Ryan White Treatment Modernization Act – Part A Comprehensive Plan 2009 – 2011

Fort Lauderdale/Broward County EMA

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Acronyms Used in This Plan

ADAP	AIDS Drug Assistance Program
AETC	AIDS Education and Training Center
AHCA	Agency for Health Care Administration
AICP	AIDS Insurance Continuation Program
AIDS	Acquired immunodeficiency syndrome
APA	AIDS pharmaceutical assistance
ARV	Antiretroviral
BARC	Broward Addiction Recovery Center
BCHD	Broward County Health Department
BHP	Bureau of Health Professions
BRHPC	Broward Regional Health Planning Council
CBO	Community-based organization
CCB	Coordinating Council of Broward
CDC	Centers for Disease Control and Prevention
CDTC	Children's Diagnostic and Treatment Center
CEO	Chief Executive Officer
CHC	Community health center
CLAS	Culturally and Linguistically Appropriate Services
CLD	Client level data
CQA	Clinical quality assurance
CQI	Continuous quality improvement
CTS	Counseling and testing site
DAWN	Drug Abuse Warning Network
DCF	Department of Children and Families
DEA	Drug Enforcement Agency
DOT	Directly observed therapy
ED	Emergency department
EIS	Early intervention service
ELR	Electronic lab reporting
EMA	Eligible Metropolitan Area
FDOC	FL Department of Corrections
FIMR	Fetal Infant Mortality Review
FL	Florida
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
FY	Fiscal Year
HAART	Highly active retroviral therapy
HAB	HIV/AIDS Bureau
HARS	HIV/AIDS Reporting System
HCSUS	HIV Cost and Services Utilization Evaluation Study
HIV	Human immunodeficiency virus
HIVPC	HIV Planning Council
HOPWA	Housing Opportunities for Persons With AIDS
HP	Healthy People
HPSA	Health Professional Shortage Area
HRSA	Health Resources and Service Administration
IDU	Injecting drug user
MAI	Minority AIDS Initiative
MOU	Memorandum of Understanding
MSA	Metropolitan Statistical Area
MSM	Men who have sex with men
MUP	Medically Underserved Populations
NIR	No identified risk
NQC	National Quality Center
OI	Opportunistic infection
OOS	Out of State
PCP	*Pneumocystis carinii* pneumonia
PDSA	Plan-Do-Study-Act Cycle
PHS	Public Health Service
PLWHA	Person living with HIV/AIDS
QA	Quality assurance
QI	Quality improvement
QIP	Quality improvement project
QM	Quality management
RARE	Rapid Assessment Response Evaluation
SCHIP	State Children's Health Insurance Program
SCSN	Statewide Coordinated Statement of Need
SPMI	Severe and persistent mental illness
SPNS	Special Projects of National Significance
SSA	Social Security Administration
SSI	Supplemental Security Income
STI	Sexually transmitted infection
TA	Technical assistance
TANF	Temporary Assistance to Need Family
TB	Tuberculosis
TOT	Training of Trainers
VA	Veterans Administration
WICY	Women, infants, children, and youth
ZIP	Zone Improvement Plan Code

Section 1. Introduction

The Part A program is authorized by Part A of Title XXVI of the Public Health Service (PHS) Act, as amended by the Ryan White HIV/AIDS Treatment Modernization Act of 2006. The HIV/AIDS Bureau (HAB) of the Health Resources and Services Administration (HRSA) operates programs funded by the Treatment Act. HAB refers to these programs as the Ryan White HIV/AIDS Program (RWHAP).

Part A funds provide direct financial assistance to Eligible Metropolitan Area (EMA) or Transitional Grant Areas (TGAs) that have been severely affected by the HIV epidemic. Part A formula and supplemental grants assist eligible program areas to develop or enhance access to a comprehensive continuum of high quality, community-based care for low-income individuals and families with HIV.

Part A program grantees are responsible for planning for and organizing a comprehensive continuum of HIV care that may include up to 13 core medical services specified in the Treatment Act. HAB requires that Part A grantees use no less than 75% of grant funds (after reductions for program administration and quality management), for core medical services that are needed in the EMA/TGA. Part A funds may be used for: outpatient and ambulatory health services; (2) AIDS Drug Assistance Program (ADAP) treatments in accordance with Section 2616 of the PHS Act; (3) AIDS pharmaceutical assistance (APA); (4) oral health care; (5) early intervention services (EIS); (6) health insurance premium and cost sharing assistance for low-income individuals in accordance with Section 2615; (7) home health care; (8) medical nutrition therapy; (9) hospice services; (10) home and community-based health services as defined under Section 2614(c); (11) mental health services; (12) substance abuse outpatient care; and (13) medical case management, including treatment adherence services.

Comprehensive HIV/AIDS care beyond these core services may include support services that meet the criteria of enabling individuals and families living with HIV/AIDS to access and remain in primary medical care and improve their clinical outcomes. No more that 25% of Part A funds may be used for support services as defined by the RWHAP as: case management (non-medical); child care services; emergency financial assistance; food bank/home-delivered meals; health education/risk reduction; housing services; legal services; linguistics services; medical transportation services; outreach services; psychosocial support services; referral for health care/supportive services; rehabilitation services; respite care; and treatment adherence counseling.

Part A grantees were required to submit to HAB a comprehensive plan in January 2006. Grantees were instructed in HAB correspondence dated June 6, 2008 that they must update their comprehensive plan and submit it to HAB by January 5, 2009. The updated plan must address the organization and delivery of health and support service in their EMA/TGA. The plan must include appropriate strategies, goals, and timelines. In developing the plan, Part A grantees should incorporate the legislative requirements under section 2602 (b) (4) (D) of the Treatment Act.

Part A grantees are required by HAB to consider how they will evaluate and report on the degree of success or failure achieved by funded initiatives undertaken to improve and maintain a system of care that is responsive to the change epidemic in their EMA. HAB requires grantees to update their plan to reflect an HIV comprehensive care that:

- Ensures availability and quality of all core medical services in the EMA/TGA;
- Eliminates disparities in access to core and support services for individuals with HIV among disproportionately affected sub-populations and historically underserved communities;

- Specifies strategies for identifying individuals who know their HIV status but are not in care, informing them about available treatment and services, and assisting them in using those services;
- Includes a discussion of clinical quality measures;
- Includes strategies that address the primary health care and treatment needs of individuals who know their HIV status and are not in care, as well as the needs of individuals currently in the HIV/AIDS care system;
- Provides goals, objectives, timeliness, and appropriate allocation of funds, as determined by the grantees' needs assessment.
- Includes strategies to coordinate the provision of service programs for HIV prevention, including outreach and EIS; and
- Includes strategies for preventing and treating substance abuse.

HAB requires that the comprehensive plan must include data from local needs assessments that meet legislative requirements. Identified needs, particularly for HIV-related core services, should be a primary impetus for developing the comprehensive plan, guiding the EMA/TGA in setting goals, identifying clinical performance measures, and making resource allocation decisions.

The Ft. Lauderdale/Broward County EMA has developed a comprehensive plan that addresses HAB's requirements, while addressing increased demand for HIV services, limited State and local funds, and HAB's payer of last resort requirements.

Section 2 addresses the questions, "Where are We Now?" and "What is Our Current System of Care?" We summarize trends in HIV epidemic in Broward County, emerging populations, the current HIV/AIDS service systems, trends in HIV public funds, and estimation of unmet need.

Section 3 addresses the questions, "Where do we need to go?" and "What is our vision of an ideal system?" This section reflects the input of key stakeholders including the HIV Planning Council (HIVPC), other RWHAP grantees, consumers, and others to develop a shared vision for system changes. In a community planning process, this group developed an operational definition of the continuum of care, and core and support services. The group also identified shared values for system changes and guiding principles that shape the HIV-related system of care in the Ft. Lauderdale/Broward County EMA. The group addressed the Statewide Coordinated Statement of Need (SCSN), the Florida Part B comprehensive plan, cost effectiveness, high quality services, and other environmental consideration.

Section 4 addresses the questions, "How Will We Monitor Our Progress?" and "How Will We Evaluate Progress in Meeting Our Short- and Long-Term Goals?" This sections summarizes the process undertaken by the Grantee to implement a new client level data (CLD) system to monitor utilization to care, quality of services provided, and the impact of serviced provided. The section also describes the Part A quality program and long-term plan, and its application in monitoring quality of care and subgrantee performance. The process for monitoring clinical outcomes is described. The section also discusses approaches for monitoring the implementation of the comprehensive plan, and ensuring its timely implementation.

Section 2. Where Are We Now: What is Our Current System of Care?

A. Demonstrated Need

1. HIV/AIDS Epidemiology

In the last two decades the HIV/AIDS prevalence in the Fort Lauderdale/Broward County Eligible Metropolitan Area (EMA) in Florida (FL) has remained consistently high relative to the top ranked five EMAs (Source: Centers for Disease Control and Prevention (CDC), HIV/AIDS Surveillance Report). For brevity, we refer to the EMA as Broward County.

Through December 2007, 24,257 Broward County residents were diagnosed with AIDS or HIV (non-AIDS), with 14,357 (69%) persons living with HIV/AIDS (PLWHA). Among living PLWHA, 7,680 have AIDS (53%) and 6,677 have HIV (non-AIDS) (47%). Tables 1 and 2 summarizes HIV/AIDS case data in the EMA by demographic and HIV exposure categories assigned by the FL Department of Health (FDOH). Data presented in Tables 1 and Table 2 exclude EMA residents incarcerated in the FL Department of Corrections (FDOC).

FDOH reported 1,403 new AIDS cases diagnosed in the EMA for the two-year period between January 1, 2006 and December 31, 2007. This figure significantly under-estimates the number of AIDS and HIV (non-AIDS) cases diagnosed during this period due to implementation of a FL laboratory reporting law that went into effect on November 20, 2006. Under the new law, laboratories processing detectable viral load tests (> 75 copies/mL) or CD4 tests below 200 (or 14%) are required to submit an electronic case report to FDOH. In 2007, laboratories switched from paper to electronic lab reporting (ELR). Due to technical difficulties, tests conducted in 2007 were not retrievable from the ELR in 2007. In January 2008, FDOH staff conducted a retrospective review of Western Blot and viral load tests. FDOH staff reported in March 2008 to the Broward County Part A grantee, that at least 1,300 AIDS and HIV (non-AIDS) case reports submitted for tests performed in 2007 were not investigated and submitted to the FDOH. Thus, incidence and prevalence estimates presented in this application are likely to significantly under-estimate the number of HIV seropositive Broward residents. Seeming trends in AIDS and HIV (non-AIDS) incident cases may in fact have increased rather than decreased in 2007. The Part A Grantee has discussed with FDOH and HAB this matter, as it presents a serious challenge in accounting and planning for newly identified AIDS and other HIV seropositive Broward residents. Despite the challenge of accurately measuring the size of the HIV/AIDS epidemic in Broward County, the impact of the epidemic remains profound. Broward continues to rank second in AIDS cases per 100,000 population in the US, only surpassed in population-adjusted AIDS case rates by Miami/Dade County(Source: CDC, HIV/AIDS Surveillance Report). One in 125 Broward County residents live with HIV/AIDS, compared to one in 218 Floridians.

Broward County has effectively addressed its pediatric AIDS epidemic. In response to Broward's ranking as fourth in pediatric AIDS cases through 2006, the HIV care system has created effective systems to prevent perinatal HIV infection. For example, 112 known births to HIV seropositive mothers were identified in 2007 (Broward County Health Department). Through the rapid intervention of HIV clinicians to diagnosis and treat HIV seropositive pregnant women and their newborns, all but two infants were seronegative (1.8%). Substantial effort was made to engage the two pregnant women in HIV treatment prior to, during, and following delivery. However, they did not engage in care. Among the 218 Broward County HIV infected children and youth below 20 years of age, 55% were diagnosed with AIDS and 45% with HIV (non-AIDS). Among the 121 living AIDS cases, 17% are less than 13 years of age and 83% are between 13 and 19 years of age. Among the 97 living HIV (non-AIDS) cases, 46% are less than 13 years of age and 54% are between 13 to 19 years of age.

Table 1. HIV and AIDS Incidence and Prevalence, By Demographic Group								
Demographic Group/ Exposure Category: Risk Redistributed	**AIDS Incidence in 2006-2007**		**AIDS Prevalence through 2007 as of 04/15/08**		**HIV (not AIDS) Prevalence through 2007 as of 04/15/08**		**Total HIV Prevalence through 2007 as of 04/15/08**	
	AIDS incidence is defined as the number of new AIDS cases diagnosed during the period specified, (excluding DOC cases). Data from HARS as of 01/08/08.		**Number of AIDS cases alive and reported in HARS or out of Broward County database (OOS) in this reporting area (excluding DOC cases)**		**Number of HIV (not AIDS) cases alive and reported in HARS or out of Broward County database (OOS) in this reporting area (excluding DOC cases)**		**Combined total of AIDS and HIV (not AIDS) cases alive and reported in HARS or out of Broward County database (OOS) in this reporting area (excluding DOC cases)**	
Race/Ethnicity	**#**	**% of Total**	**#**	**% of Total**	**#**	**% of Total**	**#**	**% of Total**
White, not Hispanic	409	29%	2,792	35%	2,364	36%	5,156	35%
Black, not Hispanic	814	58%	3,979	50%	3,260	49%	7,239	50%
Hispanic	155	11%	948	12%	878	13%	1,826	13%
Asian/Pacific Islander	4	0%	11	0%	26	0%	37	0%
American Indian/Alaskan Native	1	0%	5	0%	9	0%	14	0%
Not Specified/Other	20	1%	164	2%	105	2%	269	2%
Total:	1,403	100%	7,899	100%	6,642	100%	14,541	100%
Gender	**#**	**% of Total**	**#**	**% of Total**	**#**	**% of Total**	**#**	**% of Total**
Male	932	66%	5,715	72%	4,482	67%	10,197	70%
Female	471	34%	2,184	28%	2,159	33%	4,343	30%
Total:	1,403	100%	7,899	100%	6,641	100%	14,540	100%
Age at Diagnosis (Incidence) / Current Age (Prevalence)	**#**	**% of Total**	**#**	**% of Total**	**#**	**% of Total**	**#**	**% of Total**
0-12 years	2	0%	21	0%	45	1%	66	0%
13-19 years	19	1%	102	1%	53	1%	155	1%
20-44 years	832	59%	3,317	42%	3,862	58%	7,179	49%
45+ years	550	39%	4,459	56%	2,682	40%	7,141	49%
Total:	1,403	100%	7,899	100%	6,642	100%	14,541	100%

Table 2. HIV and AIDS Incidence and Prevalence, By HIV Exposure Category								
Demographic Group/ Exposure Category: Risks Redistributed	**AIDS Incidence in 2006-2007**		**AIDS Prevalence through 2007 as of 04/15/08**		**HIV (not AIDS) Prevalence through 2007 as of 04/15/08**		**Total HIV Prevalence through 2007 as of 04/15/08**	
	AIDS incidence is defined as the number of new AIDS cases diagnosed during the period specified, (excluding DOC cases)		**Number of AIDS cases alive and reported in HARS or out of Broward County database (OOS) in this reporting area (excluding DOC cases)**		**Number of HIV (not AIDS) cases alive and reported in HARS or out of Broward County database (OOS) in this reporting area (excluding DOC cases)**		**Combined total of AIDS and HIV (not AIDS) cases alive and reported in HARS or out of Broward County database (OOS) in this reporting area (excluding DOC cases)**	
Adult/Adolescent AIDS Exposure Category	**#**	**% of Total**	**#**	**% of Total**	**#**	**% of Total**	**#**	**% of Total**
MSM	555	40%	3,466	44%	3,107	47%	6,573	45%
IDU	113	8%	758	10%	419	6%	1,177	8%
MSM/IDU	34	2%	308	4%	163	2%	471	3%
Heterosexual	683	49%	3,186	40%	2,873	44%	6,060	42%
Other	17	1%	160	2%	33	1%	193	1%
Total:	1,401	100%	7,878	100%	6,596	100%	14,474	100%
Pediatric AIDS Exposure Categories (ages 0-12)	**#**	**% of Total**	**#**	**% of Total**	**#**	**% of Total**	**#**	**% of Total**
Mother with/at risk for HIV infection	2	100%	21	100%	44	67%	65	98%
Risk not reported/Other	0	0%	0	0%	1	2%	1	2%
Total:	2	100%	21	100%	66	100%	66	100%

Aging of HIV cases and Broward County's popularity as a retirement community contributes to the prevalence of PLWHA who were 50 years or older at AIDS or HIV diagnosis. Between 2003 and 2007, 675 Broward residents 50 years of age or older were reported to have AIDS or HIV (non-AIDS), with 75% male and 25% female. A total of 604 older PLWHA were alive by the end of 2007 (89%). Among older male PLWHA, 77% were between 50 and 59 years of age at diagnosis, 13% were 60 to 64, 8% were 65 to 69, and 3% were 70 or older. The majority of these older PLWHA are White non-Hispanic males (53%), with 34% Black non-Hispanic, 12% Hispanic, and the remainder of other or mixed races. Among older PLWHA males, men who have sex with men (MSM) made up 47% of cases, while 13% were associated with heterosexual contact, 5% with injecting drug use (IDU), 2% with IDU and MSM contact, and 34% had no identified risk (NIR). Among older female PLWHA, 70% were between 50 and 59 years of age at report, 14% were 60 to 64, 11% were 65 to 69, 5% were 70 or older, and 1% had missing age data. The majority of these older PLWHA females are Black non-Hispanic (80%), while 11% are White non-Hispanic, 8% Hispanic, and the remainder are other or mixed races. Among older PLWHA females, 44% of cases were associated with heterosexual contact, 4% with injecting drug use, and 52% had NIR.

Rates of AIDS among Broward County adult women are growing rapidly. About two-thirds (63.4%) of adults living with AIDS are male and 36.6% are female. One in 87 Broward County male residents live with HIV/AIDS, compared to 1 in 154 Floridians. One in 212 Broward female residents live with HIV/AIDS, compared to 1 in 361 Floridians. While females represented 31.0% of AIDS cases in 2006, they made up 36.6% in 2007. The ratio of male to female AIDS cases, or the number of male cases divided by female cases, has shifted significantly in the last decade. While the ratio of males to females was 2.4 males to every 1 female in 1998, the gap between males and females closed significantly by 2007 (1.7 males to 1 female). In contrast, trends in gender among HIV (non-AIDS) cases are unclear. In 1998, the ratio was 1.5 males to 1 female, while in 2007 it was 2.4 males to 1 female.

Over the past decade, adult male HIV (non-AIDS) cases have climbed steadily, with a slight dip in 2007 reflecting the impact of delayed ELR data. In contrast, among adult female HIV (non-AIDS) cases, there were decreases in case reports until 2006, when an increase was documented. Broward County is increasing rapidly in its racial and ethnic diversity. Since 1990, Broward has risen from the 16th to the third most racially diverse FL county. Using a Census Bureau diversity formula, the Broward County Department of Urban Planning and Redevelopment (2008) reports that Broward is now more racially diverse than Miami-Dade. Broward is third in diversity score to Hendry and Orange Counties, and ranks 13th in diversity score among other US Metropolitan Statistical Areas (MSAs). Among the 1.5 million adults residing in Broward in 2007, 53% are White non-Hispanics, 23% are Black non-Hispanics, 21% are Hispanic, and 3% are other or mixed races. Broward will achieve a "majority of minorities" by the next decade, with rates of racial and ethnic minority residents higher than White non-Hispanics. Shifts in Broward's demographics are fueled by immigration of foreign-born minorities and White non-Hispanic decreased birth rates and increased death rates. Broward's diversity is shifting so rapidly it is projected to be the second most diverse US county by 2030.

HIV/AIDS disproportionately impacts Broward County racial/ethnic minorities. Broward County adults living with AIDS tend to be racial or ethnic minorities. As of 2007, prevalent HIV/AIDS case data demonstrate the disproportionate impact of the HIV epidemic on Black non-Hispanics, with 1 in 61 living with HIV/AIDS compared to 1 in 180 White non-Hispanics- a three-fold difference. Among Hispanics, 1 in 219 live with HIV/AIDS. Among the 641 adult AIDS cases reported in 2007, 59% are Black non-Hispanics, 12% Hispanic, 27% White non-Hispanic, and

2% other or mixed race. Among the 823 adult HIV (non-AIDS) cases reported in 2007, 46% are Black non-Hispanics, 18% Hispanic, 46% White non-Hispanic, and 2% other or mixed race.

Growth in HIV incidence among adult males is strongly associated with White non-Hispanics. This growth is largely associated with MSM HIV cases, which increased by 23%, while heterosexual male cases decreased by 5%, and IDU male cases decreased by 53%. The percent of black non-Hispanic male HIV cases has decreased from 57% in 1998 to 33% in 2007.

Despite important advances in HIV treatment, including highly active antiretroviral therapy (HAART), the number of Broward County deaths related to HIV/AIDS continues to increase slightly each year. While PLWHA mortality rates dramatically decreased since the advent of HAART, the number of

Broward deaths due to AIDS remains the second highest among FL counties. After a decrease in the number of deaths associated with adoption of HAART in the late 1990s, HIV/AIDS-related deaths have increased slightly annually throughout the last six years. HIV-related mortality disproportionately impacts Broward racial/ethnic minorities. Mortality rates for Black non-Hispanics are particularly high, with 65% of all AIDS deaths in 2006 (most recent available annual data) reported among this group.

FDOH's report Impact of HIV/AIDS on Broward County cites the disproportionate impact of AIDS mortality on Broward County Hispanic and Black non-Hispanic residents compared to White non-Hispanics. The report also documents racial disparities in median months of life expectancy from AIDS diagnosis to death. Gains in survival were made among Hispanics, White non-Hispanics, and Black non-Hispanics living with AIDS. While each of the groups experienced significant gains in life expectancy during the course of the AIDS epidemic, White non-Hispanics achieved much longer median life expectancy than Hispanics and Black non-Hispanics. The median life expectancy for White non-Hispanics was 43 months from AIDS diagnosis to death for individuals initially diagnosed in 2002 to 2006. In contrast, median life expectancy was 26 months for Black non-Hispanics and 21 months for Hispanics. (Source: FDOH Bureau of HIV/AIDS).

