FY 2013 RYAN WHITE
NEEDS ASSESSMENT: EXECUTIVE SUMMARY REPORT

ADOPTED: February 5, 2014

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WHO WE ARE

The health councils were created in 1983 by Florida Statute to identify, address and resolve health care issues of local concern. Each health council is a private, non-profit organization governed by a Board of Directors. The Board members are appointed by County Commissioners to represent the concerns of health care consumers, providers and purchasers.

The Health Council of West Central Florida, Inc. (HCWCF) serves Hardee, Highlands, Hillsborough, Manatee and Polk counties The Suncoast Health Council, Inc. (SHC) serves Pasco and Pinellas counties. The two councils share staff to optimize resources and to coordinate services across planning districts. Working together as The Health Councils, Inc. "we make health care better" for area residents. Collaboration and cooperation are critical to the success of our mission.

We have three strategic goals: (1) support the accessibility of health care and social support systems through *comprehensive health planning*; (2) obtain and provide *education* about essential community health challenges and solutions; and (3) participate as collaborative partners to address current and emerging health issues to develop and sustain efficient and cost effective *service delivery* systems.

To Learn More About the Health Council

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WEST CENTRAL FLORIDA RYAN WHITE CARE COUNCIL

Mission Statement

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

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I. BACKGROUND

The Ryan White Care Council conducts an annual needs assessment for the purpose of gathering service need data. The results are utilized in conjunction with other information to prioritize and allocate Ryan White funding throughout an eight-county service area. Covered counties include Hardee, Hernando, Highlands, Hillsborough, Manatee, Pasco, Pinellas and Polk.

The needs assessment is a three-year process and consists of multiple components updated at periodic intervals. The following components were utilized in the FY2013 assessment and the year the component was completed is noted in parentheses:

- Client Survey (2013)
- Epidemiologic Profile (2013)
- Funding Stream Analysis (2013)
- Resource Analysis (2010)
- Unmet Need Estimate (2012)
- Early Identification of Individuals with HIV/AIDS (2013)

II. METHODOLOGY

The needs assessment utilized a variety of techniques to gather information from relevant sources. The specific methodology for each component of the process completed during the last three years is explained below.

A. Client Survey (2013)

PLWH/A residing throughout the Care Council's total service area (TSA) were surveyed. A total of 1,154 surveys were returned. With the use of online data collection software, all surveys can be used for each question that was answered. The 2004 Client Survey consisted of 901 usable responses, the 2007 client survey consisted of 1,747 useable surveys and the 2010 survey consisted of 2,199 responses.

The 2013 questionnaire was developed by the State of Florida Department of Health HIV/AIDS and Hepatitis Section in conjunction with the Patient Care Planning Group for Part B consortias. The survey was required for all Part B consortia areas, but since our local area is a combined Part A planning body and Part B consortia, one survey was used for the purposes of both. Now a single survey could be used locally for both Part A and B without creating survey fatigue for clients.

The survey was intended to provide quantitative (measurable) data and to assure client

input into the needs assessment process.

The instrument was composed of check boxes and fill-in-the-blank questions. The content of the questions included demographic information, participation in medical care, housing, and service needs and barriers. To facilitate the participation of Spanish-speaking people living with HIV/AIDS (PLWHA), the questionnaire was translated into Spanish and was made available at all survey sites.

A survey link was distributed through the Care Council email list and posted on the Care Council's website. In addition, the survey link was posted on the Care Council's Facebook page and on the pages of other providers. Paper surveys were distributed to a total of 17 sites selected to ensure diversity and representativeness in the sample. The sites consisted of primary care providers (public and private) and HIV/AIDS case management organizations.

The surveys were placed at locations where they were highly visible to clients, when appropriate. In some cases, confidentiality concerns led sites to find less obvious means of distributing the surveys including attaching the survey to a client file when an appointment was scheduled during the survey period. Each survey contained an introduction explaining the purpose of the survey and contact information for the Care Council. A postage paid return envelope was provided with all surveys at sites without a collection box. Key staff at several of the sites collaborated in the distribution by asking clients to complete the survey and by providing assistance with completing the survey as needed. Several agencies also distributed the survey by mailing copies with return envelopes to each client of record.

