Fort Lauderdale / Broward County EMA
Broward County HIV Health Services Planning Council
An Advisory Board of the Broward County Board of County Commissioners
200 Oakwood Lane, Suite 100, Hollywood, FL, 33020 - Tel: 954-561-9681 / www.BRHPC.org

MEETING AGENDA

Committee: Priority Setting & Resource Allocation (PSRA)
Date/Time: Wednesday, March 18, 2015, 12:30 p.m.
Location: Governmental Center Annex Room A-337
Chair: Carla Taylor-Bennett **Vice Chair:** Rick Siclari

1. **CALL TO ORDER:** *Welcome, Ground Rules, Sunshine, Introductions, Moment of Silence, & Public Comment*
2. **APPROVALS:** 3/18/15 Agenda and 2/18/15 Meeting Minutes
3. **STANDARD COMMITTEE ITEMS:**
   a. Monthly Expenditure/Utilization Report by Category of Service (WP Item 2.1)
4. **UNFINISHED BUSINESS:**
   a. Update Planning Documents (WP Item 5.3) (Handouts A-1 & A-2)
   ACTION ITEM: Review the work plan and policies & procedures and make any necessary changes.
5. **MEETING ACTIVITIES**

Goal/Work Plan Objective #:	*Accomplishments*
Develop PSRA Timeline (Handout B) (WP Item 1.1)	ACTION ITEM: Develop PSRA timeline including all relevant activities to take place in FY 2015-2016.
Review PSRA Data & Scorecards (WP Item 1.2) (Handouts C-1-C-5)	ACTION ITEM: Review relevant data to the PSRA process. Determine how the data relates to the PSRA process and how it can be used in the FY16-17 PSRA process.

6. **SUBCOMMITTEE REPORTS**
   a. ad-Hoc Local Pharmacy Advisory Committee (LPAC) (Handout D)
   ACTION ITEM: Review recommendation to add Januvia to the Part A Formulary.
   b. ad-Hoc Food Services Eligibility Committee
7. **GRANTEE REPORTS**
8. **PUBLIC COMMENT** (Please sign up on the Public Comment Sheet)
9. **AGENDA ITEMS/TASKS FOR NEXT MEETING:** April 15, 2015,12:30 p.m. **Venue:** A-337

Goal/Work Plan Objective #:	*Accomplishments*
Review PSRA Data & Scorecards (WP Item 1.2)	ACTION ITEM: Review relevant data to the PSRA process. Determine how the data relates to the PSRA process and how it can be used in the FY16-17 PSRA process.

10. **ANNOUNCEMENTS**
11. **ADJOURNMENT**

PLEASE COMPLETE YOUR MEETING EVALUATIONS

THREE PRINCIPLES IDEAS OF THE BROWARD COUNTY HIV HEALTH SERVICES PLANNING COUNCIL

• Linkage to Care • Retention in Care • Viral Load Suppression •

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MEETING MINUTES

Committee: Priority Setting & Resource Allocation (PSRA)
Date/Time: Wednesday, February 18, 2015, 12:30 p.m. **Location:** Governmental Center Room GC-301
Chair: Carla Taylor-Bennett **Vice Chair:** Rick Siclari

ATTENDANCE					
#	**Members**	**Present**	**Absent**		**Guests**
1	DeSantis, M.	**X**			Albury, S.
2	Gammell, B.	**X**			Lewis, L.
3	Grant, C.	**X**			
4	Hayes, M.	**X**			**Grantee Staff**
5	Katz, H. B.	**X**			Copa, R.
6	Reed, Y.		**E**		Degraffenreidt, S.
7	Schickowski, K.	**X**			Green, W.E.
8	Proulx, D.	**X**			Jones, L.
9	Siclari, R., *Vice Chair*	**X**			
10	Taylor-Bennett, C., *Chair*	**X**			**HIVPC Staff**
					Bente, A.
	Quorum = 6	**10**			Sandler, C.

1. CALL TO ORDER:

The Chair called the meeting to order at 12:44 p.m. The Chair welcomed all present. Attendees were notified of information regarding the Government in the Sunshine Law and meeting reporting requirements, which includes the recording of minutes. Attendees were advised that the meeting ground rules are present, for reference. In addition, attendees were advised that the acknowledgement of HIV status is not required but is subject to public record if it is disclosed. Chairs, committee members, guests, Grantee staff and HIVPC staff self-introductions were made.

2. APPROVALS:

Motion #1: To approve today's meeting agenda.
Proposed by: Hayes, M. **Seconded by:** Katz, H.B
Action: Passed Unanimously

Motion #2: To approve meeting minutes of 1/21/15.
Proposed by: Katz, H.B. **Seconded by:** DeSantis, M.
Action: Passed Unanimously

3. STANDARD COMMITTEE ITEMS:

a. Monthly Expenditure/Utilization Report by Category of Service (WP Item 2.1)
Grantee staff explained that the monthly/utilization report is not available for this month, due to Grantee staff working to close out the fiscal year.

4. UNFINISHED BUSINESS:

None.

5. MEETING ACTIVITIES / NEW BUSINESS

a. Review PSRA Data & Scorecards (WP Item 1.2) (Handouts A-1-A-4)
Staff explained Early Identification of Individuals living with HIV/AIDS (EIIHA) data, including the importance, relevance to the PSRA process, and how it is used in the Ryan White Part A grant. Staff explained this data comes from the Florida Department of Health (FLDOH) and is utilized to target populations that experience disproportionately high HIV/AIDS population-adjusted incidence and prevalence rates among Broward HIV+ residents. Three target populations were identified by the FLDOH-BC for the FY 2015 EIIHA Plan: white MSM, black non-Hispanic MSM, and black non-Hispanic women.

The FY 2015 EIIHA Plan's overarching goals align with the reduction in the number of undiagnosed and late diagnosed residents and ensure that they access HIV care and treatment.

The committee reviewed the scorecards for Centralized Intake and Eligibility Determination (CIED), Legal Services, and Pharmacy. The Grantee explained that these scorecards are drafts and more information will be added to them. He explained that a narrative will supplement the scorecards to clarify the information presented. The Grantee asked the committee for additional information to be added to the scorecards. A member asked where the definitions regarding housing status came from. Staff explained that definitions come from HRSA. The Grantee stated that information such as housing definitions will be included in scorecard narratives. The PSRA Vice Chair asked for data related to the number of clients lost to care. The PSRA Chair explained that when data is presented, the committee must connect the dots to address gaps in care, including those that are lost to care. Grantee staff explained that the QMC will review data and pass findings to PSRA and the System of Care (SOC) Committee. A member asked that demographics be included for viral load (VL) rates. Grantee staff recommended including any deficiencies in the narrative. A member asked for VL rates for Part A clients and clients that utilize private providers. The Grantee stated that this information can only be presented for Outpatient Ambulatory Medical Care (OAMC). A member stated that inclusion of clients that utilize private providers would divulge system wide gaps in care. The Grantee stated the committee has historically looked at clients that are achieving greater health outcomes and now the committee must identify how to achieve those successes for a majority of clients. A member stated the *Voices* study was a good catalyst for the changes in service category allocations. The Grantee stated that minority MSM populations are not achieving health outcomes and recommended that MAI funding be geared towards this population. A member stated that data must be presented to prove that theory.

Grantee staff recommended the committee focus on information relevant to the priority setting process, such as VL rates. The Chair asked if VL rates have a direct correlation to health outcomes. A member suggested analyzing VL rates along with duration of diagnosis. The committee reviewed current Provide Enterprise (PE) VL data along with demographics and risk factors. A member asked if VL data is reviewed by provider. Grantee staff explained that VL data is reviewed and tracked monthly. The committee asked for scorecards by VL suppression rates, clients not retained in care, and demographics that are not achieving health outcomes. The committee also asked for a scorecard with clients that are entering the Part A system as a new client.

b. Needs Assessment Components (Handout B)
Staff explained that needs assessment components for 2015. Staff explained that the needs assessment will include focus groups, key informant interviews, a survey for unmet need with targeted question on items that came out of last year's needs assessment. A member recommended that MSM focus groups be divided between ages 16-21 and 22-29. The Chair asked about consumer rankings. Staff explained that CEC will conduct priority rankings. A member asked how many people are included in focus groups. Staff explained that the consultants have experience hosting focus groups and they will ensure an adequate sample. The Grantee stated that focus groups are just a piece of data and a portion of the big picture. A guest asked if rankings can be broken down by age group to gain their feedback. Staff also explained that focus groups will look at issues that came out of last year's needs assessment. A member asked to think about having Health Insurance Continuation Program (HICP) clients specifically conduct rankings, to gather information about what services are needed for clients obtaining primary medical care outside of the Part A system.

c. Work Plan and Policies & Procedures (WP Item 5.3) (Handouts C-1 & C-2)
The Chair tabled these items until the next meeting.

d. Case Management (Handout D)
The Chair stated that when reviewing this item the committee must have a discussion regarding MAI Medical Case Management (MCM). The Chair asked for allocations for each case management (CM) category. The Chair explained that MAI MCM has been funded for the past several years and that issues regarding this service category must be resolved. The committee reviewed the motion and recommendation from the Executive Committee. There was discussion regarding the integration of all CM service categories into the service category. A member stated that Prevention staff attended a meeting and stated that

Prevention completes a number of the tasks being discussed at the ad-Hoc MAI MCM Committee meeting. The following motion was made:

Motion #3: To disband the ad-Hoc MAI MCM Committee in order to allow the Grantee's office to collect data on best practices and model for all CM services for the PSRA process that will take place in 2016.
Proposed by: Hayes, M. **Seconded by:** Schickowski, K.
Action: Passed Unanimously

The committee continued discussion. A member stated that this item should be forwarded to the SOC due to this being a system wide issue. The Chair stated that because the CM model is targeted toward minority groups that have been lost to care, an alternative model needs to be created. A member stated that maybe another service category needs to be funded to retain clients into care. The Chair stated that a model be devised and implemented. Members felt the discussion got off track and the following motion was made:

Motion #4: To call the question.
Proposed by: Katz, H.B. **Seconded by:** Gammell, B.
Action: Passed with two oppositions

A member asked staff to review the work plan and see where the MAI discussion falls into work plan.

6. SUBCOMMITTEE REPORTS

a. ad-Hoc Local Pharmacy Advisory Committee (LPAC)
The LPAC Chair stated that the committee is in the process of scheduling their first meeting for 2015. Staff explained the committee will be reviewing data regarding medication utilization.

b. ad-Hoc MAI Medical Case Management Committee
No report.

c. ad-Hoc Food Services Eligibility Committee
The ad-Hoc Food Services Eligibility Chair explained the food services eligibility model and explained the eligibility flow chart. The committee is recommending that clients have a medical need to be eligible for food services. A member stated that consumer feedback must be included in model development. A member expressed her disapproval for the model. The Chair stated that many other EMAs utilize the same criteria for food services eligibility. Grantee staff stated this model was modeled after many other EMAs in similar size. A member stated that because consumers are being medically evaluated to receive food, the food must be able to meet their medical necessities. A member stated that menus are currently being redesigned to meet nutritional guidelines for specific diagnoses. There was discussion regarding the sustainability of the food services program in the future and how the model will function in the future. A member suggested looking at the reasons why clients utilize food services. Grantee staff stated the committee would look at VL rates among food services clients. The PSRA Chair stated that food services expenditures in this EMA will send a red flag to HRSA and grant funding can be affected. The PSRA Chair suggested creating a model with a reduced benefit that will provide greater health outcomes.

7. GRANTEE REPORT

The Grantee explained they received a partial grant award which was 80% of the FY 2014-2015 award, approximately $12.6 million. Grantee staff explained that ACA enrollment ended on Sunday and though navigator appointments have ended that there is still a large amount of work to complete. Grantee staff reported that there have been 146 clients enrolled in HICP and 890 client enrolled in ADAP. There has been a tremendous amount of work associated with the enrollment of these clients. The Grantee will ask the committee for an increase in HICP funding due to increasing premiums. Grantee staff explained that there will be medical and pharmacy savings due to ACA enrollment. A member asked if there will be indicator in PE to enroll clients into ACA plans. Grantee staff explained that something will included into PE for that purpose. A member asked if deductibles will be paid. Grantee stated that deductibles will be paid and this process will be completed through PE. A member asked if there will be a retroactive process for clients that will delay providing their billing statement. The Grantee stated that these expenses and out of pocket expenses will be paid. A member asked if there will be any identifier in PE that displays who makes payments for each individual client. Grantee

staff stated that this mechanism is already in place. The Chair thanked the Grantee's office for their support and dedication to enroll clients.