A large portion of the Broward EMA in which PLWHA reside also is designated by the HRSA Bureau of Health Professionals (BHP) as a Medically Underserved Populations (MUP) and Health Professional Shortage Area (HPSA). The HRSA BHP has designated 94 Broward County Census Tracts (34% of all Census Tracts in the County) and 10 low-income population groups as MUPs who face economic, cultural, or linguistic barriers to health care. BHP has also designated 125 (45%) Broward Census Tracts and 13 low-income population groups, community health centers (CHCs), and Native American tribal populations as primary medical care provider HPSAs, 2 as dental provider HPSAs, and 2 as mental health provider HPSAs. A HPSA is a geographic area, demographic (population groups, such as low income or homeless), or an institution (medical or other public facilities) that has a shortage in health care professionals , specifically primary medical care, dental, or mental health providers. Shortage of Practicing Physicians: Increased frequency of malpractice judgments and skyrocketing malpractice insurance has reduced the number of practicing physicians, particularly specialists treating patients with complex conditions. Among Broward County's indigent population, 20 to 30% reported "major trouble" accessing health care in close proximity to their neighborhood. According to the 2004 Client Needs Assessment, a significant portion of PLWHA report that services are needed but unavailable. The EMA's 2007 Provider Needs Assessment cited a variety of reasons why expressly needed services were inaccessible or unavailable, such as an

insufficient number of service providers, waiting lists, and consumer perception. Broader forces in the US health care market also impact the delivery of HIV clinical and specialty medical care.

In the East West Research Corporation's 2005 Research on Florida's Professional Liability Crisis, it reported that, "Florida physicians and hospitals are frequently sued; the odds of being sued are highly correlated with certain specialties." As a direct result of the growing frequency of malpractice lawsuits, settlements, and court judgments against physicians, FL malpractice insurance premiums average 50% above the US average. An estimated 30% of FL physicians are self-insured, with over 40% of South FL physicians reporting that they no longer provide some high-risk procedures. (Source: 2005 Research on FL's Professional Liability Crisis). The critical shortage of specialists in the EMA fuels the unmet needs of PLWHA, with many PLWHA reporting needing but not getting specialist care. Insufficient access to specialists is of significant concern, as these providers manage opportunistic infections (OIs), chronic diseases associated with HIV infection, and HAART side effects.

Analysis of Ryan White HIV/AIDS Program service utilization rates identified subgroups of PLWHA in the EMA that are under-represented in the Ryan White Program-funded system of outpatient/ambulatory medical care and other programs that support their continuation in care (e.g. AIDS Insurance Continuation Program, or AICP). The Part A Grantee analyzed service utilization rates for outpatient/ambulatory medical care by reviewing the 2006 CARE Act Data Reports (CADR) for outpatient/ambulatory medical care in Broward County across all Ryan White Parts (formerly Care Act Title Programs). In 2006, 6,259 unduplicated PLWHA received outpatient/ambulatory medical care. While combined Ryan White Parts A, C, and D serve all races and ethnicities in approximate proportion to their prevalence in the EMA, the AICP has a disproportionate under-utilization rate of enrollment for Black non-Hispanics compared to their prevalence in the EMA (Source: Ryan White Data Report, 2006). These findings may reflect disparities in access among Black non-Hispanics to employer-sponsored commercial insurance, regardless of HIV serostatus. Rates of utilization in 2006 of Part A-funded outpatient/ambulatory health services by race and ethnicity closely mirrored HIV/AIDS prevalence (within 1 to 2%) for all races and ethnicities. For example, Black non-Hispanics make up 50% of prevalent HIV/AIDS cases and constitute 50% of individuals using Part A-funded outpatient/ambulatory medical care.

Broward County has a large and growing population emigrating from other countries of origin. According to 2006 US Census data, FL ranks fourth in the US in the percentage of foreign born residents, with 19% being foreign born (n=412,387). Broward, with 30% of its residents born outside the US, exceeds even California (27%) in the rate of residents born abroad. International immigration is the most significant source of population growth in the South FL region, accounting for more than seven of every ten new residents in the last decade. Latin America and the Caribbean continue to be the primary sources of international migration into South FL, although there is growing diversity due to recent immigrants from Europe and Asia. These and other established communities from Haiti, Jamaica, Bahamas, and Brazil now attract direct immigration to Broward County. Haitians are the immigrant population most disproportionately impacted by the AIDS epidemic in Broward County. The World Health Organization (WHO) reports Haitians have the highest HIV seroprevalence among Caribbean Island populations. The Broward County Department of Planning and Environmental Protection estimates that 62,000 Broward residents have Haitian ancestry, including 14,000 children. Among this group, 53,000 speak French-Creole. Broward has experienced a 2,466% growth in the Haitian-born population from 1980 to 2000. Haitian community leaders in Broward report that the actual number of Haitians residing in Broward County is actually closer to 100,000, as many Haitians have undocumented immigration status. Although Haitians comprise 3 to 4% of

Broward County's population, they account for 10% of new AIDS incidence and 8% of HIV prevalence. Adults born in Haiti represent 21% of Black non-Hispanic Broward residents living with HIV or AIDS. In contrast, US-born adults make up 71% of all Black non-Hispanics, Jamaican-born adults make up 4%, Bahamian-born adults make up 1%, and Blacks of other or unknown country of birth make up 2%.

Broward County's Hispanic population is growing at a faster rate than Black non-Hispanics. From 2000 to 2006, Broward's Black non-Hispanic population increased by 28%, while Hispanics increased 39.5% (Source: Miami Herald Newspaper, citing US Census Bureau Statistics: August 9, 2007). The EMA's Hispanic population continues to grow more diverse, as new residents from Puerto Rico, Columbia, Nicaragua, Mexico, Dominican Republic, Peru, Honduras, and Venezuela established communities in the region (each with more than 30,000 residents). The established Cuban community has also increased as well. According to revised 2006 US Census estimates, Broward is now home to more than 400,000 self-identified Hispanics, comprising 21% of the Broward population. The EMA's growth among the Hispanic population represents a 44% increase between 2000 and 2006.

The estimated level of service gaps among PLWHA in the EMA are determined through the EMA's needs assessment activities. These activities include ongoing analysis of service utilization data, client needs surveys and focus groups (2007), a provider needs survey (2007), and annual targeted population assessments. These activities describe the EMA care continuum and the HIV/AIDS population served by the continuum to determine "where are we now" and provide a basis to project "where are we going," which is consistent with the FY 2006 – 2009 Comprehensive Plan. The annual analysis of the local epidemic describes the overall population, the HIV/AIDS population, and defines "severe need" or "emerging populations" disproportionately impacted by HIV/AIDS. Emerging population assessments assist the EMA to document service needs, types of services needed, unique costs, service gaps, and barriers experienced by PLWHA in and not in care. The needs assessment includes a detailed inventory of all identified core and support resources in the EMA, as well as HIV/AIDS-specific resources. Part A and other Ryan White Program grantees annually forecast anticipated funds needed to support services in the next grant period, types of service categories to be funded, and number of clients to be served. Consumer input is integrated into all needs assessment activities including client surveys, focus groups, community outreach meetings, and emerging population assessments with activities conducted in English, Spanish, and Creole.

Insufficient funds to meet demand for services have led to Broward County PLWHA reporting significant service gaps. A significant portion of PLWHA participating in the 2007 Client Needs Assessment reported that services are needed but unavailable to them. About one-quarter (23%) of respondents stated they would access primary medical care as often as needed if they felt they could, 19% needed oral health, 23% needed food vouchers, 17% needed drug co-payment assistance, and 17% needed support groups. The critical shortage of medical specialists in Broward fuels the unmet needs of PLWHA, with 19% of respondents reporting that they needed but could not get specialist care. Insufficient access to specialists is of significant concern, as these providers have a major role in managing the chronic diseases associated with HIV infection and HAART side effects. Assessment respondents also identified unmet need for other services. From 10 to 15% needed but could not access outreach and referral, legal services, mental health counseling, case management, home health care, nutrition counseling, or transportation. About 7% of respondents stated they needed but could not access addictions treatment or day/respite care. These data may under-represent the need for these services, as the responses of individuals with addictions or disabilities were not analyzed separately.

Part A subgrantees also identified service gaps, and cited a variety of reasons why expressly needed services were inaccessible or unavailable (EMA 2007 Provider Needs Assessment). The most frequent reasons cited for these barriers were insufficient funding, insufficient number of service providers, waiting lists, eligibility restrictions, and perceptions of service unavailability. Part A funding has remained relatively level. The EMA provides highly accessible, culturally sensitive, expert HIV medical care to its diverse population despite funding constraints. It has become extremely difficult; however, to sustain this high quality system of HIV care in light of insufficient Part A funds, flat Part B awards, and significantly decreased HOPWA funding.

"Emerging population" assessments and service category analyses identify specific service gaps. Since 2003, the HIV Planning Council (HIVPC) has commissioned several assessments of groups for focused services to understand and respond to their needs. The assessments are designed to provide a profile of each population while identifying barriers in accessing medical care, social, cultural, and economic factors influencing retention in medical care and providing recommendations to the Grantee and the HIVPC for their consideration. The emerging populations assessed to date include: Haitians (2003), homeless (2004), recently incarcerated (2005), MSM (2006), Hispanics (2007), and PLWHA not in care (2002). The common issues identified underscore the need for targeted education and specialized front-line provider training that addresses cultural competency and linguistic appropriate service delivery. A lack of information and awareness of services was a common theme identified by many participants in these assessments. PLWHA participating in the EMA's 2007 Client Needs Assessment Survey identified obstacles that make it difficult to access health care. "Not knowing where to go for care" and "not having all the paperwork" (documentation required) were reported by 47% of the respondents. Additionally, 52% stated that HIV-related socially imposed and perceived stigma creates a barrier to entering care and remaining engaged in care.

Service gaps can result from cultural belief systems and values among some individuals that can impede their engagement in HIV care. Within the rich ethno-cultural diversity of Broward County, there are factors that influence health care decision making among some minorities that may limit or inhibit engagement in or acceptance of care. For example, the EMA's 2003 Haitian PLWHA Assessment revealed several common themes resulting from the responses of Haitian community leaders and Haitians participating in interviews and focus groups. Themes include problems associated with decisions about seeking and accepting care in outpatient/ambulatory care settings that are frequently grounded in and influenced by cultural belief systems and values. For instance, some racial or ethnic populations tend to value "self-reliance" as a coping habit and thus are reluctant to seek assistance no matter how badly needed or readily available. The EMA's 2003 Haitian PLWHA Assessment reported the tendency among Haitians to rely on self and family to address issues like substance abuse or mental health.

Similar cultural factors among Hispanics are evident in their underutilization of Part A substance abuse and mental health services (Source: Part A Service Utilization Data; 2007 Hispanic PLWHA Assessment). Some minority PLWHA report that they do not seek mental health care due to culturally ingrained self-sufficiency, as well as stigma, fear, mistrust, or a lack of familiarity with mental illness concepts or substance abuse conditions. For example, many cultures like Latinos and Native American Indians, interpret mental health problems in spiritual or other culturally sanctioned terms (Source: Walker, R. D., 2006; One Sky: Addictions and Mental Illness in Native Populations). Thus, the EMA's continuum of HIV care must be flexible enough to meet and address these cultural beliefs if service gaps are to be eliminated.

The EMA's Dental Impact Evaluation Assessment (2005) identified service gaps in oral health care. The assessment reviewed HIV dental clinic utilization rates at Part A-funded dental clinics

and reported that only 25% of the estimated HIV seropositive Broward County residents "in care" received regular dental care between 2002 and 2005. Comparison with national data regarding service gaps/barriers and perceived need for dental care was made to the HIV Cost and Services Utilization Evaluation Study (HCSUS), 2001. HCSUS was the first study that collected data on a nationally representative sample of HIV seropositive persons in care. Broward respondents were about three times more likely (61%) to report unmet need for dental care in the year before the survey than HCSUS respondents (19%). Broward respondents reporting that they had unmet dental needs were asked to identify why they did not get dental care. Significant differences between Broward respondents and the HCSUS sample were identified. HCSUS respondents were about twice as likely (47%) than Broward respondents (26%) not to get dental care when they needed it in the last year because they could not afford it. About one-tenth (8%) of Broward respondents report that they did not get treatment they needed due to concern about their privacy being protected, compared to 0.9% of HCSUS respondents.

2. Impact of Co-Morbidities on the Cost and Complexity of Providing Care

The impact of co-occurring conditions and HIV infection varies among Broward PLWHA. Tables 3 and 4 illustrates that co-morbidities increase the cost and complexity of HIV care, as well as increase the likelihood of secondary HIV transmission. Sexually transmitted infections (STIs) occur more frequently, are more serious, and more difficult to treat in immune compromised individuals. STIs also increase the risk of transmitting HIV infection during unprotected sex (Source: CDC). Individuals with co-occurring conditions require additional treatment and support services that must be coordinated among diverse service providers. The combination of HIV with other illnesses such as hepatitis C, tuberculosis (TB), and STIs make disease management highly complex. For example, the CDC reports that HIV infected individuals co-infected with mycobacterium tuberculum are ten times more likely to develop active TB than HIV seronegative individuals.

The FDOH assessed HIV co-infection among Broward County residents with STIs in 2007 (Source: FDOH Bureau of STD Prevention and Control, 2007). Forty percent of the 2,518 individuals reported with acute and/or chronic viral hepatitis C were co-infected with HIV. About one-fifth (19.3%) of the 155 individuals reported with syphilis were co-infected with HIV. About one-tenth (11.1%) of the 81 individuals reported with TB were co-infected with HIV. Among the 2,359 individuals reported with gonorrhea, 2.9% were co-infected with HIV. Of the 4,822 individuals reported with Chlamydia, 1.1% were co-infected with HIV. The number of reported cases is likely a conservative estimate as only "documented" co-morbidity cases by the FDOH are reflected in these data.

Co-infection of HIV and other STIs is rising sharply, particularly in racial or ethnic MSM (Source: FDOH Bureau of STD Prevention and Control, 2007). Following years of decline, the incidence of Chlamydia in Broward County rose by 76% between 1999 and 2007. Increased rates of Chlamydia in 2006 occurred primarily among Blacks and Hispanics, with an increase of 14% over 2005 levels. The EMA infectious syphilis rate increased from 1999 to 2005 by 76%, and then declined in 2006 by 24%. Despite this overall decline, FDOH documents elevated rates in Black and Hispanic populations, particularly in MSM. In response to the significant increase in STIs in MSM over the last three years, the Broward County Health Department (BCHD) established a centrally located men's STI clinic in 2004. The clinic documented a 125% increase in MSM STI rates from 2005 to 2006 in patients with a reactive syphilis test. Black non-Hispanics continue to have the majority of gonorrhea cases (68%) reported. For the past three years, BCHD has worked with local health care providers through its TB and Refugee Health

Program to target HIV infected patients for TB testing and short-course TB treatment. This disease management initiative helped stabilize HIV co-infection rates in 2006 versus 2005. For people with active hepatitis, the cost of care has increased enormously as combination treatment for hepatitis C with pegylated interferon and ribavirin ranges from $12,000 (for generic ribavirin) to $18,000 for a single course of treatment. Hepatitis C viral load tests also cost almost twice that of HIV viral load testing, $250 versus $130. The FDOH estimates that less than 4% of people with hepatitis C and HIV co-infection receive hepatitis C treatment. With the addition of hepatitis C medications to the FL AIDS Drug Assistance Program (ADAP) in 2006, the number of co-infected individuals receiving treatment rose considerably.

Table 3. Co-Morbidity, Cost, and Complexity of Broward County HIV/AIDS Cases					
Documented Co-morbid Cases in 2007	**Prevalence of the HIV/AIDS population in Broward County (N = 14,131)**	**Prevalence rate of this indicator per 100,000 living HIV/AIDS cases in Broward County**	**Data Source**	**Date of Data**	**Prevalence rate of this co-morbidity in the general population in Broward County**
AIDS Cases diagnosed through 2007 with TB diagnosed in 2007	9	63.7	HARS	Data through 2007 (as of 03/08)	4.6
Infectious syphilis reported in 2007 among HIV/AIDS patients by BCHD (minimal estimate, based on STI client data only)	30	212.3	STDMIS	Data through 2007 (as of 03/08)	9.4
Gonorrhea reported in 2007 among HIV/AIDS patients by BCHD (minimal estimate, based on STI client data only)	68	481.2	STDMIS	Data through 2007 (as of 03/08)	129.4
Chlamydia reported in 2007 among HIV/AIDS patients by BCHD (minimal estimate, based on STI client data only)	53	375.1	STDMIS	Data through 2007 (as of 03/08)	309.7
Hepatitis C: defined as *any* HIV/AIDS case noted with a history of acute and/or chronic viral Hepatitis C and documented in HARS and/or MERLIN	1,017	7,196.9	HARS (local use variable) and/or matched with reported cases in the Hepatitis database	Data through 2007 (as of 03/08)	

Table 4. Co-Morbidity, Cost, and Complexity of Broward County HIV/AIDS Cases					
Other Factors / Surrogate Markers Documented in 2007	**Prevalence of the HIV/AIDS Population Broward County**	**Prevalence rate of this indicator per 100,000 living HIV/AIDS cases from Broward County**		**Data Source**	**Date of Data**
Homelessness (defined as any living HIV/AIDS case who was homeless at diagnosis of HIV or AIDS and documented in HARS)	125	884.6		HARS (address variable)	Data through 2007 (as of 03/08)
Substance Abuse (defined as any living HIV/AIDS case noted with a history of substance abuse, e.g.. alcohol, methamphetamine, cocaine, inhalants, etc, and documented in HARS)	1,760	12,454.9		HARS (local use variable)	Data through 2007 (as of 03/08)
Chronic Mental Illness (defined as any living HIV/AIDS case noted with a history of mental illness and documented in HARS)	640	4,529.0		HARS (local use variable)	Data through 2007 (as of 03/08)
MSM (estimated seroprevalance of males with HIV/AIDS who have an MSM or MSM/IDU risk)	6,732	47,641.6		(Determined by PLWHA data)	Data through 2007 (as of 03/08)
IDU (estimated seroprevalance of persons with HIV/AIDS who have and IDU or MSM/IDU risk)	1,575	11,145.7		(Determined by PLWHA data)	Data through 2007 (as of 03/08)
Release of FL Department of Corrections Cases into Broward County	**Total Offenders Released**	**HIV-infected Offenders Released**		**Data Source**	**Date of Data**
		Number	**% HIV+**		
Offenders who returned to Broward County in 2007	2,559	173	6.8%	DOC Offender-based Information System	CY 2007, data as of 02/08
Offenders who returned to Broward County in 2006	2,415	200	8.3%	DOC Offender-based Information System	CY 2006, data as of 01/07
Offenders who returned to Broward County in 2005	2,569	235	9.1%	DOC Offender-based Information System	CY 2005, data as of 04/06

Table 5. Socio-Economic and Health Insurance Coverage of the Broward County General Population									
Race/ Ethnicity	Civilian Labor Force Unemployed			Population Living Below 100% Poverty			Without insurance coverage including without Medicaid.		
	Broward County		Florida	Broward County		Florida	Broward County		Florida
	Number	Percent	Percent	Number	Percent	Percent	Number	Percent	Percent
White	25,139	53.1%	4.7%	99,162	43.7%	9.6%	78	22.0%	14.7%
Black	13,032	27.5%	9.1%	80,422	35.4%	23.4%	142	40.1%	26.0%
Hispanic	988	2.1%	5.4%	45,142	19.9%	16.5%	134	37.9%	33.2%
Other*	8,219	17.3%	6.5%	2,397	1.0%	18.2%	N/A	N/A	18.0%
Total	**47,378**	**100.0%**	**6.4%**	**227,123**	**100.0%**	**16.9%**	**354**	**100.0%**	**23.0%**

Source: Selected Socioeconomic Indicators, Florida (U.S. Census 2000)
Note: Data on unemployment, poverty level, and insurance coverage are not available for Broward County residents living with HIV/AIDS.
**Other race includes Asian/Hawaiian, Native American/Alaska Native, Other and multiple races.*
*** Numbers and percentages may not reflect all counties associated with the partnership because data was not available*
*** Due to the sample population, the insurance coverage data may not actually depict the true percentage of persons without health insurance*

HIV infection is common among Broward County injecting and other drug users. Several factors impact drug abuse problems and corresponding HIV seropositivity rates in South FL. South FL's close proximity to Latin America and the Caribbean increases the rapid entry and distribution of illicit drugs. The Drug Enforcement Agency (DEA) has designated South FL as a High Intensity Drug Trafficking Area and identified the regional as one of the US's leading cocaine importation centers (DEA, 2008). Extensive coastline and numerous private air and sea vessels make it difficult to pinpoint drug importation routes into FL. Lack of a prescription monitoring system in FL at this time situates the State as ground base for trafficking illicit prescription medications in the southeastern US (Source: National Illicit Drug Prices, 2006; Broward Sheriff's Office (BSO) Crime Lab).

Epidemiological data document that 8% of Broward County's 14,357 PLWHA have IDU as their HIV infection risk factor. Thus, based on reported HIV and AIDS cases, there are a minimum of 1,584 IDUs in Broward County living with HIV. According to the FDOH, an additional 410 chronic cocaine users also have HIV. Of all female IDUs, 60% are Black non-Hispanics. Among male IDUs, 47% are Black non-Hispanics and 41% are Hispanic. The high incidence of co-occurring mental health conditions among substance abusing populations (dually diagnosed), the need for psychotropic pharmaceuticals (e.g., anti-depressants, anxiolytics, anti-psychotics) factors into the increased cost of treatment. Based on the average estimated cost of medication, psychotropics can increase the cost of care by $150 to $400 per month for PLWHA with substance abuse co-morbidities (Source: Mental Health Association of Broward County, 2006). Many substance abusing PLWHA require additional medication to control pain, manage addiction, and improve adherence. Intensive outpatient substance abuse treatment ranges from $10,000 to $15,000 annually, while residential drug treatment can range from $35,000 to $50,000 annually (Source: Memorial HealthCare System, Broward County, 2006). BCHD reports 60 to 70% of HIV infected IDUs are co-infected with hepatitis C, increasing annual treatment costs for hepatitis C by at least $12,000.

The co-occurring condition of mental illness is common among Broward County PLWHA, with mental illness disproportionately impacting Black non-Hispanics. The EMA's 2004 Substance Abuse and Mental Health Cost Effectiveness and Impact Evaluation found that approximately 15,000 Broward County residents receive treatment annually for severe and persistent mental illness (SPMI). Among PLWHA receiving mental health services under Part A funds, the study

reported that Black non-Hispanics are statistically (with a significance level of $p<0.05$) less likely to access and receive mental health services than are White non-Hispanics. The proportion of the Black non-Hispanic PLWHA reflected in Part A service utilization data in 2006 confirms this disparity, with Black non-Hispanics comprising 50% of the EMA's PLWHA but representing 29% of individuals using mental health services. In comparison, Hispanic PLWHA were statistically (with a significance level of $p<0.05$) more likely to receive mental health services than their proportion of the PLWHA population. Among the several recommendations generated by the survey, interviews, and focus groups with consumers, approximately 40% of respondents stated, "more Spanish and Creole speaking mental health counselors and case managers are needed to address the needs of the clients." Some consumers of mental health services reported that many monolingual Spanish or Creole speakers have limited access to mental health because there are few practitioners in the County who can provide these services in their native languages.