Initially, surveys were only to be available from April 1, 2013 – April 30, 2013. At the end of April, the state decided to leave the survey open another month, so the survey was available from April 1 – May 31, 2013.

Representativeness of data was monitored as surveys were returned, and attempts were made to gather more responses in areas where under sampling occurred. In spite of these efforts, there were issues with under and over sampling as described below:

The state encouraged an overall return rate of 20% of the cumulative HIV and AIDS reported cases through December 2011. Overall results indicated a sample size of 8.8%. Due to the low response rate, the survey results should not be generalized as representative of the HIV/AIDS population in the TSA. The Planning and Evaluation Committee is determining how the survey results should be used and what further attempts should be made to get a representative sample.

Demographic information of respondents including gender, race/ethnicity, age and orientation are included in Table 1.

Table 1
Demographics of Survey Respondents

Characteristic	Number	Percent
Gender		
Male	776	68%
Female	360	31%
Transgender	10	1%
Race		
White/Caucasian	626	57%
Black or African American	420	38%
Asian	2	0%
American Indian/Alaska Native	6	1%
Native Hawaiian/Pacific Islander	0	0%
Mixed/More Than One Race	51	5%
Ethnicity		
Hispanic/Latino	199	19%
Non-Hispanic/Latino	829	80%
Haitian	9	1%
Age		
Under 12	2	0%
13-24 years	22	2%
25-44 years	315	28%
45-64 years	720	64%
65 years and older	64	6%
Orientation		
Straight	528	46%
Gay	506	45%
Lesbian	6	1%
Bisexual	65	6%
Men who have Sex with Men (MSM)	32	3%

B. Epidemiologic Profile (2013)

The demographics and epidemiology report was completed in 2013. As in the past, the report examined the following demographic characteristics: gender, ethnicity, county of residence, mode of transmission and age at diagnosis. Information was broken out by geographic area including Total Service Area (TSA), Eligible

Metropolitan Area (EMA) and non-EMA counties. Incidence data was provided to assess the increases and decreases in the epidemic.

Some of the findings of the report indicated that as of December 31, 2012, a total of 7,659 living AIDS cases and 5,484 living HIV cases had been reported for the TSA.

1. Race, Ethnicity and Gender (TSA)

- Overall, White males accounted for the highest percentage of reported living AIDS cases (39.1%) followed by Black males (22.5%) and Black Females (15.6%). The proportional breakdown among the living HIV (non-AIDS) cases was: White males 37.6%, Black males 22.4%, and Black females 16.1%.

- Among males, Whites accounted for the highest percentage of reported living AIDS cases (54.1%) and living HIV (non-AIDS) cases (50.9%) followed by Blacks (31.0% and 32.0%, respectively) and Hispanics (13.1% and 14.9%, respectively). Blacks are disproportionately impacted by HIV/AIDS with a rate of 1371.0 infections per 100,000 population compared to Hispanics at 401.6 and Whites at 394.4.

- Among females, Blacks accounted for 56.4% of reported living AIDS cases and 55.1% of living HIV (non-AIDS) cases. Whites accounted for 26.0% of AIDS cases and 28.4% of HIV (non-AIDS) cases followed by Hispanics (15.5% and 14.1%, respectively). Blacks are disproportionately impacted by HIV/AIDS with a rate of 897.0 infections per 100,000 population compared to Hispanics at 177.0 and Whites at 76.8.

2. Mode of Transmission and Gender (TSA)

- Among males, MSM transmission accounted for the largest percentage of reported AIDS and HIV (non-AIDS) cases (65.5% and 74.7%, respectively) followed by heterosexual transmission for AIDS (16.9%) and HIV (non-AIDS) at 13.6%. Injection Drug Use (IDU) ranked third for AIDS cases (9.5%) and HIV (non-AIDS) at 5.8%.

- For female AIDS and HIV (non-AIDS) cases, heterosexual transmission ranked highest (76.5% and 83.2%, respectively) followed by cases reported as IDU for AIDS (19.4%) and for HIV (non-AIDS) at 14.3%. The remaining cases for females, 4.1% and 2.5% respectively for AIDS and HIV (non-AIDS), were classified as Other Identified Risk

  Attachment 1 provides a synopsis of some additional data captured in the report.