8. PUBLIC COMMENT

None.

9. AGENDA ITEMS/TASKS FOR NEXT MEETING: March 18, 2015 Venue: A-337

Goal/Work Plan Objective #:	*Accomplishments*
Develop PSRA Timeline (WP Item 1.1)	ACTION ITEM: Develop PSRA timeline including all relevant activities to take place in FY 2015-2016.
Review PSRA Data & Scorecards (WP Item 1.2)	ACTION ITEM: Review relevant data to the PSRA process. Determine how the data relates to the PSRA process and how it can be used in the FY16-17 PSRA process.
Review Part B Scorecards	ACTION ITEM: Review relevant Part B data to the PSRA process. Determine how the data relates to the PSRA process and how it can be used in the FY16-17 PSRA process.
Work Plan and Policies & Procedures (WP Item 5.3)	ACTION ITEM: Review the work plan and policies & procedures and make any necessary changes.

10. ANNOUNCEMENTS

None.

11. ADJOURNMENT

The meeting was adjourned at 3:48 p.m.

Priority Setting Resource Allocation Committee Attendance CY 2015

Count	Meeting Month:	Jan	Feb
	Meeting Date:	21	18
1	DeSantis, M.	X	X
2	Gammell, B.	X	X
3	Grant, C.	X	X
4	Hayes, M.	X	X
5	Katz, H.B.	X	X
6	Proulx, D.	X	X
7	Reed, Y.	X	E
8	Schickowski, K.	X	X
9	Siclari, R., *Vice Chair*	X	X
10	Taylor-Bennett, C., *Chair*	X	X
	Quorum = 6	10	9

Priority Setting & Resource Allocation Committee

Policies and Procedures

The Priority Setting & Resource Allocation Committee shall recommend priorities and resource allocations to the Broward County HIV Health Services Planning Council (Council) for the disbursement of Ryan White Part A funds in Broward County. Priority Setting and Resource Allocation to service categories involves all members of the Council. The process is designed to protect against perceived conflict of interest by adhering to Conflict of Interest policies as identified in the By-Laws of the Council. The Committee may offer input regarding the Housing Opportunities for Persons with HIV/AIDS (HOPWA) Program based upon the collaborative needs assessment results for the HOPWA Grantee to take into consideration. However, the Committee will not provide priority setting and resource allocation for the HOPWA Program.

The Committee shall include members of the Council and community stakeholders to ensure collaboration and coordination across funding streams. The Committee shall have a Chair and Vice Chair appointed by the Council Chair .The Committee shall meet on an as-needed basis as determined by the Council, the Committee Chair, and the Committee Vice Chair.

Persons Living with HIV and community involvement shall be solicited and encouraged at all meetings. The decision making process is publicly stated and implemented as stated.

The Committee shall recommend language to the Council on factors that the Grantee should consider in disbursing funds under a grant based on: the documented needs of the local HIV infected population; cost and outcome effectiveness of proposed strategies and interventions, to the extent that such data are reasonably available (either demonstrated or probable); priorities of the local HIV-infected communities for whom the services are intended; percentage constituted by the ratio of infants, children and women in the HIV positive population; availability of other local resources and other local priorities as stated.

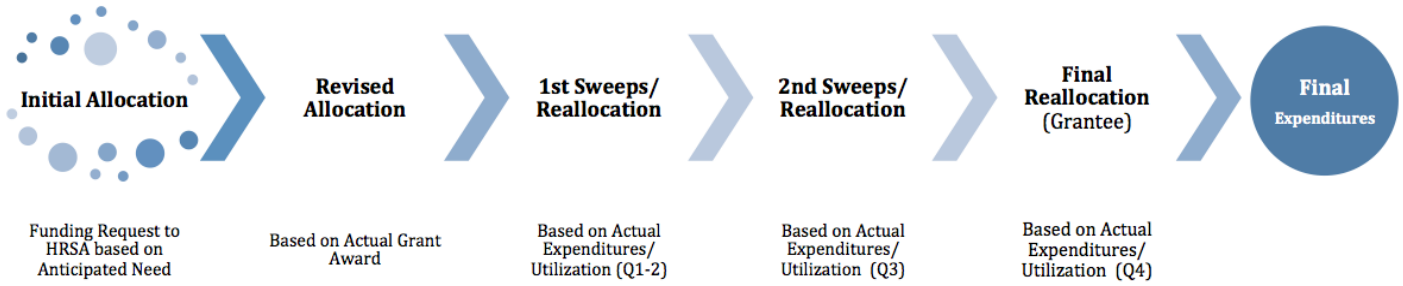
The decision making process is publicly stated and implemented as stated.The Committee shall utilize a "nominal group process method" to set priorities as outlined in the procedures below.The Committee shall review, at least quarterly, any deviations in planned expenditures exceeding 10% in any given funding category for possible reallocation and/or reprioritization. Unexpended amounts less than 10% in any given funding category may be reallocated by the Administrative entity of the Grantee.

Priority and allocation recommendations shall be forwarded to the Council and if approved to the applicable funding source for disbursement of Ryan White Part A dollars. The Grant Administrator shall submit the Part A funding priority award recommendations to the Board of County Commissioners' designated Division Director, who in turn forwards to the Broward County Board of County Commissioners for its approval.

The Planning Council has identified the following core medical services as those which have a documented need for funding. The Health Resources and Services Administration (HRSA) has classified these services as core medical services, which are in line with the Florida Statewide Coordinated Statement of Need:

1. Outpatient/Ambulatory Health Services
2. AIDS Pharmaceutical Assistance (local)
3. Health Insurance Continuation Program (HICP)
4. Oral Health Care
5. Mental Health Services
6. Medical Case Management (including Treatment Adherence)
7. Substance Abuse Services (outpatient)

Fort Lauderdale/Broward County Annual Resource Allocation/Reallocation Cycle



Initial Allocation (Funding Request to HRSA based on Anticipated Need for the Next Fiscal Year)

The Committee shall determine service priorities and funding allocations with justifications that can be linked back to the Needs Assessment and Comprehensive Plan. This should ensure that service priorities as set by this Committee are being addressed and conforming to a comprehensive continuum of HIV care.

Review Data

- Statewide Coordinated Statement of Need and State and Local Comprehensive Planning Documents
- Surveillance, HIV+ Unaware Estimate (EIIHA) and HIV+ Not In Medical Care (Unmet Need) Estimate
- Client Needs, Priorities and Other Needs Assessment Data
- Client Utilization Data and Spending Patterns
- Quality Management Data
- Other Data as applicable and available

Allocate Funding to Service Categories. The Committee shall first allocate funding to the core services followed by the remaining support services. The process to be utilized when estimating resources needed shall be: # of clients needing service (based on utilization, surveillance and unmet need data) * *the* cost to provide needed service (units per client per year x dollars per unit) - other local resources and/or funding sources + other documented community needs = resources needed to fund anticipated need.
[# of clients* cost] – [other funding + other documented community needs] = resources needed

Estimate Client Need. The Committee shall develop an estimate of the number of clients that have a need for each service category based on current service utilization, prevention and surveillance data, and unmet medical need (aware and not in care) and service gap estimates.

1. Determine current Part A and/or Part B service utilization by service category
2. Estimate # of new clients that will need services
   a. Estimate # of eligible PLWHA needing but not receiving services (service gaps & unmet need)
   b. Estimate # of eligible newly diagnosed PLWHA that will need services

Other Funding. The committee should review the availability of other funding sources/resources for similar services and estimate the number of clients that are likely to be served by other funding.

3. Estimate # clients to be served through other funding of similar services
   a. Subtract # of PLWHA likely to be served through increase in available other funding
   b. Add # of PLWHA estimated to need services due to decreases in other available funding

Revised Allocation (Based on Actual HRSA Ryan White Grant Award)

The following process shall be used to revise allocations based on the receipt of a grant award that is either greater than or less than the amount that was requested by the EMA.

Funding Increase: In the event of a funding award greater than the amount received the previous year, service categories will be funded first at the most recent fiscal year's final expenditures, if applicable. The Grantee will exercise discretion in applying any remaining increase to services based on the ranking of service categories and service category needs.

Funding Shortages: In the event of funding shortages (i.e., level funding or less than level funding), core-service categories will be funded at the prior year's final funded allocation level minus un-obligated administrative and carryover funds. If not feasible or if doing so would result in a reduction equal to or greater than 15% of the final expenditure amount of the previous year allocated to support services, the Grantee's office will convene the committee to revise funding allocations. Deviations in expenditures in excess of 10% in any given funding category shall be reviewed by the Committee for possible reallocation utilizing the same processes as outlined above.

Sweeps and Reallocation Process (Based on periodic review of service utilization)

The Committee shall review, at least quarterly, any deviations in planned expenditures exceeding 10% in any given funding category for possible reallocation and/or reprioritization. Unexpended amounts less than 10% in any given funding category may be reallocated by the Administrative entity of the Grantee.

For *periodic reallocation* of resources the following process shall be utilized: The Grantee should present the Committee with estimates of funding deviations with an explanation as to possible causes of the deviation. The funding should be maintained within the service category if possible. If it is not possible to maintain the funding within the service category, the funding should be moved in ranked order to the next highest ranked category which will experience a shortfall. The Committee reserves the right to deviate from this process to address emergent needs of under-served populations in lower or non-ranked categories. Any deviations from the planned allocation will be documented with justification for why the deviation will occur.

Final Reallocation: In order to fully expend funds at the end of the fiscal year, the Committee authorizes the grantee to move funds between categories within a service provider's contract. This authority is given with the understanding that the reallocation process has occurred prior to this shifting of funds, that the amount of dollars involved would be less that 10% of the funding award and that there are less than 120 days left in the fiscal year.

HANDOUT A-2

DRAFT - Broward County HIV Health Services Planning Council FY2014-16 **Priority Setting & Resource Allocation Committee** Work Plan

Objective 1. Priority Setting and Resource Allocation	Outcome	Annual Target	Start	Due	Progress
1.1 Develop PSRA timeline.	PSRA process	100%	3/15	3/15	
1.2 Review data relevant to the PSRA process (including recommendations from QM, SOC, & NAE and service category scorecards): a. Community input (through needs assessment, town hall meetings) b. Epidemiology (including co-morbidities) c. Unmet Need d. EIIHA e. Implementation Plan f. Cost data (utilization, expenditures, MAI, ACA, other funders) g. QM performance measures (HRSA & HAB) h. NHAS and HIV Care Continuum measures	Data driven PSRA process	80%	1/15	6/15	
1.3 Review How Best to Meet the Need language recommendations from SOC committee.	Data driven PSRA process	100%	5/15	5/15	
1.4 Review recommendations from SOC committee for scope of services and eligibility for each service category; update eligibility for at least 2 services.	Data driven PSRA process	50%	7/15	7/15	
1.5 Priority rank Part A & MAI service categories.	Ensure PSRA process	100%	5/15	5/15	
1.6 Allocate Part A & MAI funds by service category.	Ensure PSRA process	100%	6/15	6/15	
Objective 2. Execute Implementation Plan					
2.1 Monitor expenditures and allocations; identify at least 3 areas for "sweeps."	Appropriate funding	66%	Monthly	Monthly	
2.2 Recommend reallocations ("Sweeps") to ensure sufficient core funding and the distribution of additional funds.	Appropriate funding	100%	1/15	1/15	
Objective 3. Assess the Administrative Mechanism					
3.1 Assessment of Administrative Mechanism training. Review the purpose of the assessment and required components.	Ensure compliance	100%	1/15	1/15	
3.2 Make at least 2 recommendations for activities to include in the assessment of Administrative Mechanism.	Ensure compliance	50%	1/15	1/15	
Objective 4: Review Data and Make Recommendations for an Integrated System of Care					
4.1 Hold a "mini retreat" with all committees to discuss how committees work together to complete activities.	Educated PSRA members	100%	12/14	12/14	
4.2 Discuss at least 2 possible new services identified through the PSRA process to address goals of the EMA.	Data driven PSRA process	50%	7/15	7/15	
Objective 5: Update Work Plan and Policies & Procedures					
5.1 Review at least 3 PSRA accomplishments and challenges.	Improved process	66%	1/15	1/15	
5.2 Conduct annual evaluation to assess past year and recommend improvements; identify at least 3 areas of improvement for upcoming year.	Improved process	66%	1/15	1/15	
5.3 Review and update Work Plan and Policies & Procedures.	Updated planning documents	100%	2/15	2/15	

