PLWHA, and reducing HIV-related health disparities. By making more people aware of their infection and linking them to care, these NHAS goals will be addressed.

E. Proposed solution for closing gaps in care

The CARE Council reviews and discusses the findings in the Comprehensive Needs Assessment 2010 which demonstrate gaps in several service categories. Those service categories are: food, emergency financial assistance, transportation, health insurance, legal services, and rehabilitation services. The CARE Council uses this information in their Priorities and Allocations process and funds many of the services in the attempt to close the gaps in receiving care for PLWHA.

F. Proposed solution for addressing overlaps in care

Data reported to the CARE Council is used to evaluate service delivery. A thorough eligibility system has been implemented which consists of a core group of well trained eligibility workers. Additionally, a continuous quality improvement (CQI) project is conducted that consists of a

case management utilization study. In collaboration with our local Part B, case management files are reviewed to determine how services are utilized and to what extent. The EMA wants to ensure that clients are receiving necessary assistance and that overlaps in care are not occurring. This helps to determine the specific services provided and the time accounts for providing those services. Ultimately, a discussion of strategic long-term range service delivery plans to improve the quality of client services provided is prompted. Additionally, agencies as part of their CQI plan conduct quarterly client chart reviews which include a thorough screening of client eligibility.

It is ensured that Ryan White is the payer of last resort thorough monitoring of client eligibility. The monitoring tool is modified, and implements fiscal and monitoring policy and procedures.

G. Proposed coordinating efforts

Part B Services, including the AIDS Drug Assistance Program (ADAP)
Ryan White Parts A and B work very closely in identifying HIV positive unaware individuals to care. Both parts have a joint planning council (CARE Council). The three Part B funded agencies are also funded by Part A. Parts A and B use the same client database (CAREware), have joint monthly provider (sub-recipient) meetings, and both parts are able to communicate effectively regarding identifying individuals unaware of their status.

The AIDS Drug Assistance Program (ADAP) of Florida instituted a medication waitlist June 1, 2010. A computer software program for the EMA was utilized to allow case manager to enter client information and prescribe medications one time. Applications for free medications were sent to all appropriate pharmaceutical companies. The State works closely with the pharmaceutical companies to ensure ease in the use of Patient Assistance Programs (PAP), which results in PLWHA receiving necessary medications. In the case that a client is on the ADAP waitlist and is not eligible for PAP, or PAP was not available, Part A has additional funding in the Drug Reimbursement line to cover the cost of medications. The Part A grantee meets with all Ryan White case management agencies and ADAP staff every month to discuss issues/questions regarding access to prescribed medications for PLWHA.

Part C Services
Our EMA does not receive Ryan White Part C funding.

Part D Services
Our EMA does not receive Ryan White Part D funding.

Part F Services
The Clinical Quality Management Committee was established to determine measurement priorities and methods for PLWHA care on an ongoing basis. The committee facilitates cross coordination with Part F by collaborating with consumers, representatives from A&B, and the AIDS education Training Center (AETC). Responsibilities for this committee include: a) providing input and direction on the Palm Beach County EMA CQM Program b) reviewing and updating the CQM plan annually c) developing standards of care and outcome measures utilizing

Planning Council Committees, in cooperation with the grantee d) make recommendations to the Part A grantee office for appropriate education relating to quality improvement concepts and techniques and e) report cumulative service outcome results to the CQM committee which were presented to the CARE Council for review to initiate improvement plans.

Private Providers (non-Ryan White funded)
Private providers are included as part of the standard procedures in verifying that medical care/services are accessed in the care of PLWHA. The program implements with private providers ensuring that the relationship with Part A is enhanced so that all access to care is visible.

Prevention Programs including; Partner Notification Initiatives and Prevention with Positive Initiatives
The Early Intervention Services (EIS), Prevention Training Consultants (PTC) and STD Disease Intervention Specialists (DIS) staff within the Palm Beach County Health Department (PBCHD) coordinate the prevention and disease control/intervention programs with the EMA. Part A coordinates with EIS, PTC, and STD DIS without supplanting funds with regards to indentifying HIV positive unaware individuals. The majority of this coordination is accomplished through the efforts of the local prevention planning group, Community Prevention Partnership (CPP).

The CARE Council works collaboratively with the CPP, many members of the CARE Council are also members of the CPP. The CARE Council includes "CPP Updates" as a standing agenda item in order to inform the CARE Council members of local prevention and testing activities. The Ryan White CARE Council support and grantee staff frequently attend CPP meeting. PBCHD, EIS, PTC, and STD staff participate in CARE Council activities, and update the members on HIV testing and prevention efforts throughout the EMA. The coordinated groups described above allow for reviews on the statistics of the number of persons informed of their status.

Staff of the Bureau of STD prevention and control, provide HIV partner notification services (PS) to partners of HIV-positive clients. DIS is responsible for offering PS and follow-ups of sex partners and other at-risk individuals elicited during the PS session. Part A staff collaborates with area STD and HIV prevention programs and community-based organizations to promote PS as a unique means to have persons notified of their exposure while maintaining the confidentiality of the client. The community-based counselor shares any partner information elicited during the post-test counseling of a HIV-positive client with a DIS for the notification of partners.

Substance Abuse Treatment Programs/Facilities
EIS, PTC, and DIS staffs within Palm Beach County Health Department as well as case managers coordinate appropriate referrals are made to ensure substance abuse treatment programs and facilities are accessed. The EMA is also the recipient of SAMHSA funds whereby Part A coordinated to ensure RW is the payer of last resort.

STD Programs
Coordination with STD programs allow for a review of statistics on the number of persons informed of their status within 30 days. The STD program improve on the existing relationships with private medical providers and continue to improve on collaborative partnerships with providers. STD program staffers contact private providers to inform them of their intent to contact their patient to offer PS.

The Florida Department of Health Bureaus of HIV/AIDS and STD are fully integrated at the service delivery level. HIV prevention programs and testing venues provide educational materials on STDs.

Medicare/Medicaid
Clients seeking services are screened for eligibility for other funding sources before the use of Ryan White, sources such as Medicaid, Health Care District, Medicare, and private insurance. The Health Care District is a local taxing district providing low cost affordable insurance to Palm Beach County residents with low income. Only those clients determined to have no other coverage are considered Ryan White eligible. The subcontractors that provide medical services ensure that Ryan White is the payer of last resort by viewing the eligibility documentation which is scanned into the client database, CAREWare. The scanned documentation includes the Medicaid online application (unless Medicaid application documentation verifies prior application) completed by case managers and clients. Copies of the Medicaid applications are retained in the case management files for future reference of client's "payer status." Only those clients without any other coverage and who qualify are billed to Ryan White funds.

Children's Health Insurance Program/Community Health Centers
The Continuum of Care includes community based health centers and social services organizations that provide all of the services through contracts with the Part A Grantee office. The Part A agencies collaborate with one another through monthly Provider Meetings. All Part A funded agencies participate in system-wide quality activities that are responsible for developing quality systems of care. Service (process) indicators and health outcomes are tracked, documented and reported to the Part A Grantee office through the CAREware Data System by all funded agencies. Part A funded agencies participate in the annual, standardized, EMA-wide Client Satisfaction Survey. Most of the children living with HIV/AIDS in the EMA are covered by CHIP and Medicaid. Part A fills the gaps in services for children, if there is a need.

SECTION 3

S E C T I O N 3

How Will We Get There: What is the Strategy, Plan, Activities, and Timeline associated with achieving specified goals and meeting identified challenges?