C. Funding Stream Analysis (2013)

Another component consisted of an analysis of funding sources from federal, state and local government. All decisions relating to allocations must be viewed in the context of overall identified need as well as available resources. Services that have multiple funding sources may be less likely to require Ryan White dollars while those with little or no resources require Ryan White support.

The funding streams were analyzed by the Total Service Area (TSA), Eligible Metropolitan Area (EMA) which includes Hernando, Hillsborough, Pasco and Pinellas counties, the non-EMA counties (Hardee, Highlands, Manatee and Polk counties) and by county. However, the most accurate assessment was at the TSA level.

Medicaid is the largest funding source for all services in the Total Service Area (TSA), accounting for 60.9% of total funding. The AIDS Drug Assistance Program (ADAP) represents 16.6% of the total service area expenditures, while Ryan White Part A accounts for another 9.4% of funds received in the area. Housing Opportunities for Persons with AIDS (HOPWA) contracted allocations totals 4.1% of the funding.

General Revenue (GR) (both County Health Department and Network) accounts for 1.5% of the funds. Ryan White Part B represents 1.8% of PLWH/A funds received in the area. Ryan White Part C and Ryan White Part D each represent approximately 1% of total area funding. The AIDS Insurance Continuation Program (AICP) funds represent 0.8% of funds received. Combined county governments (Hillsborough, Manatee, and Pinellas) also represent 0.6% of the funds.

The services with the greatest expenditures included AIDS Pharmaceutical Assistance (41.8%), outpatient/ambulatory care (19.1%), AIDS Drug Assistance Program (19.0%), housing assistance (4.4%), medical case management (3.0%), and non-medical case management (2.5%).

D. Resource Analysis (2010)

Another component of the needs assessment was an analysis of the resources available in the TSA. The purpose of this analysis was to obtain information to help identify services within the continuum of care that may be unable to meet current needs, services that may not exist in certain geographic areas, and services where the number of providers is inadequate or exceeds the need.

The focus of the 2010 analysis was to obtain information on each of the Health Resources and Services Administration (HRSA) service categories. The geographical scope included all eight counties in the TSA.

The rural counties generally had minimal to non-existent public transportation. The large land areas and low population densities of many of these counties make travel to service providers problematic for some clients. The urban counties have bus service, but depending upon where a client lives, it can take several hours to reach a service provider located along a bus line. In addition, crossing county lines for service not readily available in the county of residence can also be problematic.

All counties had at least some services that were available in other languages, primarily Spanish, and all providers can access the state TDD assistance for the speaking and hearing impaired. Creole was available for some services in areas with concentrations of Haitian populations.

Waiting lists were not indicated for most services, however public housing across all counties indicated waiting lists that are often in excess of one year. The lack of a waiting list should not necessarily be interpreted to mean a service is readily available. Some providers simply do not maintain waiting lists, and access to service may be dependent upon having an acceptable payer source, or in the case of inpatient substance abuse treatment, an available bed.

Most areas also had some services provided after traditional hours (Monday-Friday 8 a.m. to 5 p.m.). Services most likely to have non-traditional hours included ambulatory/outpatient care, case management, counseling and support groups, substance abuse treatment, emergency shelters and food banks.

E. Unmet Need Estimate (2012)

Unmet need estimates must be considered when making allocations to services that would be initial points of entry for new clients accessing care. These data are generated from the enhanced HIV/AIDS Reporting System (eHARS) database and the out of state (OOS) database. The OOS database contains those cases reported out of state but living and in care in Florida. The combination of these two databases provides a more complete picture of the epidemic of living HIV/AIDS cases in need of care in Florida, than by just using eHARS data alone. This process of excluding cases known to be living outside of Florida and including cases reported outside of Florida but obtaining care in Florida provides a more complete picture of those cases in need of care in Florida as well as addressing the in-migration and out-migration of cases in Florida. Note that total

number of HIV and AIDS cases will not reflect the same numbers reported in the Demographics and Epidemiology report since the OOS database is not used in generating the case numbers for that data set.

Due to the sheer volume of these OOS (Out of State) 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 underreported. The 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.