March	April	May	June	July	Aug
- Monitor expenditures & allocations - Review PSRA scorecards & relevant PSRA data - Develop PSRA timeline	- Monitor expenditures & allocations - Review PSRA scorecards & relevant PSRA data	- Monitor expenditures & allocations - Review PSRA scorecards & relevant PSRA data - Review language on HBTMTN - Priority rank service categories	- Monitor expenditures & allocations - Review PSRA scorecards & relevant PSRA data - Allocate Part A & MAI funds	- Monitor expenditures & allocations - Discuss new services identified through PSRA process - Review scope of services & eligibility for service categories	- Monitor expenditures & allocations
Sep	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**
- Monitor expenditures & allocations	- Monitor expenditures & allocations	- Monitor expenditures & allocations - Assessment of the Administrative Mechanism training and recommendations - “Sweeps”	- Mini retreat	- Review accomplishments & challenges - Conduct annual evaluation - Review PSRA scorecards & relevant PSRA data - Monitor expenditures & allocations - “Sweeps”	- Monitor expenditures & allocations - Review PSRA scorecards & relevant PSRA data - Review and update WP and P&Ps

2015 PRIORITY SETTING AND RESOURCE ALLOCATION (PSRA) TIMELINE

HANDOUT B

TASK	DATE
PSRA Requests for Additional Data	March
Data Review	
Allocations, Expenditures, & Utilization	Monthly
Unmet Need	January
Early Identification of Individuals with HIV/AIDS (EIIHA)	February
Epidemiology	March
Needs Assessment	April
Other Funders	May
Community Empowerment Committee (CEC) Priority Rankings	May
Service Category Scorecards	
Pharmacy, Centralized Intake and Eligibility Determination (CIED), and Legal Services	March
Oral Health Care, Case Management, and Outpatient Ambulatory Medical Care (OAMC)	April
Mental Health, Substance Abuse, Food Services, Part A Overall	May
Review Language on How Best To Meet The Need (HBTMTN)	May
PSRA Data Review Presentation	May & June
Priority Setting for FY 2016-2017	May
Allocations for FY 2016-2017	June
HIVPC Approval of FY 2016-2017 Priority Setting & Allocation Recommendations	June

PSRA DATA REVIEW: EPIDEMIOLOGY

WHAT IS EPIDEMIOLOGY?

The Centers for Disease Control and Prevention (CDC) defines **epidemiology** as:

> *The study of the distribution and determinants of health problems in specified populations and the application of this study to control health problems. Epidemiology is the scientific method used by epidemiologists ("disease detectives") to get to the root of a public health problem or emerging public health event affecting a specific population*.

WHY IS IT IMPORTANT?

Epidemiology data provides more information about who the people are that are HIV positive and how they contracted HIV. Epidemiology provides a demographic breakdown of the HIV epidemic, including the race and ethnicities of the HIV positive population, ages, risk factors, and socioeconomic factors. It is important to know and understand these demographics, because certain demographics, for example, those who identify as injection drug users, may be at higher risk for contracting HIV.

HOW IS IT USED IN THE PSRA PROCESS?

Understanding epidemiology and who is most at risk for contracting HIV can be used to implement effective interventions or plan for services in the areas where they are needed most. For example, knowing that certain neighborhoods have larger populations of people living with HIV may lead to the Planning Council directing the Grantee to ensure service providers are located within those neighborhoods. This would help clients have access to care where they live, and would make it easier for clients to retained and engaged in care.

HOW IS IT USED IN THE GRANT?

Two basic epidemiology data points, prevalence and incidence, form the basis of the formula that is used to determine Part A funds. Prevalence and incidence both measure HIV, but have important differences:

- **Prevalence** measures the total number of living cases of HIV and AIDS as of the date specified. Prevalence can be expressed as a number (for example, 8,362 living HIV cases through calendar year 2013) or as a proportion (for example, 475.4 living HIV cases per 100,000 population).
- **Incidence** measures new cases of HIV and AIDS during a specific period of time. Incidence can also be expressed as a number (for example, 498 new AIDS cases during calendar year 2013) or as a proportion (for example, 28.3 AIDS cases per 100,000 population).

Thus, accurate reporting of epidemiology data in the Part A grant is crucial to receiving the funds needed to provide services to clients. The most recent complete incidence and prevalence data for Broward are shown in the tables below.

Epidemiology data is also used to provide information about who the population is that is being served, and what kind of services they may need. A large population of older clients

would likely mean a need for different services than a large population of younger clients. While older clients are more likely to need care related to aging in addition to care for HIV, younger clients may be more in need of support services such as transportation or psychosocial support. Epidemiology can help highlight disparities among subpopulations, and the need for targeted services or targeted funds to help combat those disparities.

	HIV				AIDS			
	2012	2013	2014	%Δ (2012-14)	2012	2013	2014	%Δ (2012-14)
White	214	298	175	-18%	72	119	99	38%
Black	326	453	418	28%	224	288	247	10%
Hispanic	116	178	381	228%	54	63	42	-22%
Other	11	10	19	73%	7	10	15	114%
Total	667	939	993	49%	357	480	403	13%

Table 1. HIV and AIDS Incidence in Broward County, 2012-2014

	2012	**% of total**	**2013**	**% of total**
Race/Ethnicity				
White	5,677	34.1%	5,856	34.0%
Black	8,233	49.5%	8,521	49.4%
Hispanic	2,331	14.0%	2,476	14.4%
Other/Unknown	391	2.4%	398	2.2%
Gender				
Male	11,772	70.8%	12,275	71.2%
Female	4,860	29.2%	4,973	28.8%
Age				
<13 years	39	0.2%	34	0.2%
13 - 24 years	560	3.4%	552	3.2%
25 - 44 years	5,573	33.5%	5,562	32.3%
45 - 60 years	8,388	50.4%	8,745	50.7%
60+ years	2,072	12.5%	2,355	13.7%
Exposure Category				
Men who have sex with men (MSM)	8,030	48.3%	8,468	49.1%
Injection drug users (IDU)	1,225	7.4%	1,241	7.2%
MSM IDU	474	2.8%	474	2.7%
Heterosexuals	6,630	39.9%	6,794	
Other/Unknown	273	1.6%	271	
Total	**16,632**	**100%**	**17,248**	**100%**

Table 2. HIV and AIDS Prevalence in Broward County, 2012-2013

HANDOUT C-2

HIV/AIDS Epidemiology Partnership 10

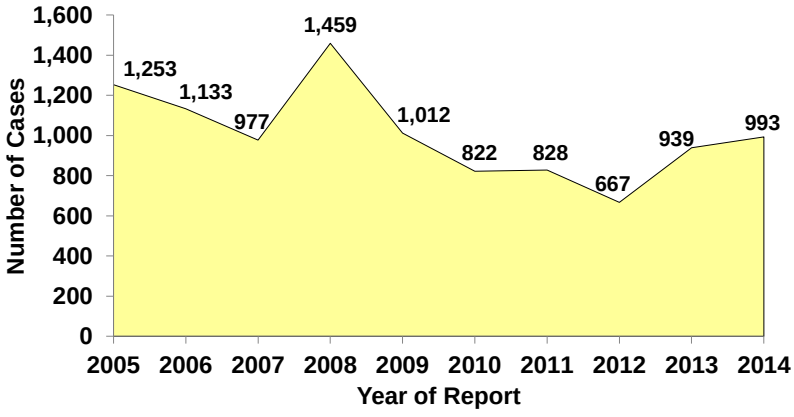
Broward County

Excluding Dept. of Corrections

Created: 12/03/14
Revision: 02/23/15

Florida Department of Health
HIV/AIDS Section
Annual data trends as of 12/31/2014
Living (Prevalence) data as of 06/30/2014

HIV Infection Cases and Rates*
By Year of Report, 2005-2014, Partnership 10

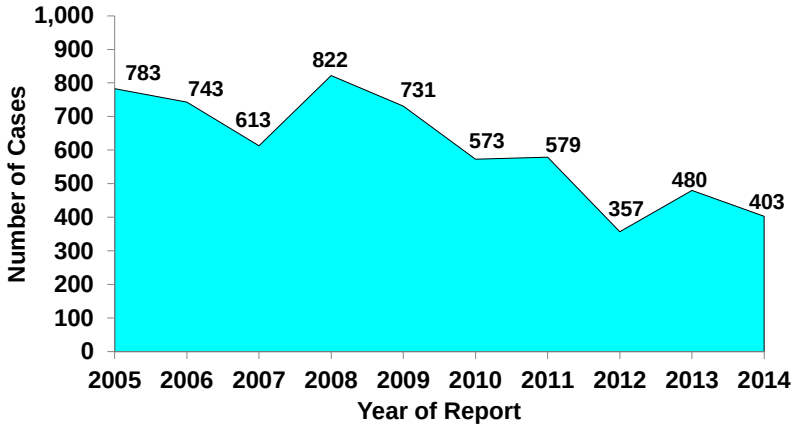


Year	Rate
05	72.2
06	64.9
07	56.1
08	84.3
09	58.5
10	47.1
11	47.8
12	38.3
13	58.5
14	55.4

Note: Enhanced laboratory reporting (ELR) laws in 2006 and the expansion of ELR in 2007 led to an artificial peak in newly reported cases of HIV infection in 2008. This was followed by a general decline in reported cases through 2012. Another surge in the expansion of ELR in 2012 was followed by another increase in newly reported cases of HIV infection in 2013. An additional 6% increase was observed in 2014 compared to the previous year. This is lower than the 12% incline observed by the state during the same time period.
***Source: Population estimates are provided by Florida CHARTS as of 12/19/2014. Rates are expressed as per 100,000 population.**

HANDOUT C-2

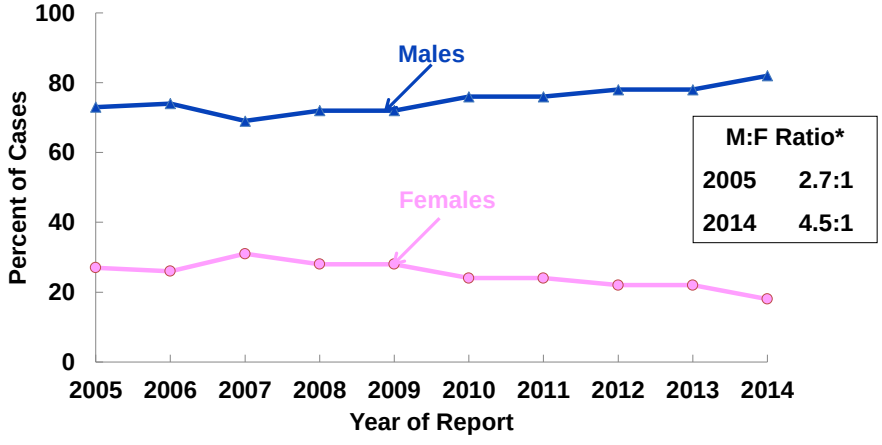
AIDS Cases and Rates*
By Year of Report, 2005-2014, Partnership 10



Year	Rate
05	45.0
06	42.6
07	35.2
08	47.4
09	42.1
10	32.8
11	33.1
12	20.0
13	27.9
14	22.5

Enhanced laboratory reporting (ELR) laws in 2006 and the expansion of ELR in 2007 led to an artificial peak in newly reported cases of AIDS in 2008. This was followed by a general decline in reported cases through 2012. Another surge in the expansion of ELR in 2012 was followed by another increase in newly reported cases of AIDS in 2013. AIDS cases in 2014 dropped by 16% from the previous year. This is higher than the 15% decline observed by the state during the same time period.
*Source: Population estimates are provided by Florida CHARTS as of 12/19/2014. Rates are expressed as per 100,000 population.