The following plan was developed in order to improve the current system of care, and enhance planning for the system of care for PLWHA. The goals of this implementation plan follow the goals of the National HIV/AIDS Strategy (NHAS). The strategies and activities align with the new components of the 2012 Comprehensive Plan focus points; Monitoring and Evaluation, Early Identification of Individuals with HIV/AIDS (EIIHA), The National HIV/AIDS Strategy, Healthy People 2020, and The Affordable Care Act. This implementation plan builds on the idea of measurable activities which can be monitored and evaluated by the timeline indicated in the chart. Also, there is an area for status and comments which will allow for improvement, if need be. Achieving the goals in the chart below will ensure the provision of high quality of care and treatment services to all PLWHAs in our EMA.

A: Strategy, plan, activities, timeline, and responsible entity(s) to close gaps in care

Focus Point Key: EIIHA = Early Identification of Individuals with HIV/AIDS HP2020 = Healthy People 2020
NHAS = National HIV/AIDS Strategy ACA=Affordable Care Act

Goal 1: Increase Access to Care and Optimize Health Outcomes for People Living with HIV						
Strategy/Plan	**Activities**	**Timeline/ Due Date**	**Responsible Entity(s)**	**Progress Reporting**	**Status**	**Comment**
A. Increase PLWHA knowledge of HIV (Services, prevention, medication)	1. Host or participate in health fairs and outreach via partnerships with businesses and community centers twice a year	1. 2012-2015	1. Community Awareness Committee	1. Member Support Liaison		
	2. Refer participants of health fairs and outreach community events to the 211 confidential community helpline and crisis hotline, and HIV service information	2. 2012-2015	2. Community Awareness Committee	2. Member Support Liaison		
	3. Develop public service announcements for Ryan White Services	3. 2012-2015	3. Community Awareness Committee	3. Member Liaison Coordinator		

	4. Eligibility workers will report quarterly on "who" referred new clients into care	4. 2013-2015	4. Eligibility workers	4. Grantee		
	5. Update Redbook and 211 HIV/AIDS list of services	5. 2012-2015	5. CARE Council Secretary	5. Grantee		
	6. Continue the use of disease intervention specialists for partner notification and referral of HIV medical care and testing	6. 2012-2015	6. Department of Health	6. Department of Health		
	7. Disease intervention specialists will report quarterly on the number of clients told of partner notification and clients referred to care	7. 2012-2015	7. Disease intervention specialist	7. Grantee		
B. Increase collaboration with agencies and providers	1. Conduct quarterly case management and eligibility worker training on services available to PLWHAs	1.2012-2015	1. CARE Council, Community Planning Partnership	1. CARE Council		

	2. Collect reports from Ryan White Providers on what community meeting they have attended	2. 2012-2015	2. Grantee	2. Grantee		
C. Develop and implement a Quality Management (QM) Plan	1. Review HRSA/CDC/NIH/DOH standards and requirements	1. 2012-2015	1. QM Committee	1. Report at QM Committee, as needed		
	2. Review and revise QM plan	2. 2012-2015	2. QM Committee and CARE Council	2. Annual report at QM Committee, revised every 3 years		
	3. Monitor Ryan White funded agencies on adherence to Standards of Care	3. 2012-2015	3. QM Coordinator	3. Annual report at QM Committee and CARE Council		
D. Ensure service cost effectiveness	1. Annual monitoring of reports reviewing eligibility, billing, and areas that need improvement	1. 2012-2015	1. Grantee	1. Grantee		

	2. Offer web-based trainings for case management on CAREWare and eligibility to avoid travel cost	2. 2012-2015	2. Lead/Grantee	2. CARE Council		
E. Measure client satisfaction	1. Annually gather, monitor, and assess tabulated client satisfaction survey responses, and implement corrective action if needed	1. 2012-2015	1. Grantee	1. CARE Council		
	2. Develop a fact sheet for consumers on provider confidentiality	2. 2012-2015	2. Support & Medical Services Committee	2. CARE Council		
	3. Provide Ryan White Providers training on confidentiality standards	3. 2012-2015	3. Grantee	3. CARE Council		
	4. Continue to require Ryan White Providers adhere to confidentiality standards and require participation at confidentiality trainings	4. 2012-2015	4. Grantee	4. CARE Council		
Aligns with following focus points: EIIHA, HP2020, NHAS, ACA						

B: Strategy, plan, activities, timeline, and responsible entity(s) to address the needs of individuals aware of their HIV status, but are not in care

Focus Point Key: EIIHA = Early Identification of Individuals with HIV/AIDS HP2020 = Healthy People 2020 NHAS = National HIV/AIDS Strategy ACA=Affordable Care Act

Goal 1: Increase Access to Care and Optimize Health Outcomes for People Living with HIV						
Strategy/Plan	**Activities**	**Timeline/ Due Date**	**Responsible Entity(s)**	**Progress Reporting**	**Status**	**Comment**
A. Enhance post-test counseling referral and linkage	1. Ensure that a referral is made to peer mentors during post-test counseling	1. 2012-2015	1. Social Services Counselor, Health Service Representative, Post-Test Counselor, Private Physician, Case Management	1. Grantee		
	2. Increase and improve follow-up with recently diagnosed PLWHA by enhancing coordination between early intervention, counseling, testing, and case management providers	2. 2012-2015	2. Ryan White Funded Programs	2. CARE Council		

	with established meetings					
	3. Educate medical professionals and case managers to refer recently diagnosed PLWHA to counseling and mental health services	3. 2012-2015	3. Grantee	3. CARE council		
	4. Explore mental health and substance abuse assessment tools for case mangers of newly diagnosed clients	4. 2012-2015	4. Grantee	4. CARE council		
Aligns with the following focus point: EIIHA, HP2020, NHAS, ACA						

C: Strategy, plan, activities, timeline, and responsible entity(s) to address the needs of individuals unaware of their HIV status

Focus Point Key: EIIHA = Early Identification of Individuals with HIV/AIDS HP2020 = Healthy People 2020
NHAS = National HIV/AIDS Strategy ACA=Affordable Care Act

Goal 2: Reduce the Number of People Who Become Infected with HIV						
Strategy/Plan	**Activities**	**Timeline/ Due Date**	**Responsible Entity(s)**	**Progress Reporting**	**Status**	**Comment**
A. Increase HIV testing opportunities	1. Suggest HIV tests as routine part of medical care	1. 2012-2015	1. Health Department, Early Intervention Specialist Consultant	1. Community Planning Partnership, CARE Council		
	2. Recruit private sector on Community Planning Partnership and CARE Council	2. 2012-2015	2. Community Planning Partnership, CARE Council	2. Member Support Liaison, Community Planning Partnership Staff		
	3. Analyze unmet needs and gaps in HIV testing through review of available data	3. 2013	3. Health Planner	3. Ryan White Staff		

	4. Explore additional funding opportunities for testing	4. 2012-2015	4. Grantee, Ryan White Providers, Community Planning Partnership	4. Ryan White Staff		
	5. Integrate HIV and STD services by developing a flow chart to track and display referral and linkage to care	5. 2012-2015	5. Department of Health	5. Department of Health		
B. Increase HIV testing sites	1. Expand HIV testing in schools, based on the Palm Beach Lakes High School model	1. 2012-2015	1. Health Department, Public School Administration	1. Health Department		
C. Identify and eliminate or reduce barriers to HIV testing in public and private sectors	1. Encourage attendance of private doctors at focus groups to ask how can HIV testing be increased	1. 2013	1. Health Planner in conjunction with Community Planning Partnership	1. Health Planner		
	2. Review bi-annual re license curriculum (add component on prevention counseling and post test counseling)	2. 2013	2. Health Department	2. Health Department		