TAMPA-ST. PETERSBURG TSA
UNMET NEED FRAMEWORK TABLE

Population Sizes		**Value**		**Data Source(s)**
Row A.	Number of persons living with AIDS (PLWA), aware for the period of 01/01/2011 - 12/31/2011	8,052		eHARS[1] and OOS[2] data sets plus matches with ADAP[3], Medicaid, HMS[4], CAREWare[5], and Labs[6].
Row B.	Number of persons living with HIV (PLWH)/non-AIDS/aware, for the period of 01/01/2011 - 12/31/2011	6,038		
Row C.	Total number of HIV+ aware, for the period of 01/01/2011 - 12/31/2011	14,090		
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	5,835	72%	eHARS[1] and OOS[2] data sets and matches with ADAP[3], Medicaid, HMS[4], CAREWare[5], and Labs[6].
Row E.	Number of PLWH/non-AIDS/aware who ***did*** receive the specified HIV primary medical care services in 12-month period	3,726	54%	
Row F.	Total number of HIV+/aware who ***did*** receive the specified HIV primary medical care services in 12-month period	9,111	65%	
Calculated Results		**Value**	**Percent**	**Calculation**
Row G.	Number of PLWA who ***did NOT*** receive primary medical services	2,217	28%	Value: Value A - Value D. Percent: Value G/Value A.
Row H.	Number of PLWH/non-AIDS/aware who ***did NOT*** receive primary medical services	2,762	46%	Value: Value B - Value E. Percent: Value H/Value B.
Row I.	Total HIV+/aware who ***did NOT*** receive specified primary medical	4,979	35%	Value: Value G + Value H.

	care services (quantified estimate of unmet need)			Percent: Value I/Value C

[1] The eHARS (enhanced HIV/AIDS Data Reporting System) provided estimates of the number of infected individuals and proportions of HIV (non AIDS) and AIDS cases for the TSA.
[2] An out of state (OOS) database tracks cases reported from other states, but in care in specific Florida counties.
[3] The ADAP (AIDS Drug Assistance Program) was used to determine individuals receiving anti-retroviral treatment.
[4] HMS is the local county health departments' database.
[5] CAREWare is an HIV/AIDS patient care data set.
[6] Paper labs and the electronic lab database have yet to be imported into eHARS so matches must be made manually.

Rows A, B and C of the Unmet Need Framework Table provide populations estimates. Florida has had HIV reporting since July 1, 1997. The eHARS data are specifically tailored to each EMA and consortia. Data from 2011 was used to determine the number of people reported as living with HIV (non-AIDS) and the number of people reported with AIDS. It is estimated that 8,052 people are living with AIDS and 6,038 people are living with HIV in the Total Service Area (TSA).

Rows D, E and F of the Unmet Need Framework Table provide estimates of numbers of people in care according to the HRSA definition (received HIV primary medical care as evidenced by one of the following in a defined 12-month time frame: viral load testing, CD4 count and/or the provision of anti-retroviral therapy). It is estimated that 9,111 HIV/AIDS cases are in care in the TSA.

Rows G, H and I of the Unmet Need Framework Table provide estimates of unmet need. Number in-care is subtracted from living HIV and AIDS cases to obtain the number and percent not in care according to the HRSA definition. It is estimated that 4,979 people are living with HIV/AIDS in the TSA and are not in care.

F. Early Identification of Individuals with HIV/AIDS (EIIHA) (2013)

To ensure consistency throughout the state, the EMA will continue to implement the 2012-2014 Florida Jurisdictional HIV Prevention Plan. Because of this, the target populations remain: MSM Youth age 18-24, MSM Substance Abusers, White MSM age 18-40, Black MSM age 18-40, Black Women of Childbearing Age, Black Heterosexual Men age 13-24, Black Heterosexual Men age 24-65, Black Substance Abusers, Hispanic Heterosexual Men age 13-24, Hispanic Heterosexual Men age 24-65, Hispanic Substance Abusers, and Hispanic Women of Childbearing Age. The EIIHA Plan will focus on a subset of these populations: White MSM 18-40, Black MSM 18-40, and Black Women of Childbearing age (15-44).