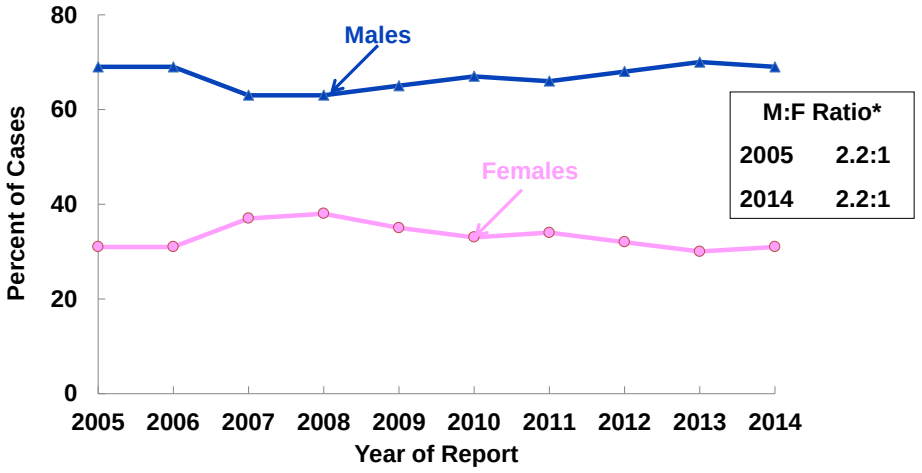
Adult HIV Infection Cases, by Sex and Year of Report, 2005-2014, Partnership 10



Note: Recent trends in HIV transmission are best described by the HIV case data. The relative increases in male HIV Infection Cases might be attributed to proportional increases in HIV transmission among men who have sex with men (MSM), which may influence future AIDS trends. *The male-to-female ratio is the number of cases among males divided by the number of cases among females.

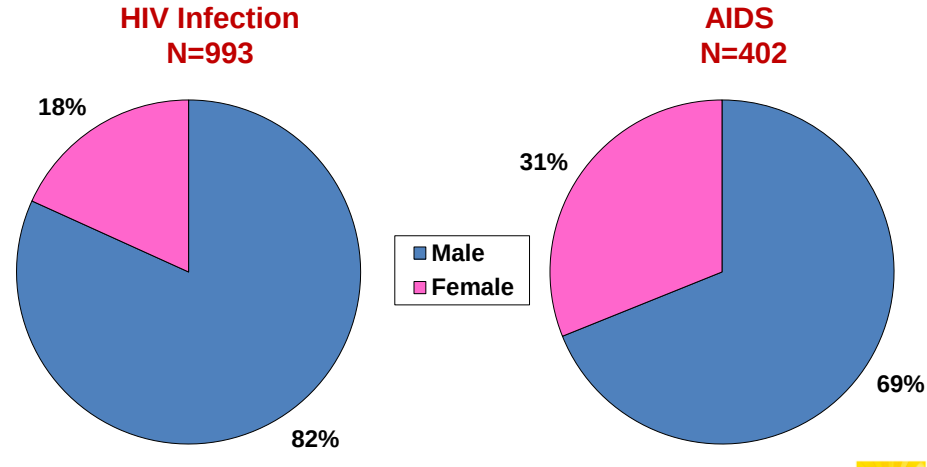
HANDOUT C-2

Adult AIDS Cases, by Sex and Year of Report, 2005-2014, Partnership 10



Note: AIDS cases tend to represent HIV transmission that occurred many years ago. The relative increases in males cases reflect the changing face of the AIDS epidemic over time. *The male-to-female ratio is the number of cases among males divided by the number of cases among females.

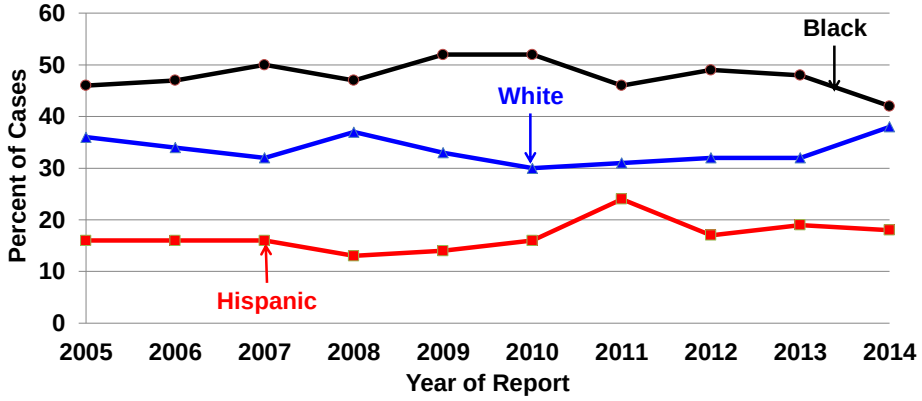
Adult HIV Infection and AIDS Cases by Sex, Reported in 2014, Partnership 10



Note: Partnership 10's Adult Population is: 48% Male and 52% Female.

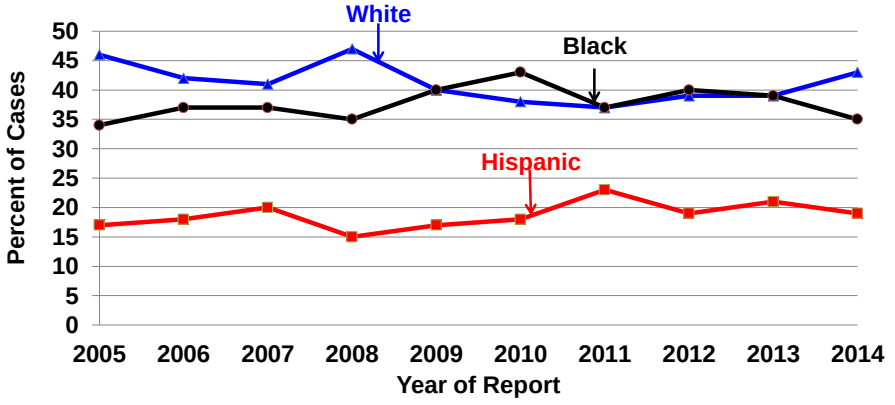
HANDOUT C-2

Adult HIV Infection Cases by Race/Ethnicity and Year of Report, 2005-2014, Partnership 10



Note: HIV case reporting reflects more recent trends in the epidemic with respect to the distribution of cases by race/ethnicity. For the past ten years, blacks represented 42% or more of the cases each year. From 2005 to 2014, the proportion of HIV infection cases among whites and Hispanics increased by 2 percentage points respectively. In contrast, the proportion of HIV infection cases among blacks decreased by 4 percentage points. Other races represent less than 3% of the cases and are not included.

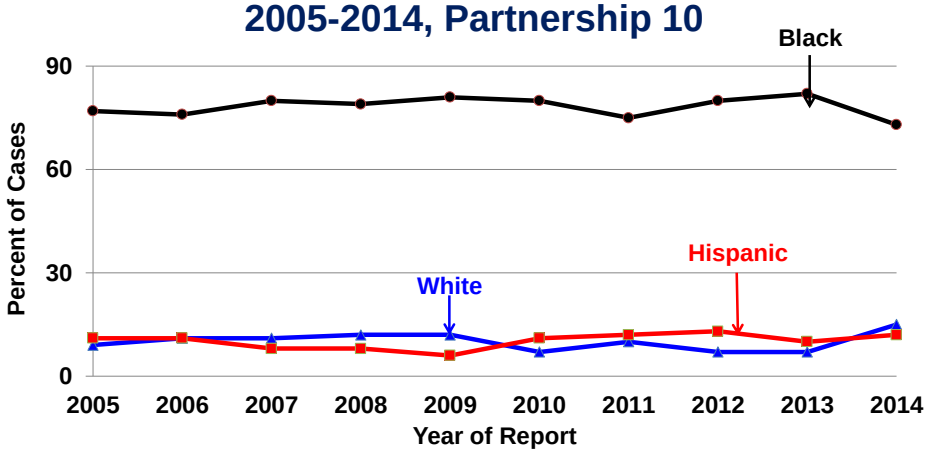
Adult Male HIV Infection Cases by Race/Ethnicity and Year of Report, 2005-2014, Partnership 10



Note: The proportion of adult male HIV infection cases among blacks and whites has shifted up and down over the years, at times, crossing paths. From 2005 to 2014, the proportion of HIV infection cases among black and Hispanic males increased by 1 and 2 percentage points, respectively. In contrast, HIV infection cases among white males decrease by 3 percentage points. Other races represent less than 3% of the cases and are not included.

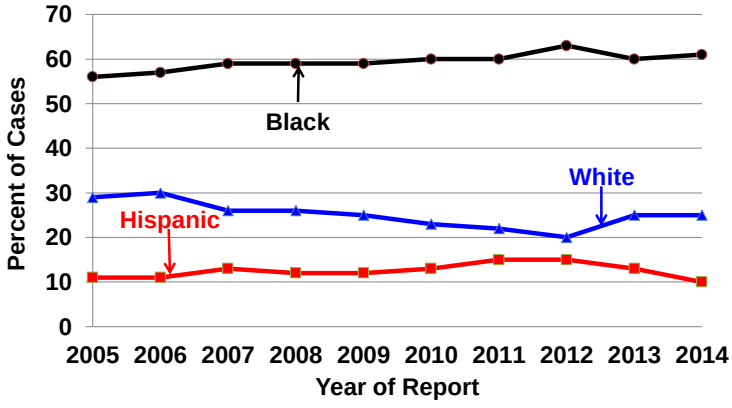
HANDOUT C-2

Adult Female HIV Infection Cases by Race/Ethnicity and Year of Report, 2005-2014, Partnership 10



Note: HIV case disparities are more evident among women than men. For the past ten years, black women represented 75% or more of the cases each year. From 2005 to 2014, the proportion of HIV infection cases among Hispanic and white females increased by 1 and 6 percentage points, respectively. In contrast, the proportion of HIV infection cases among black females decreased by 4 percentage points. Other races represent less than 5% of the cases and are not included.

Adult AIDS Cases by Race/Ethnicity and Year of Report, 2005-2014, Partnership 10



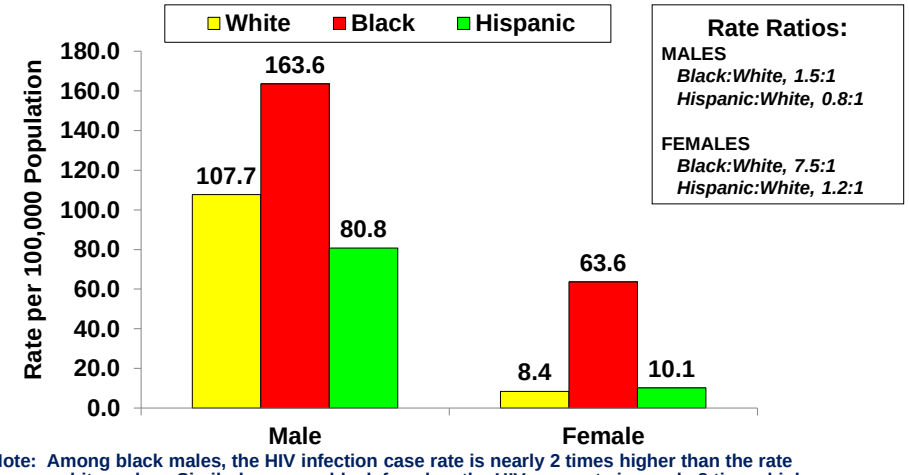
Factors Affecting Disparities

- *-Late diagnosis of HIV.*
- *-Access to/ acceptance of care.*
- *-Delayed prevention messages.*
- *-Stigma.*
- *-Non-HIV STD's in the community.*
- *-Prevalence of injection drug use.*
- *-Complex matrix of factors related to socioeconomic status*

Note: In 2014, blacks accounted for 61% of adult AIDS cases, but only 25% of the population. From 2005 to 2014, the proportion of AIDS cases among blacks increased by 5 percentage points. In contrast, the proportion of AIDS cases among Hispanics and whites decreased by 1 and 4 percentage points, respectively. Numerous disparities can affect the increases of HIV disease in a given population. Other races represent less than 4% of the cases and are not included.

