FY 2012- 2015 RYAN WHITE COMPREHENSIVE HIV/AIDS SERVICES PLAN

Prepared by

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Adopted

May 2, 2012

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Robert Marlowe, SHC Chair
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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) influence the accessibility of health care and social support systems through *comprehensive health planning*; (2) provide *education* about essential community health challenges and solutions; and (3) participate as a collaborative partner to address current and emerging health issues to develop and sustain efficient and cost effective *service delivery* systems.

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

INTRODUCTION

The comprehensive plan guides the actions of the West Central Florida Ryan White Care Council and area partners during the years 20012-2015 as they strive to maintain and improve services for people living with HIV/AIDS so that they enter and stay in care.

Planning has always been a central focus of the Ryan White legislation, and a critical part of Part A and B programs. Since the inception of the Comprehensive AIDS Resources Emergency (CARE) Act now known as the Ryan White Treatment Modernization Act, planning councils have been establishing service and resource allocation priorities, and goals and objectives for each grant year. However, comprehensive HIV services planning goes beyond annual service or resource allocation. Comprehensive planning should result in a road map for incremental development of a system of care over the longer term.

The purpose of comprehensive planning is to help the Care Council and its committees make better decisions about services for People Living With HIV/AIDS (PLWH/A) and how to develop and maintain a continuum of care. A comprehensive plan examines HIV care needs for the entire community and assesses all available resources and barriers. Comprehensive planning builds upon epidemiologic and needs assessment information. Most important, the comprehensive plan sets out long-term goals by outlining the values and vision that will guide the community's system of care. Comprehensive planning helps to answer four basic questions.

1) Where are we now?
2) Where are we going?
3) How will we get there?
4) How will we monitor our progress?

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

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

The Care Council has incorporated the structure of the planning council, which is required by the Health Resources and Services Administration (HRSA), with the critical role of the consortium in networking and planning for actual service delivery. Care Council by-laws allow for a maximum of 40 voting members.

The goal of streamlining coordination while maintaining effective and efficient quality services is an ongoing process. The utilization of funds in a manner that will best meet the real needs of the HIV/AIDS affected in our Total Service Area (TSA) is the greatest challenge. The Care Council's committee structure was designed to meet the challenge.

Nine committees address specific issues and provide an opportunity for input from consumers, providers and interested individuals. Committees include: Client Services; Health Services Advisory; Membership, Nominations, Recruitment and Training; Minority Advocacy; Planning and Evaluation (P&E); Resource Prioritization and Allocation Recommendations (RPARC); Rural Issues; Standards, Issues and Operations (SIOC); and Women, Infants, Children, Youth and Families (WICYF)

Committees are open to any interested person and are co-chaired by a member of the Care Council. Each member of the Care Council must be an active member of at least one committee. Each committee is also encouraged to have a consumer as one of the co-chairs.

The four mandated duties, conducting a needs assessment, prioritizing the needs identified, developing a comprehensive plan for the delivery of services and assessing the administrative efficiency, are each assigned to a designated committee. Supporting committees including Client Services, Minority Advocacy, Rural Issues, and Women, Infants, Children, Youth and Families are intended to bring the issues and ideas of the disproportionately affected and hard to reach communities and populations into the planning and decision-making process. The Health Services Advisory Committee provides expertise on issues related to primary care, dental, medications, new treatments, adherence, and other clinical issues related to the maintenance and improvement of health.

In order for the Care Council to be successful in accomplishing its goals, there must be coordination between the committees. Adequate representation of all committees in all aspects of the planning and decision making process is imperative. The Care Council continues to strive for excellence in its pursuit of community involvement, meeting the needs of People Living with HIV/AIDS (PLWH/A), and in the provision of quality service.

Part A, Part B, Part C, Part D and the AETC are represented on the Care Council and its nine committees ensuring coordination of efforts and sharing of information. The Grantee/Lead Agency for Parts A and B also administers some Housing Opportunities for People with AIDS (HOPWA) funds and state general revenue funds dedicated to HIV care and treatment. A representative of the Grantee/Lead Agency attends Care Council and committee meetings. The Care Council also has a designated representative for the statewide advisory group on patient care and several members participate in the Community Prevention Planning (CPP) process, in order to facilitate coordination and integration of HIV prevention and early intervention efforts in the local continuum of care.

EXECUTIVE SUMMARY

The 2012-2015 Comprehensive HIV/AIDS Services Plan developed for the Tampa – St. Petersburg Eligible Metropolitan Area (EMA) and consortia area (combined into our TSA – Total Service Area) is the result of an open community planning process. This plan represents the efforts of many people working together to improve the medical care and support services available to people living with HIV. Input from a wide range of perspectives including members of the planning council, affiliated and unaffiliated consumers, HIV service providers, representatives of community-based organizations and other stakeholders shaped the elements within the plan.

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

The combined Total Service Area (TSA) covers 6,836 square miles with an estimated population of 3,764,210 which includes 20% of the state's population. The racial composition of the area is 69% White, 12% Black and 16% Hispanic. An estimated 17,648 individuals are homeless, 14.1% live in poverty and 22.1% are uninsured. All eight counties comprising the TSA are designated as health professional shortage areas (HPSA) and medically underserved areas/medically underserved populations areas (MUA/MUP).

As of December 31, 2010, there were an estimated 7,335 persons living with AIDS and another 5,466 individuals living with HIV, for a total of 12,801 living with HIV infection in the eight county service area. This represents a TSA-wide HIV infection prevalence of 340.1 per 100,000 persons. Infections among Whites account for 45.8% of those infected, 38.5% are Black and 13.9% are Hispanic. The data shows a disproportionate impact on minority populations. Blacks are infected with HIV/AIDS at a rate of 1,090 of every 100,000 and 296 of every 100,000 Hispanics are infected compared to 225 of every 100,000 Whites.
The number of new reported cases (incidence) of HIV (regardless of AIDS) is 781, which represents a rate of 20.7 per 100,000 total population. The number of new AIDS cases (incidence) reported in 2010 is 474.

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

The two largest providers of ambulatory outpatient care report that 80%-85% of their case load requires level two or three care. Level two is HIV disease (possibly Centers for Disease Control - CDC defined AIDS) with co-morbid conditions requiring healthcare visits every six to eight weeks. Level three is defined as advanced HIV disease, CDC defined AIDS, with co-morbid conditions requiring healthcare visits on average every four weeks with phone triage management every one-two weeks. Clinical care providers express a severe need for the expertise of specialist consultation due to the complexity of many of the co-morbid conditions within the PLWH/A population.

Multiple data sources (including the National HIV/AIDS Strategy, Healthy People 2020, EIIHA and health care reform legislation) were reviewed and summarized to provide information for developing goals and objectives that ensure a high quality continuum of care for people living with HIV and AIDS in the TSA. The 2012-2015 Comprehensive HIV/AIDS Services Plan will serve as a living document to guide our planning for an effective continuum of care in an environment of diminishing resources and increasing need. The Plan serves as our road map to bring and retain high-need populations into care and to improve the quality and efficiency of the current service delivery system.

Full execution of the Patient Protection and Affordable Care Act, Florida's proposed statewide Medicaid Reform package, the Florida Department of Health's expected re-organization, long-term economic recovery of both the nation and Florida, and uncertainty of the future of the Ryan White Act's reauthorization will all factor into the landscape of patient care services in our local area. Our plan remains as fluid as possible to accommodate changes while maintaining a commitment to HIV/AIDS services.

SECTION 1: WHERE ARE WE NOW?

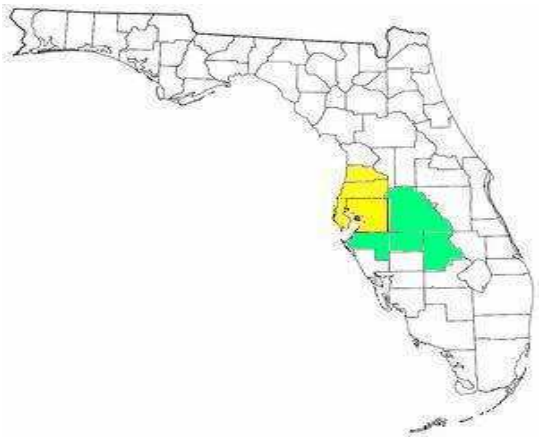
CHAPTER 1:
DESCRIPTION OF SERVICE AREA

Geography

The Total Service Area (TSA) of the West Central Florida Ryan White Care Council includes eight counties, that can be divided into the Eligible Metropolitan Area (EMA) and the non-eligible metropolitan area counties (non-EMA). The EMA receives funds under Part A while all counties in the TSA can access Part B funds.

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

The total service area comprises 6,836 square miles with individual county size ranging from 280 square miles to 1,875 square miles. Population densities in the area range from a low of 44 persons per square mile in Hardee County to 3,353 persons per square mile in Pinellas County, the most densely populated county in the state of Florida.



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

County	Square Miles	Population Density (persons per square mile)		County	Square Miles	Population Density (persons per square mile)
Hardee	637	44		Hernando	478	345
Highlands	1,028	97		Hillsborough	1,051	1,142
Manatee	741	429		Pasco	745	589
Polk	1,875	312		Pinellas	280	3,353
Total Non-EMA	4,281	241		Total EMA	2,554	1074
Total Service Area	6,835	552		Florida	53,926	349

Source: Florida Statistical Abstract, 2009

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

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

Demographic Composition

The following tables describe gender and race/ethnicity of the general population of each county in the TSA. Overall, the population is predominately White. While representing 12% of the total TSA population, Blacks range from a low of 3% in Pasco County to a high of 17% in Hillsborough County. Hispanics, who can be of any race, range from a low of 8% in Pinellas County to a high of 42% in Hardee County and represent 16% of the total TSA population. Females average 51% of the population throughout the TSA, with a low of 46% in Hardee County and a high of 52% in Pinellas County and Hernando County.

County	Non-Hispanic White		Non-Hispanic Black		Hispanics		Others		County Totals	
Hardee	13,406	47%	2,598	9%	11,851	42%	427	2%	28,282	100%
Hernando	140,959	85%	7,846	5%	14,535	9%	2,418	1%	165,758	100%
Highlands	71,701	72%	9,297	9%	16,897	17%	1,930	2%	99,825	100%
Hillsborough	665,565	55%	203,168	17%	285,843	24%	46,178	4%	1,200,754	100%
Manatee	234,748	74%	28,188	9%	50,238	16%	5,526	2%	318,700	100%
Pasco	369,927	84%	14,421	3%	45,453	10%	10,815	2%	440,616	100%
Pinellas	718,652	78%	101,221	11%	73,925	8%	32,419	4%	926,217	100%
Polk	386,947	66%	85,008	15%	100,378	17%	11,725	2%	584,058	100%
Total	2,601,905	69%	451,747	12%	599,120	16%	111,438	3%	3,764,210	100%

County	Total Males		Total Females		County Totals	
Hardee	15,367	54%	12,915	46%	28,282	100%
Hernando	79,613	48%	86,145	52%	165,758	100%
Highlands	48,462	49%	51,363	51%	99,825	100%
Hillsborough	588,066	49%	612,688	51%	1,200,754	100%
Manatee	155,753	49%	162,947	51%	318,700	100%
Pasco	214,504	49%	226,112	51%	440,616	100%
Pinellas	448,829	48%	477,388	52%	926,217	100%
Polk	287,852	49%	296,206	51%	584,058	100%
Total	1,838,446	49%	1,925,764	51%	3,764,210	100%

Source: Florida CHARTS, 2010

Socioeconomic Status

As reported in the 2009 US Census Bureau Poverty and Median Income Estimates, the EMA has an estimated 13.7% individuals living below the federal poverty level (FPL) with Hillsborough County having the highest rate at 15.2% followed by Pinellas at 13.3%, Pasco at 13.2% and Hernando at 13.1%. When considering the non-EMA counties, 28.4% of Hardee County, 19.9% of Highlands County, 16.8% of Polk County and 14.4% of Manatee County is living below the federal poverty level. Residents receive many types of local assistance including all forms of social security, Medicaid, Temporary Assistance to needy Families, food stamps and so on.

Poverty creates a multitude of problems when treating HIV. Safe and affordable housing is in short supply in the EMA. The City of Tampa Housing and Community Development Division published their HIV/AIDS Housing Plan[1] in September 2007. Their report indicated that there are more than 5,076 persons living with HIV/AIDS that are low-income and in need of some type of housing assistance. Their survey of 515 persons living with HIV/AIDS in the Tampa area found that 85% of respondents are unstably housed. The lack of stable housing and/or utilities can adversely affect an individual's ability to participate in treatment and be adherent to complex treatment regimens. In August 2011, Hillsborough County ranked 4th and Pinellas County ranked 8th among the top 10 counties with foreclosures in Florida according to RealtyTrac. The past three years have seen a dramatic increase in the number of foreclosures across the country with Tampa – St. Petersburg ranking 25th among all US metro foreclosures for 2010/11. The EMA had 25,142 properties with foreclosure filings over the past year with an additional 8,290 foreclosures in the Non-EMA counties.

Homelessness affects individuals in the same way poverty does but to a greater extent. With no permanent address, locating clients to link them with services becomes difficult. Without proper storage and refrigeration, medications may not be as effective even when taken as prescribed. Weakened immune systems, exposure to the elements, poor nutrition, greater stress, and poor hygiene can make an individual more susceptible to a large variety of infections and illnesses, causing further decline and increasing the cost of treatment when care is finally accessed. The Florida Department of Children and Families Council on Homelessness estimates there are 56,771 persons in Florida who are homeless in its 2011 Council Report on Homeless. The same report indicates that according to their annual survey the counties represented in this EMA have an estimated 15,816 homeless individuals and the TSA has 17,648 homeless (31.1% of all of the estimated homeless persons in the State of Florida). The rate per 100,000 of homelessness among the general TSA population is 468.83 compared to the rate of homelessness among the PLWH/A population in the TSA at 792.7. The rate in the general EMA population is 578.6 compared to 4,713.2 among the PLWH/A in the EMA. Based on the methodology used to estimate the numbers of homeless individuals in this report, local homeless advocates believe the numbers of homeless are potentially 10% higher than estimated in this report.

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

Homelessness by County and Area

County	Number	Percent of FL homeless		**County**	Number	Percent of FL homeless
Hardee	104	0.2%		Hernando	196	0.3%
Highlands	105	0.2%		Hillsborough	7,336	12.9%
Manatee	528	0.9%		Pasco	4,442	7.8%
Polk	1,095	1.9%		Pinellas	3,890	6.9%
Total Non-EMA	1,832	3.2%		Total EMA	15,816	27.9%
Total Service Area	17,648	31.1%		Florida	56,771	100%

Source: Florida Department of Children and Families, 2011

According to Florida's Agency for Workforce Innovation in cooperation with the Bureau of Labor Statistics, Tampa-St. Petersburg lost thousands of jobs over the past few years and unemployment has risen from 7.2% in August 2008 to 11.6% in August 2009 to 12.6% in August 2010. It has finally begun to decrease to 11.0% in August 2011 which is still higher than the state level at 10.9% and the national level at 9.1%. Pinellas has the lowest unemployment of the TSA counties at 11.8%, followed by Hillsborough at 12.2%, Manatee at 12.7%, Highlands at 12.8%, Pasco at 13.0%, Polk at 13.1%, Hardee at 13.5% and Hernando at 14.5%. The deterioration of the economy and diminished resources has caused clients to become more transient due to the loss of jobs, homes or both. More clients are seeking short term employment, migratory work, or are relocating.

The more rural counties in the service area including Hardee, Highlands, Manatee and parts of Hillsborough rely heavily on agriculture for employment. While both Hernando and Pasco counties are also rural in nature, their dependence on agriculture for economic growth is considerably less. Hernando and Pasco counties have become bedroom communities for the Tampa-St. Petersburg area. The remaining counties have more diverse economies including tourism, manufacturing, service, retail, technologies, education, and health care industries.

Directly related to the economic base is the impact of migrant and seasonal farm workers in the rural counties. Florida provides work for residents of the state as well as attracting out-of-state migrants, as Florida's climate has jobs available during the winter season for farm workers from other parts of the country. There are an estimated 50,000 migrant workers and their families in the TSA.

The more rural and less populated counties face limitations in accessibility to services due to the lack of qualified providers for some services and the great distances that must be traveled in order to receive services. Insufficient or non-existent public transportation further complicates access even if services are available locally. Limited transportation funds can be expended quickly when great distances must be traveled. The lack of diversity in the economic base in the rural counties limits options for employment, especially for individuals

who may require adjustments or accommodations to work schedule and/or environment due to HIV.

Access to Health Care

All eight counties comprising the TSA are designated as Health Professional Shortage Areas (HPSA) and Medically Underserved Areas/Medically Underserved Populations (MUA/MUP). Lack of insurance coverage can greatly limit access to health care. According to the 2010 State Health Facts from the Kaiser Family Foundation, 22.1% of Florida's population under age 65 is uninsured. Many uninsured patients present at emergency rooms (ERs) for care. The cost of treatment in an ER is much higher than clinic care, and the care is often uncompensated. For those PLWH/A who are able to work, the threat of losing their jobs due to illness or to the side effects of medications, or discrimination once their diagnosis becomes known, is a daily reality. Many do not have the resources to maintain insurance benefits and manage co-pay and deductible requirements without assistance from programs such as the Ryan White insurance services program. The Grantee Part A services database (RWIS – Ryan White Information System) tracks client demographic and eligibility data and shows that 40% of the clients served are uninsured. Providers also note that the complexity of co-morbid conditions require the expertise of specialists and that expert consultation is either difficult or impossible to obtain since many of these patients have no health insurance. The lack of adequate health insurance and prescription coverage along with the constant concern of losing such coverage continues to threaten this at-risk population. The lack of education and growing concern that help is limited is what drives many of our clients to the emergency room, which continues to drive up the cost of medical care.

Stigma is an ongoing problem that inhibits care. Individuals experiencing high levels of stigma are over twice as likely to have less than optimal adherence to their HIV treatment and are more likely to report poor access to medical care. Stigma seems to be an even greater problem for those living in the rural parts of the service area than those residing in more urban areas.

CHAPTER 2:
EPIDEMIOLOGICAL PROFILE

Current Local Epidemic

The Florida Department of Health's 2010 Epidemiological Profile reports the number of cases in the TSA living with HIV (non-AIDS) is 5,466. The number of individuals reported as living with AIDS is 7,335. The total living cases of HIV (non-AIDS) and AIDS in the TSA are 12,801 accounting for 13.4% of HIV/AIDS cases in the state of Florida. The number of new reported cases (incidence) of HIV (regardless of AIDS) is 781, which represents a rate of 20.7 per 100,000 total population. The number of new AIDS cases (incidence) reported in 2010 is 474.

TSA Prevalence	**Group (gen. pop. #)**	**Number**		**Rate per 100,000**		**Percentage**		**Total HIV/AIDS**		
		AIDS	HIV	AIDS	HIV	AIDS	HIV	#	%	rate
Gender	**Male** (1,838,446)	5,310	3,761	288.8	204.6	72.4%	68.8%	9,071	70.9%	493.4
	Female (1,925,764)	2,025	1,705	105.2	88.5	27.6%	31.2%	3,730	29.1%	193.7
	Total (3,764,210)	***7,335***	***5,466***	***194.9***	***145.2***	***100***%	***100***%	***12,801***	***100%***	***340.1***
Race/ Ethnicity	**White** (2,601,905)	3,452	2,409	132.7	92.6	47.1%	44.1%	5,861	45.8%	225.3
	Black (451,747)	2,745	2,181	607.6	482.8	37.4%	39.9%	4,926	38.5%	1090.4
	Hispanic (599,120)	1,004	769	167.6	128.4	13.7%	14.1%	1,773	13.9%	295.9
	Other/Unk. (111,438)*	134	107	120.2	96.0	1.8%	1.1%	241	1.9%	216.3
	Total (3,764,210)	***7,335***	***5,466***	***194.9***	***145.2***	***100***%	***100***%	***12,801***	***100%***	***340.1***
Age	**0-12** (588,607)	12	25	2.0	4.2	0.2%	0.5%	37	0.3%	6.3
	13-19 (321,630)	66	75	20.5	23.3	0.9%	1.4%	141	1.1%	43.8
	20-24 (222,355)	114	297	51.3	133.6	1.6%	5.4%	411	3.2%	184.8
	25-29 (226,495)	242	491	106.8	216.8	3.3%	9.0%	733	5.7%	323.6
	30-39 (440,365)	1,078	1,249	244.8	283.6	14.7%	22.9%	2,327	18.2%	528.4
	40-49 (504,020)	2,870	1,778	569.4	352.8	39.1%	32.5%	4,648	36.3%	922.2
	50-59 (510,475)	2,196	1,118	430.2	219.0	29.9%	20.5%	3,314	25.9%	649.2

	60+ (950,264)	757	433	79.7	45.6	10.3%	7.9%	1,190	9.3%	125.2
	Total (3,764,210)	***7,335***	***5,466***	***194.9***	***145.2***	***100***%	***100***%	***12,801***	***100%***	***340.1***
Mode of Transmission	MSM	3,267	2,423			44.5%	44.3%	5,690	44.4%	
	IDU	835	431			11.4%	7.9%	1,266	9.9%	
	MSM/IDU	341	167			4.6%	3.1%	508	4.0%	
	Hetero	2,088	1,508			28.5%	27.6%	3,596	28.1%	
	Other	148	91			2.0%	1.7%	239	1.9%	
	Risk Not Specified	656	846			8.9%	15.5%	1,502	11.7%	
	Total	***7,335***	***5,466***			***100%***	***100%***	***12,801***	***100%***	

Source: Florida Department of Health, HIV/AIDS Bureau, 2010

Florida has had HIV reporting since July 1, 1997. The Florida HARS (HIV/AIDS Reporting System) data provides exposure data for adults by sex and with risks redistributed according to the history of the local area. This is more precise than the CDC's (Centers for Disease Control) protocol which uses history of risk reclassification for the entire southeast quadrant of the United States. In addition, Florida provides a more comprehensive breakdown of HIV and AIDS cases by current age group. Using local historical reclassified data takes into account the different risk profiles for each EMA and Consortia area.

Epidemiological data is updated each year and is provided by the State Department of Health to the local areas for analysis. There are limitations to the HARS system. Reports are limited to confirmatory tests performed in confidential settings since July 1, 1997. Reporting of cases identified prior to 1997 and anonymous test sites are not included in HARS. The State has made attempts to reclassify "no specified risk" transmissions to other categories so comparisons between years for mode of transmission should be made with caution. Finally, age data used to be reported as age at diagnosis, but in 2003 reports were adjusted to reflect current age therefore caution should be used in interpreting trends with this factor as well.

One issue faced by the TSA is the significant number of individuals migrating here from other areas, which will not be reflected in TSA numbers unless a confirming HIV test is conducted in the state or the individual has a CD4 or viral load test (which became officially reportable in November 2006). Florida also began electronic lab reporting in 2006, but not all labs report electronically at this time. An HIV+ person who converts to AIDS while in the state will be captured in the incidence estimates but the impact of the in-migration upon existing resources could be significant.