Homelessness among Broward County residents has grown significantly in Broward County, contributed to by insufficient affordable rentals, increases in the cost of living, and a sharp increase in foreclosures. The FL Department of Children and Families (DCF) Office on Homeless estimates that in 2007, 5,218 Broward County residents were homeless, an increase of 128.3% since 2005. The FL DCF, December 2006 Census of the homeless population found that almost 88,000 Floridians were homeless on any given day. More than 20,000 homeless individuals reside in Broward at some time during the year. About 40% of homeless Floridians reported homelessness for less than six months, while up to 28% have not obtained permanent housing for more than a year. About 30% of the homeless were not homeless before, while 70% were homeless more than once. The 2006 Annual Report of the Broward Coalition for the Homeless estimated that an estimated 13% had HIV infection. The report indicates that homeless families with dependent children rose 32% over 2005. Black non-Hispanics comprise 77% of all homeless persons. According to the report, 63% of all homeless families are Black non-Hispanics. The report also revealed that one in four (25%) homeless people in Broward report experiencing violence in the last year.

In the EMA's 2005 Homeless PLWHA Assessment, 100 interviews conducted with homeless PLWHA showed a median period of homelessness of three years, with 54% continually homeless for one year or more. Additionally, 60% of respondents reported drug or alcohol addiction or mental illness. Over one-third (36%) reported that HIV and other medical problems contributed to their homelessness. Almost one-half (46%) of homeless PLWHA respondents reported having no income during the previous month, obtaining no Food Stamps or other public funding, and receiving no child or other financial support. Without income, a stable domicile, basic subsistence needs, or transportation funds, the homeless are among the most likely subpopulations to be unable to overcome barriers in accessing care. The cost of providing medical care to homeless PLWHA is substantially higher than for people with stable housing (2006 Broward County Coalition for the Homeless Annual Report). Without access to food, water, and other resources to facilitate adherence to treatment, the homeless must receive basic arrangements for medication storage. Some homeless may require special provisions like directly observed therapy (DOT) at shelters and other temporary domiciles. As noted above, homeless people tend to have higher rates of mental illness, alcohol abuse, and other substance abuse. Treating these conditions and providing housing may cost $30,000 to $50,000 annually above other costs of HIV medical care.

Economic crises increase the number of individuals and families at risk of becoming homeless. The growing foreclosure crisis among FL homeowners has created a new group of homeless individuals and added to the demand for affordable rental housing. The National Coalition for

the Homeless reports that in 2007 there were 279,325 FL foreclosure filings. As a result, 195,000 homes were lost to foreclosure. By February 2008, FL foreclosures were up 69% over February 2007 filings. FL ranks second in the US in the number of foreclosures, with Broward ranking first in foreclosures. It is unclear the extent to which Broward's foreclosure crisis has directly impacted PLWHA. It is likely, however, that increased demand for affordable rental housing among individuals and families experiencing foreclosures is likely to make the search for affordable housing even more difficult for indigent PLWHA.

Previously incarcerated individuals demonstrate multiple support service needs. The FDOC reports that more than 95% of inmates are eventually released and defined as "recently incarcerated." Since most recently incarcerated PLWHA do not have health insurance, they are heavily dependent on public programs such as Medicaid or the Ryan White Program. The 2004 Recently Incarcerated PLWHA Assessment revealed that many released inmates do not know where to go for HIV services upon release. Many HIV infected former inmates reported minimal knowledge about living with HIV and the need for treatment. Recently incarcerated PLWHA comprised 9.5% of respondents in the EMA's 2007 Client Needs Assessment. The survey findings confirmed the earlier findings from the 2004 assessment, where 47% of respondents cited "not knowing where to go (for HIV care)" as a major barrier to accessing medical care.

FDOC estimates that 4% of FL's State and Federal prison inmates are HIV infected. An average of 13,000 Broward County residents are incarcerated daily in County jails or State and Federal prisons. FDOC reports 78,000 detainees are processed annually through Broward County jails. Black non-Hispanics represent a disproportionate percent of the population in the Broward jail systems (53%), as compared to 24% of the County's overall population.

Broward County is one of four CDC jail demonstration sites in the US with a rapid testing initiative with about 600 tests conducted monthly. Over 15,000 inmates have been tested through the demonstration. In 2007, 5,231 rapid HIV tests (18% of FL total) were conducted. The HIV seropositivity rate was 1.8% for males and 0.9% for females. HIV seropositivity rates for Black non-Hispanics (2.29%) are significantly higher than for White non-Hispanics (0.74%). BCHD estimates that over 200 HIV infected inmates are incarcerated at any given time in County jails. In 2006, about 416 inmates received HAART each month, or 60% of the estimated 693 HIV infected inmates. All inmates who have tested HIV seropositive have been referred to the Jail Release Linkage Program, which prepares a pre and post-release plan. Most (90%) of prisoners served by the program are linked to community medical care and social services prior to release. The 2004 Recently Incarcerated PLWHA, found that after discharge, 70% of former inmates had a medical visit at least quarterly and 60% were prescribed HIV medications. The services needed by the recently incarcerated significantly impacts the cost of care in Broward County. Ranking high among their needs is securing stable affordable housing, addiction treatment, and mental health treatment including stabilization with pharmaceuticals for anxiety and depression.

3. Assessment of Emerging Populations with Special Needs

The RWHAP requires Planning Councils and community input processes to determine the needs of emerging populations from the most recent local needs assessment, incorporate them into the implementation plan and comprehensive plan, and identify service gaps so that Part A funds can be directed to PLWH/A who may have limited access or are disenfranchised from existing HIV/AIDS care services. Costs associated with providing services to these populations will be considered a factor in determining supplemental funding. Six emerging populations with special needs have been identified In the Ft. Lauderdale/Broward County EMA: MSM, non-

Hispanic black women, homeless PLWHA, recently incarcerated populations, injecting and other drug users, and immigrants from other countries of origin.

a) Men Who Have Sex With Men (MSM)

Service gaps exist among Broward County MSM PLWHA. In 2006, HIV-infected MSM were surveyed to evaluate access, retention, adherence, and barriers to outpatient/ambulatory medical care. Results identified unique challenges encountered by MSM with co-morbidities such as STIs, hepatitis, TB, mental illness, and addictions. About two-thirds (65%) of respondents reported that they access primary care within four months of diagnosis, while 30% waited two or more years. Black non-Hispanic and Hispanic MSM are reported to be less likely than White non-Hispanic MSM to disclose their sexual behavior because of stigma and disclosure issues in family, church, or other social environments. As a result, these men may seek health care later, go outside their neighborhoods for care due to fear of disclosure, or forego care entirely. Many MSM of color only become aware of their AIDS diagnosis at emergency department (ED) visits, resulting in expensive OI hospitalizations. A 2003 HIVPC assessment of Haitian PLWHA found that Haitian MSM were five times less likely to seek HIV care than White non-Hispanic MSM and were equally less likely to have visited a doctor in the last year. Haitian MSM identified more barriers to care and unmet needs than non-Haitian MSM.

Several factors drive the cost of care for HIV infected MSM. The EMA's 2006 MSM PLWHA Assessment cited minority MSM PLWHA as being diagnosed later in the course of HIV infection and are more often diagnosed during a hospitalization or incarceration than their counterparts. The assessment also reported that many studies have found that MSM PLWHA are more likely to experience major depression and anxiety than the general population and require medication to treat anxiety, adjustment disorders, and/or depression costing $150 or more per month. Improved knowledge and use of aggressive HAART regimens have resulted in extended survival among MSM who will be in HIV care for many years (Source: 2006 MSM PLWHA Assessment). Extended survival is associated with medical compliance including frequent medical visits, HIV-related lab testing, and use of more costly later generations of HAART, such as fusion inhibitors and HAART medications for salvage regimens. While the benefits of these services are clear, the long-term cost of HIV/AIDS has increased significantly in the last decade. The cost of care for Broward County MSM PLWHA is impacted by a relatively high rate of crystal methamphetamine ("meth") use. Crystal meth has been reported by the DEA and local law enforcement to be used among Broward County MSM more commonly than anywhere else in FL. Crystal meth use negatively affects the immune system, reducing HAART therapy effectiveness. Broward HIV clinicians report club and prescription drug abuse among their MSM patients. MSM report increased sexual risk taking behaviors and decreased HIV treatment adherence while under the influence of illicit drugs. Substance abuse treatment costs about $81,000 to serve approximately 20 people for one year of outpatient treatment.

b) Non-Hispanic Black Women

There are unique challenges among Black women living with HIV/AIDS in Broward County. The proportion of women diagnosed with AIDS increased from 18% in 1995 to 31% in 2006. Non-Hispanic Black women represent less than one-quarter (21%) of Broward's female population, yet they account for over 80% of female AIDS incidence for the last decade. Black females comprised 33% of all new AIDS cases in 2006, which is almost double the rate of non-Hispanic Whites. HIV seropositivity rates in incarcerated Black females are higher in comparison to their White counterparts. In 2006, 4,493 HIV tests were conducted in Broward County with 65 (or 1.45%) new infections identified (Source: BCHD Jail Linkage Program). Incarcerated women

were twice as likely as men to be HIV infected. The Black female HIV seropositivity rate was 4.5% with White females at 2%. Minority populations, particularly women, are less likely to seek early medical care. Black non-Hispanic women have historically entered into care at a later age than their White non-Hispanic and Hispanic women. A high percentage of HIV seropositive Black women participating in Broward focus groups in 2007 reported that they do not set their own health care as a priority. Rather, they tend to focus on securing health care for their children and male partners. Consequently, recent epidemiological data indicate that mortality rates are disproportionately impacting all minority women (Source: FDOH Bureau of HIV/AIDS).

The 2003 Haitian PLWHA Assessment reported that Black non-Hispanic females living with HIV are culturally diverse, with a substantial number born in Haiti and other Caribbean nations. Many female PLWHA are recent immigrants, and do not speak or understand English well. The majority of female PLWHA live in central Broward neighborhoods, which experience high rates of poverty, teen pregnancy, infant mortality, STIs, and substance abuse (Source: FDOH Bureau of HIV/AIDS). The EMA's 2006 Needs Assessment indicates female PLWHA are more likely to be poor and enrolled in Medicaid than other PLWHA, with only 7% covered by private insurance. Stigma has been consistently identified as a barrier by racial or ethnic minorities.

Service gaps are reported among PLWHA women. In the 2007 Client Needs Assessment, women identified several factors contributing to their ability to access and use core medical and support services. When asked to report issues that affect their participation in care, 54% stated not wanting others to know they have HIV was their primary concern. Almost one-half (43%) stated they lacked information on where to go for services, while 45% stated they did not have all the needed paperwork. In addition, 40% stated service sites were too far away, findings that are consistent with 41% of women surveyed who reported they have transportation problems. About two-thirds (65%) of female PLWHA reported needing assistance with food, 24% needed oral health, and 25% needed substance abuse or mental health treatment.

To assess service gaps further, the Grantee and HIVPC reviewed BCHD surveillance data by ZIP Code. They found that the fastest growing group with HIV in Broward County was Black non-Hispanic females, particularly those residing in the northern section of the EMA. To understand better this population, the EMA participated in the FY 2004 Rapid Assessment Response Evaluation (RARE) Project. RARE found unmet HIV primary care need and service gaps in substance abuse treatment in the Northern Broward for Black non-Hispanic women of childbearing age. Economic factors and social problems were perceived as critical conditions that make black females in the target area vulnerable to HIV/AIDS. Access barriers resulting in service gaps were similar to those identified in the 2007 EMA Client Needs Assessment.

Part D funds provide medical services and case management for the majority of women and pediatric PLWHA in Broward County. The Part D-funded CDTC initiated an adult women's treatment program in 1999 to complement its pediatric HIV program. In 2006, CDTC provided family-centered case management and medical care to 1,100 women and 2,664 affected family members. Over 95% of these clients were Black non-Hispanic and/or Hispanic women. CDTC reports that female adult PLWHA frequently have family and childcare responsibilities making them less likely to be employed outside the home. Complex factors related to socioeconomic status, cultural attitudes, and beliefs contribute to lack of engagement in services.

The cost of caring for Black non-Hispanic female PLWHA is expensive. Minority populations in Broward County, particularly Blacks, tend to have a later diagnosis of HIV. Over 50% of Blacks testing positive for HIV meet the criteria for an AIDS diagnosis (Source: BCHD). The EMA's Part D grantee reports that treatment of minority women who have tested with late stage AIDS are

more complex because they require highly specialized medical care. These patients present with medical challenges due to a high incidence of drug resistant HIV. The EMA's Part D grantee further reports that clinical research has illustrated that many of these women have failed numerous HAART regimens or exhausted their treatment options. Subsequently, the cost and complexity of HIV clinical services is high, frequently compelling the need for extensive testing and lab procedures such as genotype ($275 per test) and phenotype testing ($500 to $600 per test). The cost of care for women, many of whom care for younger children and elderly parents, may increase due to need for more frequent transportation, childcare, and delayed oral health care. Transportation can range up to $40 for round trip taxi fare, as public transportation is inadequate in some sections of Broward.

c) Homeless PLWHA

The growing number of Broward County homeless PLWHA presents significant and complex challenges to the HIV care continuum. Broward has a large, growing homeless population estimated to be about 20,000 individuals (2006 Broward Coalition for the Homeless Annual Report). Children and families are the fastest growing segment of the homeless. As described earlier, Broward has high rates of seasonal and permanent immigration. The Broward Coalition for the Homeless reports that many homeless people arrive in winter and stay because the climate allows them to live outside without shelter, exposing them to a host of social, environmental, and health-related dangers. Many undocumented immigrants and part time workers come to Broward because of its attractive seasonal labor market from November to April but cannot afford housing. More than 3,000 PLWHA received HOPWA-funded housing, utility, or emergency assistance in 2006. For several years, however, there have been no new HOPWA housing vouchers issued due to limited funding, lack of affordable units, and a doubling of renters in the last ten years. In the 2005 Homeless PLWHA Assessment, 100 homeless PLWHA were interviewed, focus groups were convened, and key service providers were interviewed. Over one-half (58%) of the homeless PLWHA interviewed attributed their homelessness and unemployment to disability related to HIV infection or other conditions.

Significant service gaps exist for homeless PLWHA. More than 30% of homeless PLWHA surveyed do not receive regular medical care, with most using EDs as their primary source of outpatient/ambulatory medical care. Living conditions among Broward County homeless residents are reported to present significant obstacles to the complex activities that an effective HIV treatment regimen requires. Lack of permanent housing and insufficient basic subsistence, make it difficult for homeless PLWHA to access available services. Without basic sustenance, a stable domicile, and transportation, the homeless are among the most likely groups to be unable to access care. According to the 2007 Client Needs Assessment, mental illness was reported by 55% of homeless respondents, with 76% reporting taking psychotropic medications. Drug or alcohol problems were reported by 33% of respondents, of which 64% report participating in Narcotics Anonymous, Alcoholics Anonymous, or other recovery programs. Furthermore, in the 2005 Homeless PLWHA Assessment several service level gaps were identified including inability to provide residential documentation required to establish eligibility for services, lack of transportation (such as bus passes) to community agencies, and long bus rides to HIV clinics.

The cost of providing medical care to homeless PLWHA is substantially higher than for PLWHA with stable housing. Commonly, medical and mental health treatment must be provided to homeless PLWHA in off-site locations, requiring special arrangements for medication storage and/or DOT at shelters and other temporary domiciles. Many of the homeless rely on hospital EDs for even routine health care needs. The cost of medical care provided to homeless clients at EDs may approach $800 to $1,500 per visit, compared to $75 to $150 for an outpatient visit

(Source: 2006 Florida Agency for Health Care Administration (AHCA) Report on ED Costs and Utilization in Florida). Reliance on EDs for routine medical care among homeless PLWHA dramatically increases the cost of HIV care. In the 2007 Client Needs Assessment, more than 70% of homeless PLWHA report needing food assistance, but only 50% received it. Homeless PLWHA also reported high rates of mental illness and alcohol and other substance abuse. Outpatient treatment for mental illness or substance abuse increases the over cost of care by an estimated $3,000 to $15,000 annually. Treating these conditions and providing housing add an estimated $30,000 to $50,000 annually above the other costs of HIV care.

d) Recently Incarcerated Populations

Recently incarcerated PLWHA in Broward County present unique challenges. An estimated 13,000 Broward residents are incarcerated daily in Broward County's jails and State and Federal prisons. A 2006 study, Indicators of Substance Abuse in Broward County, conducted by the United Way Commission on Substance Abuse, concluded that alcohol and/or illicit drugs were related to more than 70% of all crimes resulting in detention or incarceration. A significant number incarcerated males are substance abusers, while female prisoners are detained commonly for trading sex for drugs or money (Source: Broward Sheriff's Office, FL DOC). Both substance abusers and sex trade workers frequently have STIs that increase risk of HIV transmission. In 2007, a total of 5,231 rapid HIV tests were conducted. The HIV seropositivity rate was 1.8% for males and 0.9% for males. HIV seropositivity rates for Black non-Hispanics (2.29%) are significantly higher than the rate for White non-Hispanics (0.74%). BCHD estimates that over 200 HIV infected inmates are incarcerated at any given time in County jails. Many detainees and inmates comprise higher risk populations for HIV, with many prisoners incarcerated for drug-related crimes (e.g., drug dealing, drug paraphernalia possession, or prostitution). Many prisoners have had hepatitis C infection and are at high risk for TB co-infection.

Service gaps are common among the recently incarcerated. They comprised 9.5% of respondents participating in the 2007 Client Needs Assessment. They reported a greater than average need for alcohol and drug treatment, oral health care, housing assistance, and emergency financial assistance. Over one-third (39%) of newly released prisoners report being homeless after release and 25% report receiving no HIV medical care following release. Lack of awareness of "where to go" for medical care was identified as a service gap. This assessment confirmed the findings of the 2004 Recently Incarcerated PLWHA Assessment, where 47% of survey respondents cited "not knowing where to go (for HIV care)" as a major difficulty in accessing medical care. To address these barriers to care, beginning in 2006 BCHD (Part A subgrantee) published and widely circulated to recently released individuals a comprehensive re-entry resource guide to enhance and facilitate their transition from the criminal justice system into the community.

The cost of care for recently incarcerated PLWHA is high in part due to deferred treatment. While medical and oral health care has improved recently in the Broward County jail and FL prison system, recently incarcerated PLWHA participating in EMA focus groups report that the level of medical and oral health needs of prisoners is inadequately met, with some specialty medical and dental services unavailable. This deferred care contributes to the increased cost and complexity of care among the recently released. Other costs associated with stabilizing this subpopulation include stable housing, substance abuse treatment ($7,000 to $20,000 annually for outpatient treatment), and outpatient mental health treatment with associated medication ($150 per month). The need for mental health services, drug treatment, and transitional and permanent housing is very high, as indicated in the 2004 Recently Incarcerated PLWHA

Assessment. These costs are further compounded by the need for specialty medical care and oral health services. Medical care is costly due to diagnostic and treatment procedures such as complex surgical interventions and gastrointestinal, pulmonary, and skin complications. Oral health care costs for the recently incarcerated ranges from $300 to $5,000 per year.

e) Injecting and Other Drug Users

HIV infected drug users present profound challenges to the HIV care continuum. The FDOH and the Broward Commission on Substance Abuse estimates there are 16,000 IDUs in Broward County. The FDOH estimates the HIV seroprevalence among Broward IDUs to be 17%, or an estimated 2,720 PLWHA. According to the 2006 Annual Report on Indicators of Substance Abuse in Broward County, more than 78,000 residents over the age of twelve used one or more illicit drugs during the past six months. In the last two years, more than 2,000 Broward residents died of drug or alcohol overdoses. Many of the deaths were due to overdoses resulting from combinations of illicit drugs. Cocaine-related deaths in 2006 increased 5.6% over 2005 (150 versus 136 deaths). The abuse of prescription pain medications has also increased, accounting for 13% of all Broward Addiction Recovery Center (BARC) clients. Local prevalence reports document a rapid rise in crystal meth use via injection delivery during the last two years, greatly increasing HIV transmission risk. Crystal meth-related FL deaths totaled 117 in 2006, up slightly from 2004 (115). In Broward alone, the hospital ED reporting system via the Drug Abuse Warning Network (DAWN) identified 77 meth-related ED visits in 2006. Also, more than 40% of MSM report using club drugs during the last six months.

According to 2006 BCHD surveillance data, about 11% of the EMA's cumulative HIV and AIDS cases are attributed to the sharing of HIV infected drug injection equipment. In recent years, IDU represented 6 to 8% of new AIDS and HIV cases. A substantial proportion of PLWHA substance abusers are current or former prisoners, many of whom resort to crime or prostitution to support their addiction. Continuity of care in and out of incarceration is a major problem addressed in Broward by the BCHD jail linkage project and Part A-funded outreach workers. In 2004, the profile of PLWHA drug users was specifically assessed. Over one-half of respondents (51%) report using cocaine. About one-fifth (17%) had injected drugs, with 2% injecting drugs in the last six months. About one-tenth (9%) used cocaine in the last six months. The Broward Sheriff's Office reports crystal meth abuse spreading to new populations (e.g., young African American heterosexual males, white heterosexual women), demonstrating the local epidemic's progression beyond the MSM community who has historically comprised the majority of crystal meth users.

Service gaps are common among IDUs. Almost one-half (48%) of self-identifying IDUs responding to the 2007 Client Needs Assessment report being homeless. IDUs and other substance users, comprised 17% of respondents who cited their drug/alcohol problems as interfering with their engagement and retention in medical, oral health, and nutritional care. Active substance abusers often have unique treatment issues, including a high likelihood of hospitalization and death due to overdose, increased need for pain management, poor oral hygiene, and tooth decay exacerbated by substance use, frequently missed medical appointments, complicated pre-existing health conditions, an increased probability of OIs, and negative interactions of street drugs with HIV medications. The lack of available detoxification program slots and specialized treatment programs is a significant gap, further exacerbated by recent reductions in State-funded alcohol, drug abuse, and mental health funding.