	3. Revisit PTC phone policy to allow results given over the phone	3. 2013	3. Health Department	3. Health Department		
	4. Review local outcomes from Social Networking Strategy (SNS) programs	4. 2012-2015	4. Department of Health, Participating Providers	4. Health Department		
D. Support testing initiatives	1. Annually increase the proportion of HIV-infected people in Palm Beach County who know they are infected	1. 2012-2015	1. Early Intervention Services (EIS) Funded Parties, Agencies Funded for HIV Testing	1. Early Intervention Services (EIS) Funded Parties, Agencies Funded for HIV Testing		
	2. Annually increase the proportion of HIV-infected people in Palm Beach County who are linked to appropriate prevention care and treatment services at testing	2. 2012-2015	2. Community Planning Partnership, CARE Council	2. Community Planning Partnership, CARE Council		
	3.Quarterly reports on all new testing sites and ETI sites	3. 2012-2015	3. Department of Health, Department of Corrections, Community Based Organizations,	3. Health Department		

			and Universities			
	4. Quarterly reports on State registered HIV test sites positivity rates	4. 2012-2015	4. Department of Health, Participating Providers	4. Health Department		
E. Market HIV testing and testing sites	1. Purchase and disseminate promotional items, when funding is available, that reference CARE Council, HIV testing and services, and Redbook	1. 2012-2015	1. Community Planning Partnership, CARE Council Support	1. Community Planning Partnership, Grantee		
	2. Provide promotional items, when funding is available, to private doctor offices and at community outreach events	2. 2012-2015	2. Community Planning Partnership, CARE Council, Grantee	2. Health Department, CARE Council, Ryan White		
Aligns with the following focus point: EIIHA, HP2020, NHAS, ACA						

D: Strategy, plan, activities, timeline, responsible entity(s) to address the needs of special populations including but not limited to; adolescents, injection drugs users, homeless, and transgender

Focus Point Key: EIIHA = Early Identification of Individuals with HIV/AIDS HP2020 = Healthy People 2020
NHAS = National HIV/AIDS Strategy ACA=Affordable Care Act

Goal 3: Reduce HIV-related health disparities						
Strategy/Plan	**Activities**	**Timeline/ Due Date**	**Responsible Entity(s)**	**Progress Reporting**	**Status**	**Comment**
A. Access health outcomes of PLWHA in Emerging Special Populations	1. Annually present client-level data from CAREWare on "Emerging Special Population" and sub-categories such as Aging Out of Foster Care-18+ Youth, Senior Citizens, Drug Treatment Clients, Men and Women in Prison, Temporary Migrant Workers, Transgender and Homeless	1. 2012-2015	1. Ryan White Part A Staff	1. CARE Council		

	2. Conduct focus groups and surveys with PLWHA to access those falling out of care	2. 2012-2015	2. Health Planner	2. Health Planner		
	3. Continue the position of regional Minority AIDS Coordinator	3. 2012-2015	3. Department of Health	3. Department of Health		
	4. Continue to target MSM populations within agency specific campaigns and events that focus attention on HIV/AIDS	6. 2012-2015	6. Department of Health	6. Department of Health		
	5. Continue the Mama Bear Coalition and opt-out testing for pregnant HIV-positive women	7. 2012-2015	7. Department of Health	7. Department of Health		
	6. Continue, as funds are available, the inmate HIV testing program and the jail linkage program for the incarcerated	8. 2012-2015	8. Department of Health	8. Department of Health		

	7. Continue Aging out of Foster Care-18+ youth workgroup so as to identify and remove barriers to care by distributing county wide information	9. 2012-2015	9. Aging out of Foster Care_18+ youth work group	9. Aging out of Foster Care_18+ youth work group		
B. Enhance capacity of housing services to accommodate all PLWHAs who are aware of their status	1. Discuss with the Homeless and Housing Alliance, the possibility of applying for additional housing grants	1. 2012-2015	1. Planning Committee	1. Health Planner		
	2. Discuss with the Homeless and Housing Alliance, regarding the creation of a task force of agencies interested in applying for housing grants	2. 2012-2015	2. Planning Committee	2. Health Planner		
C. Enhance capacity of substance abuse and mental health services to accommodate all PLWHA	1. Join the Palm Beach County Substance Abuse Coalition and report on efforts that raise awareness of substance abuse to the CARE Council	1. 2012-2015	1. Health Planner	1. Planning Committee		

	2. Encourage the Priorities and Allocations Committee to maintain level or increase funding for mental health services based on available utilization trends and budget	2. 2012-2015	2. Health Planner	2. CARE Council		
D. Enhance access to HIV/AIDS services for PLWHA who are aware of their status	1. Assess PLWHA access to continuum of care through identification of barriers in needs assessments, review of post test counseling surveys, review of utilization data, and lost to care survey findings.	1.2012-2013	1. Health Planner	1. CARE Council		
E. Ensure continuity of care for PLWHA upon release from jail and prison	1. Ensure discharge staff have up to date HIV services information	1. 2012-2015	1. Health Planner	1. CARE Council 2. Planning Committee		
	2. Contact Department of Corrections Pre-Release Planner for data and program successes	2. 2012-2015	2. Health Planner	2. Planning Committee		

	3. Ensure EIS program targets population through a monitoring program	3. 2012-2015	3. Grantee	3. CARE Council		
Aligns with the following focus point: EIIHA, HP2020, NHAS, ACA						

E. Activities to implement with varying programs:

Part B Services, including the AIDS Drug Assistance Program (ADAP)
Ryan White Part A and Part B will work closely in identifying HIV positive unaware individuals and bring them to care. This will be accomplished through a commitment to funding EIS and maintaining an appropriate level of funding for core medical services, particularly OPMC and medications. Additionally, a thorough eligibility screening is completed for clients every six months to ensure funding for the most severe need. Part A and Part B will continue to come together for joint monthly provider (sub-recipient) meetings. This works to enhance communication and ensure consistency throughout the continuum of care. Part A and B will use the same client database, CAREWare, to keep track of clients. This works to avoid duplication of service. Finally, both Part A and B will work together to implement the activities of the Comprehensive Plan 2012-2015, with both Parts making an effort to ensure reciprocal communication with the AIDS Drug Assistance Program (ADAP).

Part C Services
Our EMA does not receive Ryan White Part C funding.

Part D Services
Our EMA does not receive Ryan White Part D funding.

Part F Services
Ryan White Part A and Part F will collaborate in developing medical standards of care for services of PLWHA. We will also request input and direction from Part F for the Palm Beach County EMA Quality Management Plan. All Quality Management reports will be presented to the Planning Council for review to initiate improvement plans on an as needed basis.

Private Providers (non-Ryan White funded)
Ryan White Part A will collaborate with private providers in ensuring they are a part of our continuum of care. We will collaborate with the private providers by referring clients to the medical care/services when appropriate. The private providers will be listed in our resource inventory.

Prevention Programs including; Partner Notification Initiatives and Prevention with Positives Initiatives
Ryan White Part A will collaborate with the prevention programs of Palm Beach County to bring forth to the Planning Council, all testing and prevention efforts throughout the EMA. Updates on activities will consistently be provided at committee and Planning Council meetings. Through the initiation of the newly funded EIS program there will be effective communication with the Part A program regarding the partner notification initiatives.