The following table shows the distribution of the PLWH/A population by county. Hillsborough County has the largest percentage of PLWA and PLWH, 43.9% and 46.7%, respectively while Hardee County has the smallest percentage at <1% each.

Distribution of TSA's PLWA/PLWH Population by County

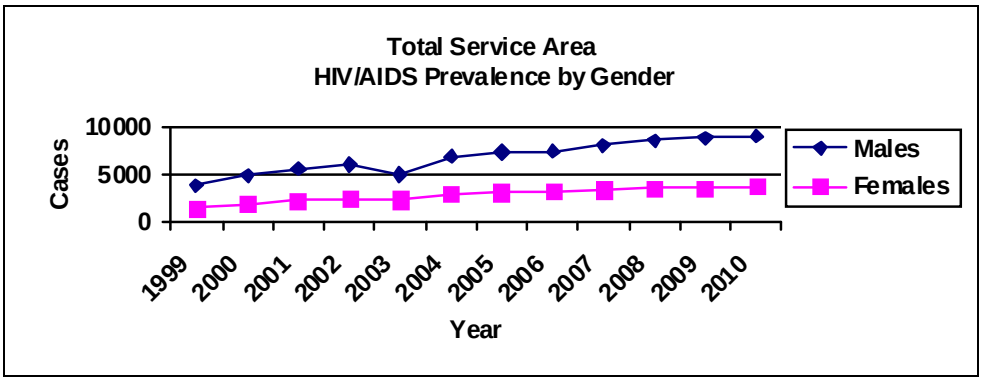
County	% total TSA general population	% PLWA	% PLWH	% PLWHA
Hardee	0.8%	0.6%	0.4%	0.5%
Hernando	4.4%	1.2%	1.6%	1.4%
Highlands	2.7%	1.4%	1.4%	1.4%
Hillsborough	31.9%	43.9%	46.7%	45.1%
Manatee	8.5%	6.8%	6.3%	6.6%
Pasco	11.7%	5.1%	5.0%	5.1%
Pinellas	24.6%	27.4%	26.8%	27.1%
Polk	15.5%	13.6%	11.6%	12.8%
TOTAL	100%	100%	100%	100%

Source: Florida Department of Health, December 2010

The Florida Department of Health HARS (HIV/AIDS Reporting System) data excludes the Department of Corrections (DOC) population. Annually, statewide more than 1,400 HIV+ inmates are released from state correctional institutions with around 200 (13%) of them returning to the TSA. According to the Florida DOC, 549 HIV+ state system inmates have been released to the TSA during the last three years. Approximately 2% of all the local jail inmates released are HIV+. The local jail systems report approximately 2,400 releases of HIV+ inmates, but the local jail system estimates are based on actual releases rather than individuals as often the same inmate is incarcerated and released multiple times. According to the Florida Department of Corrections, the average stay in a Florida jail is about 23 - 46 days. The average stay in prison is between three and five years.

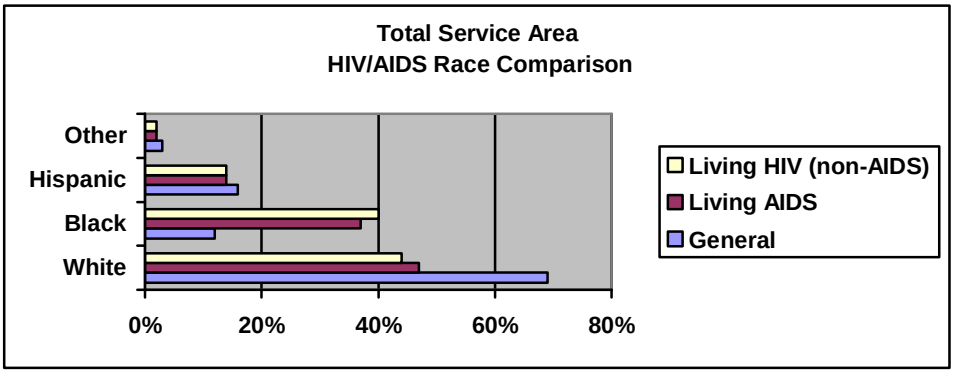
Profile of PLWH/A by Age, Gender, Race and Exposure Category

Male PLWHAs - Men continue to represent the greatest number of both HIV and AIDS cases at 69% and 72%, respectively. The number and percentage of HIV and AIDS cases among men has increased, which is to be expected with the most common mode of transmission in the TSA being MSM (men who have sex with men). Analysis of HIV prevalence data over the years as displayed in the following chart provides an accurate account of trends within the TSA.



The data show that HIV/AIDS has a disproportionate impact on Black males as can be seen in the case data information, as well as the rate data information that follows. Case data shows neither a disproportionate impact on white males nor Hispanic males, but the rate data shows that Hispanic males have a greater burden of HIV/AIDS than do their White male counterparts. White males are approximately 34% of the total population of the TSA. Twenty-five percent of the 2010 AIDS incidence in the TSA and 35% of the HIV (non-AIDS) prevalence was found in this population. Black males represent 12% of the AIDS incidence and 22% of the HIV (non-AIDS) prevalence but are only approximately 6% of the TSA's total population. Hispanic males are approximately 8% of the TSA's total population, and represent approximately 5% of the AIDS cases reported in 2010, and 7% of the HIV cases reported in 2010.

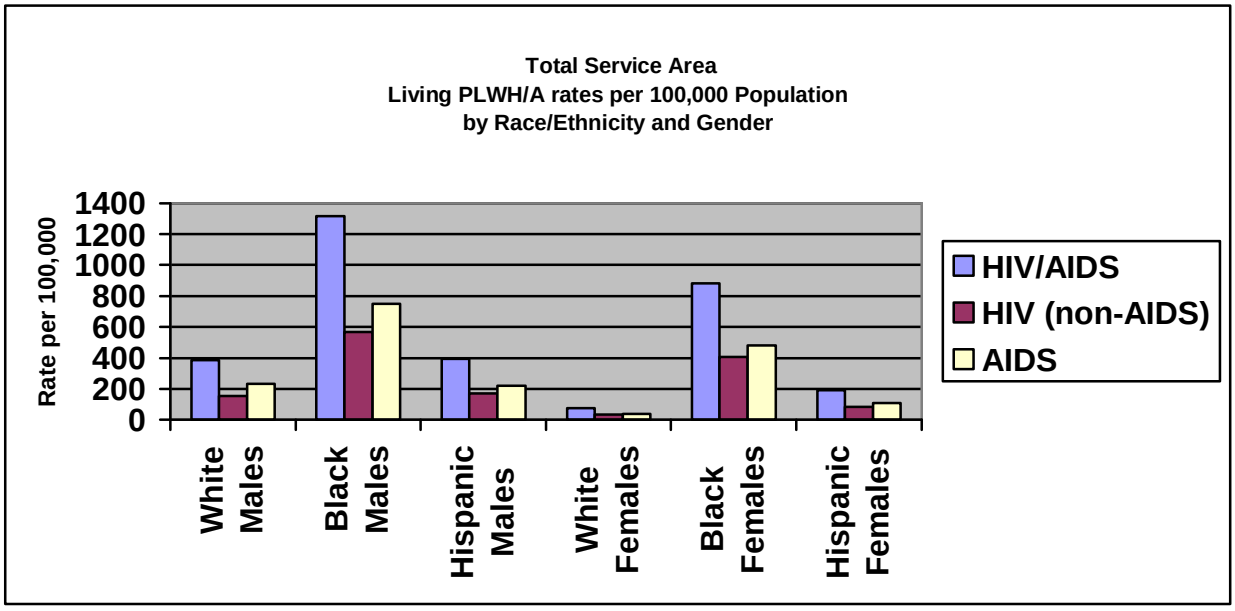
Female PLWHAs – The data show that HIV/AIDS has a disproportionate impact on Black females. As with Hispanic males, Hispanic female rate data shows that they have a greater burden of HIV/AIDS than do their White female counterparts. White females are approximately 34% of the total population of the TSA. Eight percent of the 2010 AIDS incidence in the TSA and 9% of the HIV (non-AIDS) prevalence was found in this population. Black females represent 17% of the AIDS incidence and 18% of the HIV (non-AIDS) prevalence but are only approximately 6% of the TSA's total population. Hispanic females are approximately 8% of the TSA's total population, and represent approximately 4% of the AIDS cases reported in 2010, and 5% of the HIV cases reported in 2010.



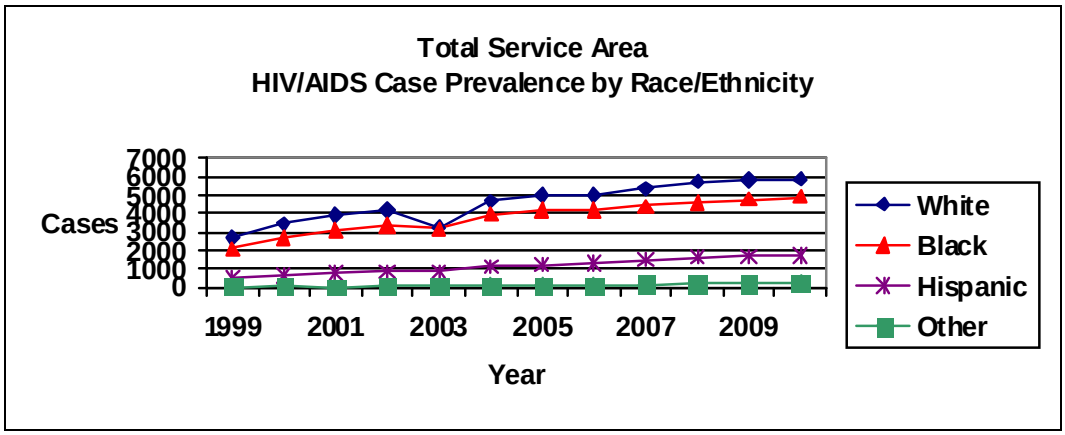
Among Black males, the rate of AIDS is 3.28 times higher than in White males and the rate of HIV is 3.82 times higher. The rate of AIDS is 11.43 times higher in Black females than in White females and the rate of HIV is 12.27 times higher.

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

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



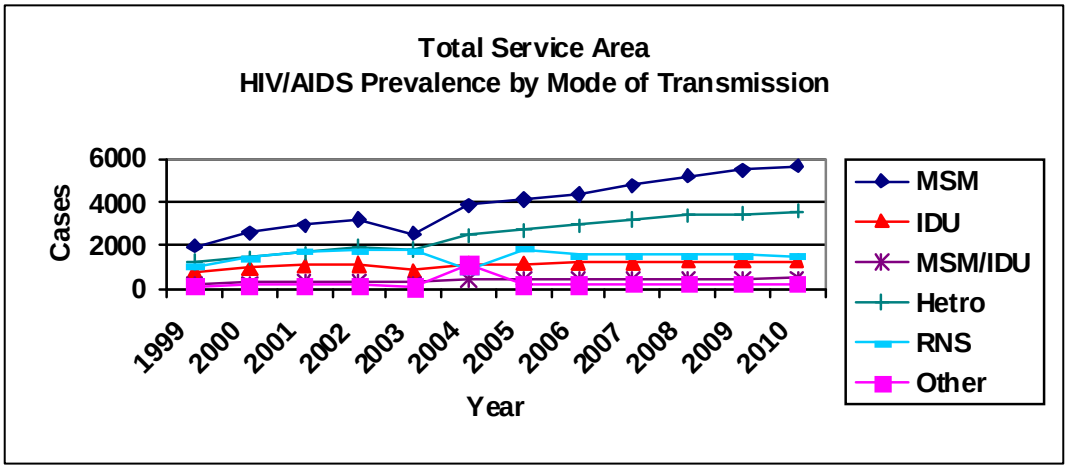
Trends over time show a steady, slight increase among all racial/ethnic population groups.



The following table more clearly illustrates the disproportionate impact among minority populations by gender. The data shows that even though White males represent the largest number of HIV/AIDS cases and the largest percentage of cases in the TSA, minority men and women are more disproportionately impacted by this disease. When reviewing rate per 100,000 data, Black males are most significantly impacted (1,316per 100,000), followed by Black females (883 per 100,000) and then Hispanic males (395 per 100,000) compared to White males at a rate of 385 per 100,000.

	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 (34%)	2,918	231.4	39.8%	55.0%	1,934	153.4	35.4%	51.4%	4,852	384.7	37.9%	53.5%
Black (6%)	1,615	748.2	22.0%	30.4%	1,226	568.0	22.4%	32.6%	2,841	1,316.2	22.2%	31.3%
Hispanic (8%)	684	231.4	9.3%	12.9%	531	172.5	9.7%	14.1%	1,215	394.6	9.5%	13.4%
Other/Unk. (1%)	93	173.7	1.3%	1.8%	70	130.8	1.3%	1.9%	163	304.5	1.3%	1.8%
Total (49%)	5,310	288.8	72.4%	100%	3,761	204.6	68.8%	100%	9,071	493.4	70.9%	100%
FEMALES												
White (34%)	534	39.8	7.3%	26.4%	475	35.4	8.7%	27.9%	1,009	75.3	7.9%	27.1%
Black (6%)	1,130	479.0	15.4%	55.8%	955	404.8	17.5%	56.0%	2,085	883.9	16.3%	55.9%
Hispanic (8%)	320	109.0	4.4%	15.8%	238	81.7	4.4%	14.0%	558	191.6	4.4%	15.0%
Other/Unk.* (2%)	41	70.8	0.6%	2.0%	37	63.9	0.7%	2.2%	78	134.7	0.6%	2.1%
Total (51%)	2,025	105.2	27.6%	100%	1,705	88.5	31.2%	100%	3,730	193.7	29.1%	100%
TSA Total	7,335				5,466				12,801			

Men who have sex with men remain the largest exposure category in the TSA (44% of HIV/AIDS prevalence). Heterosexual transmission is the second most common exposure category (28% of HIV/AIDS) and is the most common exposure category among women (64% of female prevalence). Injection drug use is the third most common known exposure category (10% of HIV/AIDS prevalence).



EMERGING POPULATIONS/TRENDS

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

(MSM) Men who have Sex with Men: MSM represent 52% of the AIDS prevalence and 53% of its HIV prevalence. In 2010, 53% of all new AIDS diagnoses were among this population. In addition to the challenges resulting from prevailing psychosocial factors affecting this group, such as fear of discrimination at work and/or denial of services by health care providers based on sexual orientation, the greatest challenge to the existing HIV systems of care is this population's high HIV/AIDS prevalence. Although the AIDS incidence and mortality among MSM have declined nationally since the mid 90's due in part to the increased availability and success of antiretroviral therapies, the rate of decrease has slowed over the past five years. In the service area, the AIDS incidence in this group has actually increased from 36% in 2002 to 53% by the end of 2010. In addition, MSM represented 61% of all new HIV cases reported in 2010. Twenty-five percent of the HIV/AIDS case deaths for 2010 were reported among White MSM, 8% were reported among Black MSM and 3% were reported among Hispanic MSM. Minority men have a much shorter survival time between an AIDS diagnosis and death. The median survival time for total deaths from 2001-2009 is 43 months for Black males and 45 months for Hispanic males compared to 66 months for White males.

Gay men of color seem significantly disproportionately impacted in the TSA. The Florida Department of Health's "Man Up" report states that in Hillsborough County, 1 in 157 White men are living with HIV, yet 1 in 55 Black men are infected. In Pinellas County 1 in 177 White men are living with HIV and 1 in 62 Black men have HIV. The TSA's HIV education and prevention partners have identified MSM as a priority population and the success of their efforts will impact the Ryan White system of care.

This TSA has unique concerns regarding the increase of HIV cases and cost to the health care system. According to Public Health Officials, there are several recreation destinations and specific entertainment venues catering to MSMs located within the TSA. These resorts are popular vacation destinations for MSM from across the U.S. and abroad, increasing the risks for HIV infection in this area. Public Health Officials in the TSA report they have seen a significant increase in STD cases among this population. Many MSM who do not reside in the TSA and therefore are not reflected in the area's HIV statistics are seeking and receiving publicly funded medical care while visiting in the area.

In addition to the high number of MSM cases previously described, MSM who are HIV+ have issues and/or characteristics that present unique challenges to the existing system of care. In particular, societal attitudes toward homosexuality make it difficult for an individual to cope with an HIV/AIDS diagnosis. Low self-esteem and other psychological issues such as social isolation, depression, rejection (and the fear of) by family and friends, and substance abuse compromise the individual's ability to seek and adhere to treatment. This situation increases the demand for supportive services such as mental health, case management and substance abuse treatment.

Staff conducting a local support group for behaviorally infected youth has noticed increasing numbers of HIV+ young males who have sex with other males. Additional resources are needed to target this high-risk group.

Because of the vulnerability of women and children, many existing social services are targeted to serve them (Medicaid, public assistance). MSM who do not have children are often unable to access non-Ryan White services. MSM who are long-term survivors and have returned to the work force are often challenged with the physical side effects of the multiple medications they have to take, as well as keeping their status and sexual orientation hidden to avoid discrimination. Some resort to misrepresenting their employment status to receive Ryan White services rather than accessing their job's health insurance to avoid being "outed".

The client survey conducted by the Planning Council as part of the annual needs assessment process was found to be demographically representative and is therefore being used to make some assumptions about this population.

Of the 2,199 respondents, 1,049 were MSM. Seventy-eight percent of MSM responding to the survey were White, 16% were Black. Twelve percent of all MSM were Hispanic. Twenty-one percent of both White and Black MSM and 27% of the Hispanic MSM were employed full time, and 44% of White MSM, 36% of Black MSM and 40% of Hispanic MSM

reported that they were on disability. Black MSM were more likely to have been in jail/prison than White or Hispanic MSM (10% vs. 3%).

Almost 12% of the MSMs cited that not knowing where to get services was their biggest barrier to care. Another 12% could not pay for services, 7% did not qualify for assistance, 6% did not seek care because they were depressed, 5% could not get appointments and another 5% were put on a wait list for services.

Service gaps for MSMs were dental care (27%), health insurance premium and co-pay assistance (20%), legal support (20%), food bank (19%), nutritional counseling (12%), transportation (11%), mental health services (11%) and rehabilitation (9%).

Youth (13 -24 years of age): In the TSA, individuals' ages 13 to 24 years account for approximately 2.5% of the living AIDS cases and 5.4% of the HIV (non-AIDS) cases. This age group represents 6% of the new AIDS cases in 2010 and 17% of the new HIV cases. There is a disproportionate impact among the minority populations in this age group. While Hispanics represent 15% of the general population in all age groups combined, they represent 14% of the HIV/AIDS cases among the 13-24 year age group alone. Blacks represent 12% of the EMA's general population and an overwhelming 64% of HIV/AIDS cases in this age group with Black males being the hardest hit group with 42% of the total cases.

The disproportionate impact on minorities can further be seen in the poverty levels among this age group. According to the 2000 Kid Count Census data, 35% of Black children and 23% of Hispanic children live below the poverty level and 1.4% of teens in the area drop out of high school. Teenage patients report that the absence of an adult caretaker or the stigma and lack of HIV knowledge on the part of the adult caretaker is a persistent barrier in receiving the necessary support that would help them fully engage in care. Missed appointments and lack of treatment adherence results in the need to re-evaluate treatment plans and repeat appointments and diagnostic tests. In many instances, there is minimal familial support because the youth are emancipated or have deceased parent(s).

Florida Kid Count data shows eight percent of children have difficulty speaking English. The local USF (University of South Florida) Department of Pediatrics Infectious Diseases Division provides primary medical care to HIV positive youth from birth to age 24. This ever-increasing HIV+ adolescent, young adult population is composed of behaviorally acquired clients and perinatal infected youth. They estimate that 15-20% of their patients and/or their adult caretakers have limited English proficiency requiring complex scheduling between patient, caretaker and a bilingual medical provider or medical interpreter.

The USF program staff is currently studying the fact that more than 30% of their clients have an IQ of less than 70. The lower the IQ of the young patient, the less likely they are to be able to follow medical guidance and learn to manage their illness as they age.

In years past, the older youth were primarily composed of behaviorally infected young women identified through testing during pregnancy. The population is shifting with an increased number of newly identified adolescent males who acquired their infection through MSM behavior. This has prompted the need for additional staff training and new resources to assist current patients and identify others to enroll in care.

The problems and challenges often associated with normal growth and development in young individuals is exacerbated by HIV/AIDS making successful outcomes for this population a more challenging goal. This population tends to be very crisis-oriented with housing, food and basic needs taking priority over medical care. High risk behavior in both the behaviorally and perinatal infected youth cause frequent sexually transmitted diseases, unplanned pregnancies and possible secondary infection.

This population is very labor-intensive for providers as they are not ready to take responsibility for their health care and are living chaotic lives with no job training, multiple pregnancies and minimal support systems in place. Many clients lack the basic skills necessary to navigate the health care system. There are several safety net programs for those under the age of 21, but the 21-24 year olds have minimal options for funding assistance having aged out of many programs such as Children's Medical Services and Healthy Kids, a statewide insurance program for economically-disadvantaged, under-insured children. These young people are no longer covered under their parents and many are emancipated so when they are newly diagnosed with HIV, funding options are limited and they are unprepared to navigate the adult system alone.

Providers often report that access to transportation is a major barrier to serving this population. Many PLWH/A youth are not old enough to drive, and those who are often do not have their own automobiles. Family poverty makes access to stable, reliable transportation difficult and utilizing the limited and fragmented public transportation system makes it difficult to keep appointments. While most of these individuals have Medicaid because of their age and income, using Medicaid transportation services is often not feasible. Teens and young adults are typically forgetful about medical and psychosocial appointments and therefore often fail to follow through with arranging Medicaid transportation services.

Medical care providers report that teens and young adults often experience complex emotional problems caused by the perceived "death sentence" associated with their HIV diagnosis. These providers estimate that at least half of the individuals in this group are in need of professional mental health treatment. Issues may include the need to take a multitude of medications at various times during the school day and missing school or other normal after school activities to go to the doctor or other providers. The stigma of HIV forces young people to hide their HIV status from friends and even members of their extended family. The fear of rejection by peers and society in general often results in social isolation and depression. Providers believe that sexual abuse and other forms of trauma may disproportionately impact HIV positive youth resulting in increased levels of risk-taking behavior and decreased ability to maintain treatment adherence.

According to the Florida Department of Health, the 2010 rates of STDs for this age group indicate a need for continued education prevention programs. The rate per 100,000 for Chlamydia is 2,615.6, for Gonorrhea is 673.7 and 16.8 for infectious Syphilis. These rates indicate increases for each of the past two years and the Chlamydia cases among youth represent 71% of all Chlamydia cases, the Gonorrhea cases are 64% of the cases and the infectious Syphilis cases represent 31% of all cases. Infected youth and young adults require intensive secondary prevention education and support to prevent re-infection and co-infection with other STDs. Appropriate sexual education is another challenge presented by this group who must learn to negotiate disclosure and the related safer sex skills necessary to protect themselves. Increased resources are needed to target high-risk youth and bring them into care. In the past three years, program staff has noticed increasing numbers of adolescents with behaviorally acquired HIV infection, particularly young males who have sex with other males.