Early intervention programs offering HIV counseling and testing have been a priority within the EMA for several years, recently implementing initiatives to ensure that every

resident in the EMA and in Florida has access to HIV testing services. However, more programs are needed to guarantee universal access throughout Florida and ensure the early identification of individuals living with HIV/AIDS.

The local partnerships have a rich history of collaborating on HIV prevention, care, and treatment issues throughout the EMA. This tradition will continue as the local networks implement a plan to incorporate HIV Early Intervention Services (EIS) with a goal of ensuring 100% of HIV+ clients are linked to services with the local Ryan White programs. Bi-monthly meetings between the Grantee and the local DOH HIV/AIDS Administrators occur to ensure optimal service delivery using limited federal, state, and local resources. Included in the agenda are discussions on linking HIV care and prevention services. Meetings focus on service coordination between Ryan White Part A and B (ADAP and Patient Care) programs and ways to maximize funding as well as planning program integration (HIV, STD, TB, Hepatitis) within the EMA.

As stated with the 2013 EIIHA plan, the following objectives are used to evaluate the progress made on the EIS activities: (1) integration of EIS in all HIV prevention services; (2) outreach and recruitment to HIV testing services; (3) 95% post-test counseling for HIV positive tests; (4) case finding and identification of clients; (5) develop a tracking method for HIV infected individuals from HIV testing to primary care providers; and (6) enhancement of referral linkages into primary care programs that link back with HIV testing services. To date, goals one through five have been met and progress has been seen on goal six, which remains in the planning stages.

The Planning Council has incorporated a local HIV prevention perspective by utilizing the "other federal HIV programs" seat specifically for HIV prevention services. The Planning Council has an HIV prevention update as a standing agenda item at every Planning Council meeting. This ensures that monthly updates on early intervention services are occurring, but also allows for ongoing enhancement and collaboration.

The Grantee has incorporated the EIIHA strategy into the local Requests for Proposals document by giving additional consideration and weight to those bidders who demonstrate viable descriptions and narrative which requires them to explain how they will further expand, integrate, and link their patient care activities with counseling and testing. The Grantee specifically references EIIHA and the importance of this objective in the bidder's pre-conference to ensure the understanding of the objective and the expected outcome.

III. Service Priority Recommendations

Since the Care Council is a committee-driven structure, the Planning and Evaluation

Committee was responsible for overseeing the completion of the needs assessment elements. Each element was reviewed, in conjunction with the comprehensive plan, unmet need estimates and emerging issues in the EMA. The limitations and strengths of each element were discussed.

A matrix was developed listing each HRSA service category in the previous year ranking, the service utilization from the surveys, expenditures and allocations to this service category across public funding streams and estimates of unmet need (see Attachment 3). The committee then discussed the implications of the service rankings, availability of other funding sources to support services, waiting list and unmet need data to further refine the priority recommendations.

1. Outpatient/Ambulatory Medical Care
2. AIDS Pharmaceutical Assistance
3. Medical Case Management
4. Health Insurance Premium and Cost Sharing Assistance
5. Oral Health Care
6. Mental Health Services
7. Substance Abuse Services - outpatient
8. Medical Nutrition Therapy
9. Early Intervention Services
10. Home Health Care
11. Hospice Services
12. Home and Community Based Health Services
13. Emergency Financial Assistance
14. Housing Services
15. Food Bank/Home Delivered Meals
16. Medical Transportation
17. Case Management (non-medical)
18. Health Education/Risk Reduction
19. Treatment Adherence Counseling
20. Outreach Services
21. Psychosocial Support
22. Rehabilitation Services
23. Linguistic Services
24. Respite Care
25. Child Care Services
26. Legal Services
27. Substance Abuse Services- residential
28. Referral Services

Mandated Services – HRSA requires that these administrative services be in place to support the local planning effort and to ensure the highest quality services for

clients.