Substance Abuse Treatment Programs/Facilities
Ryan White Part A will collaborate with substance abuse treatment programs to ensure substance abuse services are available to PLWHA. The continuum of care consists of a network of substance abuse residential providers which affords our EMA the ability to respond to the individual needs of the clients. Additionally, substance abuse outpatient services are available.

STD Programs
Ryan White Part A will coordinate with STD programs to review epidemiological data highlighting co-morbidity statistics. These data assist in assessing the cost complexities of delivering care to PLWHA within our EMA. The local STD program will be administering the Part A EIS program. This natural link allows for an effective outreach and linkage to care for PLWHA who are co-infected with STDs, as well as outreach to high risk populations.

Medicare/Medicaid
Ryan White Part A will continue to screen individuals for eligibility to ensure that Ryan White funds will be payer of last resort. It will work hand in hand with Medicare and Medicaid to know the standards needed to qualify for services for both programs. Additionally, Medicaid representation on the Planning Council assists in coordinated efforts in planning for PLWHA care within the EMA.

Children's Health Insurance Program/Community Health Centers
Ryan White Part A will provide services in children's health insurance programs and community health centers as needed. Currently Part A funds a CHC Look Alike, which provides support and medical services to PLWHA within the EMA. Services for WICY focus for our EMA and data is provided to the Planning Council for planning purposes.

F. How does the implementation plan address the objectivities of Healthy People 2020?

The Healthy People 2020 initiative is a national movement that establishes 10-year national objectives for improving the health of all Americans. The vision of this idea is to have a society in which all people live long, healthy lives, the same vision we have set for our Comprehensive Plan. The implementation chart of this Comprehensive Plan will strive to identify health improvement priorities, increase public awareness and understanding of the determinants of HIV/AIDS, and seek opportunities for progress, aligning with the overall mission of Healthy People 2020. The activities of this implementation plan will provide measurable objectives and goals that are applicable to our EMA. It will engage multiple sectors to take actions to strengthen policies and improve practices that are driven by the best available evidence and knowledge. It will identify critical research, evaluation, and data collection needs of PLWHA. For example, an effort will be made to increase HIV testing opportunities, it will attempt to support testing initiatives within the county, and it will try to increase the knowledge of services available to PLWHA. In order to ensure the activities reflect those of Healthy People 2020 we have referenced which activities are associated with the Healthy People 2020 goals within the Implementation Plan.

G. How does the implementation plan reflect the Statewide Coordinated Statement of Need (SCSN)?

The collaboration of the State with Part A grantees allows the implementation plan to reflect the Statewide Coordinated Statement of Need.

The CARE Council maintains representation in the SCSN process by providing PLWHA survey

data from our local Palm Beach County area. Through the use of the data collection system, Survey Monkey, data was complied into the system and shared with the State. The State was able to use this data to represent the PLWHA in our local area to better the continuum of care.

Grantee staff, CARE Council Support staff and CARE Council member representation at the SCSN State planning meetings assists in local input on the implementation plan onto the SCSN.

Both, the State and our EMA implementation plan, aim to attain high-quality health, eliminate disparities, and improve the health of all PLWHA groups. Our implementation plan works to create an environment that will promote good health for all and meet the needs identified in the SCSN.

H. How will the implementation plan coordinate and adapt to changes within the Affordable Care Act (ACA)?

The Affordable Care Act (ACA) is a health reform law that seeks to expand health insurance coverage while also reforming the health care delivery system to improve the quality and value of life. The implementation plan will seek to fulfill the goals that comprise the act by working towards eliminating disparities in HIV/AIDS health care, assessing health outcomes of focus groups and surveys of PLWHA in emerging special populations. It will also strengthen public health and health care access by creating an analysis of unmet needs and gaps in HIV testing. The implementation plan will invest in the improvement of the health care workforce by educating private physicians on reimbursement possibilities which will ultimately extend the service to a greater amount of clients and will assist in expanding health care coverage. To adapt to change the activities that align with the Affordable Care Act will be measured and the status will be managed to put forth the best possible health care system for PLWHA.

I. How will the comprehensive plan address the goals of the National HIV/AIDS Strategy (NHAS)?

The National HIV/AIDS Strategy contains three primary goals, (1) aims to reduce the number of people who become infected with HIV, (2) increase access to care and optimize health outcomes for people living with HIV, (3) reduce HIV-related health disparities. The deciding body of the Palm Beach County EMA, the CARE Council, believed that each of the goals outlined in the National HIV/AIDS Strategy were goals that once accomplished would provide a stable system of care for all PLWHA within the EMA. The integration of HIV and STD services is an example of an activity that will reduce the number of people who become infected with HIV. Continuing the use of disease intervention specialists in the health care of PLWHA will increase access to care and optimize health outcomes for all groups of PLWHA by an increase in knowledge of the disease and linkage to care. Expanding the "emerging special populations," to include the sub-categories of aging out of foster care-18+ years old, senior citizens, drug treatment clients, men and women in prisons, temporary migrant workers, and homeless will work to reduce HIV-related disparities. As Palm Beach County strives to meet its own proposed goals, it will also be contributing to the national coordinated effort to achieve the NHAS's vision of a nation committed to stopping the HIV epidemic and supporting all infected persons with dignity, and access to high-quality care.

J. What is the strategy to respond to any additional or unanticipated changes in the continuum of care as a result of state or local budget cuts?

Palm Beach County will be ready to respond to changes in funding levels by continuing to adhere to practices that ensure Ryan White funds as the payer of last resort. It will continue to have case managers assist clients in applying for Health Care District, Medicaid, Medicare, Social Security and Disability, and/or Veterans Administration coverage. Client financial eligibility screening will continue to be reviewed every six months to guarantee correct coverage. Also, the Legal Aid Society of Palm Beach County will continue to assist clients in preserving their private health insurance as well as assisting clients in attaining governmental assistance, i.e., Medicaid, Medicare, Social Security and Disability. An eligibility grid for services will continue to be reviewed on an annual basis by the Planning Council to ensure that all provisions of service are maintained for the neediest sections of the population of PLWHA. Training programs will continue to focus on building the front line eligibility workers', case managers', and Ryan White staffs' knowledge of the other available funding sources and their service coverage and eligibility criteria. Grantees and administrators from various funding sources, including Ryan White Part A and B, HOPWA, the Florida State HIV/AIDS Program Coordinator (HAPC) from the Palm Beach County Health Department, Veterans Administration, Medicaid, Local Health Department CDC testing and prevention program, and SAMHSA will continue to share information about their current allocations with the CARE Council's Priorities and Allocations committee to ensure service categories will be funded at correct amounts due to budget.

SECTION 4

S E C T I O N 4

How will we monitor and evaluate progress?

Execution of the implementation plan requires monitoring the progress made in achieving stated strategy/plan and activities. Monitoring will allow recognition of problems in the plan so that barriers to progress can be identified and reported to planning bodies. Adjustments and modifications will be made in programs and services mentioned in the plan so as to remedy the problems that could arise throughout the three year duration of implementation.

The impact of the Early Identification of Individuals with HIV/AIDS (EIIHA) initiative will be assessed quarterly by the Planning Committee and CARE Council. Both of the goals of EIIHA will be monitored so as to consistently make individuals who were unaware of their HIV status aware of their status and to make certain that referrals and linkages to care can be made to the newly diagnosed with HIV/AIDS.

The CARE Council will serve as the mechanism for evaluating changes in the environment and determining when and how each component of the evaluation will be completed. The information gathered by relevant committees in regards to the implementation of the Comprehensive Plan will be evaluated on a quarterly basis and used in the decision making.