Another issue is that most of the perinatally infected children are now reaching adolescence. These youth have been on medications for most of their life and thus have many resistance mutations to the various classes of HIV medications. Although there is an advantage to the newer combination pills, most of the perinatal patients are on complex regimens. In addition, the young teens have not reached adult size and may not be able to take fixed dose drugs; some still require liquid medications in order to dose appropriately based on their size.

The Planning Council conducted a client survey as part of its annual needs assessment process. Of the 2,199 respondents, 59 were youth ages 13-24. Sixty-four percent of the PLWH/A in this age group were male, 36% were female. The racial breakdown of this group was 27% White, 66% Black, 5% mixed race and 2% other. Eighteen percent of the youth identified themselves as Hispanic. Six percent of the respondents stated that they had been pregnant within the last twelve months.

The most common barrier to care among this age group was not knowing where to go for help selected by 12% of respondents. Seven percent listed lack of ability to pay as a barrier to care, 5% did not seek care due to being depressed, 4% had transportation problems and 4% missed scheduled appointments.

Service gaps for youth were dental care (32%), food bank (29%), health insurance premium and co-pay assistance (26%), legal support (22%), transportation (15%), mental health services (12%), outreach (10%) and health education/risk reduction (10%).

While approximately 97% of the youth served have Medicaid coverage, the frequent changes in Medicaid and Medicaid HMOs creates variations in medical coverage and can interrupt the continuum of care. Adjusting care to specific drug formularies, laboratories and diagnostic testing facilities to conform to insurance coverage as well as counseling patients on the impact of these changes is time consuming. Primary care providers must be aware of and be comfortable in dealing with this group's cultural diversity as it pertains to not only racial and ethnic background, but more importantly to age.

The uniqueness of this population requires pooling extensive resources. Though in the TSA the majority of the primary medical care, medications and case management expenses for this population is covered by other resources such as Medicaid, Ryan White Part D, Healthy Kids insurance and local county indigent care programs approximately 4% of the Part A funds are allocated to services for youth.

Black WCBY (Women of Childbearing Years): While women of childbearing years (15-44) have not seen the same increases in incidence as MSM and youth and are less of an 'emerging' population, their numbers are increasing and the disproportionate impact to Black WCBY is concerning. WCBY make up approximately 12% (n=886) of the total AIDS cases and approximately 18% (n=978) of all the HIV cases while Black WCBY account for 6.8% of the total living AIDS cases and 10.5% of the HIV cases. In the service area, 76% of AIDS cases and 83% of the HIV cases among females are attributed to heterosexual transmission according to eHARS statistics.

In the Department of Health's report, "Organizing to Survive", the disproportionate impact on minorities within this population is easily seen. For example, in Hillsborough County, 1 in 1,007 White women are living with HIV compared to 1 in 403 Hispanic women and 1 in 92 Black women. In Pinellas County 1 in 1,382 White women are living with HIV, 1 in 578 Hispanic women and 1 in 92 Black women have HIV.

The unique challenges presented to the TSA's system of HIV care by this population are reflective of the socio-economic characteristics of women in the general population. These factors include higher rates of unemployment and poverty. Based on the Florida DOH Office of Evaluation and Data Analysis CHARTS and U.S. Census data, in Hillsborough County, for example, the percentage of families with a female head of household living in poverty is twice as high as the national average (24.8% vs. 12.3%). Women of childbearing years in the TSA who are infected with HIV tend to be poor, young, Black and living in communities in economically deprived inner city neighborhoods. Such neighborhoods are usually designated as Medically Underserved Areas (MUAs). MUAs lack sufficient medical clinics and providers in proportion to the population. The risk of contracting HIV or for those already infected the risk of becoming re-infected or acquiring other STDs, is greater for women who are financially dependent on male partners. This dependence puts them in a disadvantaged position when trying to negotiate safer sexual behaviors.

The results of various needs assessment activities have shown that more HIV+ women of childbearing years than HIV+ men lack their own transportation making it more difficult for these women to access available services. Women also experience gender-specific manifestations of HIV disease that require specialized and costly medical care. Pre-natal care for HIV+ women is very costly as well.

Women with HIV are likely to receive fewer health care services and HIV medications compared to men with HIV. Service providers for this population often report that women may postpone taking medications or keeping medical appointments to take care of others' needs, or because of economic or transportation problems. It is not rare for women with children to consider their HIV infection as the least of their problems; more pressing and

urgent are issues such as lack of income, housing, access to health care for their children, possible abusive relationships and caring for other family-related concerns. Women also tend to have a shorter time between an AIDS diagnosis and death. The median survival time for total deaths from 2001-2009 is 37 months for Hispanic females, 35 months for Black females and 49 months for White females compared to 66 months for White males.

The client survey conducted by the Planning Council as part of the annual needs assessment process was found to be demographically representative and is therefore being used to make some assumptions about this population.

Of the 2,199 respondents, 357 were Black WCBY. Seventy one percent of the Black WCBY were unemployed. Forty-eight percent were on disability, 11% were seeking employment, 6% were students or attending job training and 8% had been incarcerated.

More than 10% of the Black WCBY cited that not knowing where to get services as their biggest barrier to care. Another 6% did not seek care because they were depressed, 6% had no transportation, 5% could not pay for services, 4% did not want others to know their status, 3% did not qualify for services and another 3% missed their scheduled appointments.

Service gaps for Black WCBY were dental care (25%), food bank (20%), transportation (16%), legal support (15%), health insurance premium and co-pay assistance (14%), mental health services (11%), outreach (11%) and rehabilitation (10%).

Though in the EMA the majority of the primary medical care, medications and case management expenses for this population is covered by other resources such as Medicaid and Ryan White Part D, the provision of supportive services represent approximately 25% of the Part A funds allocated to services.

Prevalence of Co-Morbidities

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

HIV care costs continue to increase due in significant part to the increasing complexities in the clinical management of persons living with HIV/AIDS. The additions of new procedures, drug regimens, patient adherence, new lab tests, specialty services/referrals and maintaining an effective provider network present many challenges for the provision of high quality HIV medical care. Many patients have complications that require assistance beyond the scope of basic medical care including homelessness, inadequate nutrition,

transportation difficulties, mental health disorders, poly-substance abuse and lack of education or understanding of their condition. The cost and complexity of care increases as new medications become available. Additional clinical provider time is required for the patient assessment and prescribing process. Additional costs of testing for potential adverse reactions to new medications as well as having long-term survivors developing resistance to medications which requires resistance testing, also impact the complexity of care. The limited and decreasing supplemental community resources due to the poor economy, coupled with the increased need for treatment, has overwhelmed the HIV system of care.

In addition to the constant increase in HIV cases and the increase in longevity among those infected with the virus, local clinics report an increasing number of clients who have significant, complex medical problems evident in the growing rates of chronic diseases such as Hepatitis C, mental illness and drug use co-morbidities. As the infected population ages and individuals are coming into care later in their disease stage, there is a significant rise in the number of individuals also being treated for heart disease, liver disease, kidney disease and diabetes. These factors increase the demand and use of other support services and often result in additional costs for non-HIV related medications, primary care, and behavioral support services. Multiple acute and chronic health problems require frequent and extensive medical management. Infectious disease doctors report that even asymptomatic HIV patients require more intense follow up and medication regimens due to co-morbidities.

CHAPTER 3:
HISTORY OF RESPONSE TO THE EPIDEMIC

The Tampa – St. Petersburg EMA and surrounding counties which help comprise the TSA have a long history of responding to the HIV epidemic. The history of the area's response is tied directly to events at the state and national level as most funding sources and regulatory authority occurs at these levels of government.

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

Florida began HIV reporting in 1997 and mandatory lab test reporting in 2006. Each level of reporting brings us more sound epidemiological data to help the planning council make funding decisions, track emerging trends and plan programming.

Over the years, the local area has evolved and grown its system of HIV care to respond to changes in the epidemic and its affected populations. New developments in treatment and

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

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

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

THREE YEAR TREND IN AMBULATORY OUTPATIENT SERVICES AND AVAILABLE FUNDING

	2008	2009	2010	% Change
# Of Clients Served	3,897	3,904	4,059	4% Increase
Units of Services Per Client	5.33	9.42	9.47	78% Increase
Annual Funding Expended for this Service Category	$3,158,619	$3,239,419	$3,263,630	3% Increase
Part A Formula, Supplemental and MAI Awards	$9,524,707	$9,619,061	$9,403,477	1.3% Decrease

Data Source: Ryan White Grantee

CHAPTER 4:
ASSESSMENT OF NEED

Prevention Needs

Prevention planning occurs through a mechanism of local planning bodies called the Community Planning Partnership (CPP) and the state Prevention Planning Group (PPG). Both are part of the statewide initiative known as the Florida HIV/AIDS Community Planning Network (FCPN). Other members of the FCPN include the Patient Care Planning Group (PCPG) and the Viral Hepatitis Council.

Top Prevention Priority Populations for the TSA

RANK	2011 Target Populations for Areas 5/6/14
1	White MSM (Men who have Sex with Men)
2	Black Heterosexuals
3	Black MSM (Men who have Sex with Men)
4	Hispanic MSM (Men who have Sex with Men)
5	White Heterosexuals
6	Hispanic Heterosexuals

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

Program	Program description
Healthy Relationships Program	Healthy Relationships is a five-session, interactive group program for persons who are HIV+ to share common experiences and develop decision-making and problem-solving skills. The development of these skills will enable participants to make informed safe decisions about disclosure and safer sex practices. The Healthy Relationships programs target Black and Hispanic Heterosexuals and Black, White and Hispanic MSMs.

Partnership for Health Program	Partnership for Health (PfH) is a brief, clinic based, counseling program for men and women living with HIV/AIDS. A clinician delivers messages to individuals about safer sex, disclosure and HIV prevention as a part of their office visit. The program is designed to improve patient-provider communication and increase the patient's knowledge, skills, and motivations to practice safer sex.
CRCS – Comprehensive Risk Counseling and Services	CRCS – Comprehensive Risk Counseling and Services is an intensive, individual level, client-centered risk reduction intervention for people at high risk for HIV infection or transmission.
One on One Consultation provided by HIV/AIDS Prevention and Training Consultant	One on One Consultation is provided to clients by an HIV/AIDS Prevention and Training Consultant. These consultations are done over the phone or in person at the local health department, in the client's home or in a confidential setting at their place of work. HIV infected clients are educated on all aspects of the disease including prevention and linkage to care, as well as being informed of resources in the community.
TOPWA (Target Outreach for Pregnant Women Act)	TOPWA intervention targeting pregnant women at-risk for HIV/AIDS who are not receiving proper prenatal care. There is an emphasis on minority women.
SISTA (Sisters Informing Sisters about Topics on AIDS)	SISTA (Sisters Informing Sisters about Topics on AIDS) is a peer-led, skill-building intervention project to prevent HIV infection in African American women. The goal of SISTA is to reduce sexual risk behavior by heterosexually-active African American women at highest risk for HIV by giving women the social and behavioral skills they need to adopt HIV risk-reduction strategies. Discussions of self-esteem, relationships, and sexual health are gender and culturally relevant and include behavioral skills practice, group discussions, lectures, role-playing, a prevention video, and take-home exercises.
VOICES/VOCES (Video Opportunities for Innovative Condom Education and Safer Sex)	VOICES/VOCES is a single-session, video-based HIV/STD prevention program designed to encourage condom use and improve condom negotiation skills. The program is based on the theory of reasoned action, which explains how behaviors are guided by attitudes, beliefs, experiences, and expectations of other persons' reactions. VOICES/VOCES is grounded in extensive formative research exploring the culture- and gender-based factors that can facilitate behavior change. It is aimed at African-American and Latino adult male and female clinic clients.
Becoming a Responsible Teen (BART)	BART is a group-level, education and behavior skills training intervention designed to reduce risky sexual behaviors and improve safer sex skills among adolescents. The 8 intervention sessions provide information on HIV and related risk behaviors and the importance of abstinence and risk reduction. Through discussions, games, videos, presentations, demonstrations, role plays, and practice, adolescents learn problem solving, decision-making, communication, condom negotiation, behavioral self-

	management, and condom skills.
Blood Lines Video Discussion Group	The Blood Lines Video Discussion Group is a two hour session designed to provide information to youth about HIV prevention, transmission and testing. Blood Lines is a film directed and produced by HIV-positive youth. The film empowers those who live with HIV/AIDS, inspires compassion for people living with the virus, and motivates others to avoid getting infected. A trained facilitator follows a step-by-step process for showing and processing the video. Activities to enhance learning after the discussion are also provided. The session is designed for groups of 6 to 25 teens.

To determine the need in our local area, many factors are considered. There are estimated to be more than 2,500 individuals in our total service area who are positive but are not yet aware of their status. These undiagnosed cases represent an additional potential demand on the system of care, and is not accounted for in the calculations for determining unmet need. With increased emphasis on HIV testing in both pregnant women and the general population as a standard practice in health care, this number may decrease over time.

EIIHA (Early Identification of Individuals with HIV/AIDS)

Over the last two decades, the Grantee, in conjunction with the local Ryan White Planning Council, has focused on improving and expanding their partnership with the FCPN, PPG, PCPG, Viral Hepatitis Council, and the local Florida Department of Health (DOH) HAPCs (HIV/AIDS Program Coordinators) to ensure coordination of services and programs. The network will continue these collaborations to ensure that current and newly developed strategies within the service area will support HRSA's objective in the early identification of individuals living with HIV/AIDS and subsequently getting them into care.

Currently, no Ryan White funds are allocated to Early Intervention Services. The State of Florida, the CDC and HRSA (Health Resources and Services Administration) allocate approximately $36.5 million dollars to support the HIV prevention efforts of Florida's CBOs (community-based organizations), ASOs (AIDS service organizations), CHDs (county health departments), and DOH. In an effort to maximize the efficiency, effectiveness and allocation of limited HIV prevention resources throughout the state, the DOH has taken the lead in the area of prevention and early intervention.

Florida's PPG is responsible for the State of Florida Prevention Plan, which directs local HIV prevention planning. The Grantee serves dual roles, first as the Ryan White Part A Grantee, as well as the lead agency for the Part B patient care funds within the TSA. As a result, the TSA is in a unique position to strengthen existing and future relationships with HIV prevention by having direct access to the DOH, which serves as the Grantee for HIV prevention and testing activities. In addition, the Part A Planning Council and the Part B Consortium function as a combined planning body.

Included in the 2012-14 State of Florida Prevention Plan are three major goals (1) maintain an HIV prevention community planning process, which ensures that resources and strategies are targeted to meet the needs of priority populations, culturally sensitive, and allow for innovation, adapting, and tailoring interventions and strategies, (2) encourage at-risk persons to know their infection status by reducing real and perceived barriers to HIV testing, ensuring that CTL services are provided to at-risk populations through outreach, and by increasing the percentage of persons who receive their results after testing for HIV, and (3) ensure that all persons who test positive through publicly funded HIV counseling, testing and linkage sites are linked to appropriate medical and support services.

In order to achieve these goals, the Florida DOH has implemented one of the largest publicly funded HIV testing programs in the country, performing over 410,000 tests in 2010. There are approximately 1,600 registered HIV counseling and testing sites statewide and 85 sites located within the TSA as of February 2012. The DOH is continually adding test sites, clearly illustrating the emphasis that is being placed on expanded testing in the state. Most of the publicly funded HIV testing programs offer free HIV testing; they utilize three different methods (conventional blood draw, OraSure, and rapid testing technologies) to ensure access to at-risk populations.

HIV counseling, testing, and referrals into care and treatment will be the focus of subsequent joint planning activities between the local Planning Council and the CPP. Recently expanded early intervention activities (such as rapid testing and jail outreach programs) have resulted in successful outcomes over the past five years. The post-test counseling requires that HIV positive individuals are referred and linked to appropriate care and treatment, which are documented on the post-test counseling form. Local surveillance staff tracks each new positive to determine if they have received a CD4 or viral load test within three months of being informed of their positive status.

Early intervention programs offering HIV counseling and testing have been a priority within the TSA for several years, recently implementing these initiatives to ensure that every resident in the service area 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. Local testing initiatives work diligently to increase access for historically underserved populations.

The local partnerships have a rich history of collaborating on HIV prevention, care, and treatment issues throughout the TSA. This tradition continues as the local networks have implemented a plan to incorporate HIV EIS (early intervention services) with a goal of ensuring 100% of HIV+ clients are linked to services with the local Ryan White programs. Meetings between the Grantee and the local DOH HIV/AIDS Program Coordinators 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.

Florida began a wait list for ADAP in June 2010, just as the need for free or low cost medications dramatically increased. AIDS programs expanded testing and new federal health standards mandated treating patients at lower viral loads, requiring more

medications. All new positives needing antiretroviral (ARV) treatment are referred to patient assistance programs if they qualify. Otherwise, the Part A program is covering the cost for medications in addition to the lab testing and clinic visits to determine the treatment plan and adherence.

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 EIS are occurring, but also allows for ongoing enhancement and collaboration.

The Grantee and Planning Council work with the existing network of partnerships by supporting local initiatives to increase HIV testing services within the TSA. The EIS plan focuses on four major activities: (1) expansion of publicly supported HIV counseling sites; (2) incorporation of EIS into clinical services (STD, TB); (3) coordination of case management services; and (4) incorporation of EIS in all HIV prevention services in the TSA.

The following objectives will be 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.

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.

The EIS program and objectives will result in the enhancement of existing HIV programs, development of a local referral and tracking methodology for HIV positive individuals, and utilization of the existing system of care within the TSA.

The local priority populations targeted for the allocation of resources in the TSA are included in the EIIHA Matrix (Appendix C).

Unmet Need Estimate for Care Services

HRSA has placed an emphasis on the need to determine the number and demographics of HIV+ individuals who are aware of their status but are not in care. Unmet need estimates must be considered when making allocations to services that would be initial points of entry for new clients accessing care. In addition, HRSA further directs that the needs of such

populations and disparities in access and services among affected subpopulations and underserved communities be determined.

By HRSA definition, an individual is determined to be in care if he/she is receiving regular primary HIV-related medical care. Regular care is defined by having at least one of the following in a specified 12-month period: viral load testing, CD4 count and/or the provision of anti-retroviral therapy.

These data are generated from the electronic HIV/AIDS Reporting System (eHARS) database Significant efforts have been made to eliminate duplicate cases in the system with the matching of data bases from a variety of sources including Medicaid, Ryan White, private insurance, Medicare, local indigent health plans and the Veteran's Administration. 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. As existing data sets become more complete and all labs are imported into eHARS, the data will become more and more reliable.

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 01/01/2010 - 12/31/2010	7,706		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 01/01/2010 - 12/31/2010	5,889		
Row C.	Total number of HIV+ aware, for the period of 01/01/2010 - 12/31/2010	13,595		
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	5,171	54%	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	2,864	59%	
Row F.	Total number of HIV+/aware who ***did*** receive the specified HIV primary medical care services in 12-month period	8,035	55%	
Calculated Results		**Value**	**Percent**	**Calculation**
Row G.	Number of PLWA who ***did NOT*** receive primary medical services	2,535	26%	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	3,025	62%	Value: Value B - Value E. Percent: Value H/Value B.
Row I.	Total HIV+/aware who ***did NOT*** receive specified primary medical care services (quantified estimate of unmet need)	5,560	38%	Value: Value G + Value H. Percent: Value I/Value C

[1] The eHARS (electronic HIV/AIDS Data Reporting System) provided estimates of the number of infected individuals and proportions of HIV (non AIDS) and AIDS cases for the EMA.

[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. 2010 data 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 7,706 people are living with AIDS and 5,889 people are living with HIV in the TSA.

Rows D, E and F of the Unmet Need Framework Table provide estimates of numbers of people in care. Estimates are based on the number and percent of people in care according to the HRSA definition (received HIV primary medical care as evidenced by one of the following in a defined 12-month time frame: viral load testing, CD4 count and/or the provision of anti-retroviral therapy). It is estimated that 8,035 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. Data sources were cross matches between eHARS, ADAP, Medicaid, HMS (Health Management System, a County Health Department database for client based services), CAREWare and Labs. 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 5,560 people are living with HIV/AIDS in the TSA and not in care.

One of the biggest challenges faced in the TSA has been determining the demographics, location and needs of persons not in care. Many attempts to collect information from this population have been made with very limited results. Currently our only means of determining the demographics of those not in care is to analyze the demographics of individuals who have tested positive against those who are in care to get a possible snapshot of those who are not currently in care.

Using this methodology, it was determined that 51% of the 60 diagnosed Asian/Pacific Islanders are not reported as in care and 44% of the 5,861 diagnosed Whites are not reported in care compared to 40% for both Hispanics and Blacks. Forty-four percent of males are not reported in care compared to 37% of females. 46% of the 60+ year olds are not reported in care along with 45% of 40-44 year olds 25-29 year olds. 45% of MSMs are reported to not be in care with 44% white MSMs out of care compared to 40% Black MSMs and 42% Hispanic MSMs. Forty-nine percent of Haitian-born Males are reportedly out of care and 50% of Hispanic homeless males.

Zip code information from eHARS was provided to help identify those areas with the highest number of cases. Most cases were concentrated in the metropolitan areas of Hillsborough and Pinellas Counties. This year, the PLWHA data reflect the current county of residence, if in care, as opposed to the county of report as in previous years making it easier to begin to

identify areas of unmet need. There are pockets of PLWH/A in the rural areas of Hillsborough County, including migrant laborers, farm workers and other minority groups who are most likely not in care. We are coordinating efforts with prevention, outreach and testing programs to identify these pockets of unmet need.

Numerous attempts to determine the reasons why people who are aware of their status have decided not to access care have been made. Attempts included activities such as focus groups, one-on-one interviews, and surveys at health fairs, World AIDS day, testing and outreach events. The Planning Council has collaborated in efforts with prevention planners, Sexually Transmitted Disease (STD) workers in county health departments, Part D and Youth services programs and MAI providers. Incentives for participation were available for many of these activities, but all were met with limited or no participation. Ongoing efforts will be made in this area in an attempt to gather information.

One hundred twenty-eight (128) of 2199 respondents to the client survey collected from April-June 2010 reported themselves as not receiving care in the past 12 months. Their reasons for not receiving care are listed below and from most common to least common:

1. I could not pay for services
2. I did not feel sick
3. I did not want people to know that I have HIV
4. I was not ready to deal with having HIV
5. I was depressed
6. I did not know where to go

Based on this information, the Planning Council created a Newly Diagnosed Brochure that lists point of entry agencies such as primary care and medical case management and their contact information. These brochures have been distributed at testing and counseling sites, food pantries and social gathering places.

Marketing tools have been developed in English and Spanish to target Blacks and Hispanics and encourage them to get into care. The marketing tools have been distributed in targeted communities most disproportionately impacted. A resource directory of community resources available has been compiled and distributed to local agencies as well.

Additional work is also being done with the Planning Council to better define how the Council should balance the needs of underserved populations not currently in care with those that are currently in care given the limitations of available funding and the focus on core services. The Planning Council is exploring ways to collaborate with Prevention and Early Intervention Providers.