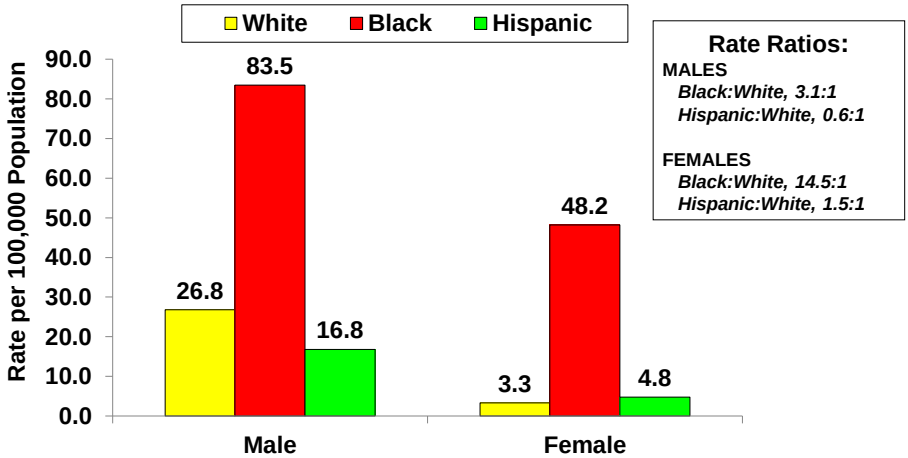
HANDOUT C-2

Adult HIV Infection Case Rates* by Sex and Race/Ethnicity, Reported in 2014, Partnership 10



Note: Among black males, the HIV infection case rate is nearly 2 times higher than the rate among white males. Similarly, among black females, the HIV case rate is nearly 8 times higher than the rate among white females. Hispanic females have a HIV case rate that is slightly higher than the rate among white females. In contrast, Hispanic males have a slightly lower HIV case rate compared to the rate among white males.
*Source: Population estimates are provided by Florida CHARTS as of 12/19/2014.

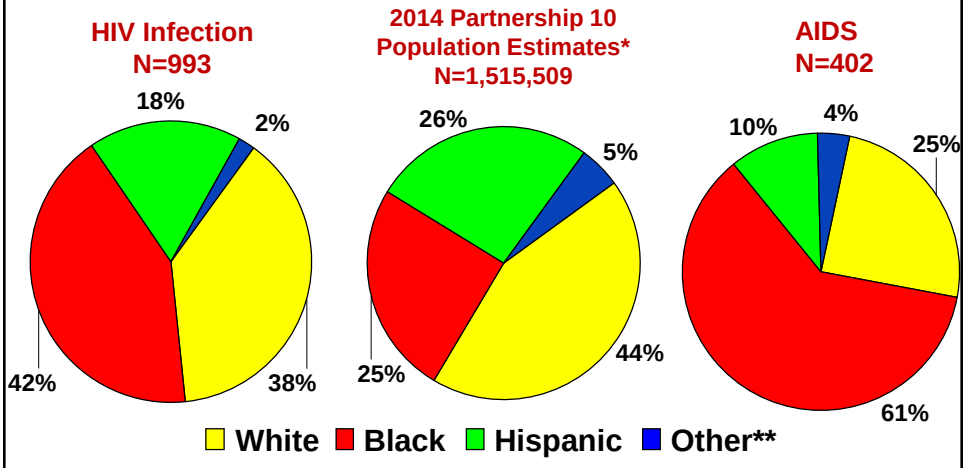
Adult AIDS Case Rates* by Sex and Race/Ethnicity, Reported in 2014, Partnership 10



Note: Among black males, the AIDS case rate is 3 times higher than the rate among white males. Among black females, the AIDS case rate is nearly 15-fold greater than the rate among white females. Hispanic males have an AIDS case rate that is lower than the rate among white males. In contrast, the AIDS case rate among Hispanic females is nearly 2 times higher than the rate among white females.
*Source: Population estimates are provided by Florida CHARTS as of 12/19/2014.

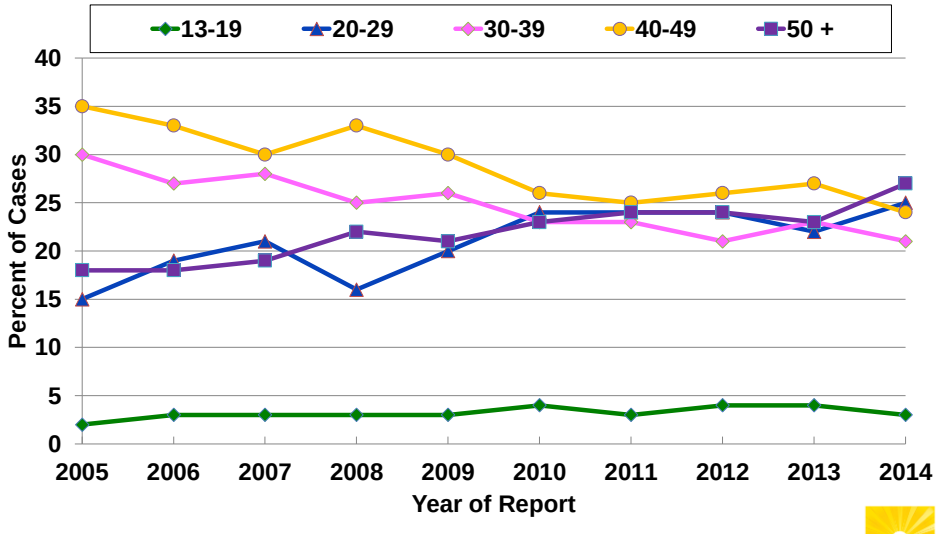
HANDOUT C-2

Adult HIV and AIDS Cases Reported in 2014 and Population Data, by Race/Ethnicity, Partnership 10



Note: In this snapshot for 2014, blacks are over-represented among the HIV and AIDS cases, accounting for 42% of adult HIV cases and 61% of adult AIDS cases, but only 25% of the adult population. A group is disproportionately impacted to the extent that the percentage of cases exceeds the percentage of the population.
*Source: Population estimates are provided by Florida CHARTS as of 12/19/2014.
**Other includes Asian/Pacific Islanders, Native Alaskans/American Indians and mixed races.

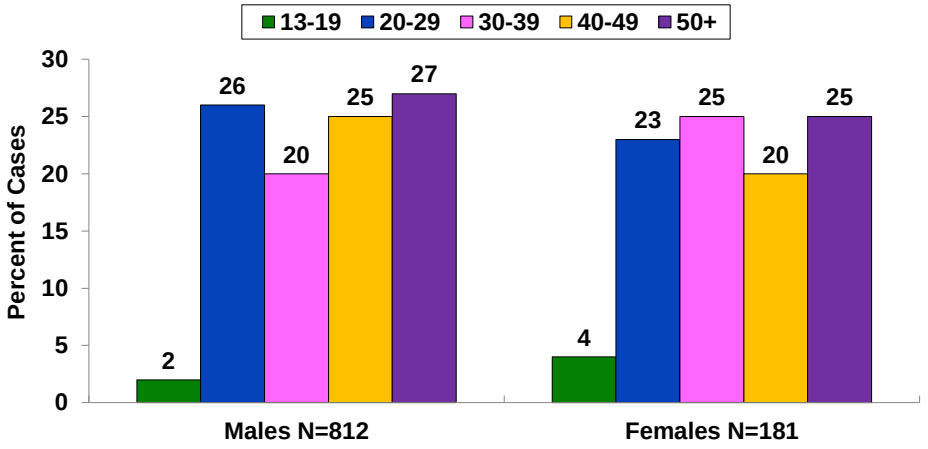
Adult HIV Infection Cases, by Age Group at Diagnosis, and Year of Report, 2005–2014, Partnership 10



Note: From 2005 to 2014, the proportion of adult HIV infection cases among those aged 20-29 and those aged 50+ increased by 10 and 9 percentage points, respectively.

HANDOUT C-2

Adult HIV Infection Cases, by Sex and Age Group at Diagnosis, Reported in 2014, Partnership 10



Note: HIV infection cases tend to reflect more recent transmission than AIDS cases, and thus present a more current picture of the epidemic. With regard to the age groups with the highest percent of HIV infection cases, recent estimates show that among males, 27% of HIV infection cases occur among those aged 50 or older, whereas among females, 25% of HIV infection cases occur among those aged 30-39 and those aged 50 or older.

Florida HEALTH

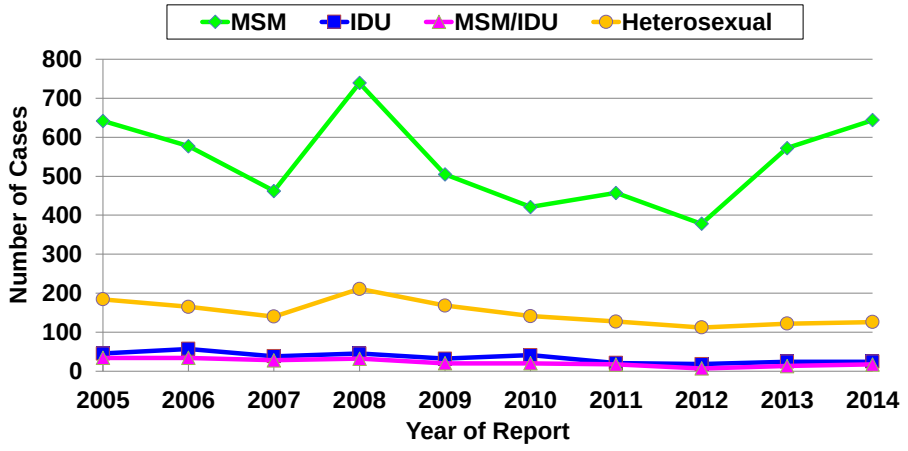
Definitions of Mode of Exposure Categories

- **MSM =** Men who have sex with men
- **IDU =** Injection Drug User
- **MSM/IDU =** Men who have sex with men & Injection Drug User
- **Heterosexual =** Heterosexual contact with person with HIV/AIDS or known HIV risk
- **OTHER =** includes hemophilia, transfusion, perinatal, other pediatric risks and other confirmed risks.
- **NIR =** Cases reported with No Identified Risk
- **Redistribution of NIRs =** This illustrates the effect of statistically assigning (redistributing) the NIRs to recognized exposure (risk) categories by applying the proportions of historically reclassified NIRs to the unresolved NIRs.

Florida HEALTH

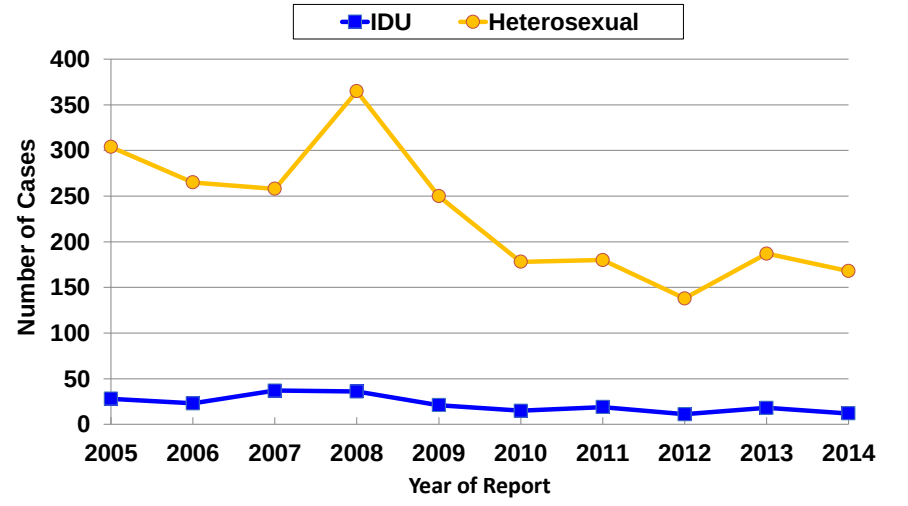
HANDOUT C-2

Adult Male HIV Infection Cases, by Mode of Exposure and Year of Report, 2005–2014, Partnership 10



Note: NIRs redistributed. Men who have sex with men (MSM) remains as the primary mode of exposure among male HIV cases in Partnership 10, followed by heterosexual contact.