Below are some examples of information to be collected:

- Activities such as health fairs and outreach community events will be monitored to work on increasing the knowledge of PLWHA of HIV services, prevention, and medication.

- Social Network Testing Programs will be encouraged and the outcomes from these programs will be evaluated to decipher an increase in HIV testing and to record the number of HIV positives identified from the program.

- Changes in the epidemiology will 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 will be reviewed. The CARE Council will serve to integrate this data and present it to the community.

- Information on service needs will be collected through needs assessment activities, including consumer and provider surveys, focus groups, interviews, and public forums. A comprehensive needs assessment will be conducted every three years and special studies will be produced on subsequent years to examine, explore and describe issues as they emerge.

- Client and system level outcomes tracking will be conducted throughout the EMA. The EMA will use the CAREWare Data System and will require all Part A funded agencies to enter information such as viral load and CD4 counts, among other important biological and clinical indicators.

APPENDIX

A P P E N D I X

A.

Resource Inventory

Contact Information	Service Area	Funding Source	Target Population	Referral Tracking Mechanism
Ambulatory Outpatient Medical Care Capacity: 1,050				
C.L. Brumback Health Center 38754 St Road 80 Belle Glade 33430 561-996-1600 Mitchell Durant, Ph.D	Western Palm Beach County	Medicaid, Healthcare District, RW Part A, Network, Patient Care, Medicare	All Populations, Migrant Workers, Communities of Color, WICY	CAREWare
County Health Department West Palm Beach Clinic 1150 45th Street West Palm Beach 33407 561-514-5300 Mitchell Durant, Ph.D	Central/North Eastern Palm Beach County	Medicaid, Healthcare District, RW Part A, Network, Patient Care, Medicare	All Populations, Migrant Workers, Communities of Color, WICY	CAREWare
County Health Department Delray Beach Health Center 225 South Congress Avenue Delray Beach 33445 561-274-3100 Mitchell Durant, Ph.D	Southern Eastern Palm Beach County	Medicaid, Healthcare District, RW Part A, Network, Patient Care, Medicare	All Populations, Migrant Workers, Communities of Color, WICY	CAREWare
Infectious Disease Consultants 5150 Linton Blvd, suite 100 Delray Beach 33484 561-381-0801	Southern Palm Beach County	Private Insurance	All Populations	Paper Referral
Infectious Disease Associates 2300 South Congress Ave Boynton Beach 33426 561-735-7531	Southern Palm Beach County	Private Insurance	All Populations	Paper Referral
Triple O Medical Services, MD 1515 North Flagler Drive, Ste 200 West Palm Beach 33401 561-832-6770 Olayemi O. Osiyemi	Central Palm Beach County	Private Insurance	All Populations	Paper Referral
Children's Medical Services 5101 Greenwood Ave West Palm Beach 33407 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 561-422-8262 M. Chris Saslo	County-wide	Veterans Administration	Veterans	VA database

FoundCare, Inc. 2330 South Congress Ave. Palm Springs 33406 561-432-5849 Yolette Bonnet	Central Palm Beach County	RW Part A, Medicaid, Medicaid Managed Care, Private Insurance, Health Care District, Local funding	All Populations, Haitian, Latin	CAREWare
Specialty Medical Care Capacity: 150				
Health Council of South East Florida, Inc. 600 Sand Tree Drive Ste 101 Palm Beach Gardens, FL 33403	Palm Beach County	RW Part A, General Revenue	All Populations, Migrant Workers, Communities of Color, WICY	CAREWare
Nurse Care Coordination Capacity: 670				
C.L. Brumback Health Center 38754 St Road 80 Belle Glade 33430 561-996-1600 Mitchell Durant, Ph.D	Western Palm Beach County	Medicaid, Healthcare District, RW Part A, Network, Patient Care, Medicare	All Populations, Migrant Workers, Communities of Color, WICY	CAREWare
County Health Department West Palm Beach Clinic 1150 45th Street West Palm Beach 33407 561-514-5300 Mitchell Durant, Ph.D	Central/North Eastern Palm Beach County	Medicaid, Healthcare District, RW Part A, Network, Patient Care, Medicare	All Populations, Migrant Workers, Communities of Color, WICY	CAREWare
County Health Department Delray Beach Health Center 225 South Congress Avenue Delray Beach 33445 561-274-3100 Mitchell Durant, Ph.D	Southern Eastern Palm Beach County	Medicaid, Healthcare District, RW Part A, Network, Patient Care, Medicare	All Populations, Migrant Workers, Communities of Color, WICY	CAREWare
FoundCare, Inc. 2330 South Congress Ave. Palm Springs 33406 561-432-5849 Yolette Bonnet	Central Palm Beach County	RW Part A, Medicaid, Medicaid Managed Care, Private Insurance, Health Care District, Local funding	All Populations, Haitian, Latin	CAREWare
Medical Case Management Capacity: 2,603				
Comprehensive AIDS Program 220 Congress Park Drive Suite 100 Delray Beach 33445 561-274-6400 Yolette Bonnet	Southern Palm Beach County	RW Part A and B, Medicaid, Medicaid Managed Care,Local funding	All Populations, Haitian, Latin	CAREWare
Comprehensive AIDS Program 1500 NW Ave L Belle Glade 33430 561-996-7059 Yolette Bonnet	Western Palm Beach County	RW Part A and B, Medicaid, Medicaid Managed Care, Local funding	All Populations, Haitian, Latin	CAREWare

Comprehensive AIDS Program 2330 South Congress Ave. West Palm Beach 33406 561-472-2466 Yolette Bonnet	Central Palm Beach County	RW Part A and B, Medicaid, Medicaid Managed Care, Local funding	All Populations, Haitian, Latin	CAREWare
Compass 201 North Dixie Hwy Lake Worth, FL 33460 561-533-9699 Marsharee Chronicle	Central Palm Beach County	RW Part A	LGBT, All Populations	CAREWare
County Health Department C.L. Brumback Health Center 38754 St Road 80 Belle Glade 33430 561-996-1600 Mitchell Durant, Ph.D	Western Palm Beach County	Medicaid, Healthcare District, RW Part A, Network, Patient Care, Medicare	All Populations, Migrant Workers, Communities of Color, WICY	CAREWare
County Health Department West Palm Beach Clinic 1150 45th Street West Palm Beach 33407 561-514-5300 Mitchell Durant, Ph.D	Central/North Eastern Palm Beach County	Medicaid, Healthcare District, RW Part A, Network, Patient Care, Medicare	All Populations, Migrant Workers, Communities of Color, WICY	CAREWare
County Health Department Delray Beach Health Center 225 South Congress Avenue Delray Beach 33444 561-274-3100 Mitchell Durant, Ph.D	Southern Palm Beach County	Medicaid, Healthcare District, RW Part A, Network, Patient Care, Medicare	All Populations, Migrant Workers, Communities of Color, WICY	CAREWare
Minority Development and Empowerment, Inc. 3175 South Congress Ave Ste. 207 Palm Springs 33461 561-296-5722 Francois Leconte	County-wide	RW Part B	Haitian Population	CAREWare
Positive Healthcare 110 SE 6th Street Fort Lauderdale, FL 1-954-522-3132 John Ferkin	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
Medical Case Management Peer Mentor **Capacity: 830**				