- Quality Management

ATTACHMENT 1
Epidemiology Fact Sheet: As of December 31, 2012

Proportions of the TSA's PLWA Population by County (through 2012)

County	County Totals	Male	Female	White	Black	Hispanic
Hardee	0.5%	0.3%	0.2%	0.1%	0.2%	0.2%
Hernando	1.3%	0.9%	0.4%	0.8%	0.2%	0.2%
Highlands	1.4%	0.9%	0.4%	0.4%	0.6%	0.4%
Hillsborough	44.0%	31.7%	12.3%	16.9%	18.9%	7.4%
Manatee	6.7%	4.7%	2.0%	2.7%	2.8%	1.1%
Pasco	5.2%	3.8%	1.4%	3.8%	0.7%	0.6%
Pinellas	27.2%	21.4%	5.8%	16.5%	8.1%	2.1%
Polk	13.7%	8.7%	5.1%	5.1%	6.7%	1.7%
TOTAL	100%	72.4%	27.6%	46.3%	38.1%	13.7%

Proportions of the TSA's PLWH Populations by County (through 2012)

County	County Totals	Male	Female	White	Black	Hispanic
Hardee	0.4%	0.2%	0.2%	0.1%	0.2%	0.1%
Hernando	1.5%	1.1%	0.4%	1.0%	0.2%	0.3%
Highlands	1.3%	0.6%	0.7%	0.3%	0.7%	0.2%
Hillsborough	46.4%	32.8%	13.5%	17.6%	19.6%	8.3%
Manatee	6.6%	3.8%	2.7%	2.7%	2.9%	0.9%
Pasco	5.1%	3.7%	1.4%	3.6%	0.7%	0.7%
Pinellas	27.1%	20.1%	6.9%	14.9%	9.4%	2.0%
Polk	11.7%	7.2%	4.4%	4.0%	5.4%	2.0%
TOTAL	100%	69.6%	30.4%	44.1%	39.1%	14.7%

TSA Living HIV (non-AIDS) and AIDS Prevalence by Gender, Race/Ethnicity, Age and Mode of Transmission (through 2012)

TSA Prevalence	Group (gen. pop. #)	Number		Rate per 100,000		Percentage		Total HIV/AIDS		
		AIDS	HIV	AIDS	HIV	AIDS	HIV	#	%	rate
Gender	**Male (1,886,486)**	**5,543**	**3,817**	**293.8**	**202.3**	**72.4%**	**69.6%**	**9,360**	**71.2%**	**496.2**
	Female (1,995,405)	**2,116**	**1,667**	**106.0**	**83.5**	**27.6%**	**30.4%**	**3,783**	**28.8%**	**189.6**
	Total (3,881,891)	***7,659***	***5,484***	***197.3***	***141.3***	***100%***	***100%***	***13,143***	***100%***	***338.6***
Race/ Ethnicity	**White (2,587,220)**	**3,547**	**2,417**	**137.1**	**93.4**	**46.3%**	**44.0%**	**5,964**	**45.4%**	**230.5**
	Black (450,587)	**2,917**	**2,144**	**647.4**	**475.8**	**38.1%**	**39.1%**	**5,061**	**38.5%**	**1123.2**
	Hispanic (639,412)	**1,051**	**804**	**164.4**	**125.7**	**13.7%**	**14.7%**	**1,855**	**14.1%**	**290.1**
	Other/Unk. (204,672)*	**144**	**119**	**70.4**	**58.1**	**1.9%**	**2.2%**	**263**	**2.0%**	**128.5**
	Total (3,881,891)	***7,659***	***5,484***	***197.3***	***141.3***	***100%***	***100%***	***13,143***	***100%***	***338.6***
Age	**0-12 (588,661)**	**8**	**23**	**1.4**	**3.9**	**0.1%**	**0.4%**	**31**	**0.2%**	**5.3**
	13-19 (331,563)	**46**	**62**	**13.4**	**18.7**	**0.6%**	**1.1%**	**108**	**0.8%**	**32.6**
	20-24 (236,691)	**148**	**287**	**62.5**	**121.3**	**1.9%**	**5.2%**	**435**	**3.3%**	**183.8**
	25-29 (234,550)	**223**	**492**	**95.1**	**209.8**	**2.9%**	**9.0%**	**715**	**5.4%**	**304.8**
	30-39 (460,160)	**1,009**	**1,177**	**219.3**	**255.8**	**13.2%**	**21.5%**	**2,186**	**16.6%**	**475.1**
	40-49 (512,005)	**2,617**	**1,623**	**511.2**	**317.0**	**34.2%**	**29.6%**	**4,240**	**32.3%**	**828.1**
	50-59 (540,755)	**2,580**	**1,253**	**477.1**	**231.7**	**33.7%**	**22.9%**	**3,833**	**29.3%**	**708.8**
	60+ (977,502)	**1028**	**567**	**105.2**	**58.0**	**13.4%**	**10.3%**	**1,595**	**12.1%**	**163.2**
	Total (3,881,887)	***7,659***	***5,484***	***197.3***	***141.3***	***100%***	***100%***	***13,143***	***100%***	***338.6***
Mode of Transmission	**MSM**	**3,632**	**2,853**			**47.4%**	**52.0%**	**6,485**	**49.3%**	
	IDU	**936**	**460**			**12.2%**	**8.4%**	**1,396**	**10.6%**	
	MSM/IDU	**386**	**179**			**5.0%**	**3.3%**	**565**	**4.3%**	
	Hetero	**2,555**	**1,908**			**33.4%**	**34.8%**	**4,463**	**34.0%**	
	Other	**150**	**84**			**2.0%**	**1.5%**	**234**	**1.8%**	
	Total	***7,659***	***5,484***			***100%***	***100%***	***13,143***	***100%***	