Currently, results of the unmet need framework are utilized primarily in the allocation of MAI funds. Programs funded under this initiative have been designed using different service delivery models, and a concerted effort to expand and enhance the variety of services available was considered by exploring best practices through the MAI Capacity Building study. A successful substance abuse program targeting Blacks and Hispanics has been implemented in the two largest counties of the service area where the majority of this

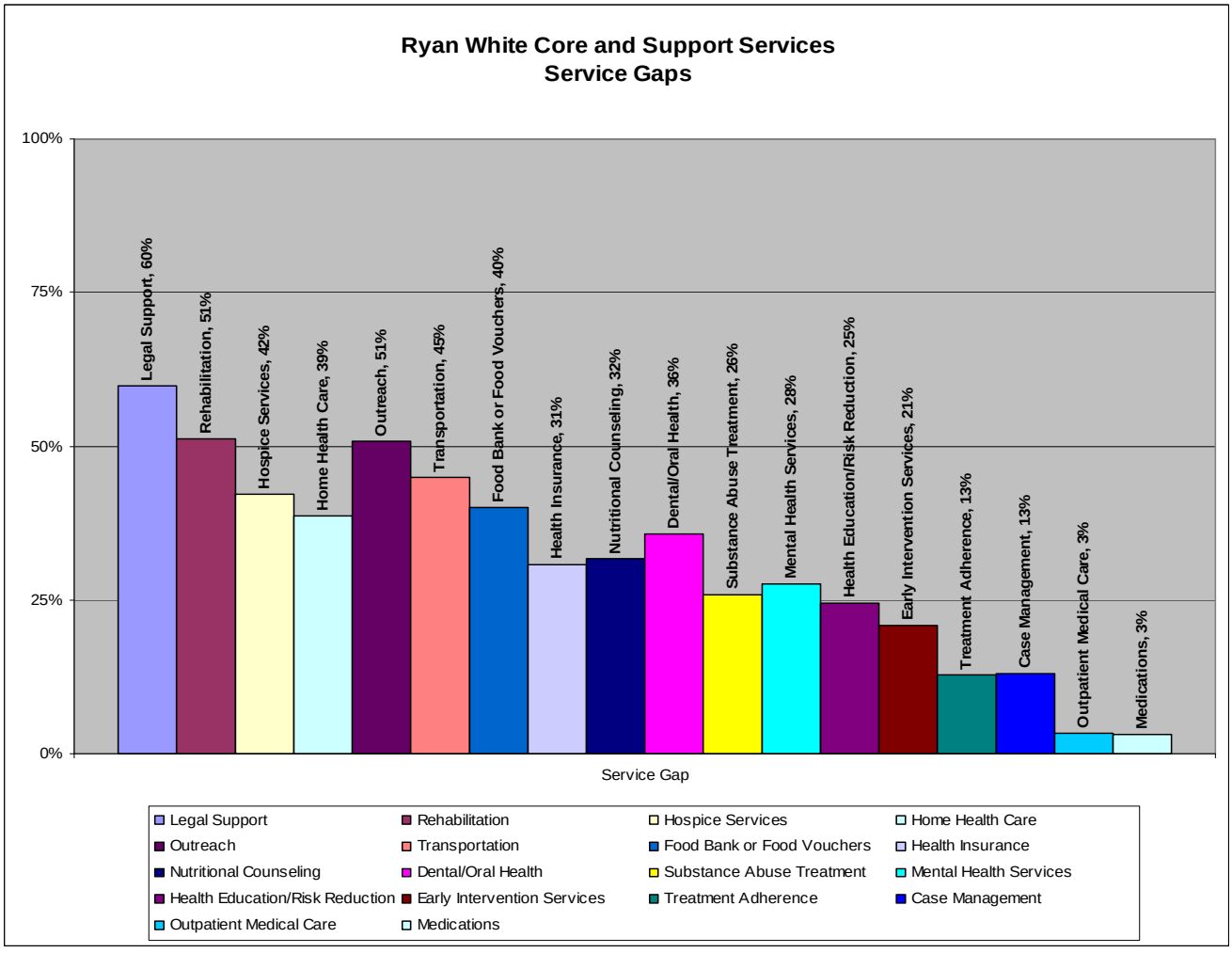
population resides. Additional MAI funds are used for treatment adherence programs to maintain minorities in care.

The number of people with unmet need is utilized in overall prioritizations and service allocations to assure that funding for primary care and medications is in place so that services are available for individuals once they are convinced to enter care. To this end, the Planning Council has implemented service caps and limits to increase capacity for new clients to enter care. The respondents to the client survey who indicated they were currently not in care listed their most critical core service gaps (in descending order) as oral health, health insurance, medical case management, mental health services, nutritional counseling, early intervention services, home health care, outpatient medical care, medications, substance abuse treatment, and hospice services. These needs are considered as one part of the priority setting process and subsequent allocations.

Gaps in Care

The Ryan White HIV/AIDS Program is designed to assist individuals living with HIV/AIDS who have no health insurance (public or private), have insufficient health care coverage, or lack financial resources to get the care they need for their HIV disease. As such, The Ryan White HIV/AIDS program fills gaps in care not covered by other funding sources. Local service gaps are assessed in part by the client survey which is conducted as part of the needs assessment. The needs assessment is a three year process, which incorporates a variety of techniques and target populations to assess overall service needs. Gaps were assessed for the TSA as well as population groups. Gaps are determined by respondents indicating which services they needed in a specified twelve-month period, but did not receive. Percentages indicate the respondents that did not receive the service. Overall need for some services may actually be low, but the gap may appear high if there is no (or limited) provider for the service.

Service Gaps for the TSA



Service gaps were analyzed for several subpopulation groups: Blacks, Hispanics, women, youth and MSM. The service gaps noted for each group are in descending order from greatest to least.

Service Gaps by Population Group

	Blacks (N= 755)	Hispanics (N= 298)	Women (N= 668)	Youth (N= 59)	MSM (N= 967)
1	Dental/Oral Health	Dental/Oral Health	Dental/Oral Health	Dental/Oral Health	Dental/Oral Health
2	Food Bank or Vouchers	Food Bank or Vouchers	Food Bank or Vouchers	Food Bank or Vouchers	Health Insurance
3	Health Insurance	Legal Support	Transportation	Health Insurance	Legal Support
4	Transportation	Transportation	Legal Support	Legal Support	Food Bank or Vouchers
5	Legal Support	Health Insurance	Health Insurance	Transportation	Nutritional Counseling
6	Case Management	Nutritional Counseling	Mental Health Services	Mental Health Services	Transportation
7	Outreach	Outreach	Outreach	Outreach	Case Management
8	Mental Health Services	Case Management	Rehabilitation	Health Education/Risk Reduction	Mental Health Services
9	Nutritional Counseling	Rehabilitation	Case Management	Nutritional Counseling	Rehabilitation
10	Health Education/Risk Reduction	Mental Health Services	Nutritional Counseling	Early Intervention Services	Early Intervention Services
11	Rehabilitation	Early Intervention Services	Health Education/Risk Reduction	Home Health Care	Outreach
12	Early Intervention Services	Health Education/Risk Reduction	Home Health Care	Case Management	Health Education/Risk Reduction
13	Other Service	Home Health Care	Early Intervention Services	Rehabilitation	Other Service
14	Home Health Care	Other Service	Other Service	Hospice Services	Home Health Care
15	Treatment Adherence	Hospice Services	Hospice Services	Treatment Adherence	Treatment Adherence
16	Substance Abuse Treatment	Treatment Adherence	Substance Abuse Treatment	Medications	Outpatient Medical Care
17	Outpatient Medical Care	Substance Abuse Treatment	Treatment Adherence	Outpatient Medical Care	Substance Abuse Treatment
18	Medications	Medications	Outpatient Medical Care	Other Service	Medications
19	Hospice Services	Outpatient Medical Care	Medications	Substance Abuse Treatment	Hospice Services

Service gap information is used to guide the comprehensive planning process to assist in determining where new funding should be allocated if it becomes available. It is also used to guide programming for Minority AIDS Initiative (MAI) services and to determine where additional cooperative agreements or service linkages should be developed**.**

CHAPTER 5:
DESCRIPTION OF CURRENT CONTINUUM OF CARE

The continuum of care is a coordinated delivery system encompassing a comprehensive range of health and support services that meet the needs of People Living with HIV/AIDS (PLWH/A) in all stages of illness. There are to some degree separate continuums for children/adolescents and adults. Some providers may serve both populations but many specialize in one or the other.

Ideally, entry into the continuum begins with HIV testing. This can occur at any of the more than 80 licensed testing sites, hospital emergency rooms, private physician's offices and outreach programs throughout the TSA. Both confidential and anonymous testing is available and requires pre-and post-test counseling. About one-half of the tests are now done with rapid testing kits. When a reactive or preliminary positive test is received, counselors inform clients of the need for a confirmatory test and provide information on HIV and available services. When the client returns for the results of the confirmatory test, the opportunity for additional information and referrals for services again occurs.

The continuum of care for children and adolescents is operated by the University of South Florida (USF) and All Children's Hospital (ACH) Pediatric HIV Program. Begun in 1990, it provides an accessible, comprehensive, family centered, culturally competent, community-based, coordinated system of care for infants, children, adolescents and pregnant women infected with or exposed to HIV. This program is the sole provider of comprehensive HIV care to children and youth within the four county EMA as well as within six additional counties encompassing west central Florida.

The program provides a "medical home" with 24-hour on-call services and intensive medical case management services that are provided by doctors, nurses, nutritionists, pharmacists, and social workers. The primary goal is to improve the health and lives of children and their families through medical care, access to clinical trials, psychosocial support and education. A second goal is to continue to decrease the transmission of HIV from mother to infants, and prevent HIV infection in adolescents through early intervention and community out-reach and education. In addition to Ryan White Part A funding, this program is funded through a variety of sources which has allowed for continued growth of the program.

Over the past four years, the division of Adolescent Medicine and Pediatric Infectious Disease has expanded clinical services for both HIV negative and HIV positive youth. Both primary and specialty care are provided simultaneously. A general adolescent clinic is offered at the same time as the HIV clinic so that there is continued support for gynecologic services and other adolescent issues that may arise. The Tampa clinic provides acute care

six days per week. Access to mental health services, both on site and through referral, has been expanded.

A multidisciplinary team is composed of a nurse case manager, social workers, nutritionists and an adherence coordinator. Access to medication consultations, psychology and psychiatry exist. Weekly team conferences and daily team contacts occur. Continuity of care coordination, including hospitalization, is provided to each patient.

In addition, a monthly comprehensive clinic occurs at the University of South Florida Main Campus, with the Adult HIV clinic. A gynecologist provides on site colposcopies and sub-specialty gynecological care.

The Mother-Baby Care program follows youth through pregnancies providing the infection disease care and a perinatal nurse case manager. Infants are evaluated in the same clinic setting to decrease appointments and provide consistency of providers. A transition program assists youth in effectively accessing services as an adult. Medication treatment adherence education and counseling are provided by an adherence nurse, and education about, and access to, a variety of therapeutic and prevention trials are provided.

Primary and subspecialty care for youth enrolled in the Adolescent Medical Trials Unit are provided in three University of South Florida clinics located in Hillsborough and Pinellas Counties that are conveniently located for patients in the most populated sections of the TSA.

In order to prevent mother-to-child transmission, the Perinatal HIV Prevention Program was developed as a collaborative community program funded by Ryan White Parts A, B, D and the Florida Department of Health's Children's Medical Services (CMS). The Program identifies pregnant HIV+ women and educates them on how to reduce the risk of transmitting HIV to their child. The client and her family are involved in activities that include confidential care coordination, counseling and support services. Hospital, medications and obstetric visits are included as is a comprehensive education component. Although there were 89 HIV exposed infants in the TSA during 2010, there has been only one HIV positive perinatal case, according to the State of Florida, Bureau of HIV/AIDS eHARS data.

Accessing the continuum of care for adults in the TSA is generally achieved through the case management system. Case managers assess the client's acuity level, develop a case plan, provide information and referrals for accomplishing the goals of the plan and monitor the progress of the client through the continuum. Most services may be accessed without the referral of a case manager and an experienced client with limited needs may navigate the system of care without assistance at any point on the continuum. The Planning Council adopted a policy that anyone presenting for Ryan White Part A funded services must show proof of primary care in the past year.

Ambulatory/outpatient care, often referred to as primary care is available in all but one of the counties within the TSA. Early entry into primary care can have a positive impact on the overall length and quality of life of an HIV infected individual. A major barrier for entry into

primary care is having a payer source. Each year the Health Services Advisory Committee conducts a survey to determine that at least one qualified public provider is serving each county. Primary care is currently available in all but one county which is covered by a neighboring county.

Medicaid is a major funding source for primary care services for HIV infected individuals. The state enacted a disease management initiative for Medicaid eligible HIV infected individuals designed to improve medical outcomes. This program provides nurse case managers and access to a wide range of medical services. Medicaid is more likely to serve women with children than single males due to eligibility criteria and generally lower incomes of women.

The Medicaid Project AIDS Care (PAC) Waiver program provides services for Medicaid eligible PLWA in their homes or in the community. An individual must have a diagnosis of AIDS and meet income and disability criteria.

Medicare is available for those individuals who meet the Social Security Administration's definition of "disabled" through the SSI and SSDI programs.

The Veteran's Administration also provides comprehensive primary care and specialty services to HIV infected veterans, both on the Pinellas and Hillsborough VA campuses, and at multiple community based outpatient clinics throughout both service areas. This comprehensive care includes all forms of diagnostic testing, specialty care, mental health care, nutrition care, psychosocial care, substance abuse programs, homeless programs, well woman care, pharmacy care with prescription services and pharmacy specialty clinics, (lipid monitoring, anticoagulation monitoring, BP monitoring, hepatitis C treatment monitoring), emergency care, urgent care, and hospitalization. Multiple specialties have a tele-medicine program, including infectious disease, in which veterans that are closer to the Ft. Myers clinic than Bay Pines, are seen via television by the specialty providers at Bay Pines. The veteran also has access to community based Ryan White case management services, who works closely with the Ryan White Coordinator at Bay Pines, to coordinate care across the continuum.

Other resources for the medically needy include the Hillsborough County Indigent Health Care Plan which pays for inpatient care and a portion of outpatient services for qualified low income individuals up to 100% FPL (Federal Poverty Level). Pinellas County Social Services supports a limited number of outpatient services.

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

Medical case management within the TSA is client centered with collaborations and linkages to health care, psychosocial, and other services to ensure timely, coordinated access to medically appropriate levels of health and support services and continuity of care.

Services are available throughout the TSA and take place at the client's home, hospital and clinic or provider offices.

Medical case management is a collaborative process that assesses plans, implements, coordinates, monitors and evaluates options and services to meet an individual's health care needs using available community resources. It is a client-centered service delivery system that works to empower individuals to make choices that enhance the quality of their lives in the least restrictive setting and in the most cost effective manner. Because of its complexity, the health care and social service delivery systems can be difficult to unravel to the client's advantage. Case management helps clients and their families make informed decisions based on the client's needs, abilities, resources and personal preferences. Case management can also personalize care in an otherwise impersonal system.

The role of the case manager is to work in partnership with the service recipient and other caregivers. Case management is necessary when the client with multiple needs is unable to define, locate or retain the resources and services necessary to ensure their continuum of care. Case management is the 'hub of the wheel" of the coordinated service delivery system. The client and the case manager work together to build relationships that add to the matrix of support services. These relationships may include services already being used by the client as well as newly identified resources. By monitoring the quantity and status of these relationships, case management is able to maintain the integrity of a coordinated service delivery system.

Successful case management requires more than just the development and implementation of a process for coordinating services. It requires that staff, both administrative and direct care, adopt a philosophy about the process. The philosophy or mission statement could include the following:

- The needs of individual clients are unique, wide-ranging and will vary over time; therefore, the system must be flexible enough to be responsive to the client and structured enough to provide support and guidance to the case manager.
- Clients can function in the community when provided with varying degrees of support and should be encouraged to function as independently as possible.
- Clients should be encouraged to assume an active, rather than a passive, role in the case management process.
- Case management is not a time-limited service, but rather an ongoing one.

There are six phases of case management:

1. Initial Intake
2. Initial Assessment
3. Initial Plan of Care Development
4. Coordination of Services
5. Monitoring and Care Plan Revisions
6. Documentation and Reporting

In the TSA, there is a standardized acuity assessment tool which is used for agencies to determine the amount of contact a case manager needs to have with a client.

Medications play a significant role in maintaining health and quality of life of HIV infected individuals. Medications make up the single largest expenditure in the treatment of HIV. In the TSA, medications represented 50.2% of the budgeted figures for all identified funding streams in 2011. This does not include payments for co-pays under the health insurance or AICP programs.

Notable advances have been made in the treatment of HIV and associated opportunistic infections. Medications play a significant role in maintaining health and quality of life of HIV infected persons.

Medications, or more frequently, a combination of medications commonly referred to as Highly Active Antiretroviral Therapy (HAART) may be prescribed when an individual develops symptoms such as wasting, thrush, unexplained fever for more than two weeks, or when their CD4 count is low. However, the decision to begin medications must be made by the client and their physician, with a full understanding of the benefits and risks involved. Pregnant women are advised to utilize medications to help prevent the transmission of the virus to the fetus.

Most medications have side effects that can range from mild to severe. In some cases, side effects can be managed; in other cases a different or additional medication must be prescribed. Beginning treatment in asymptomatic individuals creates the potential for developing drug resistance early on in the disease process, thereby limiting future treatment options. Many drug regimens are also inconvenient, and the long term toxicity of some drugs is not yet known.

Resistance can also occur when medications are not taken correctly, allowing the virus to reproduce and mutate. Genotypic and phenotypic tests are available to determine if someone is resistant to medications. Genotypic tests look for markers of resistance, or mutations in the HIV gene. Phenotypic testing inserts a medication directly into the virus to see how much is required to prevent the virus from growing. While these tests may be helpful in determining what medications may be helpful to an individual, both tests have to be conducted in very specific ways and must be interpreted by someone well versed in the tests. In addition, these tests are expensive, and may not be available everywhere.

Prophylaxis is the observance of a regimen for the sake of disease prevention. Drugs are taken before a disease develops with the intention of preventing the disease from occurring. By keeping small doses of drugs in the bloodstream, opportunistic germs can be killed when they enter the body. Prevention of opportunistic infections is important for improving the over-all well being of an infected individual, and ideally enhancing their life span.

HIV-related medications are provided through a variety of sources available within the TSA but are most frequently accessed through the AIDS Drug Assistance Program (ADAP) and

Medicaid. Ryan White also funds medication assistance, as do private insurance, the Veteran's Administration and compassionate use programs provided by drug manufacturers. Policy changes, increased co-pays and formulary restrictions/revisions make medications a service category with the potential for dramatic change and negative financial impact for the Ryan White programs.

Health insurance services are available to HIV+ individuals within the TSA to provide financial assistance to maintain continuity of health insurance or to receive medical benefits under a health insurance program. Private health insurance coverage assists in spreading the cost of managing HIV disease over both the public and private sectors. As clients remain healthier for longer periods of time due to the use of medications and lifestyle changes, the possibility to continue working, and thereby continue private health insurance, dramatically increases.

Clients may still require assistance with meeting deductibles and co-payments for services and medications. In the event that an individual becomes too ill to work, or otherwise loses employment, the Consolidated Omnibus Budget Reconciliation Act (COBRA) allows for the continuation of health insurance at the individual's expense for a period of up to 18 months and for conversion to private policies.

A primary source of health insurance coverage within the TSA is through the Florida Department of Health Bureau of HIV/AIDS run AICP (AIDS Insurance Continuation Program). AICP operates statewide by providing payment for premiums and in some cases, co-payments and deductibles to allow symptomatic and asymptomatic HIV+ individuals to continue their health insurance under COBRA, or to maintain other private insurance. In addition the program also can provide family coverage up to the limits of monthly premiums (currently $650.00), policy conversion after COBRA eligibility expires, and policy upgrades for expanded drug formulary coverage.

Additional assistance for payment of health insurance coverage is available within the TSA through Ryan White Parts A and B and the state general revenue funded HIV services program. Individuals can receive up to $400 per month for insurance premium assistance and up to $275 per month to assist with co-pay and deductibles.

There are also county operated health plans in Hillsborough and Polk counties that serve medically indigent, low income people. The high cost of operating these plans has led to limitations of coverage, exclusion of HIV medications from formularies and tighter eligibility criteria, making their role in HIV care a diminishing one.

Following a diagnosis of HIV or AIDS, the need for **mental health services** is often intensified. Feelings of anger, fear, guilt, denial and sadness can overwhelm a newly diagnosed person. Individuals who have lived with an HIV diagnosis for a long time also have to face additional stress in coping with the disease, and may have frequent episodes of bereavement following the loss of friends and family members. Pressure regarding who

to disclose one's HIV status to, as well as the impact of HIV on establishing or maintaining close relationships can contribute to the need for mental health treatment.

The assessment of psychiatric conditions in HIV+ individuals can be further complicated by many factors including the direct and indirect impact of HIV on the central nervous system, the impact of medical illness as well as pre-existing psychiatric conditions, impact of medications, and the psychological distress and adjustment difficulties mentioned above.

Types of disorders include generalized anxiety disorder, phobias, post-traumatic stress disorder, panic disorder, obsessive-compulsive disorder, bi-polar disorder, and depressive disorders. While there is mixed evidence regarding the frequency of depression and other disorders among HIV+ individuals when compared against the population at large, there does seem to be a greater likelihood of minor depressive symptoms among HIV+ individuals.

Drug interactions and/or the progression of the disease may lead to the above mentioned conditions as well as other conditions including delirium, cognitive impairment and dementia, and manic syndrome. In addition, special considerations must be made when using psychotropic drugs in conjunction with protease inhibitors. Lower dosing may be necessary, and certain medications should be avoided.

Psychiatric disorders may involve physical, genetic or medical origins, or may be in response to acute or chronic life stressors. Most disorders involve more than one factor. Treatment may involve the use of medication, psychotherapy, or a combination of both.

Support groups can be particularly helpful for an HIV+ person to develop knowledge of the disease, ease tensions relating to the disease, and provide an opportunity to remain engaged in the community. These groups are generally led by a trained facilitator, but not necessarily a licensed practitioner. However, support groups may be difficult to coordinate in rural areas due to transportation and confidentiality issues.

Publicly-funded mental health services in Florida have identified target populations among adults with serious mental illnesses including adults with severe and persistent psychiatric disabilities, adults in mental health crisis, and adults with court involvement. Services for children are also provided for, but will not be discussed in depth in this document.

Three principles of the mental health system are:

- The system is person centered
- The system is community based
- The system is results oriented

All citizens in Florida have the right to certain publicly-funded mental health services regardless of their ability to pay. However, some services may be limited when funds are not available, and not all services are available in all communities.

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

Oral health services have the primary focus of alleviating discomfort, keeping teeth and gums healthy, preventing infection and maintaining the ability to eat nutritional foods with the goal of optimizing overall health.

While an asymptomatic individual usually does not require any special consideration in the provision of dental care; as the disease advances to AIDS, lab tests (CD+4, viral loads, sensitivity tests, platelet counts) may be valuable in determining an appropriate treatment plan. Specific considerations must be given to interaction of HIV medications and agents prescribed by the dentist. Patients in advanced stages of the disease may already be taking antibiotics to prevent opportunistic infections, so additional agents should be used with caution. A thorough medical history as well as knowledge of potential interactions is essential for the clinician.