The cost of providing medical care to IDU and other drug users is higher than among other PLWHA. Increased costs of $150 to $400 per month are associated with treatment of drug

users who require medication for pain management, higher incidence of secondary HIV infections, and high rates depression, anxiety, or co-occurring psychotic spectrum disorders. Residential drug treatment costs $35,000 to $50,000 annually, while outpatient treatment costs can range from $4,000 to $15,000 annually. Oral health care for PLWHA with a substance abuse history is more costly due to their neglected oral health. Many substance abusers present with advanced periodontal disease and other complicating oral conditions. Based on the 2007 Clients Needs Assessment, 58% of IDUs report being co-infected with hepatitis B and C transmitted through use of contaminated needles. BCHD estimates the co-infection rates range among IDUs from 55 to 65%. Hepatitis treatment also contributes significantly to the cost (up to $12,000 annually) of HIV care among drugs users, sometimes not covered by commercial insurance formularies.

f) Immigrants From Other Countries of Origin

Broward County is impacted uniquely by immigration of PLWHA from other countries. As discussed earlier, the 2006 US Census documents that foreign-born residents comprise 30% of the population in Broward. Since 1991, South FL's immigrant community has grown so substantially, that, according to newly released US Census figures, Broward is now a "minority-majority" county. Broward is among 22 large US counties where Hispanic and Black residents outnumber White non-Hispanics. International migration is the most significant source of population growth in the South FL region, accounting for more than seven out of every ten new residents in the last decade. An estimated 20% of PLWHA in Broward were born abroad in non-English speaking countries according to the BCHD HIV/AIDS Surveillance Program. Currently, 52% of all county TB cases are foreign born. Among these recent immigrants, about one-third of both Haitian and Black non-Hispanics are co-infected.

The 2007 Client Needs Assessment indicates that many immigrants found the bureaucracy required to access care to be intrusive, embarrassing, or confusing. Most immigrants lack health insurance and are unfamiliar with the delivery system of US health care and benefit programs. Undocumented resident status and fear of deportation commonly contribute to fear of using publicly funded clinics and other public services. Clients frequently miss medical appointments or drop out of care. As a result, many immigrants go undiagnosed for long periods after infection or are diagnosed when they present AIDS-related symptoms. Disclosure of HIV risk behavior among many immigrants is highly sensitive and often problematic. The 2003 Haitian PLWHA Assessment found a high rate of PLWHA report fear of HIV status disclosure, stigma, and being rejected by their spouse and/or family due to their HIV infection. PLWHA immigrants interviewed also reported unwillingness to discuss drug use or mental health problems. For many, cultural sanctions, values, or taboos interfere with discussing or seeking treatment for sexual risk taking behaviors.

Service gaps exist among immigrant PLWHA. Some immigrant PLWHA identified common barriers to accessing medical care. Once in HIV treatment, new immigrant PLWHA tend to under-utilize HIV clinical and support services, despite their critical importance. Some immigrants do not understand or value the importance of case management, preferring instead to be self-reliant in accordance with ingrained cultural expectations. Such isolation fosters a lack of awareness of availability of core and support services that could benefit them (e.g., oral health care, mental health, substance abuse services). Many immigrants encounter difficulty adjusting to their HIV status, often reporting being ostracized or rejected by family members or significant others. The 2007 Hispanic PLWHA Assessment was commissioned by the HIVPC to understand the best ways to respond to service barriers for Hispanic immigrant PLWHA. This study evaluated access, retention, adherence, and barriers to medical care for this rapidly

growing population. The assessment findings were incorporated into the EMA's FY 2008 Implementation Plan, with targeted strategies to address the care needs of emergent immigrant populations.

Additional costs are incurred to meet the needs of immigrants. Due to a shortage of multilingual HIV primary care providers in the EMA, the cost of medical care is increased for non-English patients needing translation services. More than one-half of Haitians living with HIV/AIDS and about one-quarter of Hispanics require translators to ensure effective communication with clinicians. (Source: 2007 EMA Client Needs Survey). Because of lack of health insurance and lack of familiarity with health care and entitlement systems, immigrants frequently are diagnosed late in the course of their HIV infection. As a result, annual costs of care are higher than for patients detected at an earlier stage of illness. Additional lab tests, increased frequency of visits to specialists, and increased frequency of visits to primary care physicians characterize the treatment for many immigrants. Medical providers treating PLWHA immigrants report that these patients require more intensive medical, mental health, case management, and drug treatment visits. Chronic conditions that contribute to poor health are common among immigrants. Clinical research indicates that immigrants are more likely than other PLWHA to be resistant to HAART, requiring more costly salvage therapy. Outpatient non-pharmacy medical costs are estimated to be $500 to $1,000 annually. Lab costs are increased to $500 to $750 annually due to the increased need for genotype and phenotype, CD4, and HIV viral load testing. HAART for patients in advanced HIV disease costs $8,000 to $12,000 more annually, depending on treatment regimen. Inpatient costs can exceed $10,000 per admission.

4. Unique Service Delivery Challenges

Unique service delivery challenges exist in the EMA that require Part A funds. Poverty, lack of health insurance, and other social and economic factors are common among Broward County PLWHA, especially among the racial or ethnic minority population.

Poverty is pervasive among Broward County residents. Among Black non-Hispanic in Broward County, 45% live at or below 100% of the Federal Poverty Level (FPL), while 26% of Hispanics live at or below FPL. The 2006 US Census reports an estimated 12% of the general population (214,516 Broward County residents and 81,852 families) were at or below 100% of the FPL. Of those families with children under the age of 18, 11.7% (or 50,138 households) were reported at or below the FPL. One-tenth of all households have less than $10,000 in annual income and an additional 14% (or 61,203 households) have an annual income between $10,000 and $24,999.

Among all PLWHA receiving Part A-funded medical services in Broward, 95% live below 300% of the FPL. In fact, 72% of PLWHA live below 100% of the FPL. Comparative analysis of poverty data shows that those ZIP Codes most impacted by poverty also have the highest rates of reported HIV and AIDS cases. In those high impact ZIP Codes, poverty rates range from 13% to 17%, compared to 12% for Broward overall (Source: Coordinating Council of Broward (CCB) 2006 Quality of Life Survey). The challenges that poverty imposes on individuals and families are numerous. Of particular concern are the individuals who avoid or delay seeking health care due to their impoverished status. The 2006 CCB Quality of Life Survey results showed that 11% of Broward residents reported not seeing a doctor due to inability to assume their share of cost, with 15% of residents reporting not obtaining a needed prescribed medication in the past year due to cost. Among Broward's indigent population, 20 to 30% reported "major trouble" accessing health care in close proximity to their neighborhood.

Lack of health insurance results in demand for RWHAP funds. More than three million Floridians (18%) do not have health insurance as compared to 16% nationally. This is one of the highest rates of the uninsured in the US, with FL ranking 46th out of the 50 states for the percentage of insured. The 2005 FL Health Insurance Study conducted by the Research Institute on Social and Economic Policy estimated that 19% of Broward County's residents lacked commercial insurance, Medicare, or Medicaid. This percentage is consistent with FL State officials' estimates for the rate of the uninsured in Broward. Access to care is impacted for the uninsured in FL by the lack of public health funds. FL ranks last among the 50 states in Federal per capita spending for public health, according to the 2006 Trust for America's Health Study. The Commonwealth Fund developed a national scorecard on US health system performance in 2007 by analyzing key dimensions of health system performance. FL ranked 43rd out of 50 states overall, and last (50 out of 50) for the percent of adults who are uninsured. A significant portion of Floridians with insurance coverage experienced gaps in their health insurance coverage. Breaks in continuous coverage can intensify problems of access to health care and difficulty in paying medical bills, leading some individuals to forego medical care.

Based on medical care billing data for Broward County PLWHA, about 30% have commercial insurance, 32% have Medicaid, 6% Medicare, and 2% VA benefits. One-third of PLWHA have no health insurance. White non-Hispanic PLWHA are more likely to have health insurance, while Black non-Hispanic and female PLWHA are more likely to be Medicaid beneficiaries. These findings are consistent with the 2005 Employee Benefit Research Institute report that documented men and women of color are more likely to be uninsured than white non-Hispanics. The impact of being uninsured is serious for PLWHA, contributing to health care being delayed until late in HIV infection, due to perceptions of the cost of health care and inability to purchase care (Source: CCB 2006 Quality of Life Survey; 2007 Client Needs Focus Groups). Delayed HIV care is associated with increased AIDS incidence in Broward, as well as hospitalization, complex medical needs, and increased costs borne by Broward's hospitals.

Insufficient health insurance benefit packages impacts the care of insured PLWHA and demand for Ryan White Program-funded services. There are no reliable State or local data measuring the actual number of underinsured individuals whose health insurance benefits are insufficient to cover catastrophic medical events or who have capped benefits requiring large out-of-pocket payments. Nationally, the number of underinsured individuals may exceed the number of uninsured by as much as 150% (Source: 2005 Research Institute on Social and Economic Policy and the Center for Labor Research and Studies). Some managed care and commercial plans cap the number of prescriptions or other covered services in an enrollment period. Beneficiaries needing additional services in excess of the cap must pay for those services out-of-pocket. The definition used by some plans for medical necessity has resulted in a growing number of uncovered medical procedures. Additionally, many managed care and commercial insurance plans increased significantly their deductibles and co-payments, shifting a greater share of cost to beneficiaries. PLWHA and others with chronic conditions are particularly impacted by these trends in health insurance, as they have significantly greater likelihood to exceed caps and have a higher volume of services resulting in out-of-pocket expenses. Primary health care clinics in Broward County also report a growing number of PLWHA who are insured for outpatient and inpatient services, but not for pharmaceuticals. The 2004 Survey of PLWHA and the 2007 Client Needs Focus Groups substantiated these findings, with PLWHA reporting heavy dependence on Ryan White Program-funded pharmaceutical assistance programs.

Unique service delivery challenges are evident in clients' increasing share of medication costs. In recent years, most commercial health plans and managed care plans increased the share of patients' costs through increased co-payments, deductibles, and formulary restrictions. PLWHA

commonly pay from $25 to $40 or more per prescription in co-payments, representing increases of 20 to 50% in their share of cost. The RWHAP assumes the cost of indigent patients to extent to which funds are available, as clients cannot afford such dramatic increases. In Broward County Part B-funded medication co-payments increased from $131,000 in 2001 to a projected need of $541,947 for FY 2008. This program serves over 300 unduplicated clients annually. Additionally, AICP clients have experienced substantial increases in medication co-pays, affecting the number of new clients that can enroll. As a cost cutting measure, AICP discontinued co-payment and deductible coverage for new enrollees five years ago.

Unique service delivery challenges were identified in local PLWHA focus groups. In 2006 and 2007, the Broward Community Planning Partnership (BCPP) conducted 13 focus groups targeting minority PLWHA populations or subpopulations. These focus groups provided a forum where factors were identified that limit access to care and result in disparities. BCPP members are from local communities and government, and they reflect Broward County's diverse community. The focus groups were designed to reflect Broward's diverse population including older Hispanics, substance abusers, African American women, the recently incarcerated, MSM of color, Hispanic women, heterosexual teens, Haitian women, HIV infected MSM, and Black non-Hispanic men. Two additional focus groups were convened in October 2007 targeting the recently diagnosed and those "not in care." All focus groups addressed the same questions concerning perceptions, awareness, thoughts, and recommendations for the community and government response to HIV/AIDS. While each group provided some distinctive ethno-cultural, social, and experiential responses, there were common themes and suggestions that emerged about perceived gaps in services and corresponding recommendations to address them. For instance, virtually all focus identified insufficient governmental funding to meet the medical needs of PLWHA. Secondly, most participants stated that, as consumers, they could provide a more active role in helping other PLWHA. Several participants expressed a willingness to assume a peer-counseling role, especially to newly-infected PLWHA or those returning to care.

Consequently, the FY 2008 Implementation Plan incorporated a funded peer-based model of care coordination. Another common theme identified in the focus groups was the desire among PLWHA for up-to-date information about available medical and support services and where and how to access those services. The groups also discussed the need for a streamlined HIV service delivery system to address the cumbersome bureaucracy experienced by many consumers. Additionally, many focus group participants expressed the desire and importance of being treated by service providers who identify with their own culture and who are multilingual.

Seasonal clients present unique challenges for HIV services. As discussed earlier, Broward County is a popular destination for seasonal residents and tourists, as well as family members from high HIV seroprevalent Caribbean nations. A significant number of PLWHA establish residency with relatives to obtain HIV treatment. Many of these PLWHA are uninsured or underinsured and typically seek care in public clinics. Many PLWHA come to FL to find work in the service industry during the winter or "snowbird season." Typically, most small employers do not offer health insurance to short-term workers. To assess this issue further, the impact of immigration of PLWHA to Broward and other FL EMAs was studied by the FDOH in 2004. The study concluded that as many as 34% of PLWHA reportedly tested with HIV in another country, FL county, or US state, and then migrated to Broward. The funding implications of this migration are significant, as Part A and Part B funds are allocated largely based on a formula only taking into consideration place of residence at the time of initial diagnosis.

Increased hurricane activity has resulted in the need to plan for Broward County's infrastructure and public health system, including services for PLWHA The 2008 hurricane season is

underway and active. While no hurricanes have affected Broward County directly, Grantee staff must plan prior to each predicted storm to ensure shelter and access to medications for indigent PLWHA. This effort was informed by the impact of four hurricanes in 2005. More than 100,000 people live in areas that receive mandatory evacuation orders from the government due to risk of flooding, storm surge, or major wind damage. In the past three years, three major evacuations were ordered in these areas. During evacuations, more than 7,500 people were housed temporarily in public shelters (525 in special needs shelters and 250 homeless persons in the Broward Homeless Assistance Center).

When the National Weather Bureau issues a hurricane warning for Broward, all public bus transportation is discontinued until the storm passes. Depending on the extent of damage, public transportation is restarted initially on major routes only and on a very limited schedule. According to Part A and Part B transportation services utilized for 2006, over 750 PLWHA who rely on public transit as their only source of transportation are impacted severely, as access to HIV-related medications and other critical services are disrupted. Driving restrictions and curfews are imposed by County officials in the wake of storm debris and downed electric lines. In addition to limitations on access to care, many PLWHA who rely on home health care, home delivered meals, and in-home case management services are impacted severely. The National Weather Service anticipates that Broward will continue to experience significant hurricane and tropical storm damage in the future.

B. The HIV Care Continuum: An Inventory of HIV Services

1. Efforts to Find PLWHA Not In Care and Engage Them In Outpatient/ Ambulatory Medical Care

PLWHA enter the HIV care continuum through many entry points including: inpatient acute care hospitals, non-HIV identifiable family success centers, confidential and/or anonymous CTS, homeless shelters, domestic violence centers, community-based drug treatment programs, County detention centers, and numerous faith and/or CBOs. EIS, including outreach, targets minority, low income, and uninsured populations. Part A-funded providers are contractually required to establish linkages and collaborative agreements with key points of entry. Through these linkages, clients are referred to health and support services for an assessment by case managers who coordinate and manage entry into core services.

In November 2008, EMA sponsored a Consumer Forum and HIVPC retreat to obtain input on the FY 2009-2011 Comprehensive HIV/AIDS Plan. A central focus of those activities was to reaffirm outreach efforts as a central component of the Comprehensive Plan. Scheduled forum and retreat activities included encouraging participation from a representative sample of PLWHA not in care, conducting special PLWHA focus group and planning sessions, and refining core and support service strategies targeting PLWHA engagement or reengagement in care.

The EMA's RARE Project found unmet need for HIV primary care in the Northern section of Broward County for African-American women of childbearing age and Haitians. As a result, the FY 2009-2011 Implementation Plan includes adding a FQHC to provide outpatient/ambulatory medical care services in the northern geographic area. This medical provider demonstrates an ability to serve minorities, including African-American women of childbearing age, African-American men, and Haitian populations.

Part A contract language requires coordination between subgrantees and agencies providing HIV counseling and testing services (CTS), EIS, and other HAB-recognized points of entry into

HIV care. These requirements include establishing linkage agreements and Memorandum of Understanding (MOU) that clearly define referral and follow-up roles, with language requiring documented referrals and response time.

Part A service delivery models encourage client enrollment in outpatient/ambulatory medical care. Support services assist PLWHA engagement and retention in outpatient/ambulatory medical care. Subgrantee contract language requires all agencies to determine at intake and review periodically, client engagement in HIV outpatient and ambulatory health care, as well as provide medical referrals for and follow-up of consenting not in care.

Food bank services are often a point of entry into the EMA's HIV care continuum. The food bank subgrantee engages newly diagnosed PLWHA and those lost-to-care by referring them to core medical service.

Outreach service subgrantees are required to find and engage people who know their HIV serostatus but are not currently in care and reengage clients that have dropped out of care. The EMA has undertaken significant efforts to increase the efficiency and effectiveness of outreach services through increased documentation and tracking of client engagement and retention in care. Part A-funded outreach subgrantees are contractually required to coordinate outreach efforts with prevention programs to avoid duplication of outreach activities at points of entry into the EMA's HIV care continuum. These subgrantees are required to submit monthly calendars of outreach activities including dates, times, and locations of services. They also are required to attend coordination meetings.

The FY 2009-2-11 Comprehensive Plan includes strategies to expand and enhance outreach services. The EMA uses aggregate HIV test results, stratified by points of entry, from Part B FDOH to target outreach efforts accordingly. The EMA's Outreach Tracking Assessment Tool was designed to easily capture aggregate demographic, geographic data, barriers to care, and client engagement in primary medical care. These summary data are submitted monthly during Quality Improvement (QI) Network meetings. The data are synthesized into an EMA-wide database to inform the unmet need process and evaluate efforts to find people not in care, identify their barriers, and engage them in care. Contracts specify a targeted number of units of PLWHA medical engagement and retention.

Outreach workers locate clients lost to care (i.e., out of primary care for six months/or not following a doctor's medical care plan). At core services intake, clients sign an informed consent so outreach can occur if they are lost to care. Outreach subgrantees conduct outreach to identify individuals never in care and/or who recently dropped out of care. Peer outreach workers employed by outpatient/ambulatory medical care subgrantees do community follow-up to reengage patients lost to follow-up.

2. Community-Based HIV Clinical and Support Service Programs

Countywide access to HIV core services is facilitated by dedicated HIV clinics and other facilities funded through Federal (Parts, A, B, C, D, and F; AETC, HOPWA, Medicaid, Medicare), State (General Revenue, SCHIP, DCF) and local funders (Broward County Government Tax Revenue, United Way, and Community Foundation of Broward). In addition, a myriad of social and support services (e.g., food services, housing, support groups, and transportation) are available through this funding, as well as other HIV and non-HIV specific funding sources to support core services. Part A funds are leveraged to support and enhance

this existing high quality care continuum and ensure that services are concentrated to those areas hardest hit by the HIV epidemic.

HIV clinical services are provided through highly accessible strategically located freestanding clinics. Moreover, the medical and other personnel staffing these clinics are HIV experienced, highly diverse, and represent the demographics of the HIV epidemic in Broward County. The EMA has an established public primary health care system comprised of the two tax-assisted hospital districts, Broward Health and Memorial Healthcare System, with their facilities offering inpatient, emergency care, and outpatient primary medical care sites throughout the county, an FQHC (with two locations), and the BCHD. Several ASOs also provide readily accessible, strategically located clinical services.

Other HIV clinical services are available. The VA operates an outpatient clinic in Broward County with limited hours available for HIV specialty services. More comprehensive services (including inpatient care) are available in VA facilities in Miami-Dade and Palm Beach Counties.

The medical case management system's underlying focus is to assist clients to achieve access to outpatient/ambulatory medical care, adhere to medical protocols, obtain other core and support services as required, and remain in primary medical care. Case manager advocate for, broker services, and link clients to other services to achieving maximum medical outcomes and benefits. Specifically, case managers coordinate services for clients, make referrals to various service providers across varied funding sources insuring the RWHAP is the payer of last resort, and follow up with referral sources to ensure services were provided.

Case management focuses on identifying clients' needs and barriers that inhibit enrollment or retention in outpatient/ambulatory medical care. The Level of Care Assessment Form is used to identify case management acuity. It assigns newly diagnosed PLWHA in an intensive intervention level to ensure support to enter outpatient/ambulatory medical care. Within four weeks of contact with a case manager, consenting clients have a medical appointment scheduled. Collaboratively, client and case managers develop a realistic, time-framed Care Plan. Clients are assisted in accessing other non-medical services to meet pressing needs such as addictions and mental health treatment via linkages established within and outside the RWHAP-funded care continuum. Use of a standard countywide certified referral, certification, and recertification process is a contractual requirement. After eligibility is determined, the case manager certifies clients' eligibility, and agencies receiving a referral do not have to complete another eligibility determination, thus expediting client access to services in other agencies. To streamline case management services, the Grantee is designing a centralized eligibility determination system that will allow case managers to focus on care plan development, implementation, and care coordination.

Case management programs funded by Part C, Part D, and the Medicaid Project AIDS Care (PAC) Waiver complement care coordination activities conducted by Part A-funded medical case management agencies and provide the necessary linkage to the primary medical care system. RWHAP-funded case managers rely on a referral network that includes providers and services outside of the RWHAP care continuum.

The EMA benefits from a continuum of mental health and substance abuse services funded and monitored by the DCF Substance Abuse and Health Care Services. This continuum includes a psychiatric hospital and three community mental health centers that operate both residential and outpatient services. More than 30 CBOs provide mental health and substance abuse services through DCF. In addition, the comprehensive substance abuse program operated by Broward County provides detoxification, residential treatment, outpatient counseling, and support group

services. Since this existing system serves all eligible indigent residents in the EMA, prioritization of services resulting from resource limitations allows access to these services to only those PLWHA with severe mental health and addictions. Part A substance abuse and mental health services are funded to compliment existing resources to ensure that PLWHA can have mental health and substance abuse issues addressed to assist them to access and remain adherent in primary medical care.

HIV oral health services are offered by a university-based dental school, with satellite care sites co-located at HIV clinics throughout Broward County. This program receives Part A and Part F Community-Based Dental Partnership Program (CBDPP) funds. BCHD also provides Part A-funded community-based HIV oral health services at sites throughout the County.

Table 6 summarizes the inventory of Part A-funded services by subgrantee and service category. The relatively small number of service categories reflects the commitment of the Grantee and the HIVPC to allocate a significant proportion of Part A funds to core services. The number of funded support service categories has been reduced significantly since the early part of this decade. The number of Part A-funded subgrantees has also decreased during that time due to agency closures, decreased funds for support services, and the administrative cost associated with participation in the RWHAP.