Caution should be used when relying on rate per 100,000 data when the population size is less than 100,000

Living TSA AIDS and HIV (non-AIDS) Cases and Rates per 100, 000 of Population by Gender and Race/Ethnicity (through 2012)

	TSA AIDS				TSA HIV (non-AIDS)				TSA HIV/AIDS			
Group (% of pop)	# of cases	Rate per 100,000	% cases in TSA	% cases by gender	# of cases	Rate per 100,000	% cases in TSA	% cases by gender	# of cases	Rate per 100,000	% cases in TSA	% cases by gender
MALES												
White	2,996	239.3	39.1%	54.1%	1,943	155.2	35.4%	50.9%	4,939	394.4	37.6%	52.8%
Black	1,723	801.3	22.5%	31.0%	1,225	569.7	22.3%	32.1%	2,948	1,371.0	22.4%	31.5%
Hispanic	724	224.9	9.5%	13.1%	569	176.7	10.4%	14.9%	1,293	401.6	9.8%	13.8%
Other/Unk.	100	102.8	1.3%	1.8%	80	82.2	1.5%	2.1%	180	185.0	1.4%	1.9%
Total	5,543	293.8	72.4%	100%	3,817	202.3	69.6%	100%	9,360	496.2	71.2%	100%
FEMALES												
White	551	41.3	7.2%	26.0%	474	35.5	8.6%	28.4%	1,025	76.8	7.8%	27.1%
Black	1,194	506.9	15.6%	56.4%	919	390.1	16.8%	55.1%	2,113	897.0	16.1%	55.9%
Hispanic	327	103.0	4.3%	15.5%	235	74.0	4.3%	14.1%	562	177.0	4.3%	14.9%
Other/Unk.*	44	41.0	0.6%	2.1%	39	36.3	0.7%	2.3%	83	77.3	0.6%	2.2%
Total	2,116	106.0	27.6%	100%	1,667	83.5	30.4%	100%	3,783	189.6	28.8%	100%
TSA Total	7,659				5,484				13,143			

***** Caution should be used when relying on rate per 100,000 data when the population size is less than 100,000.

TSA HIV/AIDS Cases by Current Expanded Age (through 2012)

	TSA AIDS			TSA HIV(non-AIDS)			TSA HIV/AIDS		
Age Group	# of cases	Rate per 100,000	% cases in TSA	# of cases	Rate per 100,000	% cases in TSA	# of cases	Rate per 100,000	% cases in TSA
0-12	8	1.4	0.1%	23	3.9	0.4%	31	5.3	0.2%
13-19	46	13.9	0.6%	62	18.7	1.1%	108	32.6	0.8%
20-24	148	62.5	1.9%	287	121.3	5.2%	435	183.8	3.3%
25-29	223	95.1	2.9%	492	209.8	9.0%	715	304.8	5.5%
30-39	1,009	219.3	13.2%	1,177	255.8	21.5%	2,186	475.1	16.6%
40-49	2,617	511.1	34.2%	1,623	317.0	29.6%	4,240	828.1	32.3%
50-59	2,580	477.1	33.7%	1,253	231.7	22.8%	3,833	708.8	29.2%
60+	1028	105.2	13.4%	567	58.0	10.3%	1,595	163.2	12.1%
Total	7,659	197.3	100%	5,484	141.3	100%	13,143	338.6	100%