Comprehensive AIDS Program 220 Congress Park Drive Suite 100 Delray Beach 33445 561-274-6400 Yolette Bonnet	Southern Palm Beach County	RW Part A and B, Medicaid, Medicaid Managed Care,Local funding	All Populations, Haitian, Latin	CAREWare
Comprehensive AIDS Program 1500 NW Ave L Belle Glade 33430 561-996-7059 Yolette Bonnet	Western Palm Beach County	RW Part A and B, Medicaid, Medicaid Managed Care, Local funding	All Populations, Haitian, Latin	CAREWare
Comprehensive AIDS Program 2330 South Congress Ave. West Palm Beach 33406 561-472-2466 Yolette Bonnet	Central Palm Beach County	RW Part A and B, Medicaid, Medicaid Managed Care, Local funding	All Populations, Haitian, Latin	CAREWare
County Health Department C.L. Brumback Health Center 38754 St Road 80 Belle Glade 33430 561-996-1600 Mitchell Durant, Ph.D	Western Palm Beach County	Medicaid, Healthcare District, RW Part A, Network, Patient Care, Medicare	All Populations, Migrant Workers, Communities of Color, WICY	CAREWare
County Health Department West Palm Beach Clinic 1150 45th Street West Palm Beach 33407 561-514-5300 Mitchell Durant, Ph.D	Central/North Eastern Palm Beach County	Medicaid, Healthcare District, RW Part A, Network, Patient Care, Medicare	All Populations, Migrant Workers, Communities of Color, WICY	CAREWare
County Health Department Delray Beach Health Center 225 South Congress Avenue Delray Beach 33444 561-274-3100 Mitchell Durant, Ph.D	Southern Palm Beach County	Medicaid, Healthcare District, RW Part A, Network, Patient Care, Medicare	All Populations, Migrant Workers, Communities of Color, WICY	CAREWare
Non Medical Case Management Supportive Capacity: 490				
Comprehensive AIDS Program 220 Congress Park Drive Suite 100 Delray Beach 33445 561-274-6400 Yolette Bonnet	Southern Palm Beach County	RW Part A and B, Medicaid, Medicaid Managed Care,Local funding	All Populations, Haitian, Latin	CAREWare
Comprehensive AIDS Program 1500 NW Ave L Belle Glade 33430 561-996-7059 Yolette Bonnet	Western Palm Beach County	RW Part A and B, Medicaid, Medicaid Managed Care, Local funding	All Populations, Haitian, Latin	CAREWare

Comprehensive AIDS Program 2330 South Congress Ave. West Palm Beach 33406 561-274-6400 Yolette Bonnet	Central Palm Beach County	RW Part A and B, Medicaid, Medicaid Managed Care, Local funding	All Populations, Haitian, Latin	CAREWare
Compass 201 North Dixie Hwy Lake Worth, FL 33460 561-533-9699 Marsharee Chronicle	Central Palm Beach County	RW Part A	LGBT, All Populations	CAREWare
Minority Development and Empowerment, Inc. 3175 South Congress Ave Ste. 207 Palm Springs 33461 561-296-5722 Francois Leconte	County-wide	RW Part B	Haitian Population	CAREWare
Non Medical Case Management Eligibility Capacity: 2,677				
Comprehensive AIDS Program 220 Congress Park Drive Suite 100 Delray Beach 33445 561-274-6400 Yolette Bonnet	Southern Palm Beach County	RW Part A and B, Medicaid, Medicaid Managed Care,Local funding	All Populations, Haitian, Latin	CAREWare
Comprehensive AIDS Program 1500 NW Ave L Belle Glade 33430 561-996-7059 Yolette Bonnet	Western Palm Beach County	RW Part A and B, Medicaid, Medicaid Managed Care, Local funding	All Populations, Haitian, Latin	CAREWare
Comprehensive AIDS Program 2330 South Congress Ave. West Palm Beach 33406 561-472-2466 Yolette Bonnet	Central Palm Beach County	RW Part A and B, Medicaid, Medicaid Managed Care, Local funding	All Populations, Haitian, Latin	CAREWare
Compass 201 North Dixie Hwy Lake Worth, FL 33460 561-533-9699 Marsharee Chronicle	Central Palm Beach County	RW Part A	LGBT, All Populations	CAREWare
County Health Department West Palm Beach Clinic 1150 45th Street West Palm Beach 33407 561-514-5300 Mitchell Durant, Ph.D	Central/North Eastern Palm Beach County	Medicaid, Healthcare District, RW Part A, Network, Patient Care, Medicare	All Populations, Migrant Workers, Communities of Color, WICY	CAREWare
County Health Department Delray Beach Health Center 225 South Congress Avenue Delray Beach 33444 561-274-3100 Mitchell Durant, Ph.D	Southern Palm Beach County	Medicaid, Healthcare District, RW Part A, Network, Patient Care, Medicare	All Populations, Migrant Workers, Communities of Color, WICY	CAREWare

Dental Care Capacity: 1,330				
County Health Department Riviera Beach Health Center 7289 Garden Road Riviera Beach 33404 561-804-7950 Alan Lasch	Central/North Eastern Palm Beach County	Medicaid, Healthcare District, RW Part A, Network, Patient Care, Medicare	All Populations	CAREWare
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	CAREWare
County Health Department Delray Beach Health Center 225 South Congress Avenue Delray Beach 33445 561-274-3111 Alan Lasch	Southern Palm Beach County	Medicaid, Healthcare District, RW Part A, Network, Patient Care, Private Insurance, Medicare	All Populations	CAREWare
FoundCare, Inc. 2330 South Congress Ave. Palm Springs 33406 561-432-5849 Yolette Bonnet	Central Palm Beach County	RW Part A, Medicaid, Medicaid Managed Care, Private Insurance, Health Care District, Local funding	All Populations, Haitian, Latin	CAREWare
Pharmaceutical Capacity: 615				
Palm Beach County Health Care District 2601 10th Avenue North Suite 100 Palm Springs, FL 33461 561- 659-1270 Hyla Polen	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 C.L. Brumback Health Center 38754 St Road 80 Belle Glade 33430 561-996-1600 Mitchell Durant, Ph.D	Western Palm Beach County	Medicaid, Healthcare District, RW Part A, Network, Patient Care, Private Insurance, Medicare	All Populations	CAREWare
County Health Department Delray Beach Health Center 225 South Congress Avenue Delray Beach 33445 561-274-3100 Mitchell Durant, Ph.D	Southern Palm Beach County	Medicaid, Healthcare District, RW Part A,Patient Care, Private Insurance, Medicare Medicare	All Populations	CAREWare

County Health Department West Palm Beach Clinic 1150 45th Street West Palm Beach 33407 561-514-5300 Mitchell Durant, Ph.D	Central Eastern Palm Beach County	Medicaid, Healthcare District, RW Part A, Network, Patient Care, Private Insurance, Medicare	All Populations	CAREWare
Mental Health Treatment Capacity: 75				
FoundCare, Inc 220 Congress Park Drive Suite 100 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	CAREWare
FoundCare, Inc 1500 NW Ave L 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	CAREWare
FoundCare, Inc 2330 South Congress Ave. West Palm Beach 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	CAREWare
Compass 201 North Dixie Hwy Lake Worth, FL 33460 561-533-9699 Marsharee Chronicle	Central Palm Beach County	RW Part A	LGBT, All Populations	CAREWare
County Health Department C.L. Brumback Health Center 38754 St Road 80 Belle Glade 33430 561-996-1600 Mitchell Durant, Ph.D	Western Palm Beach County	Medicaid, Healthcare District, RW Part A, Network, Patient Care, Medicare	All Populations	CAREWare
County Health Department West Palm Beach Clinic 1150 45th Street West Palm Beach 33407 561-514-5300 Mitchell Durant, Ph.D	Central Palm Beach County	Medicaid, Healthcare District, RW Part A, Network, Patient Care, Medicare	All Populations	CAREWare
County Health Department Delray Beach Health Center 225 South Congress Avenue Delray Beach 33444 561-274-3100 Mitchell Durant, Ph.D	Southern Palm Beach County	Medicaid, Healthcare District, RW Part A, Network, Patient Care, Medicare	All Populations	CAREWare