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

Substance abuse treatment often begins with an assessment of the level of intensity required to meet an individual client's need, which may or may not include hospitalization. Clients progress to less intensive levels of care as treatment goals are met.

Injection drug use (IDU) is the third ranked mode of transmission in the TSA. In general, addicts who are HIV+ are less compliant with medical treatment as a result of their substance abuse. Substance abusers may also be less likely to be aware of their HIV status. HIV infection is often diagnosed later in the course of the disease among drug users than in other groups, frequently after the onset of AIDS. HIV+ clients who are drug users are more likely to be without a source of primary care and more likely to use emergency medical services than HIV+ clients who are not drug users.

Alcohol and drug abuse have also been associated with high-risk sexual behavior increasing the possibility of transmitting the virus to others, as well as increasing the risk of re-infection.

Increasingly, insurers and managed care providers pay for mental health and substance abuse treatment on a day-by-day basis, with an emphasis on minimizing both the duration and intensity of treatment. There are generally three levels of care: inpatient, intensive outpatient, and outpatient treatment. The continuum of care from most intense to least intense would generally follow the progression identified below: 1) Detoxification Services,

2) Residential Treatment, 3) Day/Night Treatment, and 4) Outpatient/Methadone Maintenance/Aftercare

Detoxification services are generally short-term in nature, and while usually provided in an inpatient setting, they can also be provided on an outpatient basis. Depending upon the substance used and the individual client's need, the goal of detoxification is to offer assistance dealing with the physical symptoms of withdrawal, and referring the client on to the next appropriate level of care.

Residential treatment programs are long-term treatment, generally lasting from six to 18 months. Often these programs are based on the therapeutic community model which provides intense peer support designed to produce behavioral changes in the substance abuser. Principals of treatment include the use of peer support, confrontation, and behavior shaping using a system of rewards and punishments. There are a number of other levels of residential treatment, including programs where day or night treatment is utilized and a client resides with a host family, and supported housing or half-way house which provides a supportive environment for a client completing treatment.

Intensive outpatient services include day or night treatment, which provide a schedule of services and activities for several hours each day. Services may be offered in the evening or on weekends to allow clients to continue working while participating in treatment.

Outpatient services traditionally involve a few hours of treatment per week and include individual and/or group counseling. This level of treatment is often the most appropriate for people who are employed and have a stable support network. Outpatient programs provide no living facilities and usually have little medical supervision. However it should be noted that methadone maintenance programs are medically supervised, to assure that the client maintains an optimal dosage level to prevent withdrawal symptoms.

Outpatient/aftercare services may also include self-help programs. The general goal is to prevent relapse. Self-help are the most widely accessible programs, they are free, and generally based on the "twelve-step" model. Programs such as Alcoholics Anonymous (AA), Narcotics Anonymous (NA), and Cocaine Anonymous (CA) have a strong abstinence orientation, and a philosophy that emphasizes medication-free treatment, which can be problematic for HIV+ individuals who must take medications in order to live.

Substance abuse treatment is also funded in the TSA through the State of Florida, Ryan White and SAMSHA (Substance Abuse and Mental Health Administration). The need for these services is great; however research has shown repeatedly that successful treatment depends on an individual's readiness to enter treatment. Multiple attempts at rehabilitation must often be made, and supportive living arrangements in the community must be in place for long term success.

In addition to the core services, there are very limited **support services** specifically transportation still funded by Ryan White. Other services, such as food bank, housing assistance, and legal assistance are only available through traditional resources.

RESOURCE ANALYSIS

Resource analysis is conducted as part of the needs assessment process. A specific set of services were identified for inclusion, which considered HRSA and Florida SCSN (Statewide Coordinated Statement of Need) core services as well as several support services including transportation, housing and food.

Hernando, Hillsborough and Pinellas counties have extensive information and referral systems known as "211". 211 can be accessed by phone (by dialing 2-1-1) or on-line. Websites also offer information in Spanish. As the listings are quite extensive and updated more regularly than would be feasible for any other form of directory, this resource is highly valuable to clients and services providers wishing to link clients with services.

To gain information not provided by internet resource site, contact were made with provider agencies by telephone, fax and e-mail communication. In addition, input from County Health Department staff particularly in rural areas.

The full resource analysis report includes wait list, hours of operation, languages spoken, public transportation accessibility and contact information for each provider. Findings from the report show that the rural counties in general do not offer public transportation. Large land areas and low population densities make travel to service providers problematic for some clients. The urban counties do have bus systems but depending on where a client needs to travel it can take several hours to reach a destination. All counties had at least some service providers that provided services in Spanish. All providers can access the statewide TDD assistance for the speaking and hearing impaired. Creole is available to a limited extent in areas with concentrations of Haitian populations. Most areas had some services (primary care, case management, counseling, support groups, substance abuse treatment, emergency shelters and food banks) that were provided outside of traditional hours.

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

RESOURCE INVENTORY
EMA Counties

CORE MEDICAL SERVICES	
Outpatient /Ambulatory Health Services	Community Health Centers of Pinellas (Pinellas) Good Samaritan Free Clinic (Pasco) Hernando County Health Department (Hernando) Hillsborough County Health Department (Hernando, Hillsborough, Pasco, Pinellas) Lee Davis Neighborhood Service Center (Hillsborough) North Tampa Community Health Center (Hillsborough) Pasco County Health Department (Pasco) Pinellas County Health Department (Pinellas) St. Joseph's Community Care Center (Hillsborough) St. Joseph's Hospital, Inc. (Hillsborough, Pasco, Pinellas)

	Suncoast Community Health Center (Hillsborough) USF Department of Pediatrics (Hillsborough, Pinellas) US Veteran's Administration (Hernando, Hillsborough, Pasco, Pinellas)
AIDS Drug Assistance Program (ADAP)	Hernando County Health Department (Hernando) Hillsborough County Health Department (Hillsborough) Pasco County Health Department (Pasco) Pinellas County Health Department (Pinellas)
AIDS Pharmaceutical Assistance (local)	AB Specialty Pharmacy (Hernando, Hillsborough, Pasco, Pinellas) Community Health Centers of Pinellas (Pinellas) Daystar Life Center (Pinellas) Health Councils MedNet (Hillsborough, Pinellas) Hillsborough County Health Department (Hernando, Hillsborough, Pasco, Pinellas) Neighborly Care Network (Pinellas) Positive Healthcare (Hernando, Hillsborough, Pasco, Pinellas) Suncoast Community Health Center (Hillsborough)
Oral Health Care	Community Health Centers of Pinellas (Pinellas) Dental Research Clinic (Hillsborough) Good Samaritan Clinic (Pasco) Hernando County Health Department (Hernando) Hillsborough County Health Department (Hernando, Hillsborough, Pasco, Pinellas) Lee Davis Neighborhood Service Center (Hillsborough) North Tampa Community Health Center (Hillsborough) Pasco County Health Department (Pasco) PHS General and Medical Assistance (Pinellas) Pinellas County Health Department – children only (Pinellas) St. Pete College Dental Clinic (Pinellas) Suncoast Community Health Center (Hillsborough) UF College of Dentistry (Pinellas)
Early Intervention Services	AIDS Service Association of Pinellas (Pinellas) Community Health Centers of Pinellas (Pinellas) Good Samaritan – Adherence Corp. (Pinellas) Hernando County Health Department (Hernando) Hillsborough County Health Department (Hillsborough, Pasco) Metro Wellness and Community Centers (Hillsborough, Pasco, Pinellas) Pasco County Health Department (Pasco) Pinellas County Health Department (Pinellas) Positive Healthcare (Hernando, Hillsborough, Pasco, Pinellas) Spirit of Life metropolitan Church (Pasco) USF Health Youth Education Services YES (Pinellas) WestCare Foundation (Pinellas)
Health Insurance Premium & Cost Sharing Assistance	Florida Kid Care (Hernando, Hillsborough, Pasco, Pinellas) The Health Councils, Inc. (Hernando, Hillsborough, Pasco, Pinellas)
Home Health Care	Bayada Nurses (Hillsborough, Pasco, Pinellas) Home Health Works (Pasco, Pinellas) Neighborly Care Network (Pinellas) Nurse Core (Pinellas)

	US Veteran's Administration (Hernando, Hillsborough, Pasco, Pinellas) Visiting Nurses Association (Hernando, Hillsborough, Pasco)
Home and Community-Based Health Services	Bayada Nurses (Hillsborough, Pasco, Pinellas) Home Health Works (Pasco, Pinellas) Metro Wellness and Community Centers (Hillsborough, Pasco, Pinellas) Neighborly Care Network (Pinellas) Nurse Core (Pinellas) Positive Healthcare (Hernando, Hillsborough, Pasco Pinellas) USF Department of Pediatrics (Pinellas) Visiting Nurses Association (Hernando, Pasco)
Hospice Services	Hernando-Pasco Hospice (Hernando, Pasco) Suncoast Hospice (Pinellas) Life Path Hospice (Hillsborough) US Veteran's Administration (Hernando, Hillsborough, Pasco, Pinellas)
Mental Health Services	AIDS Service Association of Pinellas (Pinellas) Boley Center (Pinellas) Catholic Charities (Hernando, Pasco, Pinellas) Counseling Center of Plant City (Hillsborough) Counseling Center of Tampa Bay (Hillsborough) Creative Change (Hernando) Crisis Center of Tampa Bay (Hillsborough) Directions for Mental Health (Pinellas) Family Service Association of Greater Tampa (Hillsborough) Francis House (Hillsborough) Growing Counseling Center (Hernando, Pasco) Harbor Behavioral Healthcare (Hernando, Pasco) Mental Health Care, Inc (Hillsborough) Metro Wellness and Community Centers (Hillsborough, Pasco, Pinellas) Northside Mental Health Center (Hillsborough) North Tampa Community Health Center (Hillsborough) Operation PAR (Pasco, Pinellas) Pasco County Health Department (Pasco) PEMHS, Inc. (Pinellas) St. Anthony's Pinellas Care Clinic (Pinellas) St. Joseph's Hospital, Inc. (Hernando, Hillsborough, Pasco) St. Vincent de Paul (Pinellas) Suncoast Center for Community Health (Pinellas) Suncoast Community Health Center (Hillsborough) US Veteran's Administration (Hernando, Hillsborough, Pasco, Pinellas) USF Department of Pediatrics (Hillsborough, Pinellas)
Medical Nutrition Therapy	Community health Centers of Pinellas (Pinellas) Hernando County Health Department (Hernando) Hillsborough County Health Department (Hillsborough) Pasco County Health Department (Pasco) Neighborly Care Network (Pinellas) St. Joseph's Hospital Pinellas Care Clinic (Pinellas) St. Joseph's Hospital (Hillsborough) US Veteran's Administration (Hernando, Hillsborough, Pasco, Pinellas) USF Department of Pediatrics (Hillsborough, Pinellas)

Medical Case Management (including Treatment Adherence)	AIDS Service Association Pinellas (Pinellas) Francis House (Hillsborough) Hernando County Health Department (Hernando) Metro Wellness and Community Centers (Hillsborough, Pasco, Pinellas) Pasco County Health Department (Pasco) THAP (Hillsborough) USF Department of Pediatrics (Hillsborough, Pinellas)
Substance Abuse Services–Outpatient	ACTS (Hillsborough) Counseling Center of Tampa Bay (Hillsborough) Creative Change (Hernando) DACCO (Hillsborough) Directions for Mental Health (Pinellas) Family Service Association of Greater Tampa (Hillsborough) Francis House (Hillsborough) Growing Counseling Center (Hernando, Pasco) Harbor Behavioral Healthcare (Hernando, Pasco) Lighthouse Gospel Mission and Faith Home (Hillsborough) Metro Wellness and Community Centers (Pinellas) Operation PAR (Hillsborough, Pasco, Pinellas) Phoenix House (Hillsborough) Suncoast Center for Community Health (Pinellas) WestCare Foundation (Pinellas)
SUPPORT SERVICES	
Case Management (non-Medical)	AIDS Service Association of Pinellas (Pinellas) Boley Center (Pinellas) Crisis Center of Tampa Bay (Hillsborough) Department of Children and Families (Hernando, Hillsborough, Pasco, Pinellas) Di's Imani (Hillsborough, Pinellas) Directions for Mental Health (Pinellas) Metro Wellness and Community Centers (Hillsborough, Pasco, Pinellas) Operation Hope (Pinellas) Positive Healthcare (Hernando, Hillsborough, Pasco, Pinellas) St. Vincent De Paul (Pinellas) Suncoast Center for Community Mental Health (Pinellas)
Emergency Financial Assistance	AIDS Service Association of Pinellas (Pinellas) Boley Center (Pinellas) Catholic Charities (Hillsborough, Pinellas) Crisis Center of Tampa Bay (Hillsborough) Daystar Life Center (Pinellas) Emergency Care Help Organization (Hillsborough) Lee Davis neighborhood Service Center (Hillsborough) Mercy House (Hillsborough) Mid Florida Community Services (Hernando, Pasco) PHS General and Medical Assistance (Pinellas) Pinellas Opportunity Council (Pinellas) Salvation Army (Hernando, Hillsborough, Pasco, Pinellas) St. Joseph's Community Care (Hillsborough) St. Vincent de Paul (Hillsborough, Pinellas)
Food Bank/Home-	Abundant Life Food Ministries (Pinellas)

Delivered Meals	Calvary Church of the Nazarene (Hernando, Pasco) Christ Church of Palm Harbor (Pinellas) Clearview United Methodist (Pinellas) Community Food Bank (Hillsborough) DACCO (Hillsborough) Dayspring Presbyterian Church (Hernando) Daystar Life Center (Pinellas) Emergency Care Help Organization (Hillsborough) Emergency Relief Food Pantry (Pinellas) First Baptist Church of Brooksville (Hernando) First United Methodist Church of Springhill (Hernando) FEAST, Inc (Pinellas) Food With Care (Hernando, Hillsborough, Pasco, Pinellas) Good Samaritan – Adherence Corp. (Pinellas) Lighthouse Gospel Mission (Hillsborough) Meals on Wheels (Hernando, Hillsborough, Pinellas) Metro Wellness and Community Centers (Pasco) Metropolitan Ministries (Hillsborough) Mid Florida Community Services (Pasco) Nativity Catholic Church (Hillsborough) Neighborly Care Network (Pinellas) Northside ETS Food Pantry (Pinellas) Operation Hope (Pinellas) RCS Food Bank (Pinellas) Salvation Army (Hernando, Hillsborough, Pasco, Pinellas) St. Anne Catholic Church (Hillsborough) St. Anthony's Pinellas Care Clinic (Pinellas) St. Joseph's Community Care (Hillsborough) St. Joseph's Tampa Care Clinic (Hernando) St. Pete Free Clinic (Pinellas) St. Vincent de Paul (Hillsborough, Pinellas) Tampa Bay Dream Center (Hillsborough) Tarpon Springs Shepard Center (Pinellas) Wesley United Methodist Church (Pinellas)
Health Education/Risk Reduction	AIDS Service Association Pinellas (Pinellas) Francis House (Hillsborough) Harbor Behavioral Health (Hernando) Hernando County Health Department (Hernando) Hillsborough County Health Department (Hillsborough) Metro Wellness and Community Centers (Hillsborough, Pasco, Pinellas) Pasco County Health Department (Pasco) Positive Healthcare (Hernando, Hillsborough, Pasco, Pinellas) St. Anthony's Pinellas Care Clinic (Pinellas) THAP (Hillsborough) US Veteran's Administration (Hernando, Hillsborough, Pasco, Pinellas) USF Department of Pediatrics (Hillsborough, Pinellas)
Housing Services	Boley Center (Pinellas) Brooksville Housing Authority (Hernando) Catholic Charities (Hillsborough, Pinellas)

	City of Tampa Housing Authority (Hillsborough) Community Service Foundation (Pinellas) Hernando County Housing Authority (Hernando) Mercy House (Hillsborough) Pasco Public Housing Authority (Pasco) Pinellas County & Dunedin Housing Authority (Pinellas) Plant City Housing Authority (Hillsborough) St. Vincent de Paul (Pinellas) THAP (Hillsborough)
Legal Services	Bay Area Legal Services (Hernando, Hillsborough, Pasco, Pinellas) Community Law Program (Pinellas) Community Legal Services of Mid Florida (Hernando) Gulf Coast Legal Services (Pinellas)
Medical Transportation Services	Day Star Life Center (Pinellas) Hillsborough Co. Specialized Transportation (Hillsborough) Mid-Florida Community Services (Hernando, Pasco) Neighborly Care Network (Pinellas) Pasco County Health Department (Hernando, Pasco) Pinellas Suncoast Transit Authority (Pinellas) St. Joseph's Hospital Pinellas Care Clinic (Pinellas) St. Vincent De Paul (Pinellas) Suncoast Community Health Center (Hillsborough) Transportation Disadvantaged Program (Pinellas) US Veteran's Administration (Hernando, Hillsborough, Pasco, Pinellas) USF Department of Pediatrics (Hillsborough)
Outreach Services	AIDS Service Association Pinellas (Pinellas) Good Samaritan – Adherence Corp. (Pinellas) Hillsborough County Health Department (Hillsborough) Metro Wellness and Community Centers (Hillsborough, Pinellas) USF Department of Pediatrics (Hillsborough, Pinellas)
Psychosocial Support Services	AA – Pinellas Central Office (Pinellas) AIDS Service Association Pinellas (Pinellas) Boley Center (Pinellas) Catholic Charities (Pasco) Creative Change (Hernando) Dawn Center of Hernando (Hernando) Di's Imani (Hillsborough, Pinellas) Directions for Mental Health (Pinellas) Family Service Association of Greater Tampa (Hillsborough) Francis House (Hillsborough) Good Samaritan Clinic (Pasco) Good Samaritan – Adherence Corp. (Pinellas) Harbor Behavioral Healthcare (Hernando, Pasco) Hernando County Health Department (Hernando) Mental Health Care, Inc (Hillsborough) Metro Wellness and Community Centers (Hillsborough, Pinellas) Operation PAR (Hillsborough, Pasco Pinellas) Pasco County Health Department (Pasco) Phoenix House (Hillsborough)

	Project CARE (Hillsborough) Spirit of Life Metropolitan Church (Pasco) St. Joseph's Hospital, Inc. (Hillsborough) St. Vincent De Paul (Hillsborough, Pinellas) Suncoast Center for Community Health (Pinellas) THAP (Hillsborough) USF Department of Pediatrics (Hillsborough, Pinellas) Wesley United Methodist Church (Pinellas) WestCare Foundation (Pinellas)
Referral for Health Care/Supportive Services	AIDS Service Association Pinellas (Pinellas) Good Samaritan – Adherence Corp. (Pinellas) Hernando County Health Department (Hernando) Metro Wellness and Community Centers (Hillsborough, Pasco, Pinellas) Metropolitan Ministries (Hillsborough) North Tampa Community Health Center (Hillsborough) USF Department of Pediatrics (Hillsborough, Pinellas) WestCare Foundation (Pinellas)
Rehabilitation Services	Cypress Healthcare (Pinellas) Morton Plant – Barrett Rehabilitation (Pinellas) Nurse Core (Pinellas) Tandem Health Care of Brandon (Hillsborough) US Veteran's Administration (Hernando, Hillsborough, Pasco, Pinellas)
Respite Care	Catholic Charities (Hernando) Cypress Healthcare (Pinellas) Francis House (Hillsborough) Tandem Health Care of Brandon (Hillsborough) United Cerebral Palsy of Tampa Bay (Hernando) US Veteran's Administration (Hernando, Hillsborough, Pasco, Pinellas)
Substance Abuse Services– Residential	DACCO (Hillsborough) Harbor Behavioral Healthcare (Hernando, Pasco) Operation PAR (Hillsborough, Pasco, Pinellas) Phoenix House (Hillsborough) US Veteran's Administration (Hernando, Hillsborough, Pasco, Pinellas)
Treatment Adherence Counseling	AIDS Service Association Pinellas (Pinellas) Good Samaritan – Adherence Corp. (Pinellas) Hillsborough County Health Department (Hillsborough) Metro Wellness and Community Centers (Hillsborough, Pasco, Pinellas) Operation Hope (Pinellas) Positive Healthcare (Hernando, Hillsborough, Pinellas) US Veteran's Administration (Hernando, Hillsborough, Pasco, Pinellas) USF Department of Pediatrics (Hillsborough, Pinellas) WestCare Foundation (Pinellas)

RESOURCE INVENTORY
Non-EMA Counties

CORE MEDICAL SERVICES	
Outpatient	Central Florida Health Care (Hardee, Highlands, Polk)

/Ambulatory Health Services	Good Samaritan Free Clinic (Polk) Hardee County Health Department (Hardee, Polk) Highlands County Health Department (Highlands) Hillsborough County Health Department (Hardee, Highlands, Manatee, Polk) Lakeland Volunteers in Medicine (Polk) Manatee County Health Department (Manatee) Manatee County Rural Health Services (Manatee) Polk County Health Department (Hardee, Polk) US Veteran's Administration (Hardee, Highlands, Manatee, Polk)
AIDS Drug Assistance Program (ADAP)	Hardee County Health Department (Hardee) Highlands County Health Department (Highlands) Manatee County Health Department (Manatee) Polk County Health Department (Hardee, Polk)
AIDS Pharmaceutical Assistance (local)	AB Specialty Pharmacy (Hardee, Highlands, Manatee, Polk) Health Councils MedNet (Polk) Hillsborough County Health Department (Hardee, Highlands, Manatee, Polk) Manatee County Rural Health Services (Manatee) Positive Healthcare (Hardee, Highlands, Manatee, Polk)
Oral Health Care	Central Florida Health Care (Hardee, Highlands, Polk) Hardee County Health Department (Hardee, Polk) Highlands County Health Department (Highlands) Hillsborough County Health Department (Hardee, Highlands, Manatee, Polk) Manatee County Health Department (Manatee) Manatee County Rural Health Services (Manatee) Polk County Health Department (Hardee, Polk)
Early Intervention Services	Central Florida Health Care (Hardee, Highlands, Polk) Hardee County Health Department (Hardee) Highlands County Health Department (Highlands) Manatee County Health Department (Manatee) Manatee County Rural Health Services (Manatee) Polk County Health Department (Hardee, Polk) Positive Healthcare (Hardee, Highlands, Manatee, Polk)
Health Insurance Premium & Cost Sharing Assistance	Florida Kid Care (Hardee, Highlands, Manatee, Polk) The Health Councils, Inc. (Hardee, Highlands, Manatee, Polk)
Home Health Care	Bayada Nurses (Polk) US Veteran's Administration (Hardee, Highlands, Manatee, Polk) Visiting Nurses Association (Highlands, Manatee, Polk)
Home and Community-Based Health Services	Bayada Nurses (Polk) Positive Healthcare (Hardee, Highlands, Manatee, Polk) Visiting Nurses Association (Highlands, Manatee, Polk)
Hospice Services	Good Shepherd Hospice (Polk) Life Path Hospice (Highlands, Polk) Tidewell Hospice of SW Florida (Manatee) US Veteran's Administration (Hardee, Highlands, Manatee, Polk)
Mental Health Services	Counseling Center of Plant City (Polk) Manatee Glens (Manatee) Marge Brewster Center (Highlands)