3. HIV/AIDS-Related Inpatient Hospital Admissions and Expenditures

Use of HAART in the US since 1996 has contributed to significant reductions in disease and death among HIV-infected patients and a shift in causes of death from predominately AIDS-defining OIs to chronic diseases. Nationally, hospitalization rates and length of hospital stays have decreased significantly. In the HAART era, hospitalization rates among HIV-infected patients can be used to monitor the effectiveness and durability of HAART in preventing OIs and other AIDS-defining conditions. Decreased rates may also reflect the benefits associated with funding of outpatient/ambulatory medical care and HIV medications. Increased hospitalization rates may reflect increased HIV infection rates among Broward County residents, ARV treatment failure, and exhaustion of treatment options among treated patients. Hospitalizations also may reflect increased complications or toxicities of HAART and/or late HIV disease. Finally, the hospital costs represent a significant financial burden among insurers, as well as hospitals that incur uncompensated costs.

As illustrated in Table 7, between 2004 and 2007, 11,394 HIV/AIDS-related hospitalizations occurred in hospitals in Broward County. Between 2004 and 2005, hospitalizations decreased 15.6%. Hospitalizations then increased 2.7% between 2005 and 2006, and then decreased 6.9% between 2006 and 2007. The number of inpatient days per year associated with HIV/AIDS followed a similar pattern, with inpatient days dropping 16.9% between 2004 and 2005. Inpatient days then increased 5.5% from 2005 to 2006, and dropped 11.8% between 2006 and 2007.

HIV/AIDS-related hospitalizations were associated with over $519 million in total charges between 2004 and 2007. Total hospital charges decreased 17.8% between 2004 and 2005, then rose 6.3% between 2005 and 2006, and then decreased 23.5% between 2006 and 2007. Table 7 illustrates a concerning trend in source of payment for HIV/AIDS hospitalizations. Medicaid was the payment source for 31.5% of HIV/AIDS hospitalizations in 2004, versus 26.1% in 2007. Medicaid charges then increased 8% between 2005 and 2006, and a 38.5% drop in charges between 2006 and 2007. Self-pay patients, commonly generate uncompensated charges for hospitals, represented 11.1% of charges in 2004 versus 14.3% in 2007.

Table 6. FY 2008 Part A- Funded Services and Funded Agencies										
Agency	**Core Medical Services**						**Non-Core Services**			
	Ambulatory Medical	**Pharma-ceuticals**	**Oral Health**	**Mental Health Therapy**	**Substance Abuse Treatment**	**Case Manage-ment**	**Out-reach**	**Trans-portation**	**Legal Services**	**Food Bank**
AIDS Healthcare Foundation		*								
Broward Community and Family Health Center	*					*				
Broward County Health Department	*	*	*			*	*			
Broward House				*	*	*	*	*		
Care Resource	*					*				
Legal Aid Service of Broward County									*	
Minority Development & Empowerment				*		*	*			
Mount Olive Development Corp						*				
North Broward Hospital District	*	*				*				
Nova Southeast University			*							
Poverello Center										*
South Broward Hospital District	*			*	*	*				
Walgreens		*								

Table 7. Trends in HIV/AIDS-Related Hospitalizations and Expenditures in Broward County Inpatient Facilities, 2004 – 2007											
Year	# of Hospitali-zations	# of Inpatient Days	Total Medicaid Charges		Total Medicare Charges		Total Third Party Charges		Total Self-Pay Charges		Total Charges
			$	%	$	%	$	%	$	%	
2004	3,240	26,935	$48,559,458	31.5%	$47,267,113	30.6%	$41,466,106	26.9%	$17,070,290	11.1%	$154,362,967
2005	2,734	22,372	$40,662,480	32.0%	$37,234,178	29.3%	$33,711,928	26.6%	$15,284,563	12.0%	$126,893,149
2006	2,807	23,605	$43,915,381	32.5%	$39,843,398	29.5%	$33,827,463	25.1%	$17,359,484	12.9%	$134,945,726
2007	2,613	20,814	$26,997,390	26.1%	$36,260,173	35.1%	$25,200,829	24.4%	$14,800,749	14.3%	$103,259,141
Total	**11,394**	**93,726**	**$160,134,709**	**30.8%**	**$160,604,862**	**30.9%**	**$134,206,326**	**25.8%**	**$64,515,086**	**12.4%**	**$519,460,983**

Source: Broward Regional Health Planning Council

4. Adoption of Hospital-Based HIV Testing to Identify and Engage PLWHA Unaware of Their HIV Serostatus or Out of Care

Sharply increased demand for HIV core and support services in Broward County may occur during the 2009-2011 planning period due to changes in the CDC's recommendations for HIV testing. In 2006, the CDC released revised recommendations for HIV testing that strongly encouraged universal HIV testing among the general population.[1] The CDC encouraged the offering of HIV testing as a routine component of primary medical care. Clinicians practicing in ambulatory care settings and hospital EDs are encouraged by the CDC to offer routine HIV testing. The CDC also has recommended discontinuance of counseling and risk assessment prior to HIV testing. The emphasis is now on post-test counseling of HIV-infected individuals, rapid transition into HIV treatment, and initiation of HAART. Several national medical organizations have published statements supporting routine HIV testing. These organizations include the American College of Emergency Physicians, American Academy of Family Physicians, American College of Obstetricians and Gynecologists, and the American College of Physicians.[2]

The CDC recommendations come at a time when advances in HIV oral rapid testing allow for preliminary determination of HIV serostatus in less than one hour. Rapid testing has increased greatly the rate of individuals directly receiving their test results, because they commonly do not leave the testing site. In contrast, the standard HIV testing procedure is complex and requires use of a sensitive enzyme immunoassay (EIA); followed by a Western blot if the EIA is positive.[3] This process can take one week or longer, with the return rate for test results being relatively low for many test sites. As a result, some HIV-infected individuals did not receive their results and may only become aware of their HIV serostatus due to symptoms associated with advanced HIV disease.

The Grantee recently commissioned a survey of hospitals in Broward County to assess their current HIV risk assessment and testing policies in emergency, labor and delivery, inpatient, ambulatory care, and other departments. Use of rapid testing was also assessed. Barriers to adoption of CDC's HIV testing recommendations were assessed, as well as factors that must be taken into consideration in expanding HIV testing. A 100% response rate was achieved, with all hospitals in Broward County participating in the survey.

Although all hospitals in Broward County offer HIV testing, their policies regarding which departments offer testing vary. Slightly over one-half of hospitals (59%) offer HIV testing throughout their departments. In contrast, 35% of inpatient units, 71% of outpatient departments, and 41% of hospital employee health programs do not offer HIV testing. Only 47% of hospitals report that pregnancy is an indication for HIV testing, and 41% report that rape is an indication for HIV testing.

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[1] CDC. Recommendations for HIV testing services for inpatients and outpatients in acute-care hospital settings. MMWR 1993;42[No. RR-2]:1--10; CDC. Revised guidelines for HIV counseling, testing, and referral. MMWR 2001;50[No. RR-19]:1--62; and CDC. Revised recommendations for HIV screening of pregnant women. MMWR 2001;50[No. RR-19]:63--85).

[2] Branson BM. Overview of Routine/Expanded HIV Testing in the US. A presentation at the 2008 National Summit on HIV Diagnosis, Prevention, and Access to Care. Arlington VA, November 19, 2008.

[3] Franco-Paredes C, Tellez I, del Rio C. Rapid HIV testing: A review of the literature and implications for the clinician. Curr HIV/AIDS Rep. 2006 Nov;3(4):169-75.

All but one of the 16 hospitals in Broward County operates an ED. An average of 4,036 ED visits occurred per hospital in November 2008, the month in which the survey was conducted. Among hospitals with EDs, 67% offer HIV testing in their EDs. Only one hospital offers HIV testing to all its ED patients. Only two hospitals (13%) report that they offer HIV screening to all ED patients regardless of clinical symptoms or behavioral risk factors.

Eight hospitals have labor and delivery units, with an average of 245 live births per hospital in November 2008 (the month the survey was conducted). All but one hospital (12%) reported that they offer HIV testing in their labor and delivery units. Only one-half (50%) of hospitals with labor and delivery units reports that they offer HIV screening in which all patients are tested regardless of clinical symptoms or behavioral risk factors. All hospitals reporting that they referral to a specific RWHAP-funded clinical program serving pregnant PLWHA.

Rapid HIV testing is offered to employees at 50% of the hospitals. Additionally, rapid testing is offered at 56% of EDs and 31% of hospital inpatient units.

Referral procedures for HIV-infected patients vary by hospital. Only 35% of hospitals offered HIV medical evaluation on the same day, while 59% offered referrals to BCHD, 47% offered referrals for evaluation at a hospital-based clinic, 41% offered referrals to a CHC, 23% offered referrals to another HIV clinic, and 12% did not offer referrals.

Based on the results of the survey, considerable improvement can be achieved in expanding routine HIV testing in Broward County hospitals. Federal, State, and local public health efforts to expand HIV testing and referral for treatment are likely to impact testing policies and practices in these hospitals, resulting in considerably increased demand for Part A-funded outpatient/ambulatory medical care, as well as other core and non-core services. Based on the survey results, the Grantee has identified an opportunity to collaborate with Broward County hospitals and BCHD to identify mechanisms to address expansion of hospital-based HIV testing and referrals.

C. Financing of the HIV Care Continuum

1. Impact of RHAP Funding

Table 8 describes the availability of RWHAP and other HIV public funding in the EMA. Services funded by Federal, State, and local sources (including other RWHAP parts) are taken into consideration in planning for the Broward County HIV care continuum during the priority setting and allocation processes. The EMA considers the HIV and non-HIV specific services funded by local, State, and Federal resources to maximize funds; minimize duplication in the care continuum, and ensure Ryan White Program funds used as the payer of last resort.

The EMA's established and fully integrated planning process engages representatives of key funders and stakeholders in all levels of planning, decision-making, implementation, and evaluation. Representatives include: (1) FL Medicaid field office; (2) Social Security Administration (SSA) field office; (3) State Children's Health Insurance Program (SCHIP) local liaison; (4) Broward County Department of Veterans Affairs liaison; (5) City of Fort Lauderdale Housing Opportunities for Persons with AIDS (HOPWA) grantee; (6) BCHD, the lead agency for Part B, ADAP, and CDC prevention initiatives, (7) Children's Diagnostic and Treatment Center (CDTC), the Part D grantee and services for women, infants, children, and youth (WICY); (8) FL DCF, the grantee of Federal and State SAMHSA funds; (9) Broward Health (formerly the North Broward Hospital District), current Part C and former Special Projects of National Significance

(SPNS) grantee; (10) Nova Southeastern University, Part F grantee; (11) Broward Community and Family Health Centers, Inc., a Federally Qualified Health Center (FQHC); (12) Memorial Healthcare Systems; (13) United Way and Community Foundation of Broward; and (14) Broward County government, represented by the Part A Chief Executive Officer (CEO) and the Grantee that oversees the distribution of County funding for Health and Human Services, as well as EMA Minority AIDS Initiative (MAI) funding. Broward Healthcare and Memorial Healthcare Systems provide the majority of publicly funded inpatient care services in the EMA. Those agencies, along with BCHD and Broward Community and Family Health Centers provide the majority of publicly funded outpatient/ambulatory medical care in the EMA.

The Broward Regional Health Planning Council (BRHPC) posts a detailed resource inventory of Federal, State, and locally funded HIV/AIDS providers, programs, and services to its website. Online access provides the capability to review, update, and print current information. A directory of all health and human services maintained and funded by Broward County also is accessible via website (www.211-broward.org) or by calling 2-1-1. All agencies responding to Requests for Proposals (RFPs) released by Broward County are required to update their information in this directory.

Changes in Federal, State, and local program policies and funding impact issues are considered in sustaining and expansion of the established HIV care continuum, priority setting, and allocation decisions. Ongoing analyses of factors that affect program eligibility are reviewed for impact to the HIV care continuum. The EMA has established several mechanisms through which the funding of health and social service programs are considered:

- RW grantees and key funders provide the HIVPC monthly funding and utilization reports.

- The HIVPC reviews monthly updated Part A and MAI funding data to ensure that over or underutilization of Ryan White Program funds are minimized. Through this effort, the EMA has successfully addressed unexpected service needs by rapid reallocation of funds. Grantee staff provides the HIVPC with a minimal of two “sweeps” and reallocation opportunities per year to address service shortfalls in core medical services. Despite these aggressive measures, the need for Ryan White Program-funded services remains high in the EMA.

- Key stakeholders and funders meet bi-monthly to discuss policy, legislative, cost, and funding issues that influence the EMA’s care continuum. Program, service, utilization trends, and emerging issues also are discussed. These ongoing collaborative discussions assist policymakers in the EMA to analyze and respond proactively to changes that may affect the HIV care continuum. Press releases, forums, presentations and/or technical assistance (TA) or training needs are jointly developed and provided in the EMA. This process identified potential FY 2007 issues resulting from decreased Ryan White Program funding in the EMA and pending changes in Medicare and the FL Medicaid Program.

- Medicare Part D, Medicaid covered benefits, budgetary changes, and reform activities are major considerations in planning for a comprehensive HIV care continuum, priority setting, and allocations. Services for WICY are also considered in Part A prioritization and allocation processes. Temporary Assistance to Need Family (TANF) reform reduced the number of Broward County residents eligible for Medicaid coverage. Decreased economic assistance and Food Stamps resulted in individuals traditionally dependent upon those funding mechanisms accessing Part A-funded support services.

- The impact of the HIV/AIDS Bureau's (HAB) Veterans Administration (VA) policy clarification to the EMA's care continuum is considered in planning, prioritization, and allocation. HAB advised Part A grantees that veterans may access funded services through either care system. Increased use of Part A services by veterans is anticipated. The EMA considered this factor when increasing core service allocations. The Part A Grantee is monitoring veterans' service utilization of Part A services to assess the impact of this policy.

- The expansion of the CDC HIV testing initiative is likely to increase significantly demand for HIV ambulatory/outpatient health and support services as newly identified HIV seropositive individuals are engaged in care. This major change in Federal HIV testing policies is factored into Part A allocation and priority setting.

- Federal, State, and local substance abuse and mental health treatment service funding cuts further decreased the already limited capacity of those systems. The continued demand for complex substance abuse treatment in Broward County resulted in waiting lists for detoxification and residential treatment facilities. Due to funding shortfalls, local mental health services are highly prioritized for the severely and persistently mental ill. Part A continues to increase substance abuse and mental health service provision for PLWHA to assist access, retention, and adherence to HIV medical care to the extent that new Part A and MAI funds become available. Lack of significant increases in these funds, however, has impaired the ability of the EMA to fund effectively these critically needed services.

- A collaboratively developed annual EMA Funding Report identifies government funding sources, programs, services, initiatives, and utilization. These activities, incorporated with additional EMA needs assessment activities, assist in priority setting and resource allocation.

Table 8. Public Funding in Broward County Allocated to HIV/AIDS Care and Support Services, FY 2008 - 2009										
Services	**CHD General Revenue Allocation**	**Ryan White HIV/AIDS Program**					**HOPWA Allocation**	**SAMHSA**	**OTHER Allocation**	**Total Funds**
		Part A Allocation	**Part B Allocation**	**Part C Allocation**	**Part D Allocation**	**Part F Allocation**				
Core Services										
Ambulatory/ Outpatient Medical Care	396,493	4,271,208		465,921	637,077				180,000	**$5,950,699**
Drug Reimbursement Program	131,416*	4,361,410		57,502						**$4,550,328**
Health Insurance Premium/ Cost Sharing			973,386							**$973,386**
Home Health Care			54,732							**$54,732**
Mental Health Services	50,000	110,238			151,230					**$311,468**
Nutritional Counseling		55,433			9,843					**$65,276**
Oral Health	213,397	696,414				234,747				**$1,144,558**
Substance Abuse Services (Outpatient)		225,861						254,320		**$480,181**
Treatment Adherence Services					35,006					**$35,006**
Support Services										
Treatment Adherence Counseling			98,424	81,731						**$180,155**
Case Management		1,154,840		207,503	955,894					**$2,318,237**
Food Bank/ Home Delivered Meals/ Nutritional supplements		583,654	92,000							**$675,654**
Housing Assistance							6,671,660			**$6,671,660**
Outreach Services		244,250								**$244,250**
Transportation		159,088	55,441		30,000					**$244,529**
Legal Services		80,630								**$80,630**
Hospital Services									160,000	**$160,000**
Total	**$791,306**	**$11,943,026**	**$1,273,983**	**$812,657**	**$1,819,050**	**$234,747**	**$6,671,660**	**$254,320**	**$340,000**	**$24,140,749**

* Medication Co-payment Program and Health Insurance Continuation Program

2. Trends in Part A Funding

Table 9 summarizes trends in actual Part A and MAI total expenditures between FY 2004 to FY 2007, estimated FY 2008 expenditures, and proposed FY 2009 expenditures. Part A and MAI funding levels peaked in FY 2006 and decreased 12.2% between FY 2006 and 2007. A 6.7% increase in funds was awarded between FY 2007 and 2008.

As illustrated in Table 10, the Part A program has far exceeded the Modernization Act's requirement that at least 75% of Part A and MAI direct services funds be awarded to core services. The rate of Part A and MAI funds allocated to core services increased each year between 2004 and 2008. An estimated 91.1% of Part A and MAI funds will be expended on core services in FY 2008. It should be noted that the Grantee and HIVPC recognize that significantly increased funds for support services, such as transportation and outreach, are greatly needed to continue the success of the Part A program in ensuring access to HIV core services for medically indigent PLWHA.

Table 9.Total Broward County Part A and MAI Funds, by Core and Non-Core Service Categories, FY 2004 - FY 2009

Categories	Actual Expenditures				Estimated	Proposed
	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009
Core Services	$10,179,157	$10,919,225	$11,638,239	$10,432,418	$10,875,404	$12,798,744
Non-Core Services	$1,658,798	$1,867,174	$1,517,950	$1,116,184	$1,067,352	$1,290,627
SERVICES SUBTOTAL	$11,837,955	$12,786,399	$13,156,189	$11,548,602	$11,942,756	$14,089,371
Program Support	$743,122	$739,866	$840,103	$518,872	$702,515	$828,500
Adminis-tration	$1,034,602	$1,108,705	$1,007,541	$1,103,738	$1,405,030	$1,657,000
NON-SERVICE SUBTOTAL	$1,777,724	$1,848,571	$1,847,644	$1,622,610	$2,107,545	$2,485,500
GRAND TOTAL	$13,615,679	$14,634,970	$15,003,833	$13,171,212	$14,050,301	$16,574,871

Table 10.Percentage of Broward County Part A Direct Services Funds Distributed to Core and Non-Core Service Categories, FY 2004-FY 2009

Categories	Actual Expenditures				Estimated	Proposed
	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009
Core Services	86.0%	85.4%	88.5%	90.3%	91.1%	90.8%
Non-Core Services	14.0%	14.6%	11.5%	9.7%	8.9%	9.2%
SERVICES TOTAL	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Table 11.Change in the Percentage of Broward County Part A Funds Distributed Between Core and Non-Core Service Categories, FY 2004-FY 2009					
Categories	**Rate of Change Between FY 2004 and 2005**	**Rate of Change Between FY 2005 and 2006**	**Rate of Change Between FY 2006 and 2007**	**Rate of Change Between FY 2007 and 2008**	**Rate of Change Between FY 2008 and 2009**
Core Services	-0.7%	3.6%	2.1%	0.8%	-0.2%
Non-Core Services	4.2%	-21.0%	-16.2%	-7.5%	2.5%
SERVICES TOTAL	0.0%	0.0%	0.0%	0.0%	0.0%

3. Medicaid Enrollment and Expenditures

The FL Medicaid Program plays a significant role in funding HIV clinical and ancillary services for PLWHA. Among the 250,603 Broward County Medicaid recipients, an estimated 1,598 have HIV and 485 have AIDS. These 2,083 recipients with HIV/AIDS represent less than 1% of total Medicaid recipients in Broward County. As summarized in Table 8, Broward County Medicaid recipients with HIV/AIDS generated over $48 million in Medicaid expenditures in FY 2006-2007 (the most recent period for which data are available).

As their expenditure profile illustrates in Table 12, Medicaid beneficiaries with HIV/AIDS have a broad array of inpatient, medication, physician services, case management, and ancillary services available to them.