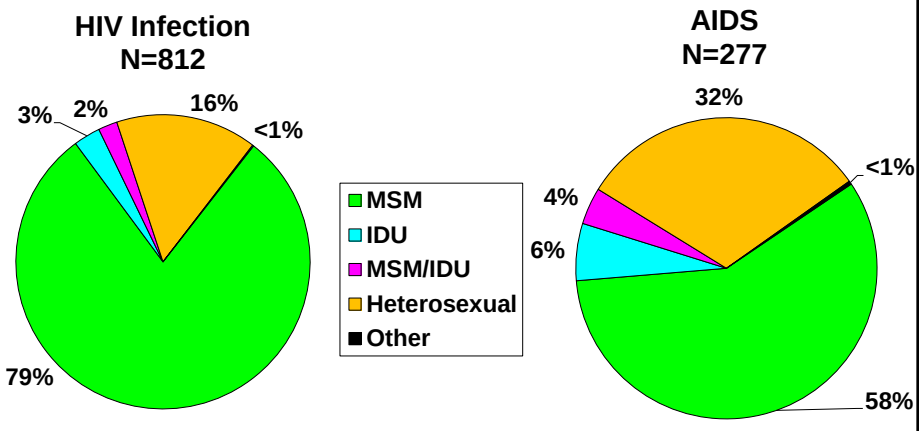
Adult Female HIV Infection Cases by Exposure Category and Year of Report, 2005-2014, Partnership 10



Note: NIRs redistributed. The heterosexual risk continues to be the dominant mode of exposure among females.

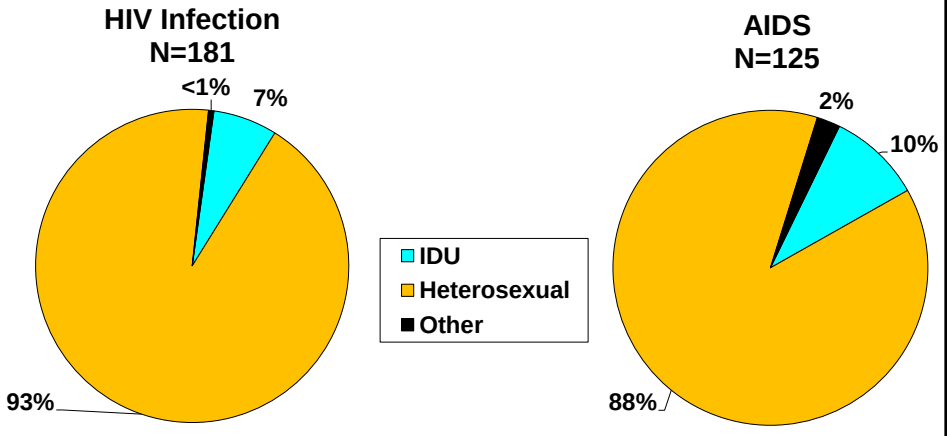
HANDOUT C-2

Adult Male HIV Infection and AIDS Cases, by Mode of Exposure, Reported in 2014, Partnership 10



Note: NIRs redistributed. Among the male HIV infection and AIDS cases reported for 2014, men who have sex with men (MSM) was the most common risk factor (79% and 58%, respectively) followed by cases with a heterosexual risk (16% for HIV and 32% for AIDS). The recent increase among MSM is indicated by the higher MSM among HIV infection cases compared to AIDS cases, as HIV infection cases tend to represent a more recent picture of the epidemic.

Adult Female HIV Infection and AIDS Cases, by Mode of Exposure, Reported in 2014, Partnership 10

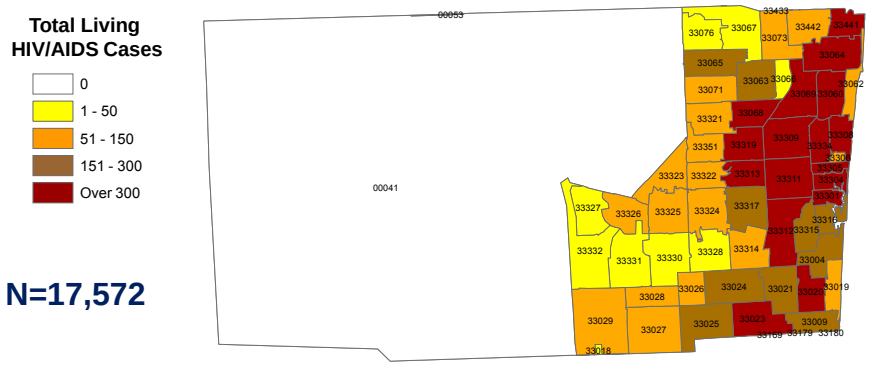


Note: NIRs redistributed. Among the female HIV infection and AIDS cases reported for 2014, heterosexual contact was the highest risk (93% and 88%, respectively).

HANDOUT C-2

Cases Living with HIV Disease

Adults Living with HIV Disease By Zip Code, Reported through 2013, Partnership 10



N=17,572

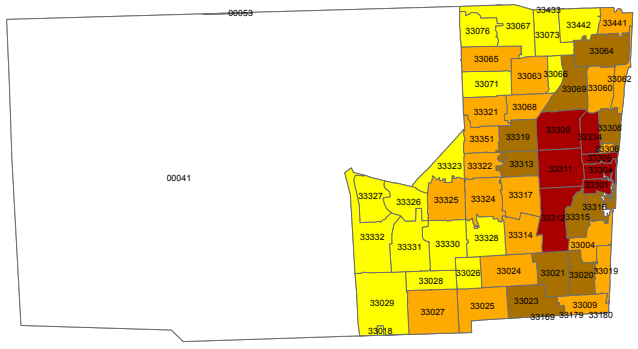
NIRs are not redistributed.
Excludes DOC, homeless, and cases with unknown zips.
Data as of 04/07/2014

HANDOUT C-2

Men who have Sex with Men (MSM)*
Living with HIV Disease
By Zip Code, Reported through 2013, Partnership 10

Presumed Living MSM HIV/AIDS Cases

- 0
- 1 - 50
- 51 - 150
- 151 - 300
- Over 300



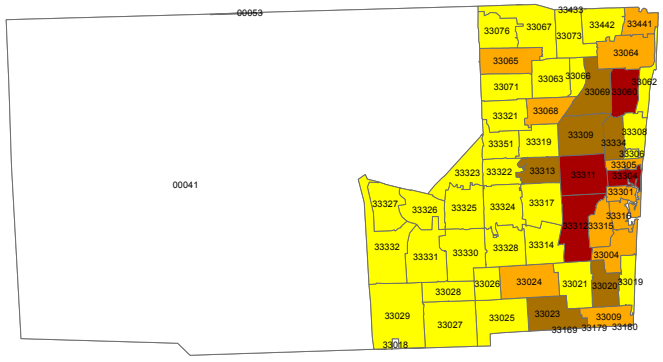
N=9,152

NIRs are not redistributed.
Excludes DOC, homeless, and cases with unknown zips.
***Includes MSM/IDU cases.**
Data as of 04/07/2014

Injection Drug Users (IDUs)*
Living with HIV Disease
By Zip Code, Reported through 2013, Partnership 10

Presumed Living IDU HIV/AIDS Cases

- 0
- 1 - 25
- 26 - 50
- 51 - 75
- Over 75



N=1,707

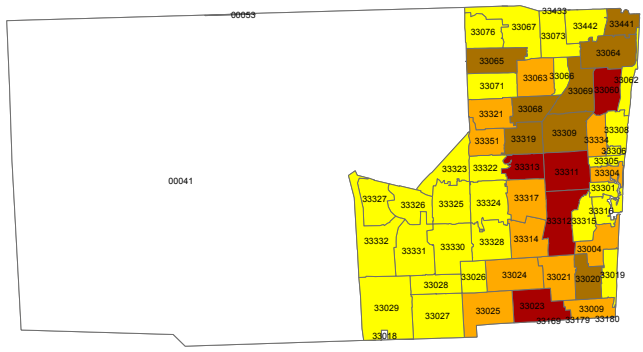
NIRs are not redistributed.
Excludes DOC, homeless, and cases with unknown zips.
***Includes MSM/IDU cases.**
Data as of 04/07/2014

HANDOUT C-2

Adult Heterosexuals Living with HIV Disease By Zip Code, Reported through 2013, Partnership 10

Presumed Living Heterosexual HIV/AIDS Cases

- 0
- 1 - 50
- 51 - 150
- 151 - 300
- Over 300



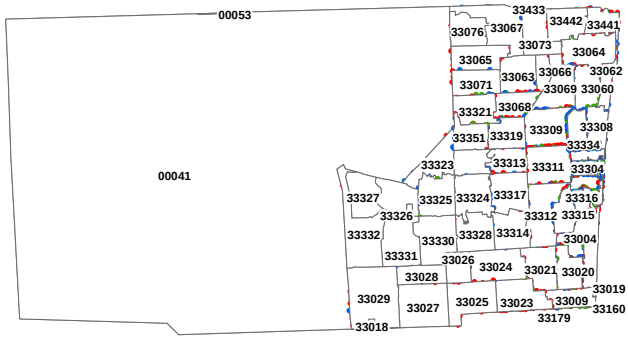
N=6,948

NIRs are not redistributed.
Excludes DOC, homeless, and cases with unknown zips.
Data as of 04/07/2014

Adults Living with HIV Disease By Zip Code and Race/Ethnicity, Reported through 2013, Partnership 10

1 Dot = 3 cases
Dots are randomly placed within zip codes.

- **Hispanic**
- **Black, not-Hispanic**
- **White, not-Hispanic**



N=17,172

Total includes all races, some which are not on map.
Excludes DOC, homeless, and cases with unknown zips.
Data as of 04/07/2014

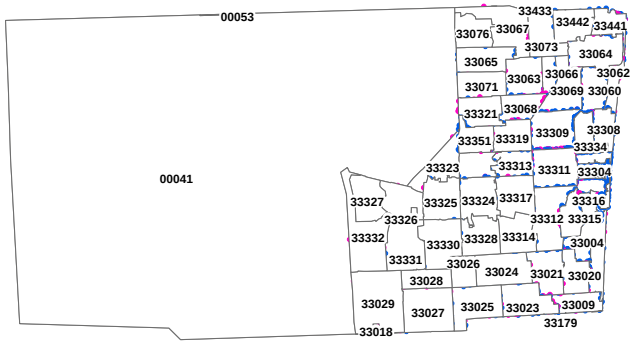
HANDOUT C-2

Adults Living with HIV Disease By Zip Code and Sex, Reported through 2013, Partnership 10