	Operation PAR (Manatee) Peace River Center (Hardee, Highlands, Polk) Polk County Health Department (Polk) Tri-County Human Services (Hardee, Highlands, Polk) Winter Haven Hospital Behavioral Health (Polk) US Veteran's Administration (Hardee, Highlands, Manatee, Polk)
Medical Nutrition Therapy	Hardee County Health Department (Hardee) Highlands County Health Department (Highlands) Manatee County Health Department (Manatee) Manatee County Rural Health Services (Manatee) Polk County Health Department (Polk) US Veteran's Administration (Hardee, Highlands, Manatee, Polk)
Medical Case Management (including Treatment Adherence)	Hardee County Health Department (Hardee) Highlands County Health Department (Highlands) Manatee County Rural Health Services (Manatee) Polk County Health Department (Hardee, Polk)
Substance Abuse Services–Outpatient	Manatee Glens (Manatee) Peace River Center (Hardee) Tri-County Human Services (Hardee, Highlands, Polk)
SUPPORT SERVICES	
Case Management (non-Medical)	Department of Children and Families (Hardee, Highlands, Manatee, Polk) Di's Imani (Manatee) Peace River Center (Hardee, Polk) Positive Healthcare (Hardee, Highlands, Manatee, Polk) Tri-County Human Services (Polk)
Emergency Financial Assistance	Hardee Help Center (Hardee) Lakeland Volunteers in Medicine (Polk) Salvation Army (Manatee, Polk) Trinity Charities (Manatee)
Food Bank/Home-Delivered Meals	Calvary Church of the Nazarene (Hardee) Church of the Nazarene (Highlands) Crossroads Community Church (Polk) Food Bank of Manatee (Manatee) Food With Care (Hardee, Highlands, Manatee, Polk) Hardee County Health Department (Hardee) Hardee Help Center (Hardee) Lighthouse Gospel Mission (Manatee, Polk) Meals on Wheels Plus (Manatee) Salvation Army (Highlands, Manatee, Polk) Talbot House Ministries (Polk) Trinity Charities (Manatee)
Health Education/Risk Reduction	Central Florida Health Care (Hardee) Hardee County Health Department (Hardee) Highlands County Health Department (Highlands) Manatee County Health Department (Manatee) Manatee County Rural Health Services (Manatee) Manatee Glens (Manatee) Peace River Center (Hardee, Polk)

	Polk County Health Department (Polk) Positive Healthcare (Hardee, Highlands, Manatee, Polk) US Veteran's Administration (Hardee, Highlands, Manatee, Polk)
Housing Services	Bradenton Housing Authority (Manatee) Hardee Health Center (Hardee) Manatee County Housing Authority (Manatee) Polk County Health Department (Hardee, Polk) Public Housing Authority (Polk)
Legal Services	Florida Rural Legal Services (Hardee, Highlands, Polk) Gulf Coast Legal Services (Manatee) Legal Aid of Manasota (Manatee)
Medical Transportation Services	Lakeland Volunteers in Medicine (Polk) Manatee County Area Transit (Manatee) Tri-County Human Services (Hardee) US Veteran's Administration (Hardee, Highlands, Manatee, Polk)
Outreach services	Manatee County Rural Health Services (Manatee) Polk County Health Department (Polk)
Psychosocial Support Services	Crossroads Community Church (Polk) Di's Imani (Manatee) Manatee County Rural Health Services (Manatee) Manatee Glens (Manatee) Operation PAR (Manatee) Peace River Center (Hardee, Highlands) Talbot House Ministries (Polk) Tri-County Human Services (Hardee, Highlands, Polk) Trinity Charities (Manatee)
Referral for Health Care/Supportive Services	Hardee County Health Department (Hardee) Hardee Health Center (Hardee) Highlands County Health Department (Highlands) Manatee County Health Department (Manatee) Manatee County Rural Health Services (Manatee) Manatee Glens (Manatee) Polk County Health Department (Polk) United Way of Central Florida (Polk)
Rehabilitation Services	US Veteran's Administration (Hardee, Highlands, Manatee, Polk)
Respite Care	US Veteran's Administration (Hardee, Highlands, Manatee, Polk)
Substance Abuse Services–Residential	Manatee Glens (Manatee) Operation PAR (Manatee) Peace River Center (Hardee) Talbot House Ministries (Polk) Tri-County Human Services (Hardee, Highlands, Polk) US Veteran's Administration (Hardee, Highlands, Manatee, Polk)
Treatment Adherence	Manatee County Rural Health Services (Manatee) Polk County Health Department (Polk)

Counseling	Positive Healthcare (Hardee, Highlands, Manatee, Polk)

PROFILE OF RYAN WHITE FUNDED PROVIDERS

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

Hardee County is the most rural county in the TSA with the fewest number of HIV/AIDS cases. The Hardee County Health Department directly provides HIV-related ADAP services. Primary care, treatment adherence education, lab tests, case management with limited nutrition and dental services are all provided to eligible residents by the Polk County Health Department through Ryan White Part B funds. Ryan White Part C funds help provide additional services for Hardee County residents, but must be accessed in Polk County. HOPWA services for Hardee County are managed through neighboring Highlands County.

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

In **Hernando County**, the Health Department provides HIV related primary care and women's health services at the Spring Hill site. Other services include treatment adherence education, labs, dental, and ADAP. Substance abuse treatment is coordinated with a community treatment provider. As in Pasco County, access to some specialty care is limited, but can be accessed in the nearby urban centers if payment source and transportation are available.

Medical case management and eligibility determination services are provided by Metro Wellness and Community Centers.

Also a rural county, **Highlands County** is also served by the Polk County Part C program. The Highlands Health Department provides HIV-related primary care, treatment adherence education, lab tests, ADAP, case management, limited nutrition and dental services, and manages HOPWA funds for Hardee and Highlands counties. Clinical services are available at two locations, Sebring and Lake Placid. Mental health services are coordinated with the Marge Brewster Center and substance abuse services are coordinated with Tri-County Human Services.

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

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

A collaborative effort between Tampa General Hospital, the University of South Florida's (USF) College of Medicine and the Hillsborough County Health Department provides a comprehensive range of services to HIV+ individuals. ARNPs and Infectious Disease specialists provide primary medical care through an outpatient clinic in Tampa. Nutritional

counseling, pharmacy, Patient Assistance Programs (PAPs), labs, dental services and treatment adherence education are provided. In addition, clinical research trials are available for clients that expand care options for many who have exhausted other treatment protocols. The Health Department conducts rapid HIV testing, and the Specialty Care Center is one of the pilot sites for the ADAP Hepatitis C treatment program. Early morning appointments are available and translation services for most languages are available given advance notice. The Specialty Care Center works closely with the USF Department of Pediatrics to transition HIV+ adolescents into the adult system of care. The Center also refers pregnant women to USF's perinatal program. The Health Department also provides an HIV/TB co-morbidity project which provides therapy for identified HIV/TB cases in the facility or at the client's home. Cases are monitored until treatment is completed.

Metro Wellness and Community Centers provides an eligibility specialist and a specialty case manager on site. The Specialty Care Center coordinates with Tampa General's Emergency Room, and local homeless and domestic violence shelters which help to link HIV+ people into care. Substance abuse treatment is referred to local providers, DACCO (Drug Abuse Comprehensive Coordinating Office) and WestCare, and a health department staff member meets with all incarcerated individuals who test positive for HIV to provide in-depth counseling and referral for appropriate medical care. Referrals for specialty care and high-risk ob/gyn services are available.

Comprehensive medical services are also provided by Tampa Care Clinic which is affiliated with the Comprehensive Research Institute of St. Joseph's Hospital in Tampa. Evening appointments are available one day per week. Services include HIV related primary care, treatment adherence education, health education, labs, dietician, and mental health social work. In addition, clinical trials are available as is acupuncture and massage (on a limited basis). Care is coordinated by ARNPs with physician oversight. Transportation is provided and coordinated for clients. Referrals to all specialties are available as needed.

Medical case management services are provided by Metro Wellness and Community Centers and Francis House. Metro Wellness and Community Centers also offers case management services for Medicaid PAC waiver clients and works in the county jail to assist HIV+ inmates in planning their release by linking them to care. The agency also provides Minority AIDS Initiative services through Part A, eligibility determination, mental health counseling, substance abuse counseling, support groups and Part D medical case management. Offices are located in Tampa and evening hours are available, as are in-home visits and occasional Saturday appointments.

Francis House is located in Tampa, and provides Ryan White, PAC Waiver and HOPWA case management, daily meals, emergency food and financial assistance and mental health services including support groups and one-on-one counseling, and HOPWA supportive services to include substance abuse relapse prevention, daily meal and transportation assistance. Services are available after hours as needed or in the client's home.

Drug Abuse Comprehensive Coordinating Office (DACCO) provides outpatient substance abuse services in Tampa and Brandon through their evidence-based Holistic Health

Recovery Program (HHRP) enhanced by dual enrollment, as appropriate, in day treatment, intensive outpatient, residential, family-centered, gender specific services and coordinated medication-assisted treatment.

Manatee County is a rural area with one major city. In many ways Manatee County is more closely related to the Sarasota area as opposed to the Tampa Bay area, and crossing county lines for medical services is not uncommon.

Manatee Rural Health Services provides an array of services through a clinic in Bradenton. A Part C program provides funding for services along with Part B and Emerging Communities funds. Services include HIV-related primary care, dental, case management, nutrition counseling, treatment adherence, mental health counseling, housing assistance, medications, and specialty referrals. The Manatee County Health Department provides ADAP assistance. Substance abuse treatment is coordinated with community providers.

Pasco County is a fast-growing bedroom community for Hillsborough County; however, it remains largely rural, particularly in the eastern portion of the county. The Pasco Health Department is the provider of HIV-related primary care, treatment adherence, ADAP and lab tests. There are two service locations, New Port Richey and Dade City. The Dade City location has limited service hours. Limited nutrition and dental services are available and specialty care is provided through referrals. Access to some specialists is problematic, but nearby urban centers can be accessed if payment source and transportation are available. Mental health and substance abuse treatment are referred to local community-based providers. Medical case management services, Minority AIDS Initiative, mental health counseling and support groups are provided by Metro Wellness and Community Centers.

Pinellas County is the most densely populated county in the state. With over 20 municipalities and two large cities (St. Petersburg and Clearwater) the county, as a whole, is urban.

The Pinellas Care Clinic, located in St. Petersburg is the largest provider of HIV-related medical care in the county. The clinic is affiliated with the BayCare Health System and the Comprehensive Research Institute at St. Joseph's Hospital in Tampa. Patient care is managed by ARNPs specializing in HIV, supervised by a physician. Evening appointments are available one day each week.

Services include HIV related primary care, treatment adherence education, health education, labs, dietician, mental health and social work. In addition, clinical trials are available as are referrals to specialty care. Transportation is coordinated for clients in need of the service, and admission to St. Anthony's Hospital can be accessed as needed.

Ryan White funds also support primary care services for HIV infected veterans at the Bay Pines VA Healthcare System.

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

Metro Wellness and Community Centers provides medical case management services, substance abuse treatment, mental health services, inmate discharge planning in conjunction with Pinellas County jail, and a women's personal care pantry, Minority AIDS Initiative, support groups, substance abuse counseling, psychiatric medication management, and thrift store. Evening hours are available one day per week.

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

The Minority AIDS Initiative (MAI) program which focuses on substance abuse outreach counseling provided by WestCare and treatment adherence, which is provided by Operation Hope.

The **Polk County** Health Department provides an array of services to residents of Hardee, Highlands and Polk counties. While rural, there are several small cities in Polk County, and Polk County has the third highest number of HIV cases in the TSA. Both Parts B and C provide funding for HIV services.

The Specialty Care Clinic is located in Bartow. Services are available five days a week. Early morning and evening appointments are available. Services include case management, HIV-related primary care, treatment adherence, labs, ADAP, nutrition counseling, mental health counseling and support groups. Transportation is provided, though funding is limited for this service. Substance abuse treatment is coordinated with local provider (Tri-County Human Services). The Health Department also provides counseling, testing and linkage to HIV medical care within the Polk County Jail.

HIV/AIDS Services Funding

The funding stream analysis is a component of the needs assessment that helps prioritize and allocate Ryan White funding throughout an eight county service area (Hardee, Hernando, Highlands, Hillsborough, Manatee, Pasco, Pinellas and Polk). The funding stream analysis provides a snapshot of services funded for persons living with HIV/AIDS (PLWH/A). Services that have multiple funding sources and significant resources committed may be less likely to require Ryan White dollars. Moreover, services that have

little or no resources may be more likely to need support. However, all decisions relating to allocations must be viewed in the context of overall identified needs as well as available resources. For instance, medications are funded from a variety of sources, including Ryan White; however, there continues to be a need for medication funding due to the increase in the number of PLWH/A in need and the cost of pharmaceuticals.

Funding sources included in this analysis are from federal, state and local government. The streams have been analyzed by the Total Service Area (TSA), the Eligible Metropolitan Area (EMA) which includes Hernando, Hillsborough, Pasco and Pinellas Counties, the non-EMA Counties (Hardee, Highlands, Manatee and Polk) and separately by county. Caution must be used when interpreting the data due to a variety of factors including:

- Different fiscal years
- Inability to obtain certain data at a county specific level
- Inability to obtain type of service funding breakouts
- Allocations which are made to multiple counties within the TSA
- Inaccuracies and/or inconsistencies in the data as reported to The Health Councils, Inc.

Appropriate notes have been added to each table to assist in the review of the data. However, it is best to keep in mind that the data presented represents the best available information at a given point in time. In some cases figures may represent actual expenditures (e.g., Medicaid, PAC Waiver, the AIDS Insurance Continuation Program-AICP, Network General Revenue and Part A and B); however, the other figures are budgeted amounts. In addition, reallocations may occur throughout the year within a funding source.

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

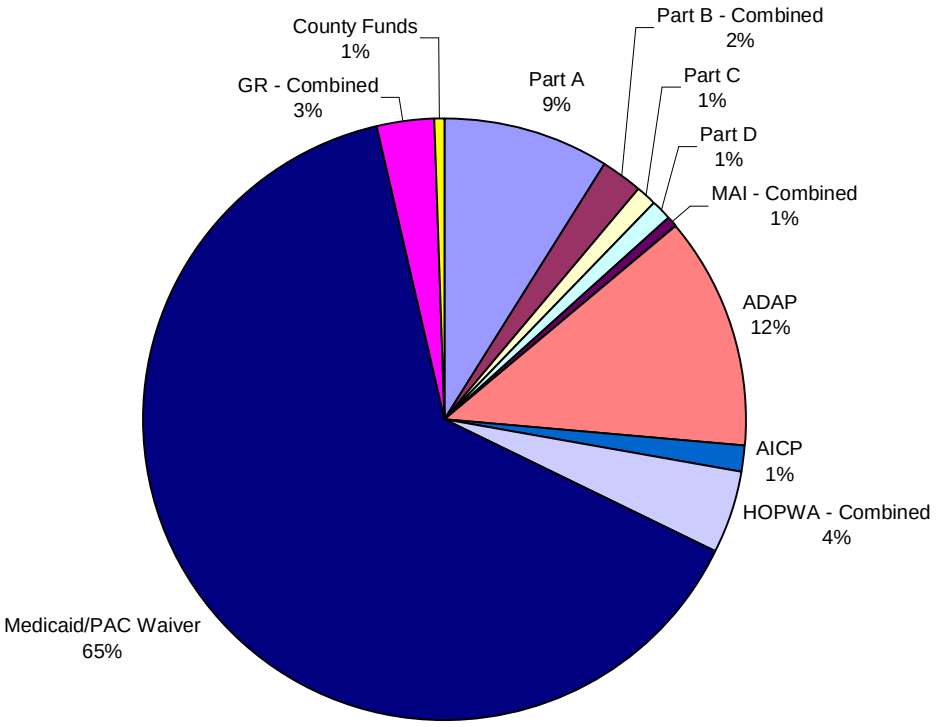
General Revenue (GR) (both County Health Department and Network) accounts for 3% of the funds. General Revenue state allocations are available through two funding streams. First, some county health departments receive an annual allocation for HIV/AIDS patient care. In addition, the state allocates funds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

Ryan White Part B represents 2% of PLWH funds received in the area. General Part B funds and Part B Emerging Communities funds received in the area are combined in Figure 2. Ryan White Part C and Ryan White Part D each represent 1% of total area funding. Ryan White Minority AIDS Initiative (MAI) funds are noted here as a separate grant but will

be a portion of our Part A grant in the 2011 fiscal year. Part A MAI and Part B MAI combined account for 1% of TSA funding.

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

Figure 2
Funding Sources - TSA



*Excluded funding sources include, but are not limited to, Veteran's Administration, Medicare and private funding.
Source: 2011 Funding Stream Analysis

CHAPTER 6:
BARRIERS TO CARE

Barriers can limit or prevent PLWH/A from receiving available services that are essential to improving or maintaining their health and well-being. Barriers to care were identified by clients in the Anonymous Needs Survey when Respondents were asked to describe the reasons they did not receive a service they needed. 69% of respondents indicated that they received the services needed during the last 12 months.

Barriers to Care in the TSA

What kept you from getting the services you needed during the past 12 months? (Mark all that apply)	
Answer Options	**Percent of Respondents**
I did not know where to get services	39%
I could not pay for services	28%
I was depressed	18%
I could not get transportation	18%
I did not qualify for services	17%
I did not want people to know that I have HIV	8%
I missed my appointment(s)	8%
I could not get an appointment	13%
I was put on the waiting list	13%
I had a bad experience with the staff	7%
I could not get time off work	4%
Services were not in my language	0%
I was too busy taking care of my partner	2%
I could not get childcare	1%
Other	14%

"Other" reasons cited included specific reasons the client was determined ineligible, length of time they had been on a waiting list, Medicare donut hole and various complications of getting through the process to receive assistance. Several respondents listed jail or prison as a barrier. Others listed the need for a service that was unavailable to them or lacks funding such as vision care, specialty dentistry and legal services.

Barriers to care were analyzed for several subpopulation groups: Blacks, Hispanics, women, youth and MSM. The barriers to care noted for each group are in descending order from greatest to least.

Barriers to Care by Population Group

Service gaps	Blacks (N= 755)	Hispanics (N= 298)	Women (N= 668)	Youth (N= 59)	MSM (N= 967)
1	Did not know where to get services	Did not know where to get services	Did not know where to get services	Did not know where to get services	Did not know where to get services
2	No transportation	Could not pay	No transportation	Could not pay	Could not pay
3	Depressed	No transportation	Depressed	Depressed	Did not qualify
4	Could not pay	Depressed	Could not pay	No transportation	Depressed
5	Missed my appointment(s)	Put on waiting list	Stigma	Missed my appointment(s)	Could not get appointment
6	Stigma	Did not qualify	Missed my appointment(s)	Could not get appointment	Put on waiting list
7	Did not qualify	Could not get appointment	Did not qualify	Busy taking care of partner	No transportation
8	Put on waiting list	Missed my appointment(s)	Put on waiting list	Stigma	Bad staff experience
9	Could not get appointment	Couldn't get time off work	Could not get appointment	Bad staff experience	Missed my appointment(s)
10	Couldn't get time off work	Stigma	Couldn't get time off work	No Childcare	Stigma
11	No Childcare	Bad staff experience	Bad staff experience	Couldn't get time off work	Couldn't get time off work
12	Bad staff experience	Not in my language	No Childcare	Not in my language	Busy taking care of partner
13	Busy taking care of partner	No Childcare	Busy taking care of partner	Put on waiting list	No Childcare
14	Not in my language	Busy taking care of partner	Not in my language	Did not qualify	Not in my language

SECTION II: WHERE DO WE NEED TO GO?

CHAPTER 7: CONTINUUM OF CARE FOR HIGH QUALITY CORE SERVICES

SHARED VISION AND VALUES

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

CARE COUNCIL MISSION STATEMENT

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

CARE COUNCIL GUIDING PRINCIPLES

- The Care Council shall support the access to a full continuum of care and support services for all HIV infected individuals throughout the service area.
- The Care Council shall ensure that care provided under Ryan White contracts is of high quality, provided with regard to protecting confidentiality and dignity of the consumers.
- The Care Council shall promote adherence to treatment plans.
- The Care Council shall respond to the changing environment of the AIDS epidemic, including responses to the needs of special populations and under served communities.
- The Care Council shall assure compliance of legislatively mandated functions.
- The Care Council shall support consumer access to culturally and linguistically appropriate treatment and support services.
- The Care Council shall promote coordination with community resources not funded by Ryan White, including prevention and early intervention services.

Continuing Issues

Trends and issues are reviewed to assist in determining where we need to go. A summary of the trends and ongoing issues for each component in the continuum and specific populations is provided below.

<u>Outpatient/Ambulatory Care</u>

- Despite numerous treatment advances, many challenges persist. The cost to care for the HIV population has increased significantly due to the overall cost of medical care, new antiretroviral medications, and the extension of the lifespan. The recent economic environment of the U.S. has had a major effect on the provision of both core and non-core services. States encourage testing for HIV, but then place clients

on a waiting list to receive medications. Services are limited or are no longer provided. The cost of inpatient care increases as clients who cannot access outpatient services wait until they become more ill to access care.

- The cost of co-infected clients will increase significantly with the development of new protease inhibitors for the treatment of hepatitis C. Treatment cost is approximately $1100 per week for the protease inhibitors alone, not including the cost of the interferon and ribavirin. Managing the long term side effects of antiretrovirals (heart disease, renal disease, lipodystrophy, hyperlipidemia, peripheral neuropathy) also adds to the cost of care.
- Changes in current eligibility criteria, services offered, and reimbursement levels of various payer sources, (including Medicaid), limit client services and access to care.
- In spite of an ongoing HIV public education program, there continues to be bias, stigma and fear of an HIV diagnosis, which limits disclosure, access to care and treatment.
- The rural areas continue to have a lack of primary care and specialty providers.
- The in-migration of individuals from other areas to our State are stretching already limited resources.

Medical Case Management

- Recruiting for position vacancies hinders the agencies' ability to provide care; new staff that is being trained can not perform optimally and other staff must shoulder an added caseload. Turnover also impacts client retention in care, and may disrupt continuity of care for those remaining in care.
- Support for case managers in the form of training and technical assistance on emerging trends within the HIV infected population is critical and community collaboration must be identified for this purpose.
- Developing a certification process for medical case managers needs to be explored to improve quality service provision and ensure that qualified staff works in the programs.
- Case managers are seeing clients with more complex needs.
- Differing eligibility determination processes for various programs and requirements create additional administrative overhead and reduce the time that case managers can devote to clients.