Table 12. Enrollment, Units of Service, and Expenditures of Broward County Residents With HIV/AIDS Enrolled in Florida Medicaid, FY 2006 – 2007					
SERVICE CATEGORY	**# of Benefi-iaries**	**# of Claims**	**# of Units**	**Total Expenditures**	**Expenditures Per Eligible Month**
HOSPITAL INPATIENT	798	1,564	9,346	$12,713,433	$476.59
HOSPITAL INSURANCE BENEFIT	75	87	18	$104,573	$3.92
HOSPITAL OUTPATIENT	1,744	8,459	37,857	$2,362,785	$88.57
HOSPITAL OUTPATIENT CROSSVER	177	738	0	$119,314	$4.47
NURSING HOME CROSSOVER	10	31	411	$46,622	$1.75
SKILLED NURSING HOME	37	160	5,059	$1,358,023	$50.91
INTERMEDIATE CARE LEVEL I	71	336	7,191	$1,203,073	$45.10
PHYSICIAN SERVICES	2,037	73,042	117,835	$2,089,417	$78.33
PHYSICIAN CROSSOVER	120	474	474	$16,439	$0.62
PRESCRIBED MEDICINE	2,048	91,124	91,124	$18,967,625	$711.04
LAB AND X-RAY	1,108	20,046	20,833	$481,886	$18.06
LAB/X-RAY CROSSOVER	8	13	13	$263	$0.01
TRANSPORTATION	589	4,104	32,753	$263,113	$9.86
TRANSPORTION CROSSOVER	48	200	200	$6,753	$0.25
FAMILY PLANNING	185	890	889	$10,491	$0.39
HOME HEALTH SERVICS	286	5,469	152,276	$291,487	$10.93
HOME HEALTH CROSSVER	23	107	107	$1,015	$0.04
EPSDT SCREENING	77	110	110	$7,900	$0.30
CHILD DENTAL	35	212	222	$2,784	$0.10
CHILD VISION	25	142	210	$3,694	$0.14
CHILD HEARING	3	11	11	$174	$0.01
ADULT DENTAL	85	318	343	$11,926	$0.45
ADULT VISION	236	1,255	1,752	$22,488	$0.84
ADULT HEARING	8	31	34	$1,884	$0.07

Table 12. Enrollment, Units of Service, and Expenditures of Broward County Residents With HIV/AIDS Enrolled in Florida Medicaid, FY 2006 – 2007					
SERVICE CATEGORY	**# of Benefi-iaries**	**# of Claims**	**# of Units**	**Total Expenditures**	**Expenditures Per Eligible Month**
CASE MANAGEMENT - CMS KIDS	14	135	319	$2,951	$0.11
CHIROPRACTIC SERVICES	20	28	28	$11,569	$0.43
NURSE PRACTITIONER	195	329	9,686	$22,266	$0.83
HOSPICE	59	110	1,606	$598,882	$22.45
COMMUNITY MENTAL HEALTH	138	2,600	18,281	$196,485	$7.37
AGING SERVICES	7	267	4,070	$15,664	$0.59
DEVELOPMENTAL SERVCS	16	943	26,901	$374,250	$14.03
AIDS WAIVER SERVICES	377	8,692	52,715	$590,326	$22.13
BIRTHING CENTER	1	8	8	$550	$0.02
PRE-PAID HEALTH PLAN - HMO	564	2,256	2,256	$3,048,490	$114.28
RURAL HEALTH SERVICS	1	7	7	$934	$0.04
PERSONAL CARE SRVCES	9	1,092	1,352	$201,045	$7.54
PRIVATE DUTY NURSE	11	2,522	25,829	$531,363	$19.92
PHYSICAL THERAPY	17	500	1,205	$21,253	$0.80
SPEECH THERAPY	15	380	1,129	$18,756	$0.70
OCCUPATIONAL THERPY	10	392	1,148	$19,828	$0.74
RESPIRATORY THERAPY	21	3,099	7,290	$124,184	$4.66
HOSPITAL INPATIENT > 45 DAYS	45	71	996	$1,378,103	$51.66
FEDERALLY QUALIFIED HEALTH CENTER	16	52	52	$6,467	$0.24
MEDIPASS - PRIMARY CARE PROVIDER	878	4,528	4,528	$13,584	$0.51
CLINIC SERVICES	220	680	680	$101,132	$3.79
DS SLAMS	2	59	781	$10,473	$0.39
MENTAL HEALTH CASE MANAGEMENT – ADULT	38	1,211	5,337	$63,776	$2.39
DEVELOPMENT E & I	6	7	7	$1,050	$0.04
TFC CASE MANAGEMENT - MENTAL HEALTH KIDS	4	93	346	$4,152	$0.16
TFC COMM MENTL HLTH	34	1,321	4,344	$132,010	$4.95
ACLF	1	40	360	$12,119	$0.45
PHYSICIAN ASSISTANT	50	60	60	$2,026	$0.08
PREPAID MENTAL HEALTH	57	61	61	$11,527	$0.43
SCHOOL BASED SERVICES	24	638	1,662	$6,262	$0.23
DIALYSIS CENTER	25	155	480	$350,704	$13.15
PSN	1,079	8,058	8,058	$24,174	$0.91
ASSISTIVE CARE SERVICES	64	543	10,937	$101,495	$3.80
HEALTHY START WAIVER	23	34	34	$6,395	$0.24
HEALTHY START MEDIPASS	74	378	378	$1,134	$0.04
DISEASE MANAGEMENT FEE	1	0	0	-$120	$0.00
TOTAL				$48,092,423	

D. Unmet Need

Table 13 summarizes the EMA's unmet need estimate and framework used to generate the estimate, including data inputs, data sources, and formulas used. The framework has been refined to include an accurate account of HIV/AIDS cases in the EMA, to the extent that HIV/AIDS surveillance data are complete. Unmet need refers to PLWHA in the EMA who know their HIV/AIDS status but are not receiving care. The EMA has 15,094 total reported HIV/AIDS cases, including 8,044 AIDS cases and 7,050 HIV cases. FDOH reported 2,990 PLWA and 3,092 PLWH were not currently in care, or 6,082 PLWHA.

1. Methods Used to Develop the Unmet Need Estimates

The EMA used surveillance and lab reporting as the primary data sources to determine unmet need estimates. The development of unmet need estimates encompassed several activities:

Step 1: Determine Separate Calculations of the Total Number of PLWH and PLWA Living in the EMA. FDOH surveillance staff documented the entire population of persons in the EMA living with HIV and AIDS based on living cases reported in the HIV/AIDS Reporting System (HARS) and the Out of State (OOS) databases diagnosed through 12/31/07 and reported through April 15, 2008. Table 7 reflects the actual reported number of PLWHA living in Broward County during FY 2007, while Table 7 only includes PLWHA with case investigations completed through the CDC cut-off date of December 31, 2007. While FL has a mature name-based reporting system, FDOH instituted mandatory CD4 and viral load lab reporting in January 2006. As discussed earlier, several problems in lab reporting resulted in under-reporting of in-care case reporting. Specifically, FDOH surveillance staff reported about 1,200 labs from Broward that were not investigated and reported by the December 31, 2007 CDC reporting deadline. These lab reports were subsequently investigated and reported by April 15, 2008, resulted in an additional 553 cases, not included in the total reported CDC case counts in Table 7. HIV and AIDS case underreporting presents a significant challenge in planning for the care of PLWHA in the EMA. Specifically, multiple Federal HIV/AIDS grant programs, including the RWHAP and HOPWA, are based on the timeliness of surveillance reporting of the actual number of PLWHA in the EMA. The implications of FDOH surveillance reporting delays described has a significant impact on the EMA's ability to maintain existing levels of outpatient/ambulatory medical care.

Step 2: Determine Total Number of PLWH and PLWA Not In HIV-Related Medical Care. Unmet need is determined by matching PLWHA reported HARS and OOS databases with PLWHA enrolled in care based on ADAP, Health Management Systems (HMS), Medicaid, ELR, and paper labs databases. Multiple reports are de-duplicated to create a unique count of PLWHA. FDOH staff populates these data into a separate database containing each HIV/AIDS case from HARS and OOS with at least one CD4, viral load, or HIV prescription recorded within the HAB-designated 12-month period. The number and characteristics of PLWHA in the EMA not currently enrolled in HIV-related outpatient/ambulatory medical care was determined by subtracting these cases from the total reported HIV and AIDS cases. Based on this calculation, there are 2,990 PLWA and 3,092 PLWH not in care, totaling 6,082 PLWHA not in care in the EMA.

Table 13. Ft. Lauderdale/Broward County Part A EMA Unmet Need Framework Table				
Population Sizes		**Value**		**Data Source(s)**
Row A.	Number of persons living with AIDS (PLWA), aware for the period of 01/01/2007 - 12/31/2007	8,044		HARS and OOS data sets plus matches with ADAP, Medicaid, and Lab databases
Row B.	Number of persons living with HIV (PLWH)/non-AIDS/aware, for the period of 01/01/2007 - 12/31/2007	7,050		HARS and OOS data sets plus matches with ADAP, Medicaid, and Lab databases
Row C.	Total number of HIV+ aware, for the period of 01/01/2007 - 12/31/2007	15,094		Value: Value A + Value B
Care Patterns		**Value**	**%**	**Data Source(s)**
Row D.	Number of PLWA who ***did*** receive the specified HIV primary medical care services in 12-month period	5,054	63%	HARS and OOS data sets plus matches with ADAP, Medicaid, and Lab databases
Row E.	Number of PLWH/non-AIDS/aware who ***did*** receive the specified HIV primary medical care services in 12-month period	3,958	56%	HARS and OOS data sets plus matches with ADAP, Medicaid, and Lab databases
Row F.	Total number of HIV+/aware who ***did*** receive the specified HIV primary medical care services in 12-month period	9,012	60%	Value: Value D + Value E. Percent: Value F/Value C
Row G.	Number of PLWA who ***did NOT*** receive primary medical services	2,990	37%	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	3,092	44%	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)	6,082	40%	Value: Value G + Value H. Percent: Value I/Value C

2. Rationale for Choosing Estimation Method and FY 2008 Revisions

The rationale for selecting the unmet need method includes recommendations to the EMA from Mosaica, HAB's unmet need TA provider. We selected this method because it uses only reported prevalence and in-care data. The existing framework incorporates recommendations that include: (1) adding PLWHA reported in 2007 but not entered by the CDC deadline to the surveillance and in care estimates, (2) assuming that 100% of PLWHA reported in HARS and OOS are aware, and (3) removing in-care multipliers developed by FDOH that were over inflated when compared to Mosaica recommendations. The major revision to the FY 2008 unmet need estimation method is the inclusion of an additional source of in-care data. The continued ELR implementation in FL has resulted in revisions to the unmet need estimation process. This year, FDOH conducted an additional match with HMS, a county health department database for client-based services. This database provides an additional in-care data source beyond FDOH's HARS match to ELR, paper lab, ADAP, and Medicaid databases to identify living PLWHA in-care.

3. Limitations to the Unmet Need Estimation Methodology

The methodology's predominate limitation is the under-reporting of prevalence and in-care estimates, resulting in estimates that are less than the actual prevalence and in-care values. Factors contributing to under-reporting include: (1) non-retroactive confirmatory reporting, (2)

mandatory lab reporting thresholds, (3) high rate of in-migration of PLWHA tested outside of FL receiving care in FL, and (4) lab and physician facilities' failure to comply with reporting mandates.

HIV (not AIDS) reports underestimate the actual number of diagnosed and in-care clients. FL HIV case reporting was not mandated until July 1, 1997 and is limited to HIV confirmatory tests performed in a confidential setting via diagnostic HIV tests (i.e., Western Blot or IFA). HIV reporting is not retroactive and therefore, HIV (non-AIDS) cases with diagnostic dates prior to July 1997 were not reportable. Additionally, on November 20, 2006, FL law mandates reporting of all active viral loads (>75 copies/mL) and CD4 counts below 200 (or 14%). Detectable viral loads greater than 75 copies/mL are reported as a new HARS case. Therefore, patients testing as "undetectable" are not be reported until they have a detectable viral load or develop AIDS.

HIV (not AIDS) reports underestimate the actual number of diagnosed clients and clients in care. FL has a large in-migration population of PLWHA tested outside of the state but are now receiving care in a FL jurisdiction. A recent migration study indicates that as many as 5% of newly reported cases could have been reported from other states. FDOH staff deletes cases from HARS previously reported "out of state." A separate database captures these cases, which is still relatively new and incomplete. Despite these shortcomings, the database provides the ability to enhance EMA prevalence estimation and in-care patterns. FDOH currently is unable to match the HARS and OOS data with Medicare, commercial insurance, and VA beneficiary data. Although FDOH reports that its continued transition to ELR will eliminate this barrier through automation, the data are still incomplete due to incomplete laboratory reporting, which may result from under-reporting. FDOH reports that they are unable to determine the exact number of unreported cases. As a result, the Grantee concluded an adjustment would compromise the accuracy of the data by possibly inflating the number of individuals in-care due to data duplication. FDOH reports continued transition to e-HARS later in 2008 and electronically reporting all labs into e-HARS in the near future.

4. Cross-Program Collaboration

Extensive collaboration with Part B facilitated FY 2009 unmet need estimates. The EMA also collaborates intensively with local Part C and D grantees. The Part A Grantee collaborates with FDOH Part B surveillance and ADAP staff to estimate unmet need through multiple activities including the annual FL All Ryan White Program Conference, FDOH Statewide "Epidemiology" Workgroup, Unmet Need Taskforce, and Joint Parts Client Needs Assessment activities.

5. Assessing Unmet Need: Determining Demographics of PLWHA Not In Care

FDOH estimates demographics of people who know their HIV/AIDS status and are not in care. As shown in Table 14, unmet need demographic characteristics include race, ethnicity, gender, age group, and transmission mode. Characteristics are determined by comparing prevalence to in-care data separately by demographic and reported risk. Demographic analyses identify subpopulations that need additional efforts to improve access to care. The demographic estimates show MSM, Black non-Hispanics, and PLWHA between the ages of 30 to 59 have the highest rate of PLWHA not in care, highlighting that these subpopulations should be the focus by the EMA to bring PLWHA into care.

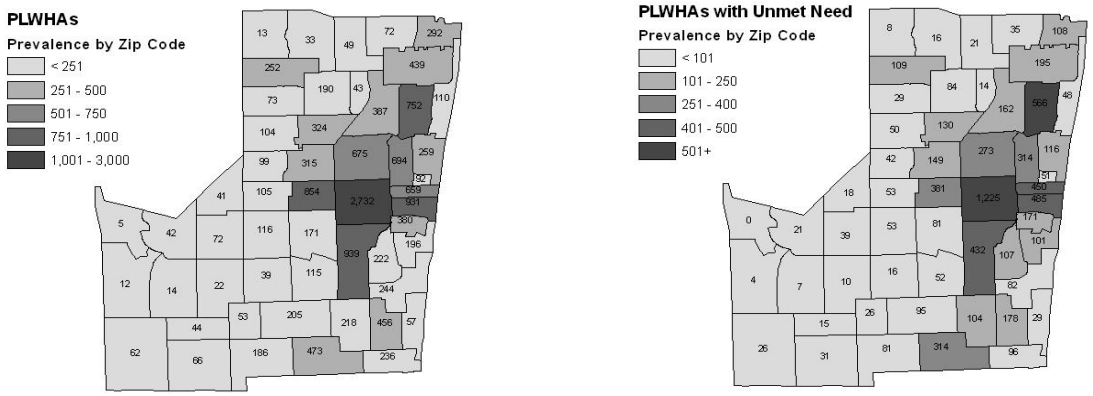
Table 14. Unmet Need By Race, Ethnicity, Age Group, Gender, and HIV Transmission Category, FDOH

Race/Ethnicity	**#**	**%**
White, not Hispanic	2,167	36%
Black, not Hispanic	3,066	50%
Hispanic	732	12%
Not Specified/Other	94	2%
Gender		
Male	4,362	72%
Female	1,720	28%
Age Group		
0-19	16	0%
20-29	450	7%
30-39	1,362	22%
40-49	2,497	41%
50+	1757	29%
Males		
MSM	2,836	65%
IDU	288	7%
MSM and IDU	166	4%
Heterosexual Contact	1,055	24%
Risk Not Reported/Other	20	<1%
Females		
IDU	200	12%
Heterosexual Contact	1,501	87%
Risk Not Reported/Other	16	1%
Total	**6,082**	**100%**

6. Assessing Unmet Need: Determining Location of PLWHA Not In Care

FDOH staff determined geographic location of people who know their HIV/AIDS status and are not in care using similar techniques applied to estimate the demographic characteristics. Chart 1 depicts both HIV/AIDS prevalence and not-in-care residence density. The prevalence density and not-in-care density are consistent. The not-in-care data are only available for those PLWHA captured in the match between HARS and OOS, ADAP, HMS, Medicaid, ELR, or paper labs databases. The location analysis, like the demographic analysis, highlights geographical areas needing increased effort to bring PLWHA into care. Maps displayed in Chart 13 show highest prevalence and unmet overlap in the central EMA quadrant.

Chart 1. 2007 HIV/AIDS Cases Versus Not In Care by ZIP Code, FDOH



* Prevalence greater than actual due to ZIP Code reporting regulations with less than 3 cases.

7. Assessing Unmet Need: Progress Assessing Needs, Gaps, and Barriers to Care

The EMA continually assesses service needs, gaps, and barriers to care of people who know their HIV/AIDS status and are not in care. Assessment activities include: epidemiological profiles and trend analyses, service gap analyses, identification of emerging populations, outreach surveys, subgrantee surveys, key informant interviews, peer-administered client needs surveys, focus groups, and quarterly HIVPC-sponsored community outreach meetings. The EMA also conducts special assessments of primary medical access, retention, and adherence. To date, the EMA has completed the following subpopulation assessments: Persons Not Regularly Seeking Medical Care Assessment, Haitian, Homeless, Recently Incarcerated, MSM and Hispanic Persons Living with HIV.

The EMA also conducted core medical service category evaluations regarding medical care, pharmaceuticals, oral health, medical case management, and mental health/substance abuse. Subpopulation and core service assessments used multiple data sources including primary data collection (e.g., key informant interviews, focus groups, and surveys) and secondary data (e.g., service utilization data, chart abstraction). Trained peer interviewers and focus group facilitators reflect client demographic and conducted interviews and focus groups in the participants' primary language. Each assessment targeted approximately 100 PLWHA currently in care and 25 not in care. A comparative analysis of all subpopulation and core medical services recommendations, executive summaries, and unmet need estimates is used for additional needs assessment and evaluation data. Service planning and funding allocations are informed by synthesized assessment findings and recommendations. Special needs of out-of-care populations derived from analysis of these data identify an unmet need profile and estimate the number of clients to be served, stratified by racial and ethnic groups targeted in the Implementation Plan.

8. Unmet Need Data Used In Priorities, Resource Allocations, and System Decision Making

The HIVPC uses unmet need data when establishing service priorities, allocations and system of care decisions. The HIVPC and its committees reviewed unmet need estimates by demographic

characteristics and estimated the percent of clients not currently in care that would likely qualify for the Ryan White Program based on the percent of the current in care population served by funding source. The HIVPC then estimated the number of new clients that the system has the capacity to engage in care. The HIVPC realized clients would likely require outpatient/ambulatory medical care, as well as the continuum of core and support services. Therefore, they estimated the need for other core medical and support services of those persons new to and lost to care based on the current percent of clients in Part A outpatient/ambulatory medical care currently using those services.

E. FY 2009 Implementation Plan

In planning for the future, it is important to take into consideration the proposed FY 2009 Implementation Plan which was submitted to HAB in September by the Grantee. The plan serves as a foundation for future priority setting, and allocation decisions. The plan reflects a modest request for increased Part A formula and supplemental funding to address rapidly growing demand for HIV care among newly diagnosed individuals, as well as those PLWHA in care that experience extended survival time and associated need for core and support services.

Table 15 summarizes the FY 2009 Implementation Plan. The Plan discusses four core medical services and two support services, which comprise the largest funding amounts for FY 2009 allocated by the HIVPC. The core medical services comprising the largest funding allocations are: (1) outpatient/ambulatory health services; (2) AIDS pharmaceutical assistance; (3) oral health care; and (4) medical case management, including treatment adherence services. The support services comprising the largest funding allocations are food bank and outreach.

For each of the four core medical services and two support services listed, one or more service goals with time limited and measurable program objectives were developed. Each objective identifies the number of targeted PLWHA served, service units, timeframe, estimated cost, and service unit definition. These service goals and objectives comprise the major elements of the FY 2009 HIV/AIDS Service Implementation Plan. The Office of Minority Health Culturally and Linguistically Appropriate Services (CLAS) Standards are incorporated into all the service delivery models. The EMA's HIVPC's requested allocation includes 86% of funds (after reductions for Grantee Administration and Clinical Quality Management) to core medical services, far exceeding the Ryan White HIV/AIDS Program 75% requirement.

The FY 2009 HIV/AIDS Service Implementation Plan pays specific attention to ensuring consumer access to the continuum of HIV/AIDS care in the EMA. The Plan demonstrates how the EMA will reduce or eliminate service and health outcome disparities among populations with specific needs, including both emerging and minority populations identified in the Demonstrated Need Section. The Plan addresses the needs of those persons in care, as well as those who know their HIV status but are not in HIV/AIDS primary medical care. The plan addresses geographic disparities through distribution of funding to community providers serving the geographic regions most impacted by HIV, co-morbidities, and other complicating factors.

Table 15. FY 2009 Implementation Plan					
CORE SERVICES					
Service Priority: AIDS Pharmaceutical Assistance				**Service Priority Number: 2**	**Total Service Cost: $4,103,499**
Ref Comprehensive Plan Goals: 1, 2, 3, & 4 ** Ref Healthy People 2010 Goals: Chapter 13 - Objectives 1-4, 12, 14- 16				**CLAS Standards 1-14**	
Service Goal: Increase access and adherence to FDA-approved HIV-related pharmaceuticals.					
# to be Served	**# Units**	**Time Frame**	**Estimated Cost**	**Service Unit Definition**	
Objective 1. Increase access to HIV-related pharmaceuticals by 20% for PLWHA not in care or new to care, with an emphasis on addressing the needs of emerging populations.					
575	16,230	3/09-2/10	$782,324	Each prescription or refill.	
Objective 2. Continue to provide AIDS pharmaceutical assistance and maximize funds by purchasing medications at 340b or lower pricing agreements.					
2,877	81,204	3/09-2/10	$3,321,175	Each prescription or refill.	
Service Priority: Outpatient/Ambulatory Medical Care				**Service Priority Number: 1**	**Total Service Cost: $5,285,450**
***Ref Comprehensive Plan Goals: 1, 2, 3 & 4 ** Ref Healthy People 2010 Goals: Chapter 13 - Objectives 1-4, 7, 11-16**				**CLAS Standards 1-14**	
Service Goal: Increase access to and retention in a high quality HIV continuum of care that is culturally and linguistically competent, consistent with PHS guidelines, and promotes parity among all populations.					
Objective 1. Increase enrollment in medical care by 20% by targeting emerging populations to ensure parity, access, and retention in care.					
# to be Served	**# Units**	**Time Frame**	**Estimated Cost**	**Service Unit Definition**	
864	17,296	3/09-2/10	$1,014,242	Each visit or telephone contact.	
Objective 2. Continue to provide HIV/AIDS diagnostic, therapeutic, and preventive outpatient and ambulatory services through the continuum of HIV disease, including CD-4 cell and viral load monitoring, ARV therapy, prophylaxis and treatment of OIs, STD treatment, TB and hepatitis screening and treatment, and patient education at nine community clinics in the EMA; Ensure provision of medical visits every three to six months and ensure engagement in care and achieve health outcomes in accordance with PHS and other national recognized guidelines; and, Continue to provide HIV/AIDS specialty medical care to ensure availability of dermatology, ENT, gastroenterology, endocrinology, gynecology, neurology, ophthalmology, oncology, pulmonary medicine, podiatry, surgical, urology, and other specialty and subspecialty services.					
# to be Served	**# Units**	**Time Frame**	**Estimated Cost**	**Service Unit Definition**	
3,082	61,706	3/09-2/10	$4,271,208	Each visit or telephone contact.	