1 Dot = 3 cases
Dots are randomly placed within zip codes.

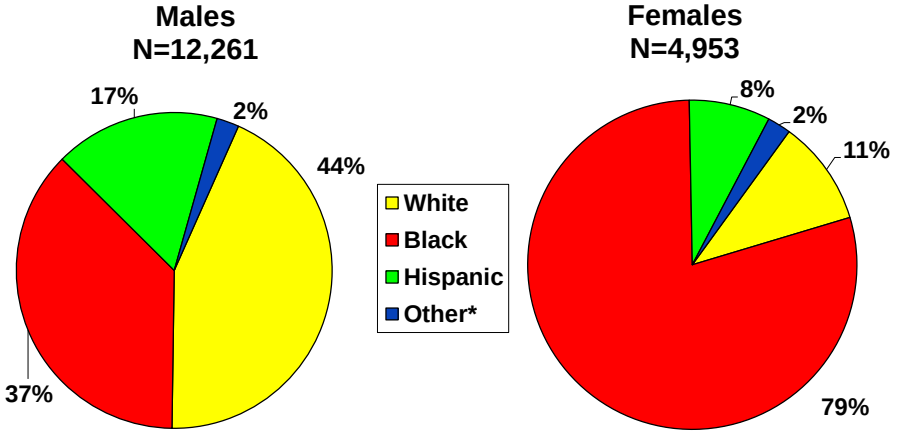
- Male
- Female

N=17,572



Excludes DOC, homeless, and cases with unknown zips.
Data as of 04/07/2014

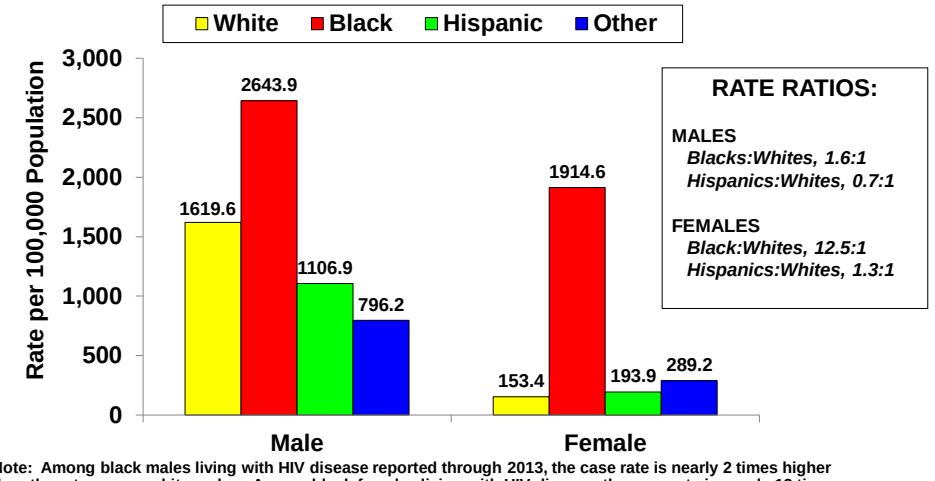
Adults Living with HIV Disease, by Sex and Race/Ethnicity Reported through 2013, Partnership 10



Note: Among adult males living HIV disease, whites represent the race most affected (44%).
Among adult females, blacks represent the race most affected (79%).
*Other includes Asian/Pacific Islanders, Native Alaskans/American Indians and Multi-racial individuals.

HANDOUT C-2

Case Rates* of Adults Living with HIV Disease, by Sex and Race/Ethnicity, Reported through 2013, Partnership 10

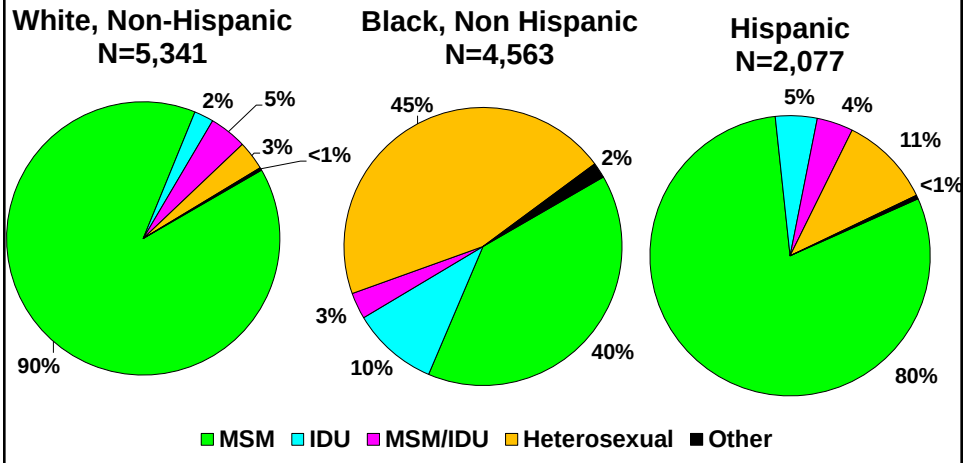


Note: Among black males living with HIV disease reported through 2013, the case rate is nearly 2 times higher than the rate among white males. Among black females living with HIV disease, the case rate is nearly 13 times higher than the rate among white females. The Hispanic male rate is less than the rate among their white counterpart, whereas the Hispanic female rate is slightly higher than the rate among their white counterpart. Data excludes Department of Corrections cases.

*Source: Population estimates are provided by Florida CHARTS.

**Other includes Asian/Pacific Islanders, Native Alaskans/American Indians and Multi-racial individuals.

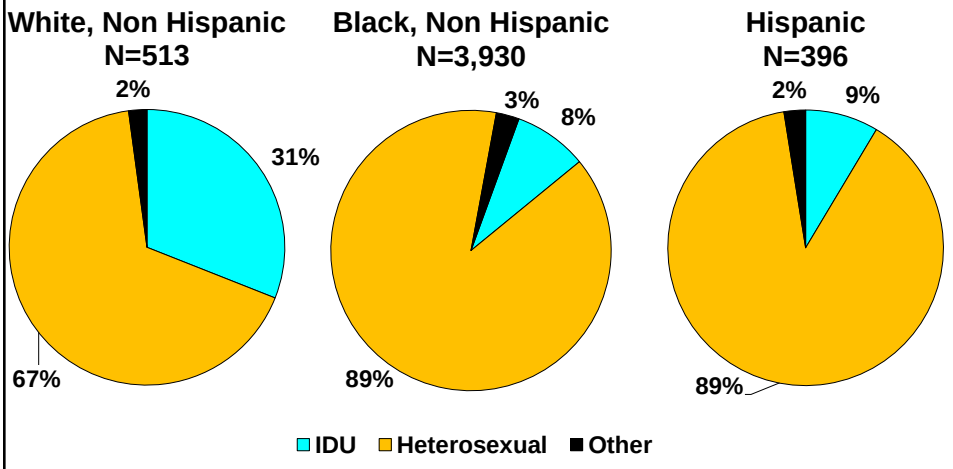
Adult Males Living with HIV Disease by Race/Ethnicity and Mode of Exposure Reported through 2013, Partnership 10



Note: NIRs redistributed. Among males living with HIV disease, the distribution of risk among blacks differs from that among whites and Hispanics. MSM represents the highest risk for all races. White males have the smallest proportion of heterosexual contact cases.

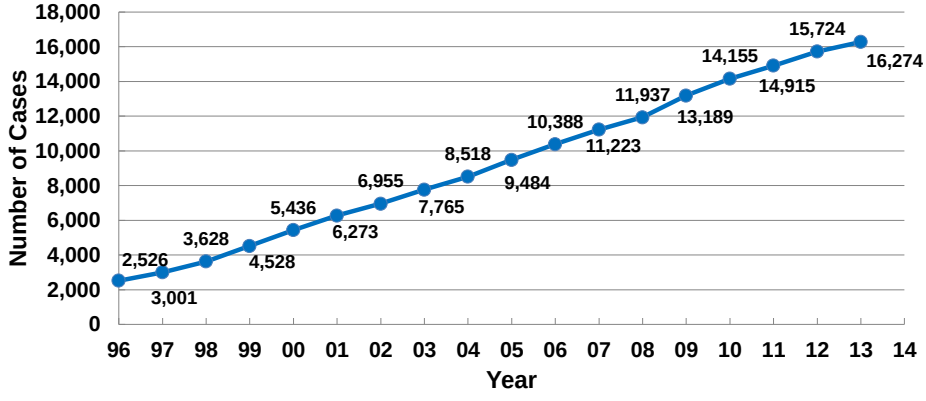
HANDOUT C-2

Adult Females Living with HIV Disease by Race/Ethnicity and Mode of Exposure Reported through 2013, Partnership 10



Note: NIRs redistributed. Among females living with HIV disease, the distribution of risk among whites differs from that among blacks and Hispanics. Heterosexual contact is the majority risk for all races. However, whites have the largest proportion of IDU cases.

Annual Prevalence of Adults Living with HIV Disease, 1995-2013, Partnership 10



As a result of declining deaths, annual HIV/AIDS diagnoses have exceeded deaths since 1995, and the number of persons reported with HIV/AIDS that are presumed to be alive has been increasing. Since 1995, the number of persons reported living with HIV/AIDS has increased over 580%. In 2013, the prevalence increased by 6% since the previous year.

HANDOUT C-2

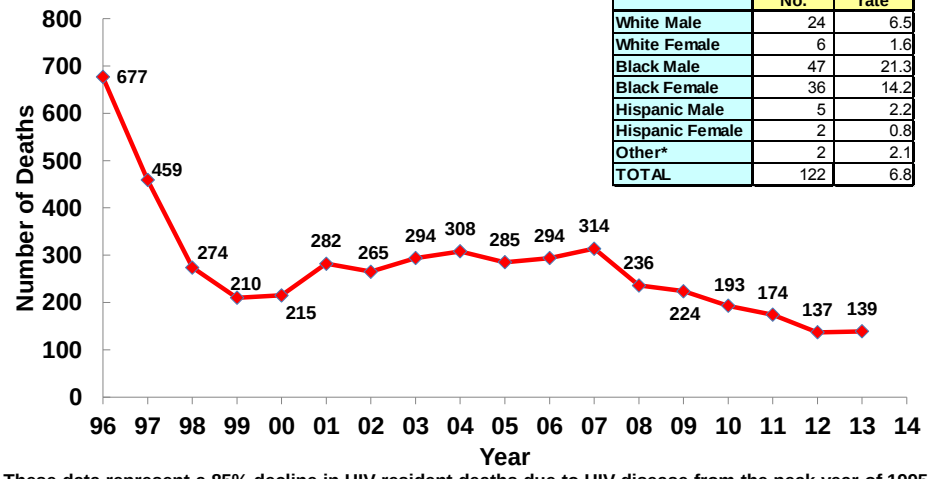
Partnership 10'sTop-9 Priority Populations in 2013 for Primary and Secondary HIV Prevention Based on Persons Living with HIV Disease

1. Black Heterosexual men and women
2. White Men who have sex with Men
3. Black Men who have sex with Men
4. Hispanic Men who have sex with Men
5. Black Injection Drug User
6. Hispanic Heterosexual men and women
7. White Heterosexual men and women
8. White Injection Drug User
9. Hispanic Injection Drug User

This final ranking is a result of ranking 9 race/risk groups among those newly reported in eHARS with HIV disease in Partnership 1 from the 3 most recent years, plus ranking these same 9 race/risk groups from all persons who were reported and living with HIV disease in eHARS in Partnership 1 through the most recent calendar year. The two ranks were then weighted and combined resulting in the final rank.

Resident Deaths due to HIV Disease, by Year of Death, 1995-2013, Partnership 10

Race/Ethnicity	2013	
	No.	rate
White Male	24	6.5
White Female	6	1.6
Black Male	47	21.3
Black Female	36	14.2
Hispanic Male	5	2.2
Hispanic Female	2	0.8
Other*	2	2.1
TOTAL	122	6.8

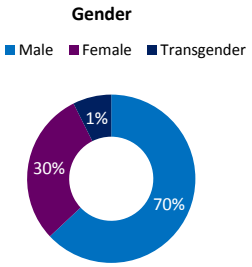


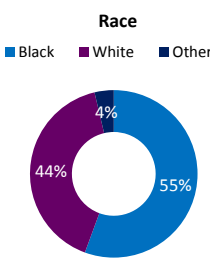
These data represent a 85% decline in HIV resident deaths due to HIV disease from the peak year of 1995 to 2013. This is much higher than the 78% decline observed by the state.

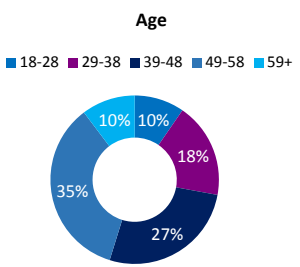
Source: Florida Department of Health, Bureau of Vital Statistics, Death Certificates (as of 05/16/2014).
Population data are provided by Florida CHARTS.
Other includes Asian/Pacific Islanders, Native Alaskans/American Indians and mixed races.