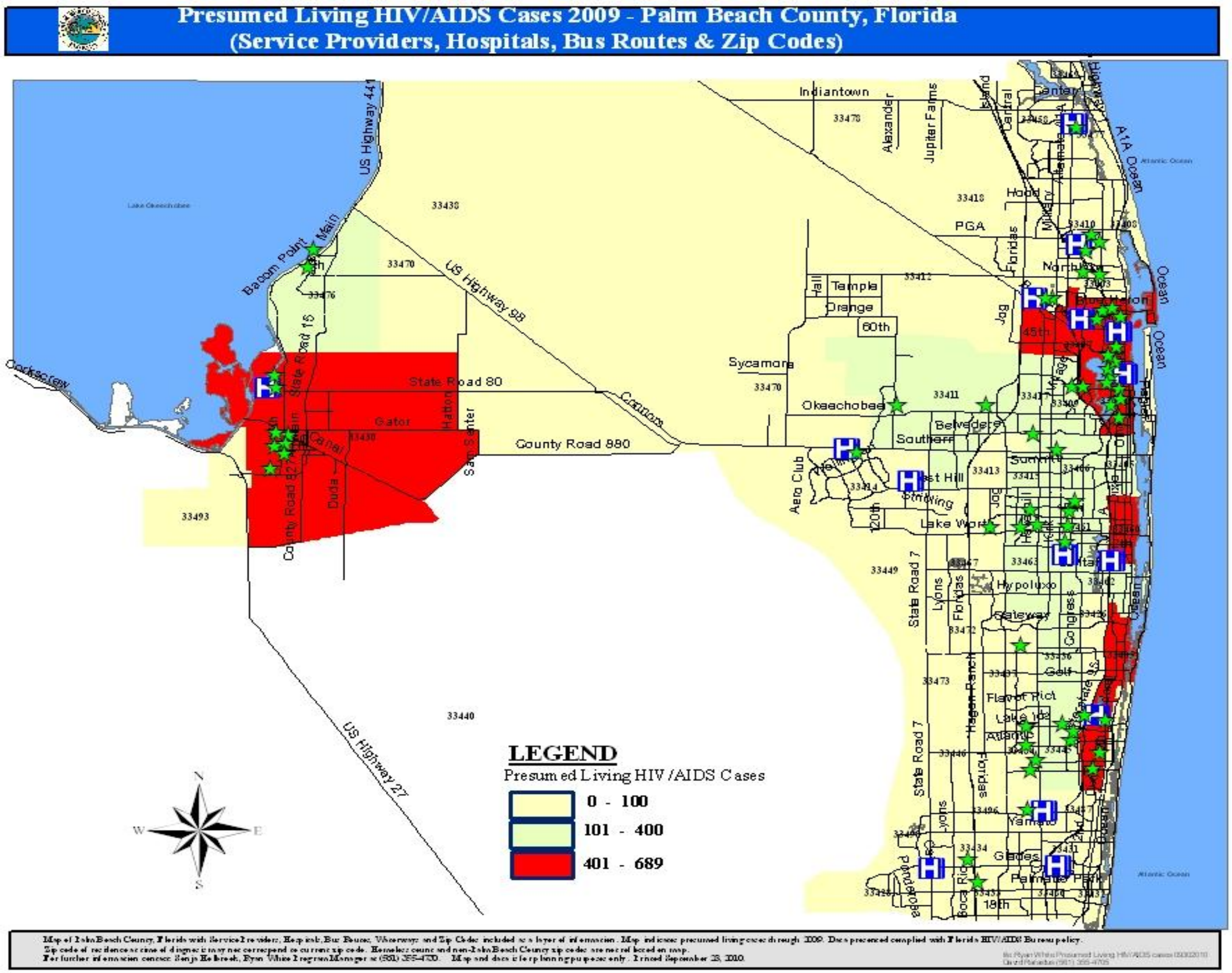
Substance Abuse Treatment Outpatient Capacity: 10				
Gratitude House 1700 N. Dixie Highway West Palm Beach 33407 (561) 833-6826 Linda Kane	All Palm Beach County	RW Part A	WICY	Paper Referral
Substance Abuse Treatment Residential Capacity: 16				
Gratitude House 1700 N. Dixie Highway West Palm Beach 33407 (561) 833-6826 Linda Kane	All Palm Beach County	RW Part B	WICY	Paper Referral
Comprehensive AIDS Program 220 Congress Park Drive Suite 100 Delray Beach 33445 561-274-6400 Yolette Bonnet	Southern Palm Beach County	RW Part A	All Populations, Haitian, Latin	CAREWare
Comprehensive AIDS Program 1500 NW Ave L Belle Glade 33430 561-996-7059 Yolette Bonnet	Western Palm Beach County	RW Part A	All Populations, Haitian, Latin	CAREWare
Comprehensive AIDS Program 2330 South Congress Ave. West Palm Beach 33406 561-472-2466 Yolette Bonnet	Central Palm Beach County	RW Part A	All Populations, Haitian, Latin	CAREWare
FoundCare, Inc. 2330 South Congress Ave. Palm Springs 33406 561-432-5849 Yolette Bonnet	All Palm Beach County	SAMHSA	All Populations, Haitian, Latin	CAREWare
Health Insurance Capacity: 65				
Comprehensive AIDS Program 2330 South Congress Ave. West Palm Beach 33406 561-472-2466 Yolette Bonnet	Central Palm Beach County	RW Part A, Private Funding	All Populations, Haitian, Latin	CAREWare
EIS Capacity: 960 **Palm Beach County** **Health Department Clients**				
Palm Beach County Health Department	County-wide	RW Part A and B	Haitian Population	CAREWare

Treatment Adherence Capacity: 1,088				
County Health Department West Palm Beach Clinic 1150 45th Street West Palm Beach 33407 561-514-5300 Mitchell Durant, Ph.D	Central/North Eastern Palm Beach County	Medicaid, Healthcare District, RW Part A, Network, Patient Care, Medicare	All Populations, Migrant Workers, Communities of Color, WICY	CAREWare
County Health Department Delray Beach Health Center 225 South Congress Avenue Delray Beach 33444 561-274-3100 Mitchell Durant, Ph.D	Southern Palm Beach County	Medicaid, Healthcare District, RW Part A, Network, Patient Care, Medicare	All Populations	CAREWare
Emergency Financial Assistance Capacity: 110				
FoundCare, Inc. 220 Congress Park Drive Suite 100 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	CAREWare
FoundCare, Inc. 1500 NW Ave L 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	CAREWare
FoundCare, Inc. 2330 South Congress Ave. West Palm Beach 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	CAREWare
Compass 201 North Dixie Hwy Lake Worth, FL 33460 561-533-9699 Marsharee Chronicle	Central Palm Beach County	RW Part A	LGBT, All Populations	CAREWare
Food Services Capacity: 303				
FoundCare, Inc. 220 Congress Park Drive Suite 100 Delray Beach 33445 561-274-6400 Yolette Bonnet	Southern Palm Beach County	RW Part A, Medicaid Managed Care, Local funding	All Populations, Haitian, Latin	CAREWare
FoundCare, Inc. 1500 NW Ave L Belle Glade 33430 561-996-7059 Yolette Bonnet	Western Palm Beach County	RW Part A, Medicaid Managed Care, Private Insurance, Local funding	All Populations, Haitian, Latin	CAREWare