TSA HIV/AIDS Cases by Mode of Transmission and Gender (through 2012)

	TSA AIDS			TSA HIV(non-AIDS)			TSA HIV/AIDS		
Group	# of cases	% cases in TSA	% cases by gender	# of cases	% cases in TSA	% cases by gender	# of cases	% cases in TSA	% cases by gender
MALES									
MSM	3,632	47.4%	65.5%	2,853	52.0%	74.7%	6,485	49.3%	69.3%
IDU	526	6.9%	9.5%	222	4.0%	5.8%	748	5.7%	8.0%
MSM/IDU	386	5.0%	7.0%	179	3.3%	4.7%	565	4.3%	6.0%
Heterosexual	936	12.2%	16.9%	521	9.5%	13.6%	1,457	11.1%	15.6%
Other	63	0.8%	1.1%	42	0.8%	1.1%	105	0.8%	1.1%
Total	5,543	72.4%	100%	3,817	69.6%	100%	9,360	71.2%	100%
FEMALES									
IDU	410	5.4%	19.4%	238	4.3%	14.3%	648	5.0%	17.1%
Heterosexual	1,619	21.1%	76.5%	1,387	25.3%	83.2%	3,006	22.9%	79.5%
Other	87	1.1%	4.1%	42	0.8%	2.5%	129	0.1%	3.4%
Total	2,116	27.6%	100%	1,667	30.4%	100%	3,783	28.8%	100%
TSA Total	7,659			5,484			13,143		

ATTACHMENT 2
Ryan White Program Services Definitions

CORE SERVICES

Service categories:

a. ***Outpatient/Ambulatory medical care*** *(health services)* is the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting. Settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not outpatient settings. Services include 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. NOTE: Early Intervention Services provided by Ryan White Part C and Part D Programs should be included here under *Outpatient/ Ambulatory medical care*.

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

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

d. ***Oral health care*** includes diagnostic, preventive, and therapeutic services provided by general dental practitioners, dental specialists, dental hygienists and auxiliaries, and other trained primary care providers.

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

NOTE: EIS provided by Ryan White Part C and Part D Programs should NOT be reported here. Part C and Part D EIS should be included under *Outpatient/ Ambulatory medical care*.

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

g. ***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.

h. ***Home and Community-based Health Services*** include 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.

i. ***Hospice services*** include room, board, nursing care, counseling, physician services, and palliative therapeutics provided to clients in the terminal stages of illness in a residential setting, including a non-acute-care section of a hospital that has been designated and staffed to provide hospice services for terminal clients.

j. ***Mental health services*** are 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.

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

l. ***Medical Case management services (including treatment adherence)*** are 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.

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

SUPPORT SERVICES

n. Case Management (non-Medical) 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.

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

NOTE: This does not include child care while a client is at work.

p. *Pediatric developmental assessment and early intervention services* are the provision of professional early interventions by physicians, developmental psychologists, educators, and others in the psychosocial and intellectual development of infants and children. These services involve the assessment of an infant's or child's developmental status and needs in relation to the involvement with the education system, including early assessment of educational intervention services. It includes comprehensive assessment of infants and children, taking into account the effects of chronic conditions associated with HIV, drug exposure, and other factors. Provision of information about access to Head Start services, appropriate educational settings for HIV-affected clients, and education/assistance to schools should also be reported in this category.

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

NOTE: Part A and Part B programs must be allocated, tracked and report these funds under specific service categories as described under 2.6 in DSS Program Policy Guidance No. 2 (formally Policy No. 97-02).

r. *Food bank/home-delivered meals* include the 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.

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

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

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

v. *Linguistics services* include the provision of interpretation and translation services.

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

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

y. *Permanency planning* is the provision of services to help clients or families make decisions about placement and care of minor children after the parents/caregivers are deceased or are no longer able to care for them.

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

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

ab. *Rehabilitation services* are 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.

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

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

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

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