Drug Reimbursement

- ADAP funding increases and the addition of new, expensive drugs to treat HIV and co-infections have not kept pace with the number of new clients eligible for the program. If this trend continues, it is possible that non-enrolled clients will develop more opportunistic infections, and experience a decrease in quality and length of life if other funding sources to support medications are not available.
- Due to a record increase in client enrollment as a result of uncertain economic times, the Bureau of HIV/AIDS was forced to take cost containment measures to ensure currently-enrolled clients continued to receive their medications without disruption in medical treatment. Beginning June 1, 2010 the Florida AIDS Drug Assistance Program has instituted a waiting list to ensure availability of HIV treatment medications for all ADAP clients currently enrolled. Also, on August 1, 2010, the

ADAP formulary was reduced to only provide Antiretroviral (ARVs) and Opportunistic Infection (OI) medications. In efforts to provide a time-sensitive, solution-based response, the Bureau of HIV/AIDS assembled a Comprehensive Cost Containment Guidance to ensure ADAP staff, case managers, and providers statewide have the necessary tools to assist clients, including Prescription Assistance Programs (PAP). PAPs are utilized for clients who are placed on the ADAP waiting list, currently; every client who has/is accessing the local RW programs is receiving their medications via PAP services.

- The Bureau of HIV/AIDS implemented the use of Medicaid and Medicare for HIV/AIDS clients accessing ADAP. The ADAP Premium Plus program is a component of ADAP created to manage clients who are ADAP eligible and have insurance coverage such as Medicare Part D or private insurance. The program provides assistance with out-of-pocket costs associated with insurance coverage such as premiums, co-pays and/or deductibles. Currently, ADAP Premium Plus is limited to ADAP clients with Medicare Part D and those receiving AIDS Insurance Continuation Program (AICP) services. In July 2011, the Bureau of HIV/AIDS contracted with a Pharmacy Benefits Manager who will provide assistance to Medicare Part D clients in covering TrOOP costs.
- Medication side effects can result in the need for additional medications including those that treat psychiatric issues.
- The ADAP Wrap Around Pilot Project (AWAPP) began July 2006 and was designed to help clients who fall in to 135% to 150% of the Federal Poverty Guidelines.
- Medicare drug coverage began in 2006. Required out-of-pocket and co-pay expenses can be difficult for some clients to afford and the system can be difficult to maneuver.

<u>Health Insurance</u>

- An increasing percentage of ISP and AICP clients have medication co-payment and health insurance premium assistance needs that exceed the current monthly benefit allowance.
- Changes in Medicaid PAC Waiver seriously limited other services. This may mean more requests on the Ryan White-funded health insurance.
- Other public providers of health insurance plans (Ex: County governments) have changed eligibility criteria, covered services, and formularies that limit HIV+ individuals from participation.
- There is an increased need for health insurance services, premiums and co-pay assistance due to the economic climate and uncertainty regarding funding levels.

<u>Housing</u>

- Housing continues to be a highly ranked need in the TSA**.** Funding through Ryan White is minimal, due to the prioritization and subsequent allocation of funds for medical care, prescriptions and case management. Coordination with other providers of housing services is essential.
- Individuals, single parents and families, and those recently released from substance abuse treatment or incarceration may have a difficult time accessing housing. Rural

areas have even greater shortages of housing. Homeless individuals encounter many barriers to care. Adherence to treatment even when it is received is often difficult.

Mental Health/Substance Abuse

- Treatment of dual-diagnosis of HIV and mental illness, or multiple diagnoses which includes substance abuse, hepatitis infection, is complicated due to possible drug interactions as well as brain chemistry changes.
- Treatment of clinical and sub-clinical issues as well as other substance abuse issues is necessary as a major component in treatment adherence, due to high rates of occurrence among PLWH and the impact of these conditions on overall health.
- The PLWHA population is steadily aging due to advances in treatment and new studies have shown those over age 50 are at a significantly higher risk of developing mental health/substance abuse issues.

Oral Health

- Dental clinics at the Health Department may not have the ability to perform all procedures due to limited equipment and staffing. There are a limited number of other dental providers and availability of appointments is an issue.
- Emergency dental services are difficult to obtain.
- There are problems with no-shows by clients in dental services and transportation is frequently cited as the reason.

Prevention/Early Intervention

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

    - Making testing a routine part of medical care for all patients in health care settings.
    - Screening those at high risk for HIV at least once per year.
    - Further decreasing mother-to-child HIV transmission by incorporating HIV testing in the routine battery of prenatal tests and then repeating the screening in the third trimester.

Transportation

- Lack of funding for transportation services presents increasing barriers to primary care and other services particularly prevalent in rural areas.

Children/Adolescents

- Adolescents transitioning into the adult system of care may fall out of care.
- Medication resistance may be seen in younger people.
- Adherence among adolescents is particularly problematic.
- Children who have lost parents are most frequently placed with relatives. Little support is available from the child welfare system for these families.
- There has been an increase in the number of late presenters (8 to 10 years old) who were most likely perinataly exposed, but not previously tested.
- Increased risk behaviors and teen pregnancy are a concern for adolescents and youth with mental health issues.
- Children and adolescents may not be aware of their status due to a parent or guardians fear of disclosure.
- Adolescents not completing high school have limited employment options as adults and are more likely to continue to depend on publicly-funded care.
- Life skills and job training is needed among this population.

Incarcerated/Formerly Incarcerated

- Releases can occur with little notice making the establishment of linkages to care difficult. Without immediate access to care and support services such as medications and primary care, individuals may fall out of care.

Minorities

- HIV rates are increasing in minority populations, especially among the Black population.
- Stigma and other underlying factors contribute to growing racial/ethnic disparities among PLWH/A.
- In the TSA, minorities are disproportionately affected by HIV/AIDS. As Illustrated in the table, in Hillsborough County, 1 in every 89 Black individuals is infected with HIV and 1 in every 315 Hispanics compared to 1 in every 345 Whites. In Manatee County, 1 in every 80 Black individuals is infected with HIV and 1 in every 381 Hispanics compared to 1 in every 754 Whites. The data is less reliable for the counties with smaller population groups, but still useful for a general comparison.
- Language barriers exist for Hispanic, Creole, Asian and Caribbean clients in the TSA.
- Culturally sensitive treatment and appropriate support services are necessary to ensure effective care.
- Issues of legal status are also problematic as illegal aliens are not eligible for Medicaid. In the case of migrant workers, continuity of care is extremely difficult.
  Life skills and job training is needed among this population.

Women

- HIV rates are increasing for women, especially black heterosexual women.
- Women may have additional responsibility of child care which can impact their adherence.
- There is a need for child care services for working women.

- Life skills and job training is needed among this population.
- Recent legislative changes made HIV testing routine in the first and third trimester of pregnancy.

CARE Act Reauthorization – Ryan White Treatment Modernization Act

- Ryan White legislation, now known as the Ryan White treatment Extension Act of 2009, will expire and be subject to Congressional re-authorization in 2013. The objectives of the program may shift significantly depending on general health care financing. Ryan White could emerge providing supportive services and prevention.
- Advocacy and local support is critical to keep congressional attention focused as a budget priority.
- Expanding the role of the AETC to include mental health and substance abuse professionals would assist the community-based care system in better serving HIV+ clients.

SECTION III: HOW WILL WE GET THERE?

CHAPTER 8: GOALS, OBJECTIVES AND STRATEGIES

As the West Central Florida Ryan White Care Council is a combined Part A and Part B planning body, considerations for both HRSA and State of Florida requirements must be made in developing the comprehensive plan. Florida has identified specific goals at the statewide level and to the extent possible, local consortia are expected to include activities to support those initiatives. HRSA has outlined comprehensive plan content and directives regarding areas of focus. Local goals, objectives and tasks have been aligned with the planning and care goals of the National HIV/AIDS strategy and the Health People 2020 objectives for HIV.

The following tables outline the goals, objectives and tasks for the Planning Council including target dates of completion. The goals are not stated in order of importance. Locally a three-year planning cycle has been adopted. However, the comprehensive plan is updated annually as determined by the Planning and Evaluation Committee. Due to policy, regulatory and funding level changes in both Ryan White as well as other funders of HIV services, and unpredicted changes in the local service continuum; goals and objectives are reviewed on an annual basis to determine their continued relevance. Activities are identified for specific years in the three-year planning process and may also be adjusted to reflect emerging needs. Other updates may include expanding or refining sections of the plan based on work that has been accomplished during the year.

Goal #1:	Increase access to care and improve health outcomes for people living with HIV	
Objective #: 1A	**Increase the proportion of newly diagnosed patients linked to clinical care within three months of their HIV diagnosis.**	
	TASK REQUIRED TO ACCOMPLISH THE ABOVE OBJECTIVE	**TARGET DATE**
Task: 1	Work with the state to further refine unmet need estimate methodology to identify individuals who know their HIV status and are not receiving services.	July 2014
Task: 2	Inform individuals of HIV services and link them to care within three months of diagnosis.	July 2014
Task: 3	Utilize surveillance office staff and data to determine if individuals who have tested positive are accessing care	September 2013
Task: 4	Review local data on service caps to determine if a larger number of individuals are able to access services. Determine if caps need to be re-evaluated.	August 2012
Task: 5	Conduct review of best practices on unmet need to determine how other areas have identified HIV+ individuals who are out of care and engaged them into care	March 2014
Task: 6	Educate individuals about what it means to be 'in care' and integrate a readiness tool into the service delivery system.	March 2015
Objective #: 1B	**Increase the proportion of Ryan White HIV/AIDS clients who are in continuous care (at least 2 visits for routine HIV medical care in 12 months at least 3 months apart)**	
	TASK REQUIRED TO ACCOMPLISH THE ABOVE OBJECTIVE	**TARGET DATE**
Task: 1	Develop ways to enhance adherence among clients in order to contribute to improved health outcomes.	July 2014
Task: 2	Analyze health outcomes data of PLWHA. Develop and implement strategies to improve health outcomes.	October 2014
Task: 3	Enhance and expand support group activities.	September 2013
Task: 4	Encourage peer mentoring to support care and treatment.	September 2014
Task: 5	Review and utilize best practices to determine possible program designs that assist underserved populations with retention in care.	April 2013
Task: 6	Monitor standards of care for local minority populations in relation to national standards of care.	April 2012
Task: 7	Expand and enhance outreach activities to racial and ethnic minorities.	August 2014
Objective #: 1C	**Increase the percentage of Ryan White recipients with permanent housing.**	
	TASK REQUIRED TO ACCOMPLISH THE ABOVE OBJECTIVE	**TARGET DATE**
Task: 1	Create linkages with non Ryan White service providers for housing options.	December 2013
Task: 2	Provide letters of support and background information for agencies seeking funding to develop/expand these services.	When requested
Task: 3	Coordinate with HOPWA needs assessment and planning efforts.	July 2012, 2013, 2014

Goal #2:	Reduce HIV-related health disparities in accessing services among the affected subpopulations (i.e.: gay and bisexual men, Blacks, Latinos, youth, sex workers, etc.).	
Objective #: 2A	Increase the proportion of persons diagnosed with HIV with an undetectable viral load.	
	TASK REQUIRED TO ACCOMPLISH THE ABOVE OBJECTIVE	TARGET DATE
Task: 1	All contracted providers will initiate and ensure culturally focused and linguistically appropriate interventions and treatment. Encourage providers to continually provide cultural competency training for new staff.	July 2012
Task: 2	Appropriate funding to increase the number of underserved populations in primary care according to Needs Assessment findings and other available data	July 2012, July 2013, July 2014
Task: 3	Support efforts to tie funding to subgroups and geographic areas that have been found to have the most severe need	July 2012
Task: 4	Assess cultural sensitivity of provider agencies via client satisfaction surveys.	July 2014
Task: 5	Support campaigns and programs that work to lower stigma.	March 2015
Task: 6	Promote improved communication between Department of Corrections and local agencies that assist recently incarcerated populations.	November 2012
Task: 7	Identify HIV+ Women of Childbearing Age and educate them regarding risks and available services.	October 2012
Task: 8	Track current statistics on co-morbidities and co-infections to determine areas to address.	December 2012
Task: 9	Prioritize the populations that receive care for targeting funding allocations.	February 2013
Task: 10	Address the migrant population.	December 2012
Task: 11	Improve linkages to care for former inmates.	September 2012

Goal #3:	Coordinate the provision of funded services with programs for HIV prevention (including outreach and early intervention) in order to reduce the number of new infections.	
Objective #: 3A	Lower the number of new infections and increase the percentage of people living with HIV who know their status.	
	TASK REQUIRED TO ACCOMPLISH THE ABOVE OBJECTIVE	TARGET DATE
Task: 1	The Care Council will coordinate with prevention providers to identify service gaps between HIV prevention providers and the care and treatment continuum.	September 2012, 2013, 2014
Task: 2	The Care Council will assist with selecting participants to serve on Patient Care Planning Group (PCPG) who report back to the Care Council.	Participants selected and reports delivered following PCPG meetings
Task: 3	Local HIV/AIDS Program Coordinators (HAPCs) will participate on the Care Council and Planning and Evaluation Committees.	June 2012
Task: 4	A report on testing and counseling sites will be provided to the Planning and Evaluation Committee annually as part of the Executive Summary report.	August 2012, 2013, 2014
Task: 5	Coordinate with outreach workers to increase community knowledge of HIV services.	December 2014

Goal #4:	**Coordinate the provisions of funded services with programs for the prevention and treatment of substance abuse.** (*including programs that provide comprehensive treatment service for such abuse*)	
Objective #: 4A	**The Care Council will coordinate with substance abuse prevention providers to identify issues related to the HIV care and treatment continuum.**	
	TASK REQUIRED TO ACCOMPLISH THE ABOVE OBJECTIVE	**TARGET DATE**
Task: 1	Assure that substance abuse treatment providers are represented on the Care Council.	June 2012
Task: 2	Seek continued involvement from substance abuse treatment providers on the Planning and Evaluation Committee.	June 2012
Task: 3	Develop and disseminate a best practices protocol for PLWH who are in need of mental health and/or substance abuse treatment and incorporate into standards of care.	January 2015
Task: 4	Improve linkages between substance abuse/mental health providers and HIV providers.	May 2014
Task: 5	Identify and address barriers to entry for PLWHA into substance abuse treatment programs.	January 2014
Task: 6	Promote HIV-friendly substance abuse treatment service provision.	March 2015

Goal #5:	**Program coordination and linkages between Parts A, B, C, D and AETC.**	
Objective #: 5A	**The Care Council will coordinate with other Ryan White programs on an ongoing basis. Expand coordination and linkages with non-Ryan White funded providers in accordance with HRSA objectives.**	
	TASK REQUIRED TO ACCOMPLISH THE ABOVE OBJECTIVE	**TARGET DATE**
Task: 1	Assure that Parts C and D, and AETC are represented on the Care Council.	May 2012, 2013, 2014
Task: 2	Coordinate planning and needs assessment activities across program parts.	August 2012, 2013, 2014
Task: 3	Provide letters of support and background information for agencies seeking funding to develop/expand these services.	When requested
Task: 4	Coordinate the information from all services (public and private) to report activities from areas 5/6/14 to improve communication and effectively market events and activities.	March 2015

Goal #6:	Build capacity in the funded service area.	
Objective #: 6A	**All contracted providers will initiate and ensure culturally focused and linguistically appropriate interventions and treatment, participate in established customer satisfaction program, and participate in available capacity-building opportunities.**	
	TASK REQUIRED TO ACCOMPLISH THE ABOVE OBJECTIVE	**TARGET DATE**
Task: 1	Improve information dissemination mechanisms for providers to be aware of capacity building opportunities that exist in the community.	December 2014
Task: 2	Survey public providers of primary care annually to determine if there is adequate access to an HIV-qualified primary care provider and their services.	April 2012, 2013, 2014
Task: 3	Conduct ongoing customer satisfaction surveys for all service providers. Review data from satisfaction surveys to determine areas for improvement, both system-wide and as individual providers.	September 2012, 2013, 2014
Task: 4	Ensure HIV community is part of the public health planning efforts in the region.	December 2014
Task: 5	Increase the number of medical specialty care providers.	March 2015
Task: 6	Expand and enhance the safety net system for PLWHA by increasing the communication between providers and bringing in agencies currently outside the Ryan White network.	February 2015
Task: 7	Strengthen and expand linkages between key points of entry and the HIV continuum of care system	January 2015

Objective #: 6B	**The Grantee/Lead Agency will maintain and enhance an information management system to allow for the tracking of quantitative and qualitative data and continually seek ways to improve communication with service providers.**	
	TASK REQUIRED TO ACCOMPLISH THE ABOVE OBJECTIVE	**TARGET DATE**
Task: 1	Improve methods for collecting and reporting data on service provision with full training of providers on using the Ryan White Information System.	March 2015
Task: 2	Maintain and enhance data collection system.	March 2012
Task: 3	Conduct regularly scheduled meeting with providers	November 2012, 2013, 2014
Task: 4	Conduct case manager training as funding permits.	January 2012, 2013, 2014

Objective #: 6C	**Improve education on the role of the Care Council and its committees while supporting an environment of volunteerism and promotion of special needs of local populations.**	
	TASK REQUIRED TO ACCOMPLISH THE ABOVE OBJECTIVE	**TARGET DATE**
Task: 1	Determine training needs for Care Council and committee members.	September 2012
Task: 2	Develop content and schedule of trainings; conduct trainings	October 2012, April 2013
Task: 3	Maintain Care Council website that provides links for volunteer and special needs groups.	March 2015
Task: 4	Develop a mechanism for service providers and other community groups to notify clients of volunteer opportunities.	March 2015
Task: 5	Designate a Care Council member or group to coordinate public information.	March 2015

Objective #: 6D	**Review and enhance performance-based standards and outcome measures for all funded services. Evaluate minimum standards of care and make revisions as needed.**	
	TASK REQUIRED TO ACCOMPLISH THE ABOVE OBJECTIVE	**TARGET DATE**
Task: 1	Review all performance standards and outcome measures including provider input in the process and align with the Quality Management program.	June 2014
Task: 2	Conduct reviews on QM data.	December 2013
Task: 3	Review minimum standards of care for all services and revise as needed to align with service philosophy and definition and include any revisions in new contracts.	September 2014
Objective #: 6E	**Providers will be knowledgeable about funding sources for health care and pharmaceuticals including anti-retroviral therapy, and will enroll clients in appropriate programs as soon as possible after obtaining the client's informed consent.**	
	TASK REQUIRED TO ACCOMPLISH THE ABOVE OBJECTIVE	**TARGET DATE**
Task: 1	Monitor impact of healthcare reforms and Medicare Part D on access to health care and medications, co-payments and out-of-pocket requirements on clients.	September 2012
Task: 2	Monitor changes in compassionate use programs from pharmaceutical companies for impact on clients.	August 2014
Task: 3	Inform clients of clinical trial opportunities.	As available
Task: 4	Monitor AIDS Insurance Continuation Program (AICP) wait lists and Ryan White funded- Insurance Services Program utilization.	June 2012, 2013, 2014

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

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

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

Service Categories	**Total FY12 Funding Part A, B and MAI**	
	Amount	**Percent**
1. Core Services for FY 12 Sub-total	**$9,740,503**	**85%**
Outpatient /Ambulatory Health Services	$3,466,158	31%
AIDS Pharmaceutical Assistance (local)	$1,742,034	15%
Oral Health Care	$718,918	6%
Health Insurance Premium & Cost Sharing Assistance	$706,500	6%
Mental Health Services	$248,303	2%
Medical Case Management (including Treatment Adherence)	$2,443,656	21%
Substance Abuse Services - outpatient	$414,934	4%
2. Support Services for FY 12 Subtotal	**$335,394**	**4%**
Case Management (non-Medical)	$320,000	3%
Direct Client Services Fund	$15,394	1%
3. Total Service Dollars	**$10,075,897**	**89%**
4. Clinical Quality Management Activities	**$60,000**	**1%**
5. Grantee Administration	**$1,115,673**	**10%**
6. Total Planned Budget	**$11,566,739**	**100%**

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

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

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

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

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

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

SECTION IV: HOW WILL WE MONITOR PROGRESS?

CHAPTER 9: IMPLEMENTATION, MONITORING AND EVALUATION PLAN

A variety of monitoring processes are used to determine how successful the efforts of the Care Council are in providing a high quality continuum of care. Ongoing monitoring of the comprehensive plan goals and objectives is undertaken by the Planning and Evaluation Committee. Quality management initiatives conducted by the Grantee, and shared with the Planning and Evaluation Committee, Health Services Advisory Committee and Care Council, also provide an opportunity to evaluate and monitor progress in providing quality services. Finally, fiscal and program monitoring of individual providers gives an additional opportunity for assessing progress and providing technical assistance with program operations. Improving client level data reporting will allow the Planning Council to make better decisions that are data driven.

Monitoring and evaluation activities do not occur in a vacuum. A number of factors must be considered over time including the changing environment, regulations and requirements, and data limitations.

It is clear that any changes to Medicaid or Medicare Part D will have an effect on planning and service provision, but it is impossible to know the full impact on Ryan White funded services and on the continuum of care. As such, goals, objectives and activities should be seen as fluid; adjusting as needed to respond to funding and policy changes. In addition, indicators (definition of success for a given objective) and measures (a measurable factor or variable that indicates progress toward an objective) may also be refined as needed.

Data limitations can also impede the ability to monitor plan performance. While consideration is given to the ability to collect specific data when developing measures, there may be a lack of baseline or other comparison data to measure improvement against. Many performance measures in the past were process measures (e.g. Were activities completed in expected time frame?) as opposed to outcome based measures (e.g. How did health of client improve as a result of the service?). This is being improved through the quality management system; however it may take several years to have enough data to conduct trend analyses.

Improving Client Level Data

The availability of funds to collect new data, or to develop new ways of collecting data, are limited but must be considered in planning. In March 2008, the grantee launched in collaboration with Hillsborough County's Information and Technology Services Department (ITS) a web based data collection system to use for all reporting and invoicing purposes. The automated system, named the Ryan White Information System (RWIS) has been very successful in achieving expectations for client level data reporting. Enhancements continue

to be made to the system based on meetings and input from providers to improve efficiency and data analysis. RWIS generates a unique client identifier to ensure an unduplicated record across multiple HIV funding sources, the system was analyzed during a HRSA site visit in 2011 and the reviewers were impressed with the fact that there were no duplicate records found. All contracted providers have training offered by the grantee when needed, such as for newly hired staff or when reporting modules change.

The grantee works closely with HRSA and the contracted client level reporting team to ensure that all data transmitted is accurate and timely. Beginning in 2011, all outcomes measures which are now collected for Quality Management purposes are being integrated into RWIS, beginning with measures for primary care. This will provide one comprehensive data source for Continuous Quality Improvement (CQI) purposes, summary level outcomes reports and analysis for planning and resource allocation activities of the Planning Council.

Measuring Clinical Outcomes

The purpose of the CQM (Clinical Quality Management) Program is to improve the quality of care and services and ultimately the quality of life for people living with HIV and AIDS. The CQM Program is a collaborative initiative between the Grantee, the Planning Council, providers within the service area and the subcontracted CQM provider. The vision of the CQM Program is "to create a strong and varied system of care that mirrors the diverse consumer base, promotes diverse community partnerships, maximizes resources, and ensures continuous quality in the delivery of care." The CQM Program is guided by the PHS (Public Health Service) Guidelines, prioritization and allocation by the Planning Council, localized Standards of Care and input from the Ryan White Quality Management Technical Workgroup. These guiding factors support the CQM Program's mission "to advance the health and well-being of all PLWH/A within the total service area by creating and delivering innovative and quality HIV care."