Table 15. FY 2009 Implementation Plan					
Service Priority: Oral Health Care				**Service Priority Number: 4**	**Total Service Cost: $865,450**
***Ref Comprehensive Plan Goals: 1, 2, 3 & 4 * *Ref Healthy People 2010 Goals: Chapter 13 - Objective 13**				**CLAS Standards 1-14**	
Service Goal: Increase access to, retention in, and adherence to high quality HIV oral health care that is culturally and linguistically competent.					
Objective 1. Increase enrollment in oral health care by 23% by targeting emerging populations to ensure access to and retention in care.					
# to be Served	**# Units**	**Time Frame**	**Estimated Cost**	**Service Unit Definition**	
242	708	3/09-2/10	$169,036	Each visit.	
Objective 2. Continue to provide prophylactic, preventive, maintenance, and specialty oral health services in five clinics in the EMA.					
1,193	3,492	3/09-2/10	$696,414	Each visit.	
Service Priority: Medical Case Management				**Service Priority Number: 3**	**Total Service Cost: $1,396,639**
Ref Comprehensive Plan Goals: 1, 2, 3, 4 & 5 **Ref Healthy People 2010 Goals: Chapter 13 - Objectives 1-4, 7, 14- 16				**CLAS Standards 1-14**	
Service Goal: Provide medical case management designed to enhance retention and engagement in HIV outpatient/ambulatory care that is culturally and linguistically competent.					
Objective 1. Increase enrollment in medical case management by 15% to ensure access to HIV outpatient/ambulatory care for newly enrolled clients or clients with fragile engagement in care.					
# to be Served	**# Units**	**Time Frame**	**Estimated Cost**	**Service Unit Definition**	
669	13,093	3/09-2/10	$241,799	Each 15-minute encounter.	
Objective 2. Continue to provide medical case management that provides care planning, monitoring, and linkage activities that remove barriers while increasing retention in and adherence to HIV outpatient/ambulatory health services; Continue to link clients through referral to HIV outpatient/ambulatory care, substance abuse, mental health, oral health, AIDS pharmaceutical assistance, and supportive services to ensure clients' access to the HIV continuum of care; Continue to provide assessments, ongoing monitoring, education, and coordination to support clients in adhering to medical appointments, therapeutics, and treatment regimens; and Expand the MAI peer/near-peer model to Part A-funded medical case management to assist clients to adhere to medical appointments, therapeutics, and treatment regimens.					
3,290	99,778	3/09-2/10	$1,154,840	Each 15-minute encounter.	

Table 15. FY 2009 Implementation Plan					
SUPPORT SERVICES					
Service Priority: Food Bank				**Service Priority Number: 1**	**Total Service Cost:$671,157**
Ref Comprehensive Plan Goals: 1, 2, 3, 4 & 5 **Ref Healthy People 2010 Goals: Chapter 13 - Objectives 1-4, 14- 16				**CLAS Standards 1-14**	
Service Goal: Increase enrollment and retention in HIV outpatient/ambulatory health services that are culturally and linguistically competent by providing nutritious and culturally appropriate food and targeting the unmet needs of emerging populations. **Objective 1.** Increase access to food bank services by 35% by targeting emerging populations to ensure access to and retention in care.					
# to be Served	**# Units**	**Time Frame**	**Estimated Cost**	**Service Unit Definition**	
174	2,369	3/09-2/10	$87,503	One weekly food box.	
Objective 2. Continue to expand access to and retention in HIV outpatient and ambulatory health services by providing nutritious and culturally appropriate food.					
1,161	15,808	3/09-2/10	$583,654	One weekly food box	
Service Priority: Outreach				**Service Priority Number: 4**	**Total Service Cost: $317,524**
Ref Comprehensive Plan Goals: 1, 2, 3, 4 & 5 **Ref Healthy People 2010 Goals: Chapter 13 - Objectives 1-4,7, 14- 16				**CLAS Standards 1-14**	
Service Goal: Increase access and identify barriers to outpatient/ambulatory care, mental health, substance abuse, and oral health services by providing peer and/or near peer outreach services that are culturally and linguistically competent. **Objective 1.** Provide orientation, referral, and linkages to increase the number of PLWHA who initiate or return to HIV outpatient/ambulatory health services after interrupting treatment.					
# to be Served	**# Units**	**Time Frame**	**Estimated Cost**	**Service Unit Definition**	
335	71,269	3/09-2/10	$317,524	Each 15-minute encounter.	

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

A. Ideal HIV/AIDS Continuum of Care

1. Shared Vision–Operational Definition of Continuum of Care and Core Services

The Broward County HIVPC has adopted vision and mission statements that describe and define the HIV continuum of care as follows:

Vision: To ensure the delivery of high quality comprehensive HIV/AIDS services to low income and uninsured Broward County residents living with HIV, by providing a targeted, coordinated, cost-effective, sustainable, and client-centered system of care.

Mission: We direct and coordinate an effective response to the HIV epidemic in Broward County to ensure high quality, comprehensive care that positively impacts the health of individuals at all stages of illness. In so doing, we:

- Foster the substantive involvement of the HIV-infected and affected communities in assuring consumer satisfaction, identifying priority needs, and planning a responsive system of care.
- Support local control of planning and service delivery, and build partnerships among service providers, private foundations, voluntary organizations, community organizations, and federal, state, and municipal governments.
- Monitor and report progress within the HIV continuum of care to ensure fiscal responsibility and increase community support and commitment.

2. Shared Values for System Changes–Guiding Principles that Shape the HIV-Related System of Care in the Region

In accordance with the Ryan White HIV/AIDS Treatment Modernization Act of 2006, the Ft. Lauderdale/Broward County EMA fully endorses the guiding principles set forth by the Treatment Act, as follows:

- Better address in the needs of the underserved in response to the HIV/AIDS epidemic's growing impact among racial and ethnic minority and hard-to-reach populations.
- Ensuring access to existing and emerging HIV/AIDS treatments that can make a difference.
- Adapting to changes in the health care delivery system and the role of RWHAP-funded services in filling gaps in HIV care.
- Documenting outcomes by integrating the guiding principles into activities that shape the HIV care continuum and achieving the goals of having 100% access to high quality care and 0% disparities in health outcomes for HAB-funded programs.

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

A. EMA's Established Continuum of HIV/AIDS Care and Access to Care

1. FY 2009 - 2011 HIV/AIDS Service Implementation Plan

Table 16 summarizes the FY 2009-2011 HIV/AIDS Service Implementation Plan. The Plan builds up the FY 2009 Implementation Plan submitted to HAB in September 2008. Few new goals were identified by the Grantee and the HIVPC due to several factors:

- The Modernization Act will sunset in 2010. The future structure of the RWHAP is unclear, as is the funding available to support HIV services in metropolitan areas particularly impacted by the HIV epidemic. The focus of the future program, Congressional priorities, and mandated activities remain unknown.
- Since 2000, the Part A Grantee has shifted most funds to core services and eliminated funding for several support service categories. Within the current Part A allocation structure, there is little flexibility for adding new core service categories or significant expansion of funding for existing categories. Part A-funded subgrantees are heavily dependent upon the current Part A awards. Significant decreases in funding for their programs would destabilize the current HIV care continuum and create serious inaccessibility and inadequate availability of life sustaining services.
- For the past several years, the EMA has conducted a series of targeted assessments to identify ways to improve efficiency and maximize Part A funds. In response to recommendations generated by these assessments, the Grantee is redesigning eligibility determination and medical case management. The Part A quality program was evaluated and TA provided to bring it into alignment with HAB's approach to continuous quality improvement. The Grantee also is adopting a new client-level data system that will be compliant with HAB's Ryan White Services Report (RSR).

Based on these factors, the Broward County EMA HIV/AIDS Service Implementation Plan addresses HAB instructions to:

- Address the primary health care and treatment needs of PLWHA who know their status and are not in care, as well as the needs of those currently in the HIV/AIDS care system;
- Ensure the availability and quality of all core medical services within the EMA;
- Address the elimination of disparities in access to core medical and support services for PLWHA among disproportionately affected sub-populations and historically underserved communities;
- Specify strategies for identifying PLWHA who know their HIV status but are not in care, informing them about available treatment and services, and assisting them to use those services;
- Include strategies for the prevention and treatment of substance abuse;
- Address clinical quality management and measurement;
- Provide goals, objectives, timelines, and appropriate allocation of funds, as determines by the needs assessment; and
- Include strategies for coordinating the provision of service programs for HIV prevention, including outreach and EIS.

Table 16. FY 2009 - 2011 HIV/AIDS Service Implementation Plan			
GOAL 1	**Increase access to HIV outpatient/ambulatory medical care and other core services in Broward County**		
OBJECTIVE 1	Identify, engage, and retain PLWHA in HIV outpatient/ambulatory medical care and other core services		
ESTIMATED IMPACT	**CLIENTS:** 500 per year	**SERVICES:** Outpatient/ambulatory medical care, medical case management, and outreach	
TASK REQUIRED TO ACCOMPLISH THIS OBJECTIVE			**TARGET DATE**
Tasks	1	Evaluate the identification, engagement, and retention activities of Part A-funded outpatient/ambulatory medical care, medical case management, and outreach subgrantees and recommend areas of improvement	April 2009 (Short-Term)
	2	Train front-line providers regarding effective identification, engagement, and retention activities and conduct capacity development with subgrantees to improve their processes	June 2009 (Short-Term)
	3	Expand outreach at all key points of entry, identify new points of entry, and establish MOUs to conduct outreach and linkage services	July 2009 (Short-Term)
	4	Expand involvement of peer workers in conducting identification, engagement, and retention activities	March 2010 (Based on Availability of Funds, Long Term)
	5	Establish an inter-agency collaborative workgroup to expand HIV testing in Broward County hospitals, identify mechanisms to adopt the CDC HIV testing recommendations, develop a work plan, and undertake expanded ongoing HIV testing	FY 2009-2011 (Ongoing)
	6	Continue to refer patients with addictions and/or mental illness to County and state-funded services programs; similarly continue to refer patients with unstable housing to the HOPWA program for assistance	FY 2009-2011 (Ongoing)
	7	Coordinate with CDC and other social marketing campaigns to expand HIV serostatus awareness among HIV high-risk populations	FY 2009-2011 (Ongoing)
Evaluation Strategy: Completion of the evaluation of identification, engagement, and retention, evaluation of the training provided, subgrantee reports, inter-agency collaborative workgroup meeting minutes and MOUs with hospitals. Service-related outcomes to be evaluated using the Grantees' client-level data system, PCIS. **Oversight:** Grantee, QI Network, QM Committee, Joint Planning Committee.			

Table 16. FY 2009 - 2011 HIV/AIDS Service Implementation Plan				
GOAL 2		**Reduce the rate of secondary HIV infection in Broward County**		
OBJECTIVE		Implement risk reduction techniques and prevention messages as a component of the routine medical visit, and Implement MMP guidelines (per CDC guidelines)		
ESTIMATED IMPACT		**CLIENTS:** 350	**SERVICES:** Outpatient/ambulatory medical care	
TASK REQUIRED TO ACCOMPLISH THIS OBJECTIVE				**TARGET DATE**
Tasks	1	Conduct a baseline assessment of HIV medical providers and their use of use of secondary prevention		August 2009 (Short Term)
	2	Distribute of CDC MMP guidelines to all HIV medical providers.		September 2009 (Short Term)
	3	Coordinate through the AETC, training and capacity development to HIV medical providers in developing secondary prevention services		September 2009 (Based on Availability of Funds, Short Term
	4	Evaluate the extent to which HIV medical providers have adopted and document secondary prevention activities in their practices		March 2010 (Based on Availability of Funds, Long Term)
Evaluation Strategy: Completion of the baseline assessment, number of MMP guidelines distributed, training and capacity development events arranged with AETC, and randomized chart audit. Service-related outcomes to be evaluated using the Grantees' client-level data system, PCIS. **Oversight:** Grantee, QI Network, QM Committee.				
GOAL 3		**Expand geographic availability of HIV outpatient/ambulatory medical care and other core services in Broward County**		
OBJECTIVE 1		Reduce structural barriers to HIV care by expanding the availability of core services		
ESTIMATED IMPACT		**CLIENTS:** 500 per year	**SERVICES:** Core services	
TASK REQUIRED TO ACCOMPLISH THIS OBJECTIVE				**TARGET DATE**
Tasks	1	Use epidemiologic data and geomapping techniques to identify underserved areas in Broward County, with subsequent annual analysis of new data		July 2009 (Short Term), FY 2010 and 2011 (Long Term)
	2	Through Part A procurement, encourage the establishment of satellite sites and co-located services in those underserved areas		March 2010 (Based on Availability of Funds, Long Term)
Evaluation Strategy: Completion of the initial and subsequent annual written analyses, RFP language prepared by Grantee staff, and subgrantee reports. **Oversight:** Grantee, QI Network, QM Committee, Joint Priorities Committee, and Joint Planning Committee				

Table 16. FY 2009 - 2011 HIV/AIDS Service Implementation Plan				
GOAL 4		**Increase access and adherence to FDA-approved HIV-related pharmaceuticals**		
OBJECTIVE 1		Increase access to HIV-related pharmaceuticals by 20% for PLWHA not in care or new to care, with an emphasis on addressing the needs of emerging populations.		
ESTIMATED IMPACT		**CLIENTS:** 575 per year	**SERVICES:** AIDS Pharmacy Assistance Program	
Task	1	Identify PLWHAs requiring HAART and other HIV-related medications, assess their eligibility for Part A and ADAP, and provide AIDS pharmacy assistance		FY 2009-2011 (Ongoing)
OBJECTIVE 2		Provide ongoing AIDS pharmaceutical assistance and maximize funds by purchasing medications at 340b or lower pricing agreements.		
ESTIMATED IMPACT		**CLIENTS:** 2,877 per year	**SERVICES:** AIDS Pharmacy Assistance Program	
Task	1	Deliver ongoing AIDS Pharmacy Assistance and coordinate benefits with FL ADAP and other payers		FY 2009-2011 (Ongoing)
Evaluation Strategy: Service-related outcomes to be evaluated using the Grantees' client-level data system, PCIS. **Oversight:** Grantee, QI Network, and QM Committee.				
GOAL 5		**Ensure retention and engagement in HIV outpatient/ambulatory care by providing culturally and linguistically competent services in Broward County**		
OBJECTIVE 1		Provide medical case management designed to enhance retention and engagement in HIV outpatient/ambulatory care that is culturally and linguistically competent.		
ESTIMATED IMPACT		**CLIENTS:** 3,290 per year	**SERVICES:** Medical case management	
Tasks	1	Continue to provide medical case management that provides care planning, monitoring, and linkage activities that remove barriers while increasing retention in and adherence to HIV outpatient/ambulatory health services		FY 2009-2011 (Ongoing)
	2	Continue to link clients through referral to HIV outpatient/ambulatory care, substance abuse, mental health, oral health, AIDS pharmaceutical assistance, and supportive services to ensure clients' access to the HIV continuum of care		FY 2009-2011 (Ongoing)
	3	Continue to provide assessments, ongoing monitoring, education, and coordination to support clients in adhering to medical appointments, therapeutics, and treatment regimens		FY 2009-2011 (Ongoing)
	4	Expand the MAI peer/near-peer model to Part A-funded medical case management to assist clients to adhere to medical appointments, therapeutics, and treatment regimens		FY 2009-2011 (Ongoing)
Evaluation Strategy: Subgrantee reports. **Oversight:** Grantee, QI Network, and QM Committee.				

Table 16. FY 2009 - 2011 HIV/AIDS Service Implementation Plan				
GOAL 6		**Increase access to, retention in, and adherence to high quality HIV oral health care in Broward County that is culturally and linguistically competent**		
OBJECTIVE 1		Increase enrollment in oral health care by 23% by targeting emerging populations to ensure access to and retention in care.		
ESTIMATED IMPACT		**CLIENTS:** 242 per year	**SERVICES:** Oral health services	
Task	1	Conduct linkages activities with HIV clinics, medical case managers, and other HIV service providers to identify PLWHA that need HIV oral health services		FY 2009-2011 (Ongoing)
OBJECTIVE 2		Continue to provide prophylactic, preventive, maintenance, and specialty oral health services in HIV clinics in the EMA.		
ESTIMATED IMPACT		**CLIENTS:** 1,193 per year	**SERVICES:** Outpatient/ambulatory medical care	
Task	1	Provide ongoing oral health services to PLWHA that need HIV oral health services		FY 2009-2011 (Ongoing)
Evaluation Strategy: Service-related outcomes to be evaluated using the Grantees' client-level data system, PCIS. **Oversight:** Grantee, QI Network, and QM Committee.				
GOAL 7		**Increase access and reduce barriers to outpatient/ambulatory care, mental health, substance abuse, and oral health services by providing peer and/or near peer outreach services that are culturally and linguistically competent.**		
OBJECTIVE 1		Conduct linkage, engagement, retention, and case finding activities by providing outreach services to newly diagnoses PLWHA or individuals that have dropped out of care,		
ESTIMATED IMPACT		**CLIENTS:** 600 per year	**SERVICES:** Outreach	
Task	1	Provide target outreach services at key points of entry into HIV counseling and testing, provide information to newly identified PLWHA, facilitate the transition of PLWHA into HIV care, assist PLWHA to schedule appointments and accompanying PLWHA as required, provide retention services at HIV core services programs, identify and counsel PLWHA likely to drop out of care, and conduct case finding if a client has dropped out of care		FY 2009-2011 (Ongoing)
Evaluation Strategy: Service-related outcomes to be evaluated using the Grantees' client-level data system, PCIS. **Oversight:** Grantee, QI Network, and QM Committee.				

Table 16. FY 2009 - 2011 HIV/AIDS Service Implementation Plan				
GOAL 8		**Eliminate or decrease disparities related to racial or ethnic minorities**		
OBJECTIVE 1		Ensure HIV core and support services are culturally competent		
ESTIMATED IMPACT		**CLIENTS:** All Part A clients	**SERVICES:** All services	
TASK REQUIRED TO ACCOMPLISH THIS OBJECTIVE				**TARGET DATE**
Tasks	1	Continue to offer cultural competency training to front-line providers and other providing direct services to PLWHA		Quarterly (Ongoing)
	2	Recruit direct service providers from diverse backgrounds and with linguistic competency		FY 2009-2011 (Ongoing)
Evaluation Strategy: Training evaluation forms and subgrantees reports. **Oversight:** Grantee, QI Network, and QM Committee.				
GOAL 9		**Increase access to and retention in a high quality HIV continuum of care that is culturally and linguistically competent, consistent with PHS guidelines, and promotes parity among Broward County residents**		
OBJECTIVE 1		Increase enrollment in medical care by 20% by targeting emerging populations to ensure parity, access, and retention in care.		
ESTIMATED IMPACT		**CLIENTS:** 3,082 per year	**SERVICES:** Outpatient/ambulatory medical care	
Tasks	1	Continue to provide HIV/AIDS diagnostic, therapeutic, and preventive outpatient and ambulatory services through the continuum of HIV disease, including CD-4 cell and viral load monitoring, ARV therapy, prophylaxis and treatment of OIs, STD treatment, TB and hepatitis screening and treatment, and patient education at community clinics in the EMA		FY 2009-2011 (Ongoing)
	2	Ensure provision of medical visits every three to six months and ensure engagement in care and achieve health outcomes in accordance with PHS and other national recognized guidelines		FY 2009-2011 (Ongoing)
	3	Continue to provide HIV/AIDS specialty medical care to ensure availability of dermatology, ENT, gastroenterology, endocrinology, gynecology, neurology, ophthalmology, oncology, pulmonary medicine, podiatry, surgical, urology, and other specialty and subspecialty services		FY 2009-2011 (Ongoing)
	4	Continue to refer patients with addictions and/or mental illness to County and state-funded services programs; similarly continue to refer patients with unstable housing to the HOPWA program for assistance		FY 2009-2011 (Ongoing)
Evaluation Strategy: Service-related outcomes to be evaluated using the Grantees' client-level data system, PCIS. **Oversight:** Grantee, QI Network, and QM Committee.				

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

A. Improving Client-Level Data

Broward County government is in the process of implementing a new enterprise system that will include a stand-alone client-level data system for the Part A Program. The system will address HAB's requirement for the collection and reporting of client-level RSR data. Grantee staff has participated actively in the vetting process for the RSR, including hosting the regional vetting meeting in February 2008 in Ft. Lauderdale. The Grantee's staff has contacted SAIC to arrange for an XML schema to ensure timely and accurate transmittal of grantee, provider, and client data.

B. Administrative Monitoring

The Broward County Human Services Department's (BCHSD) Health Care Services Section is the local agency responsible for the Ryan White Part A Program in the Ft. Lauderdale/Broward County EMA. The Broward County Board of County Commissioners (BCBCC) is the designated recipient (or Chief Executive Officer) for Part A funds in the Fort Lauderdale /Broward County EMA. The BCHSD Health Care Services Section is the designated Part A administrative entity (Grantee) responsible for fiscal and programmatic oversight of Part A formula and supplemental, as well as Part A MAI funds in the EMA. The Human Services Section Manager oversees Part A administrative operations and directs the Part A Program Office.

The Grantee maintains supervisory authority over all program staff and is the EMA's liaison to County agencies, HAB, the HIVPC, support staff, subgrantees, PLWHA, and the community. The Grantee office is divided into five functional units:

- **Fiscal Unit**: responsible for the oversight of Part A fiscal activities including reviewing and approving submitted invoices, data management, report preparation, service procurement, and expenditure monitoring.
- **Contract Unit**: responsible for developing, negotiating, and monitoring the Part A contracts. The unit also provides ongoing technical support to subgrantees in the implementation of contractual compliance and reporting requirements.
- **Clinical QM Unit**: responsible for the EMA's Clinical QM Program. Activities include ensuring that subgrantee core medical services are provided in accordance with PHS treatment guidelines and HAB quality measures, developing the EMA's clinical QM Plan, assessing service outcomes and performance indicators, overseeing QIPs, and collecting and analyzing data.
- **Management Information System (MIS) Unit**: responsible for all MIS and related issues including: configuring hardware, upgrading software; maintaining, troubleshooting and repairing the MIS, developing system documentation and user manuals, and training subgrantees.
- **Administrative Support**: responsible for administrative support to the Grantee staff.

The Grantee is accountable for the fiscal and programmatic oversight in the EMA. The fiscal and programmatic oversight includes tracking and monitoring of Part A funds, ensuring the timely distribution of unexpended funds, monitoring fiscal and programmatic requirements,

providing TA, and implementing corrective action measures for subgrantees. The Grantee also manages the subgrantees' compliance with reporting documentation, contractual outcomes and indicators, and other contractual requirements.

The Grantee has established a process for documenting subgrantee fiscal and programmatic compliance. This process is multi-level approach that is implemented at specific time intervals. Formal service agreements exist between the Grantee and all Part A subgrantees. Subgrantees' fiscal and programmatic reporting and monitoring requirements are specified in contract language. Subgrantees are required to submit several fiscal reports to the Grantee at the following time intervals: Monthly Contracted Services Invoice, Current Annual Independent Audited Financial Statement prior to the award of the contract and within 120 days of the end of each subsequent subgrantee's fiscal year, State of FL Financial Assistance Reporting Package as required by OMB Circular A-133, and the Line Item Budget for the contract year. Subgrantees must submit the following programmatic reports to the Grantee at the time intervals indicated: monthly service reports summarizing demographic data for clients served in that period; quarterly reports of outcomes' progress, special populations, and associated narratives in which subgrantees describe accomplishments, challenges, and problems encountered in implementing Part A services; and the annual Ryan White HIV/AIDS Program Data Report (RDR) and the biannual RSR.