FoundCare, Inc. 2330 South Congress Ave. West Palm Beach 33406 561-472-2466 Yolette Bonnet	Central Palm Beach County	RW Part A, Medicaid Managed Care, Local funding	All Populations, Haitian, Latin	CAREWare
Compass 201 North Dixie Hwy Lake Worth, FL 33460 561-533-9699 Marsharee Chronicle	Central Palm Beach County	RW Part A	LGBT, All Populations	CAREWare
Legal Services Capacity: 380				
Legal Aid Society of Palm Beach County 423 Fern Street Ste 200 West Palm Beach 33401 561-655-8944 John Foley	County-wide	RW Part A	All Populations	CAREWare
Transportation Capacity: 255				
FoundCare, Inc. 220 Congress Park Drive Suite 100 Delray Beach 33445 561-274-6400 Yolette Bonnet	Southern Palm Beach County	RW Part A, Medicaid, Medicaid Managed Care, Local funding	All Populations, Haitian, Latin	CAREWare
FoundCare, Inc. 1500 NW Ave L Belle Glade 33430 561-996-7059 Yolette Bonnet	Western Palm Beach County	RW Part A, Medicaid, Medicaid Managed Care, Local funding	All Populations, Haitian, Latin	CAREWare
FoundCare, Inc. 2330 South Congress Ave. West Palm Beach 33406 561-472-2466 Yolette Bonnet	Central Palm Beach County	RW Part A, Medicaid, Medicaid Managed Care, Local funding	All Populations, Haitian, Latin	CAREWare
Compass 201 North Dixie Hwy Lake Worth, FL 33460 561-533-9699 Marsharee Chronicle	Central Palm Beach County	RW Part A	LGBT, All Populations	CAREWare
Home and Community Based Healthcare Capacity: 20				
Comprehensive AIDS Program 2330 South Congress Ave. West Palm Beach 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	CAREWare

FoundCare, Inc. 220 Congress Park Drive Suite 100 Delray Beach 33445 561-274-6400 Yolette Bonnet	Southern Palm Beach County	RW Part A, Medicaid, Medicaid Managed Care, Local funding	All Populations, Haitian, Latin	CAREWare
FoundCare, Inc. 1500 NW Ave L Belle Glade 33430 561-996-7059 Yolette Bonnet	Western Palm Beach County	RW Part A, Medicaid, Medicaid Managed Care, Local funding	All Populations, Haitian, Latin	CAREWare
Housing Capacity: 309				
Found Care, Inc. 2330 South Congress Ave. Palm Springs 33406 561-472-9160 Yolette Bonnet	County-wide	HOPWA	All Populations	CAREWare
Gratitude House 1700 N. Dixie Highway West Palm Beach 33407 (561) 833-6826 Linda Kane	Eastern/Central Palm Beach County	HOPWA	All Populations	Paper Referral
Jerome Golden Center for Behavioral Health 1041 45th Street West Palm Beach, Florida 33407 561.383.8000 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

B.


Presumed Living HIV/AIDS Cases 2009 - Palm Beach County, Florida
(Service Providers, Hospitals, Bus Routes & Zip Codes)
LEGEND
Presumed Living HIV/AIDS Cases
0 - 100
101 - 400
401 - 689
US Highway 441
US Highway 98
US Highway 27
State Road 80
State Road 15
County Road 880
State Road 7
Indiantown
Okeechobee
Southern
Belvedere
Hypoluxo
Gateway
Glades
Palmetto Park
Yamato
Atlantic
N
S
E
W

C.

Acronyms

ACA (Affordable Care Act)

ADAP (AIDS Drug Assistance Program)

AETC (AIDS Education Training Center)

AFB (Acid-Fast Bacilli)

AICP (AIDS Insurance Continuation Program)

AIDS (Acquired Immune Deficiency Syndrome)

CAC (Community Awareness Committee)

CAP (Certified Addiction Professional)

CBC (Complete Blood Count)

CD4 (T-4 Helper Lymphocytes)

CD8 (T-8 Killer Lymphocytes)

CDC (Centers for Disease Control)

CMV (Cytomegalovirus)

CPP (Community Prevention Partnership)

CSN (Coordinated Services Network)

CQI (Continuous Quality Improvement)

CQM (Clinical Quality Management)

DIS (Disease Intervention Specialists)

DOC (Department of Corrections)

DOH (Department of Health)

EFA (Emergency Financial Assistance)

EIIHA (Early Identification of Individuals with HIV/AIDS)

EIS (Early Intervention Services)

ELR (Electronic Laboratory Results)

EMA (Eligible Metropolitan Area)

FDA (Food and Drug Administration)

FY (Fiscal Year)

GIS (Geographic Information System)

HAB (HIV/AIDS Bureau)

HAPC (HIV/AIDS Program Coordinator)

HARS (HIV and AIDS Reporting System)

HCV (Hepatitis C Virus)

HIV (Human Immunodeficiency Virus)

HMS (Health Management System, a County Health Department database for client based services)

HOPWA (Housing Opportunities for Persons with AIDS)

HP2020 (Healthy People 2020)

HRSA (Health Resources and Services Administration)

IDU (Injection Drug User)

IFA (Immunofluorescent Assay)

IGRA (Interferon Gamma Release Assay)

LGBT (Lesbian, Gay, Bisexual, and Transgender)

MAI (Minority AIDS Initiative)

MSM (Men Who Have Sex with Men)

NIH (National Institutes of Health)

NHAS (National HIV/AIDS Strategy)

OPMC (Office of Professional Medical Conduct)

P&A (Priorities and Allocations)

PAC (Project AIDS Care)

PAP (Patient Assistance Programs)

PBCHD (Palm Beach County Health Department)

PHS (Public Health Service)

PLWHA: (Person(s) Living with HIV/AIDS Disease)

PRISM (Patient Reporting Investigating Surveillance Manager)

PS (Partner Services)

PTC (Prevention Training Consultants)

PWA/PLWHA (Person with AIDS): A person living with HIV/AIDS.

QM (Quality Management)

RFP (Request(s) for Proposals)

RSR (Ryan White HIV/AIDS Service Report)

RW (Ryan White)

SAMHSA (Substance Abuse and Mental Health Services Administration)

SCSN (Statewide Coordinated Statement of Need)

SNS (Social Networking Strategy)

SSDMF (Social Security Death Master File)

STD (Sexually Transmitted Disease)

STI (Structured Treatment Interruption)

VA (Veterans Administration)

WICY (Women, Infants, Children, and Youth)

REFERENCES

AFrequently Used Acronyms@, National Institutes of Health (NIH)

D.

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 (H.I.V.).

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 Ahelper@ 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 Acluster 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 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 AAbout 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 Atranslating@ 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 Agive 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.

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/.)

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 Ahiding 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 County Health Department Patient Care and AIDS Network is the Department of Health.

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.

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 Awindow 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 drawn 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 that supplements the Part A formula grant, and is awarded to EMAs on a competitive bases based on 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 drawn from a population and then interviewed or otherwise studied 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 varible 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.

Weighting: A procedure for adjusting the values of data to reflect each group=s percent in the total population; for example, race/ethnicity and oversampled 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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