The overarching goals of the Clinical Quality Management Program are to:

- Monitor the extent to which HIV health services are consistent with PHS guidelines, local and national standards of care.
- Develop strategies to ensure that services are consistent with the guidelines for improvement in the access to and quality of HIV services.
- Focus on cost efficiency and quality of care through monitoring and evaluation of the core services, support services, administrative mechanisms and planning processes.
- Align quality management findings with the Care Council's priority setting and resource allocation activities.
- Align quality management findings to grant management functions, specifically procurement and contract negotiations, billing and reimbursement and program management functions.

The CQM Program is supported through multiple entities, including the Ryan White Program Grantee, the Planning Council, Ryan White Program funded providers, the Ryan White QM (Quality Management) Technical Workgroup and the HCECF (Health Council of East

Central Florida). The Grantee provides the administrative oversight to the CQM Program and contracts for a provider to coordinate the CQM activities for the Ryan White Program. As noted, the Planning Council works with the CQM Program to align quality management findings with the annual priority setting and resource allocation process. Data for the CQM Program is collected and reported by the Ryan White Program funded providers. Providers also work closely with the CQM Program to implement quality improvement activities. The Ryan White QM Technical Workgroup is a multi-disciplinary team that provides leadership and direction for the CQM Program's activities and reporting. The Health Council of East Central Florida is a subcontracted provider that facilitates and leads the Ryan White QM Technical Workgroup, coordinates CQM activities and reports to the various planning bodies.

In April 2010, HCECF worked with the Grantee to establish a multi-disciplinary quality management technical workgroup. The Ryan White QM Technical Workgroup is comprised of eight provider agency staff, two Planning Council members who are also consumers, a Ryan White program manager, the RWIS (Ryan White Information System) coordinator and a former QM manager from the private healthcare sector. The workgroup is supported by HCECF staff (1.0 FTE) and scheduled to meet monthly to allow for ongoing communication and feedback into the quality management process.

An overview of the CQM Program and its approach was presented to the Planning Council and provider network in July and August 2010. Utilizing the HRSA Quality Management Technical Assistance Manual as a guiding document, the QM Technical Workgroup conducted an assessment of the current CQM Program. Upon review of the data collection methods and indicators, the QM Technical Workgroup decided to streamline data collection to more accurately report CQM measures and outcomes. In alignment with the Grantee's SAP (Strategic Automation Plan), the QM Technical Workgroup has begun developing the process to collect performance measure data directly from the RWIS. The QM Technical Workgroup identified the following categories for performance measure data collection: 1) core clinical services, 2) medical case management and 3) oral health. Selection of the indicators was determined with input from providers and review from the QM Technical Workgroup.

Providers reviewed the HRSA/HAB performance measures while considering the impact of the measure on PLWH/A, presence of available data fields in RWIS and the capacity of providers to input new data points to capture the HRSA/HAB performance measure. Through the provider driven and data informed process, the following performance measures were identified for data collection for fiscal year 2010-11.

CORE CLINICAL PERFORMANCE MEASURES	
ARV Therapy for Pregnant Women	Percentage of pregnant women with HIV infection who are prescribed antiretroviral therapy
CD4 T-Cell Count	Percentage of clients with HIV infection who had 2 or more CD4 T-cell counts performed in the measurement year
HAART	Percentage of clients with AIDS who are prescribed HAART
Medical Visits	Percentage of clients with HIV infection who had two or more medical visits in an HIV care setting in the measurement year

PCP Prophylaxis	Percentage of clients with HIV infection and a CD4 T-cell count below 200 cells/mm^3 who were prescribed PCP prophylaxis
Cervical Cancer Screening	Percentage of women with HIV infection who have a Pap screening in the measurement year
Hepatitis B Vaccination	Percentage of clients with HIV infection who completed the vaccination series for Hepatitis B
Hepatitis C Screening	Percentage of clients for whom HCV (Hepatitis C) screening was performed at least once since the diagnosis of HIV infection
HIV Risk Counseling	Percentage of clients with HIV infection who received HIV risk counseling within the measurement year
Lipid Screening	Percentage of clients with HIV infection on HAART who had a fasting lipid panel during the measurement year
Syphilis Screening	Percentage of adult clients with HIV infection who had a test for syphilis performed within the measurement year
TB Screening	Percentage of clients with HIV infection who received testing with results documented for latent tuberculosis infection since HIV diagnosis
Substance Use Screening	Percentage of new clients with HIV infection who have been screened for substance use (alcohol & drugs) within the measurement year

MEDICAL CASE MANAGEMENT PERFORMANCE MEASURES	
Care Plan	Percentage of HIV-infected medical case management clients who had a medical case management care plan developed and/or updated two or more times in the measurement year
Medical Visits	Percentage of HIV-infected medical case management clients who had two or more medical visits in an HIV care setting in the measurement year
ORAL HEALTH PERFORMANCE MEASURES	
Dental Visits*	Percentage of clients with HIV infection who had one or more dental visits in the measurement year

*Adapted HAB performance measure based on availability of RWIS data.

In addition to the HRSA/HAB performance measures, the following outcomes are being programmed for inclusion in RWIS reporting. Tracking of the following outcomes will allow the CQM Program to assess the overall impact of outpatient and ambulatory health services and medical case management on PLWH/A.

CLIENT OUTCOMES	**INDICATOR**
CD4 T-Cell Count (Baseline <200 mm^3)	Percentage of clients engaged in outpatient and ambulatory health services, on antiretroviral therapy, whose baseline CD4 count is <200mm^3.
CD4 T-Cell Count (Baseline <200 mm^3 and Increased)	Percentage of clients whose baseline CD4 count was <200mm^3 and engaged in outpatient and ambulatory health services and on antiretroviral therapy, whose CD4 count increased.
CD4 T-Cell Count (Baseline <200 mm^3 and Increased >200 mm^3)	Percentage of clients whose baseline CD4 count was <200mm^3 and engaged in outpatient and ambulatory health services and are on antiretroviral therapy, whose CD4 count increased >200 mm^3.

Viral Load (Undetectable)	Percentage of clients engaged in outpatient and ambulatory health services, on antiretroviral therapy, with an undetectable viral load.
Viral Load (Stabilized or Decreased)	Percentage of clients engaged in outpatient and ambulatory health services who stabilize or decrease their viral loads.

This data will complement the performance measures and further support the CQM Program's goal to align quality management findings with the Planning Council's priority setting and resource allocation activities.

Working with the QM Technical Workgroup, standardized reporting for all indicators have been developed and are currently being programmed by the Hillsborough County ITS (Information and Technology Services) Department for reporting in RWIS. Reports will be formatted for the total service area as well as at the provider agency level. MAI data will also be reported in conjunction with the identified CQM measures. MAI outcomes will be reported and analyzed for Hispanic and Black clients to examine the impact of reducing disparities among those target populations.

MAI CLIENT OUTCOMES	INDICATOR
CD4 T-Cell Count (Baseline <200 mm^3)	Percentage of MAI clients engaged in outpatient and ambulatory health services, on antiretroviral therapy, whose baseline CD4 count is <200mm^3.
CD4 T-Cell Count (Baseline <200 mm^3 and Increased)	Percentage of MAI clients whose baseline CD4 count was <200mm^3 and were engaged in outpatient and ambulatory health services and are on antiretroviral therapy, whose CD4 count increased.
CD4 T-Cell Count (Baseline <200 mm^3 and Increased >200 mm^3)	Percentage of MAI clients whose baseline CD4 count was <200mm^3 and were engaged in outpatient and ambulatory health services and on antiretroviral therapy, whose CD4 count increased >200 mm^3.
Medical Visits	Percentage of MAI clients with HIV infection who had two or more medical visits in an HIV care setting in the measurement year.

Review of the data will occur quarterly with the QM Technical Workgroup. System wide data will also be shared with the Planning and Evaluation Committee, the Resource Prioritization and Allocation Recommendations Committee and the Client Services Committee on a quarterly basis and subsequently reported to the Planning Council. Review of results will generate recommendations for quality improvement activities to address identified gaps or unmet targets. Re-measurement through systematic reporting will allow CQM stakeholders to determine if continuous quality improvement initiatives have resulted in improved outcomes, both in the overall service area as well as those target populations identified through MAI. Systematic reporting utilizing RWIS data is planned for implementation in December 2011.

As a key component to the activities and function of the CQM Program, funded providers are required by the request for proposals and by specific contract provisions to have quality management and continuous quality improvement processes in place within their organizations. Provider agencies agree to collaborate with Grantee staff and quality management consultants, to participate in quality management activities and to report outcomes and service performance.

As previously noted the funded providers are monitored through a review of billing and backup documentation, annual agency site visits with corresponding audit findings and requested corrective action plans as needed. Feedback is also solicited from consumers through the collection of client satisfaction surveys. These internal quality processes ensure that services are being provided according to the local Standards of Care, in compliance with all contracted requirements and those of the National Monitoring Standards. In 2009, a new monitoring tool was developed by the QM provider to enhance the Grantee's ability to track adherence to required contract elements and documentation.

Description of Data Collection and Results

The RWIS is a web based data collection system, which is used for all reporting and invoicing purposes by the Grantee. The Grantee worked in collaboration with the Hillsborough County ITS Department in reviewing all necessary data points that were required for Client Level Data implementation and reporting began in January 2009 with outpatient/ambulatory medical care and medical case management providers. The first semi-annual reports were successfully transmitted to HRSA in September 2009 with validation from HRSA. The Grantee continued to work with the County ITS Department and the providers in preparation for the semi-annual reports for the second six months of 2009 and again for the first six months of 2010 for the RSR (Ryan White Service Report) reporting, with successful transmissions via electronic file transfer. Currently, eighteen out of nineteen provider agencies utilize RWIS for client level data reporting. Nineteen (100%) Ryan White Part A & B provider agencies are required to report data for the RSR. Of the nineteen agencies submitting RSR data, eighteen utilize RWIS for reporting (95%). The one remaining provider utilizes other reporting mechanisms.

The QM Technical Workgroup worked with providers to review the HRSA/HAB performance measures and determined which data elements were present in RWIS as a result of the Client Level Data initiatives. To improve efficiency and streamline the collection of all outcomes, the Grantee continues to work with the CQM Program to establish indicators that are desired for reporting in RWIS. The migration of outcomes to RWIS has been a part of the Strategic Automation Plan from the beginning of the automation project, and Client Level Data has given the integration more attention and higher priority. This integration will provide a comprehensive data source for continuous quality improvement activities, provider and system level outcomes reports and planning and resource allocation activities of the Planning Council. Hillsborough County ITS programmers are currently finalizing the performance measure and client outcome reports.

Hillsborough County ITS programmers have generated some preliminary baseline data that is currently being validated by the CQM Program. The following table illustrates the client level outcomes across the total service area. Tabulated data was calculated based on CD4 T-cell counts and viral loads reported from January 1, 2010 – December 31, 2010.

CLIENT OUTCOMES	NUMERATOR	DENOMINATOR	PERCENT
	NUMBER	NUMBER	
CD4 T-Cell Count (Baseline <200 mm^3)	318	1944	16.4%
CD4 T-Cell Count (Baseline <200 mm^3 and Increased)	248	318	78.0%
CD4 T-Cell Count (Baseline <200 mm^3 and Increased >200 mm^3)	109	248	44.0%
Viral Load (Undetectable)	1096	1942	56.4%

Increased efficiencies have also been incorporated through the implementation of the Ryan White Client Satisfaction Survey. In February 2011, implementation of a new standardized questionnaire began among all service providers, for administration among Ryan White clients. Questionnaires are provided in English and in Spanish. Ryan White clients are asked to provide feedback regarding the quality of services rendered on the date of service. The ongoing administration of the survey allows for continuous monitoring of satisfaction among clients at the provider level as well as across the total service area. Clients are asked to provide feedback quarterly for each service category they have utilized through the Ryan White funded provider network. Client satisfaction results are disseminated on a quarterly basis to providers, Planning Council, the Grantee, Planning and Evaluation Committee, the Resource Prioritization and Allocation Recommendations Committee and the Client Services Committee.

The following table illustrates the system wide Ryan White Client Satisfaction Survey results for the second quarter of the calendar year (February 1 – December 31, 2011).

STATEMENT	TOTAL AGREE
Staff was friendly & courteous.	98.3%
I was served in a timely manner.	96.0%
I received the information/service I needed.	97.1%
The information/service I received was clear & understandable	97.5%
The staff was knowledgeable about resources and/or referrals.	96.3%
I would recommend this service to other people.	97.2%

(n=4,102)

High rates of satisfaction in the second quarter of the calendar year reflect similar satisfaction rates measured in the first quarter. Written comments provided by the clients on the survey were also shared with individual providers and have been used internally within agencies to reinforce best practices, acknowledge staff that have been positively identified and monitor potential barriers and issues identified by clients.

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

Fiscal and Program Monitoring

The Grantee includes both fiscal and programmatic areas of the contract into one monitoring visit to provide a more meaningful comprehensive picture of the service provider activities. A comprehensive monitoring tool is used to evaluate the contractor's performance in both fiscal and programmatic contractual requirements. There is one general monitoring tool covering basic contract compliance issues used for all service contractors and then an additional tool specific to the type service being provided by the contractor. All of these monitoring tools are reviewed annually and updated as needed to comply with any changes in grant requirements or to address any new areas identified as appropriate, and include all of the HRSA monitoring standards published in 2011. The program monitoring tools have a numeric rating scale. Service providers must achieve at least a 95% compliance to fully meet contract requirements.

Program monitors review 10% (or a minimum of 30) of the active client records during the monitoring site visits. The comprehensive monitoring tools previously mentioned are utilized to ensure uniform accuracy and compliance scoring. For those contractors who deliver more than one type service, 10% of the active client records for each service category are reviewed. At least 1,500 active client records will be reviewed for compliance during FY 2012 monitoring site visits. If significant concerns are identified during the record reviews, additional records above the 10% are examined. Once the monitoring site visits are completed, a written report on the findings is prepared by the Grantee and sent to the contractors within two weeks of the site visit.

In addition to monitoring contractors through annual site visits, all contractors are required to maintain monthly fiscal reports which are held by the provider and may be reviewed by the Grantee. Performance reports can be generated by RWIS at any point in time. These reports are reviewed for contract compliance. When concerns are identified through the review of these reports, the Grantee takes appropriate action immediately and does not wait for the annual site visit to address issues.

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

SECTION V: APPENDICES

APPENDIX A: TERMS AND ACRONYMS

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

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

AHEC (Area Health Education Center) - Centers that exist to enhance access to quality health care by improving the supply and distribution of health care professionals in under served areas by facilitating community and academic partnerships.

AICP (AIDS Insurance Continuation Program) - Assists HIV+ individuals in maintaining health insurance coverage when they are no longer able to work. Covers insurance premiums, deductibles and co-pays.

AIDS - Acquired Immunodeficiency Syndrome

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

Aseptic necrosis - A condition that result from poor blood supply to an area of the bone causing bone death. The dead areas of the bone are weakened and can collapse.

ASO - AIDS Service Organization. Provides medical or support services primarily or exclusively to populations infected with or affected by HIV disease.

Care Council - The planning body whose function is to establish a plan for delivery of HIV care services and establish priorities for the use of Part A and Part B Ryan White Program funds.

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

CBO (Community Based Organizations) - Provides services to locally defined populations, which may or may not include populations infected with or affected by HIV disease.

CDC- Centers for Disease Control and Prevention**.**

CD4 Count - The absolute number of CD4+ lymphocytes per cubic millimeter of blood. The CD4+ count is used as a marker of the progression of HIV-related immunosupression. Under the CDC definition, an HIV+ person with a CD4 count of less than 200 cells/mm of blood is considered to have AIDS.

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

Child Welfare Services - Assistance in placing children younger than 20 in temporary (foster care) or permanent (adoption) homes because their parents have died or are unable to care for them due to HIV-related illness.

CMS- Children's Medical Services, State of Florida.

Community Planning Partnership (CPP) – A planning group responsible for the development of the Comprehensive HIV/AIDS Prevention Plan.

Comprehensive Plan - An official document adopted by the local Ryan White Program governing body, which sets forth long-term Goals, Objectives and Policies regarding issues impacting HIV infected individuals.

Co-morbidity - The existence of more than one disease or condition such as HIV and hepatitis.

Continuum of Care - A coordinated delivery system, encompassing a comprehensive range of health and social services that meet the changing needs of People Living with HIV in all stages of illness.

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

Direct Client Services Fund (DCSF) - Fund established by the Grantee to pay for HRSA eligible services for Ryan White clients when no contracted provider exists in the client's geographic area.

Early Identification of Individuals with HIV/AIDS (EIIHA) - Plan to Identify, Inform, Refer, and Link Unaware Population to Care

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

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

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

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

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

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

Grantee - The recipient of Ryan White Program funds. For purposes of this document, the Grantee is Hillsborough County Department of Health and Social Services.

HAART (Highly Active Antiretroviral Therapy) - A prescribed regimen of medications used in the treatment of HIV disease.

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

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

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

Hepatitis C - A liver disease caused by the hepatitis C virus (HCV), which is spread by contact with the blood of an infected person.

HIV Disease - The entire spectrum of the natural history of the human immunodeficiency virus, from post infection through clinical definition of AIDS.

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

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

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

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

Housing Opportunities for People with AIDS (HOPWA) - A program of the U.S. Department of Housing and Urban Development that provides housing and support services for low-income people with HIV/AIDS and their families.

IDU -Injecting Drug User

Incidence - The number of new cases of a disease that occur in a specified period of time.

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

Linguistics services - The provision of interpretation and translation services.

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

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

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

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

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

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

MSM - Men who have sex with men.

Needs Assessment - The process of gathering and analyzing information from a variety of sources in order to determine the current status and unmet needs of a defined population or geographic area. The focus may be on a single issue or on a wide range of issues.

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

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

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

PLWA - Person Living with AIDS**.**

PLWH - Person Living with HIV.

Primary Prevention - Any prevention services provided to uninfected persons to reduce their risk and remain uninfected, or to infected persons to reduce their risk of transmitting infection, or to person who do not know their HIV status so that they may reduce risky behaviors and learn status.

Priority Setting - The process used by the Care Council to establish service priorities for the allocation of Ryan White Program funds and to determine the best ways of meeting each priority.

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

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

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

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

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

Ryan White Comprehensive AIDS Resources Emergency (CARE) Act - Federal legislation to improve the quality and availability of care for individuals and families affected by HIV.

Secondary Prevention - Services intended to prevent progression of disease in persons who are infected.

STD - Sexually Transmitted Disease. Any disease which the primary means of transmission occurs from sexual contact. Examples include syphilis, gonorrhea, chlamydia, and genital herpes.

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

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

TB - Tuberculosis.

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

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

APPENDIX B: EMA EPIDEMIOLOGY DATA

EMA Prevalence	**Group (general pop. #)**	**Number**		**Rate per 100,000**		**Percentage**		**Total HIV/AIDS**		
		AIDS	HIV	AIDS	HIV	AIDS	HIV	#	%	rate
Gender	**Male** (1,331,012)	4,239	3,123	318.5	234.6	74.4%	71.3%	7,362	73.1%	553.1
	Female (1,402,333)	1,456	1,260	103.8	89.9	25.6%	28.7%	2,716	26.9%	193.7
	Total (2,733,345)	***5,695***	***4,383***	***208.4***	***160.4***	***100***%	***100***%	***10,078***	***100***%	***368.7***
Race/ Ethnicity	**White** (1,895,103)	2,840	2,025	149.9	106.9	49.9%	46.2%	4,865	48.3%	256.77
	Black (326,656)	1,989	1,670	608.9	511.2	34.9%	38.1%	3,659	36.3%	1120.1
	Hispanic (419,756)	762	596	181.5	142.0	13.4%	13.6%	1,358	13.5%	323.5
	Other/Unk. (91,830)*	104	92	113.3	100.2	1.8%	2.1%	196	1.9%	213.4
	Total (2,733,345)	***5,695***	***4,383***	***208.4***	***160.4***	***100***%	***100***%	***10,078***	***100***%	***368.7***
Age	**0-12** (421,316)	8	16	1.9	3.8	0.1%	0.4%	24	0.2%	5.7
	13-19 (234,842)	50	64	21.3	27.3	0.9%	1.5%	114	1.1%	48.5
	20-24 (163,811)	92	240	56.2	146.5	1.6%	5.5%	332	3.3%	202.7
	25-29 (166,390)	180	402	108.2	241.6	3.2%	9.2%	582	5.8%	349.8
	30-39 (325,470)	819	979	251.6	300.8	14.4%	22.3%	1,798	17.8%	552.4
	40-49 (375,730)	2,246	1,437	597.8	382.5	39.4%	32.8%	3,683	36.5%	980.2
	50-59 (375,925)	1,725	920	458.9	244.7	30.3%	21.0%	2,645	26.2%	703.6
	60+ (669,857)	575	325	85.8	48.5	10.1%	7.4%	900	8.9%	134.4
	Total (2,733,345)	***5,695***	***4,383***	***208.4***	***160.4***	***100***%	***100***%	***10,078***	***100***%	***368.7***
Mode of Transmission	MSM	2,798	2,104			49.1%	48.0%	4,902	48.6%	
	IDU	637	324			11.2%	7.4%	961	9.5%	
	MSM/IDU	280	151			4.9%	3.4%	431	4.3%	
	Hetero	1,416	1,092			24.9%	24.9%	2,508	24.9%	
	Other	111	66			1.9%	1.5%	177	1.8%	

	No Identified Risk	453	646			8.0%	14.7%	1,099	10.9%	
	Total	***5,695***	***4,383***			***100***%	***100***%	***9,859***	***100***%	

Source: Florida Department of Health, HIV/AIDS Bureau, 2010

APPENDIX C:

EIIHA Matrix

<table>
<tr><td colspan="11">1A. All Individuals Unaware of their HIV Status (HIV positive & HIV negative)</td></tr>
<tr><td colspan="3">2A. Tested in the Past 12 Months</td><td colspan="8">2B. Not Tested in the Past 12 Months</td></tr>
<tr><td colspan="2">3A. Individuals Not Post-Test Counseled</td><td>3B. Received Preliminary HIV Positive Result Only – No Confirmatory Test</td><td colspan="7">3C.High Risk Individuals</td><td>3D. Moderate and Low Risk Individuals</td></tr>
<tr><td>4A. Tested Confidentially</td><td>4B. Tested Anonymously</td><td></td><td colspan="3">4C. MSM</td><td colspan="3">4D. Heterosexuals</td><td colspan="2">4E. Other</td><td></td></tr>
<tr><td></td><td></td><td></td><td>5A. Black</td><td>5B.Hispanic</td><td>5C. White</td><td>5D. Black</td><td>5E. Hispanic</td><td>5F. White</td><td>5G. Partner of HIV+ Individuals</td><td>5H. Infants of Infected Mothers</td><td></td></tr>
<tr><td></td><td></td><td></td><td colspan="6">6A. Youth age 13-24</td><td></td><td></td><td></td></tr>
</table>