The Grantee has established mandatory fiscal reporting requirements for subgrantees that are included in each subgrantee's contract. Grantee fiscal staff conducts monthly monitoring of subgrantee compliance with reporting requirements. Failure of subgrantees to submit required reports on or before the due date results in the suspension of all payments due by the Grantee to the subgrantee until compliance issues are remedied.

Subgrantees are required to submit a quarterly Outcomes Progress Report and a Quarterly Narrative Report to the Grantee. These reports detail subgrantee achievement levels for established client-centered or system-centered outcomes and associated performance indicators. Grantee staff reviews the Outcomes Progress Reports to identify technical and programmatic needs of individual subgrantees. Additionally, the reports provide information on the subgrantees' progress in accomplishing performance indicators. During the subgrantee's *annual site visit* by Grantee staff, client charts are randomly selected and reviewed for achievement of outcome performance indicators. These findings are then compared to the subgrantees' *Quarterly Outcome Progress Reports*. The evaluation team is comprised of one member from each of the following functional units: Fiscal, Contract, and Clinical QM.

In the Quarterly Narrative Report, subgrantees describe their accomplishments, challenges, and problems encountered in implementing Part A-funded services during the reporting period, as well as describe steps taken to overcome challenges and request TA from the Grantee. Subgrantees report on their progress in internal continuous quality improvement (CQI) activities and issues surrounding implementation of service standards. The report also describes the subgrantees' progress in addressing their clients' cultural and linguistic needs, such as providing printed materials in English, Spanish, or Creole. The first quarterly report in each contract year also includes a written plan addressing how the subgrantee will provide culturally and linguistically competent services throughout the year. Finally, the narrative report describes any changes in the subgrantee's service delivery structure (e.g., new linkage agreements), the number and nature of client grievances, changes in the subgrantee's mission or population served, and procedures for ensuring that Part A is the payer of last resort.

The Grantee conducts fiscal and programmatic monitoring site visits to ensure compliance with contractual requirements. The frequency of fiscal and programmatic monitoring visits is documented in an established process. Each Part A subgrantee receives a minimum of two site visits per year by the Grantee's evaluation team. The team is comprised of one member from each of the following functional units: Fiscal, Contract, and Clinical QM.

For FY 2008, all 13 (100%) subgrantees received an annual fiscal monitoring site visit. The annual Grantee site visit is conducted in two phases. The first site visit is an administrative evaluation that includes a review of organizational quality, management, and leadership, fiscal practices, financial audits, insurance coverage, human resources, facility observation, subcontracting procedures, client file contents, billing practices, contracted services, and monitoring of outcomes indicators. During this visit, Grantee staff also reviews the subgrantee's Board of Directors structure, by-laws, minutes, and resolutions to comply with their Charter. The subgrantee's executive director also is interviewed. The second visit is held in November and December and is primarily a reconciliation of chart documentation to monthly invoices. The FY 2008 Grantee site visits revealed no system-wide findings within the funded service categories across the 13 subgrantees, when findings are compared to established outcomes, performance indicators, and standards of care. Additionally, an annual fiscal monitoring site visit is conducted and coordinated with program evaluation activities.

The focus of the site visit is to: (1) ensure that the subgrantee has policies and procedures addressing appropriate accounting principles and complies with those procedures, (2) ensure accuracy of invoices submitted, and (3) reconcile the submitted line item budget, consistent with OMB Circular A-122. Grantee staff reviews a sample of client files during the site visit. Supporting documentation is verified in the sampled client files for each unit billed in the review period. These charges must be invoiced within provisions established in subgrantee contracts. Special monitoring and site visits also are conducted if the subgrantee is under a corrective action plan (CAP) due to findings during an annual site visit, gross inconsistencies in monthly invoices, or negative findings identified in the subgrantee's annual independent financial audit.

The Grantee implemented a corrective action process when a fiscal or programmatic-related concern is identified. The Grantee reviews the results of fiscal and program monitoring, following the completion of each on-site contract evaluation visit and a report of findings. Contract management staff determines whether non-compliance or non-achievement items in the Contract Monitoring Report require remedial or corrective action by the subgrantee. The Contract Monitoring Report is forwarded to the subgrantee, which has 15 days to respond with a remedial CAP for approval by the Contract Administrator. Once the CAP is approved, Grantee TA is offered to the subgrantee and the subgrantee receives a follow-up visit over the course of 30, 60, or 90 days based on the severity of findings. Follow-up visits are conducted by the Grantee Program Evaluator, and Contract Manager to assess the extent to which the CAP was achieved.

Thirteen agencies received Part A-funded in FY 2008. The Grantee monitored 100% of contractors across seven core medical service categories and four support service categories. Each contractor received a fiscal and/or programmatic monitoring site visit during the FY 2008 grant year.

The Grantee identified no issues of improper charges or adverse findings in the FY 2008 monitoring visits. Therefore, no corrective actions were necessary. Grantee site visits revealed no system-wide findings within the funded service categories across the 13 subgrantees. During the Grantee Annual Contract/Program Evaluation visits, 35 client-level outcomes and 51 associated outcome indicators are examined across each Part A or MAI-funded service

category. The Grantee also monitors subgrantee submitted Quarterly Outcome Reports and provides TA to those subgrantees not achieving established indicator benchmarks. Through this process, no system-wide findings were found among client-level outcomes or indicators. The Grantee annual aggregate Contract/Program Evaluation findings and subgrantee Quarterly Outcome Report findings are shared with both the QM Committee and the respective service specific QI Network for the possible development of QIPs.

C. QM Program and Plan

The Modernization Act emphasizes access to primary core medical services and emphasizes delivery of support services as an integral component to positive medical outcomes for all consumers. The Treatment Act also directs all Part A grantees to develop and implement QM programs. The Treatment Act sets aside up to 5% of Part A and MAI funds for EMA QM initiatives. These funds are used to improve service deliveries to individuals living with HIV/AIDS and to include the following activities:

- Assess the extent to which HIV health services provided to patients under the grant are consistent with the most recent Public Health Service (PHS) guidelines for the treatment of HIV/AIDS redundant.
- As applicable, to develop strategies for ensuring that such services are consistent with the guidelines for improvement in the access to and quality of HIV health services.

1. Purpose and Mission Statements

Purpose: The purpose of the Ft. Lauderdale/Broward County Part A QM Program is to monitor, evaluate, and continuously improve systematically the quality and appropriateness of HIV care and services provided to all patients receiving Part A and MAI-funded services.

Mission Statement: To ensure access to and retention in high quality HIV medical care and support services for Part A and MAI-eligible Broward County residents living with HIV disease.

2. QM Infrastructure

The five-year QM Plan goals are developed by the Grantee in conjunction with the HIV HIVPC QM Committee and subgrantee QI Networks. The networks develop their respective annual QM plans with input from the Grantee QA Coordinator and the QM Committee. QI Networks also develop Quality Improvement Projects (QIP) to address system-wide issues or concerns. Subgrantees develop individual QM Plans and QIPs within their internal Continuous Quality Improvement (CQI) processes. Communication among the aforementioned stakeholders is facilitated by the Grantee QA Coordinator, and Clinical Quality Assurance (QA) support staff to insure consistency and continuity.

The Grantee retains the primary responsibility to provide leadership for the EMA's QM Program and successful completion of the annual and 5-year QM Plans. There are five interconnected entities carrying out various roles and responsibilities in the execution of EMA's QM Program and QM Plan. These entities include the Grantee, Part A and MAI service consumers, HIVPC QM Committee, QI Networks (subgrantees), and the sub-contracted CQA support staff. QI Networks exist for each Part A and MAI-funded service category. Committee membership includes a representative from each funded subgrantee in that service category. QI Networks include outpatient/ambulatory medical care, AIDS pharmaceutical assistance, oral health care,

mental health services, medical nutrition therapy, medical case management, substance abuse services, food bank, legal services, medical transportation services, and outreach services.

The relationship among each of the five entities is conceptualized as the Grantee's office providing the leadership to ensure that the annual QM Plan is developed and implemented. The QM Committee, in conjunction with the Grantee QA Coordinator, provides the daily management of the achievement of the QM Program and overseeing QIPs in successful completion of the QM Plan. The QI Networks create QIPs, develop performance improvement strategies, and test the topic selected for improvement. The CQA support staff will collect and apply statistical methods to analyze performance data, create reports summarizing findings and recommendations to help inform the QM program, the grantee's implementation of the QM plan, the QM Committee, and the QI Networks. It is the consumer who is ultimately impacted by the quality of Part A and MAI- funded services. Consumers will complete the feedback loop utilizing focus groups, client satisfaction surveys, individual client interviews, client participation at QI Networks and QM Committee informing the entire QM Program's stakeholders regarding the service delivery efforts.

3. Roles and Responsibilities

a) Grantee

- Maintain oversight of EMA system-wide Part A QI initiatives;
- Ensure development and implementation of the five-year QM Plan;
- Ensure development of the annual QM Plan to assess progress toward achieving the five-year strategic goals;
- Facilitate the integration of and interaction among the five major stakeholders (Grantee, Part A and MAI service consumers, QM Committee, QI Networks and CQA support staff);
- Facilitate focus groups with consumers and subgrantees to determine areas of service for which QIP might be developed;
- Evaluate progress toward successful completion of the QM Program and annual QM Plans; and
- Provider Quarterly Outcome Reports.

b) Consumer Involvement

- Solicit consumer input and feedback through Joint Client/Community Relations Committee, Consumer Advisory Board, focus groups, key informant interviews, patient satisfaction surveys, etc. regarding the efficacy and efficiency of services.
- Consumer should be sought to participate in the QIP process and client satisfaction surveys implementation
- Recruit consumers to serve on QM Committee and participate in Quality Improvement Networks through Membership/Council Development Committee
- Clients to identify aspects of service delivery models that impede access, retention and adherence to care.
- Consumers are encouraged to be involved in every level of the decision-making and planning process

c) HIVPC QM Committee

- Meet on a monthly basis;
- Participate with Grantee staff to develop Committee policies and procedures consistent with other HIVPC committees;
- Participate in the development of the five-year QM Strategic Plan;
- Participate in the development of annual QM plans to achieve the five-year Strategic QM Plan;
- Develop client-level and system-level outcomes and indicators, and review HAB and other outcomes and indicators for adoption by the grantee;
- Assess in conjunction with the Grantee, CQA support staff, and QI Networks, whether standards of care, delineated in current service delivery models, are achieving desired client-level and system-level outcomes and indicators;
- Review draft standards of care for approval; and
- Identify and prioritize potential QIPs

d) QI Networks

- Meet at least quarterly;
- Identify service delivery model standards of care requiring QIP(s) to improve quality of care or related processes;
- Develop QIPs to improve processes and increase performance rates to achieve specified standards' benchmarks;
- Test QIP, using PDSA cycle, in one subgrantee facility, collect test data results, and assess impact of improvement; and
- Implement positive QIP test changes across all subgrantees in QI Network.

e) CQA Support Staff

- Develop tools for data collection to include: ongoing management of existing data bases, including assessment of their completeness, accuracy, and timeliness; create needed electronic databases; and use of direct client chart data abstraction methods to gather data need for QIPs, performance measurement assessment, and other related activities;
- Support HIVPC QM Committee and QI Networks by providing accurate, reliable and timely data for decision support;
- Employ methods of analysis to include literature reviews; develop hypotheses or evaluative questions; develop evaluative designs; collect and analyze data relevant to achievement of client and system-level outcomes, HAB clinical quality performance measures, PHS care guideline indicators, and EMA standards for service delivery; and facilitate AETC and NQC-based trainings for the QM Committee, QI Network members, and consumers

Resources to achieve this QM Plan include a strong commitment from the Grantee leadership, HIVPC leadership, QM Committee members, QI Network members, and subgrantees to strive to deliver the highest quality services possible. Other resources include HAB QA funding, expert and well-trained staff, space to meet, databases, and consumer "first hand" experience with the Part A and MAI-funded service delivery system.

4. Annual Quality Outcomes and Indicators

Table 17 summarizes the client-level and system-level outcomes and indicators developed by the QM Committee and the respective QI Networks.

Table 17. Ft. Lauderdale/Broward County Part A QM Program Performance Measures

HAB HIV Core Clinical Performance Measures

90% of clients receive two or more CD4 T-cell counts performed annually

90% of clients with AIDS are prescribed HAART

90% of clients with HIV infection attend two or more medical visits annual

95% of clients with CD4 T-cell counts below 200 are prescribed PCP prophylaxis

100% of pregnant women are prescribed ARV therapy

Current annual goals for selected HAB Clinical Quality Performance Measures and PHS Guideline indicators for ambulatory/outpatient medical care

Clients with HIV disease receive preventive care:

95% of clients are screened for OIs

95% of clients receive stage-appropriate *pnemocystis carinii* pneumonia (PCP) prophylaxis

95% of women are assessed for gender-specific HIV-related conditions/complications

80% of women receive a PAP at least annually

80% of clients receive an annual TB screen which will, consist of PPD or chest X ray

PLWHA retained in primary medical care:

90% of clients are assessed for adherence to treatment during every routine medical visit to the physician

95% of clients receive education about their medical care given by the health care provider

75% of clients remain in ARV therapy, unless contraindicated or the client refuses treatment

Client medical condition is monitored

90% of all clients receive at least two CD4 evaluations annually

90% of all clients receive at least two viral load evaluations annually

Selected client-level and system-level outcomes and indicators

Medical Case Management Outcome: Improved ability to access independently navigate and access needed services

100% of clients receive information regarding available services and corresponding eligibility criteria

80% of clients achieve Plan of Care goals by designated target dates

Medical Case Management Outcomes: Increased access, retention and adherence to primary care

80% of clients self–report adherence with their prescribed medication regimen

80% of new clients have outpatient medical visit scheduled to occur within two weeks of intake

Oral Health Services Outcome: Reduced incidence of oral OIs

85% of clients will have documented appropriate management of oral OIs

Table 17. Ft. Lauderdale/Broward County Part A QM Program Performance Measures

Absence or reduced episodes of oral candidiasis at follow-up

Oral Health Services Outcome: Slow periodontal disease progression

50% of clients show a decrease in the Plaque Index score, bleeding index, or gingival index

Mental Health Services Outcome: Improvement in client-identified primary problem (depression, anxiety, etc.)

Clinical improvement in related clinical scale over baseline at completion of initial and subsequent treatment plan

Mental Health Services Outcome: Increased access, retention and adherence to primary medical care

85% of clients referred to primary medical care kept their initial appointment

85% of clients remain enrolled in primary medical care at time of discharge

Substance Abuse Services Outcome: Improvement in client-identified primary problem (i.e., depression, anxiety, etc.)

Clinical improvement in related clinical scale over baseline at completion of initial and subsequent treatment plan

Substance Abuse Outcome: Increased number of clients successfully completes their initial treatment plan

60% of clients complete their initial treat plan

Substance Abuse Outcome: Increased access, retention and adherence to primary medical care

60% of clients referred to medical care that kept their initial appointment

Clients referred to medical care that kept 75% of their appointments

Substance Abuse Outcome: Decreased substance use

Increase in length of sobriety as compared to baseline

Pharmacy Outcome: Improved access to medication

80% of all clients new prescriptions filled and available w/in 24 hours hour or refills filled and available within 48 hours

Increase or maintain RWHAP-eligible client enrollment in pharmacy service as compared to the previous year

Pharmacy Outcome: Clients provided an opportunity to improve medication adherence

100% of clients accepts or rejects counseling as indicated by patient's signature

5. Participation of Stakeholders

The QM Committee is comprised of consumers, subgrantee program directors who also serve on QI Networks; program directors from non-Ryan White funded non-profit agencies, and HIVPC members. The Committee is co-chaired by a HIVPC member and the Grantee QA Coordinator. In addition, three of the members are or were medical professionals. Two of the medical professionals are consumers; one is a physician and the other a nurse. The third medical professional is a nurse serving as an "at-large" member and possesses previous CQI experience. Most QM monthly meetings also have consumers present in the audience for feedback and consumers are always invited and welcomed to attend and participate in the process.

QI training will be conducted through the year for all QM Committee members, QI Network members, and consumers. QI trainings began in December 2007, with at least 8 such trainings will be conducted prior to February 29, 2009 and a schedule of future training through FY 2008 is being developed. Each training session consists of one training module and one group activity, providing new knowledge and new skills to participants. Training materials are provided by the NQC Quality Academy and supported by other materials found from research of other best practice models.

Various methods will be used to solicit feedback from consumers relative to service delivery effectiveness and efficiency. Among these methods are consumer focus groups, service specific survey, service specific client satisfaction surveys and recruitment of consumers to participate in QM Committee and QI Network functions. Subgrantees will be empowered through the QI Networks to identify QI Projects and to provide input and feedback relative to service delivery standards. Once a service delivery standard has been identified as sub-standard, the QI Network members will be encouraged to "brainstorm" solutions, test the solution through use of the PDSA Cycle and implement their solution system-wide.

6. Performance Measurement

Involve QM Committee members, QI Network members, and consumers to establish benchmarks and expected milestones to assess, at least quarterly, the progress toward achievement of the QM Plan. Data from provider quarterly outcome reports, annual Grantee Program Evaluations, AETC chart reviews, data reports, and peer review data will be used for this quarterly progress review.

Key to performance measures is the link that can quantifiably assessed between service delivery standards and Clinical Quality Performance Measures, as well as client- and system-level outcomes and Indicators as established by the QM Committee and QI Networks. Conceptually, achievement of client-level and system-level outcomes/ indicators are viewed as a result of how well the quality of service delivery standards are carried out in this EMA. Further, Clinical Quality Performance Measures are used to assess the quality of care provided across the EMA. As HAB confirms its clinical quality measures and NQC provides performance measures for non-clinical services, this EMA will adopt those measures into its Annual QM Plan. The primary day-to-day responsibility for data collection and analysis lies with the Clinical QM Support Staff. To maximize their efforts, the subgrantee for Clinical QM Support has added to its staff a PhD level biostatistician. This individual possesses the ability to conduct literature reviews, design research projects, collect and analyze data and provide written reports and feedback to the Grantee, QM Committee, QI Networks and consumers with respect to achieving milestones toward progress of completing the EMA QM Plan. The QM Committee will develop a mechanism to share findings and methodologies with local Part B, C, and D grantees, to be included in first Annual QM Plan.

7. Capacity Development

Critical to capacity development is initial and ongoing training for all stakeholders. BRHPC CQA Staff, Grantee QA staff, and AETC medical staff will conduct monthly trainings, using NQC and AETC materials to impart new knowledge and skills to QI Network Members and QM Committee Members. Monthly trainings consist of two parts. Part One is the sharing of new knowledge through the use of NQC Quality Academy and AETC training modules. The QM Committee will continue to prioritize training needs. Central to this process is the ability of the Grantee QA Staff and subcontracted Clinical QA Support staff to work in a supportive and facilitative method with

the QM Committee, QI Networks and individual subgrantees in order to facilitate QI Projects and the receipt of technical assistance. Grantee QA Staff and Clinical QA Support staff will avail themselves of the experience of other EMAs as well as NQC TA. Data from QI projects will be reported to the QM Committee, QI Networks, and consumers as reports are developed by the Clinical QA Support staff and/or Grantee QA staff.

8. Evaluation

The Grantee QA Staff and Clinical QA Support Staff will facilitate the QM Committee and QI Networks process in identifying QI projects critical to the achievement of Clinical Quality Performance Measures and client-level and system-level outcomes and indicators. On an annual basis, the QM Committee will use the NQC Part A Quality Management Program Assessment Tool to evaluate the Annual QM Plan and Quality Infrastructure. The Grantee also will seek an outside consultant also to assess the Annual QM Plan and Quality Infrastructure. On a quarterly basis, the QM Committee will review all service category client-level and system-level outcomes and indicators for progress toward achieving benchmarks. Simultaneously, the respective QI Networks will review the same client-level and system-level outcomes and indicators for progress toward achieving benchmarks. These quarterly outcome reports are submitted by subgrantees to the grantee, which will then aggregate the findings and report them to the QM Committee and the respective QI Networks. Additionally, Clinical QA Support staff will provide data relative to the achievement of Clinical Quality Performance Measures.

9. Process to Update the Annual QM Plan

The Grantee QA Coordinator will ensure that active QIP updates will be a standing item on monthly QM Committee agendas. Clinical QA Support staff will facilitate this process by collecting and analyzing clinical quality measure data, then report findings and progress to the QM Committee. While QIPs are underway, the respective QI Network will also meet monthly to review progress and make modifications as necessary.

The Grantee QA Coordinator will ensure that subgrantee quarterly outcome reports are aggregated and findings are reported to both the QM Committee and the respective QI Network. Additionally, a formal review of the QM Plan, on a quarterly basis will become a standing item on the QM Committee agenda. This process will help facilitate the identification of future QI Projects toward the accomplishment of the annual QM Plan. As the Clinical QA Support staff has collected and analyzed Clinical Quality Performance Measures, they will report findings and recommendations to the QM Committee and respective QI Networks.

At least annually, just prior to the development of the next year's QM Plan, the QM Committee and QI Chairs will review progress made on the current year's annual QM Plan and the EMA five-year plan.

10. Communication

At least two months prior to the expiration of the annual QM Plan, the QA Coordinator and the Clinical QA Support staff will draft the next year's annual QM Plan and communicate it with the QM Committee, QI Networks, Grantee Program staff, and consumers. Advertisement of this presentation will be through flyers in subgrantees facilities and email lists maintained by the Clinical QA Support staff. Through this activity it is anticipated that all stakeholders will be informed of scheduled reviews and of the need for their input and feedback. Likewise, the same

stakeholders will also be informed of the quarterly formal review of the QM Plan and associated QI Projects.

On a monthly basis the Grantee QA Coordinator, Clinical QA Support staff, and other relevant program staff will meet to discuss and review progress made on the QM Plan and QI Projects. This meeting will also include a review of other relevant materials such as best practice models, reviews of the literature, review of ancillary reports and data, other EMA efforts and other material that may potentially enhance this EMA's QM Plan. Finally, a QA e-letter quarterly newsletter is being developed for distribution to all QA staff, HIVPC members, subgrantees and consumers. Topics will include comments, thoughts and vision statements from the Grantee, QIP success stories from subgrantees, upcoming training opportunities, consumer comments about quality services, and QA and QI tips.