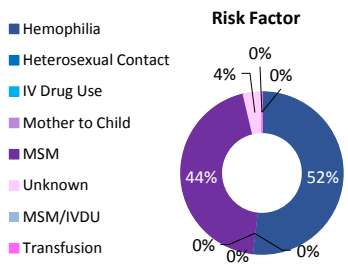
FY 2014-15 Scorecard: Legal Services — ELIGIBILITY: Proof of Income, </= 300% FPL

FY 2014-15 Demographics of Clients NOT Virally Suppressed









Male	Female	Transgender
63.0%	29.6%	7.4%

Black	White	Other
55.6%	40.7%	3.7%

Age				
18-28	29-38	39-48	49-58	59+
18.5%	7.4%	14.8%	48.1%	11.1%

Education Level	
≤8th Grade	3.7%
8th-12th Grade	74.1%
College	22.2%
Unknown	0.0%

Hispanic	non-Hispanic	Haitian
14.8%	85.2%	3.7%

Housing Status			
Permanent	Non-Permanent	Institution	Don't Know/Other
77.8%	22.2%	0.0%	0.0%

Risk Factor							
MSM	IDU	MSM/IDU	Hemophilia	Heterosexual	Mother	Transfusion	Unknown
51.9%	0.0%	0.0%	0.0%	44.4%	3.7%	0.0%	0.0%

Legal Cases^						
	FY 2013		FY 2014		% Δ FY 2013-14	^Cases are only counted if opened or closed during the reporting period
	#	%	#	%		
Medicaid	14	8.7%	18	6.6%	28.6%	
Medicare	3	1.9%	0	0.0%	-100.0%	
Food Stamps	11	6.9%	17	6.2%	54.5%	
SSDI	5	3.1%	14	5.1%	180.0%	
SSI	70	43.8%	105	38.3%	50.0%	
Unemployment	8	5.0%	17	6.2%	112.5%	
Wills & Estates	30	18.7%	64	23.4%	113.0%	
Other	19	11.9%	39	14.2%	105.3%	
Total	**160**	**100.0%**	**274**	**100.0%**		

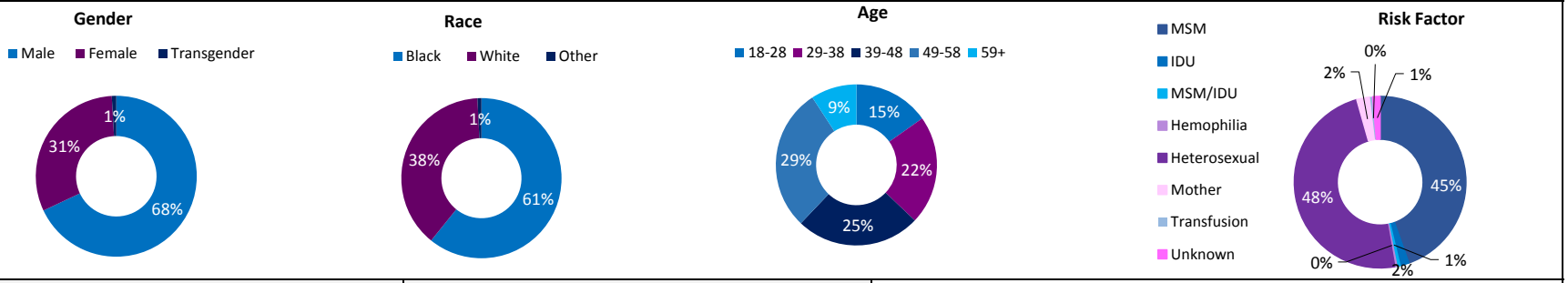
FY 2014-2015 Legal Service Category

- 210 clients served, about a 15% increase from the previous FY
    - About 51% of clients were new
- Expenditures have increased about 18% since 2010, but have stayed level over past several years
- Majority of clients seeking help for Supplemental Security Income (SSI) disputes and wills and estate planning
- About 14.7% of legal services clients not virally suppressed. There were differences among subpopulations, but the population being looked at is quite small (27 clients). Subpopulations more likely not to be virally suppressed include:
    - Women (20.5%), especially black non-Hispanic Women (25.9%)
    - White, non-Hispanic men (25.9%), closely followed by black non-Hispanic men (22.2%)
    - 18-28 year olds made up only 5% of legal clients, they were far more likely not to be virally suppressed than all of the other age categories (50% not virally suppressed)
    - Clients who were non-permanently housed (20.7%)
    - Clients with an education level between 8th and 12th grade (19.4%)
    - Clients who identified heterosexual sexual contact as a risk factor (20.3% versus 13.1% for men who have sex with men (MSM))
    - The difference between genders for clients who identified heterosexual sexual contact as risk factor was minimal, although women (21.2%) were slightly more likely not to be virally suppressed (men 19.2%)
        - Blacks were more likely than whites not to be virally suppressed (21.2% versus 14.3%), but Hispanics were most likely not to be virally suppressed (25.0%)
    - Black MSM were more likely not to be virally suppressed (16.7%), followed closely by Hispanic MSM (15.8%)

FY 2014-15 Scorecard: Part A and MAI Centralized Intake and Eligibility Determination (CIED)

ELIGIBILITY: HIV+, Broward Resident

FY 2014-15 Demographics of Clients NOT Virally Suppressed



Male	Female	Transgender
68.0%	31.1%	0.9%

Black	White	Other
60.8%	38.4%	0.8%

Age				
18-28	29-38	39-48	49-58	59+
12.6%	19.7%	24.0%	32.1%	11.6%

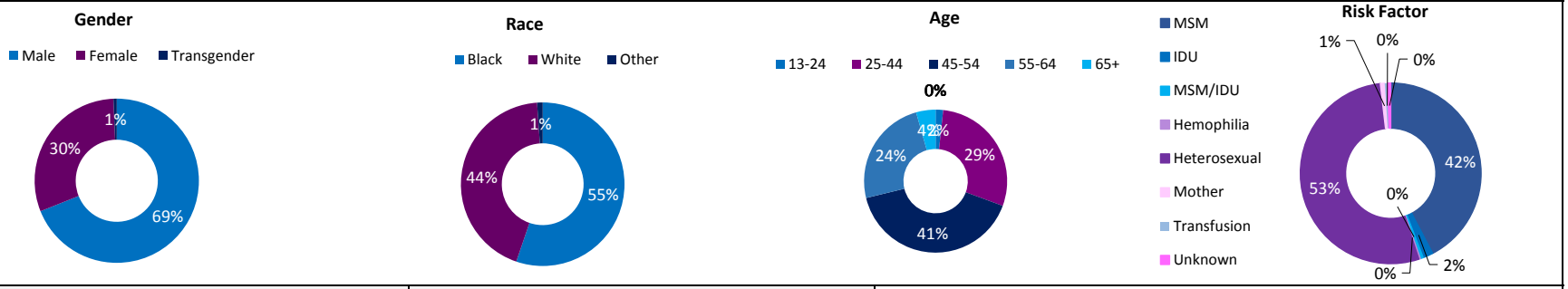
Education Level	
≤8th Grade	6.5%
8th-12th Grade	63.3%
College	30.1%
Unknown	0.1%

Hispanic	non-Hispanic	Haitian
13.6%	86.4%	9.2%

Housing Status			
Permanent	Non-Permanent	Institution	Don't Know/Other
71.0%	28.2%	0.7%	0.1%

Risk Factor							
MSM	IDU	MSM/IDU	Hemophilia	Heterosexual	Mother	Transfusion	Unknown
44.6%	1.7%	0.6%	0.4%	48.4%	2.5%	0.5%	1.4%

FY 2014-15 Demographics of Clients NOT In Care



Male	Female	Transgender
69.0%	30.4%	0.7%

Black	White	Other
55.2%	43.7%	1.1%

Age				
13-24	25-44	45-54	55-64	65+
1.7%	28.9%	40.6%	24.4%	4.4%

Education Level	
≤8th Grade	7.7%
8th-12th Grade	1.2%
College	63.5%
Unknown	0.0%

Hispanic	non-Hispanic	Haitian
15.4%	84.6%	13.1%

Housing Status			
Permanent	Non-Permanent	Institution	Don't Know/Other
74.9%	24.5%	0.1%	0.5%

Risk Factor							
MSM	IDU	MSM/IDU	Hemophilia	Heterosexual	Mother	Transfusion	Unknown
42.3%	1.8%	0.5%	0.3%	53.2%	0.8%	0.5%	0.5%

CIED Referrals									
	FY 2013			FY 2014					
	Part A	Other	Total	Part A	Other	Total		Enrolled	Applied	Approved
Medical	279		279	133		133	Medicaid	2,006	4	
Pharmaceutical	251		251	137		137	Medicare	1,451		
Oral Health	880		880	612	56	668	Private Ins.	940		
MCM	750		750	421	4	425	Food Stamps	3,376	126	13
Mental Health	109		109	28	1	29	Cash Assist.	3	5	3
Substance Abuse	15		15	7		7	**Total**	**4,012**		
Food Bank	553	10	563	699	2	701				
Legal Assistance	774	2	776	931		931				
Outreach	25		25		2	2				
AICP	74		74		41	41				
Med. Copay		28	28		4	4				
Transportation		14	14		3	3				
Housing		152	152		109	109				
Health Insurance				316		316				
Other Services		25	25		56	56				
Total	**3710**	**231**	**3941**	**3,284**	**278**	**3,562**				

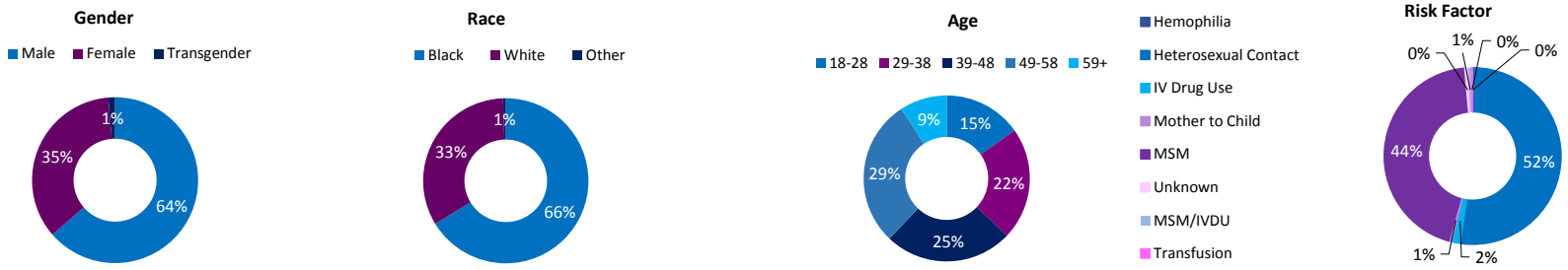
FY 2014-2015 CIED Service Category

- 7,665 clients served, about a 10% increase from the previous FY
    - About 18% of clients were new
- Approximately 189% increased expenditures since 2010 (first year of funding), due in part to HRSA changes to eligibility
- Increased referrals for food services and health insurance
- Decreased referrals for medical and pharmacy
- Approximately 22.7% of CIED clients were not virally suppressed. The subpopulations that were more likely not to be achieving health outcomes include:
    - Women (25.1% not virally suppressed), especially black non-Hispanic Women (26.4%)
    - Black non-Hispanic men (25.1% not virally suppressed)
    - Although 18-28 year olds made up the smallest portion of CIED clients (only 7%), they were far more likely not to be virally suppressed than all of the other age categories (38.7%)
    - Clients who were non-permanently housed were less likely to be virally suppressed (27.7%)
    - Clients with less than an 8th grade education, although clients who had an education between 8th and 12th grade were not far behind in likelihood of not being virally suppressed (24.1% versus 23.9%, respectively)
    - Clients who identified heterosexual sexual contact as a risk factor were slightly more likely not to be virally suppressed (22.9% for heterosexual, versus 21.3% for men who have sex with men (MSM))
    - The difference between genders for clients who identified heterosexual sexual contact as risk factor was minimal, although women were slightly more likely not to be virally suppressed (23.9%, versus 21.7% for men)
        - Blacks (24.1%) were more likely than whites (17.6%) and Hispanics (17.9%) not to be virally suppressed
    - Black MSM (28.5%) were far more likely not to be virally suppressed than both Hispanic (17.9%) and white MSM (18.9%)

FY 2014-15 Scorecard: Pharmacy

ELIGIBILITY: </=400% FPL

FY 2014-15 Demographics of Clients NOT Virally Suppressed



Male	Female	Transgender
63.6%	35.1%	1.3%

Black	White	Other
66.3%	33.2%	0.6%

Age				
18-28	29-38	39-48	49-58	59+
15.2%	21.9%	25.0%	28.7%	9.2%

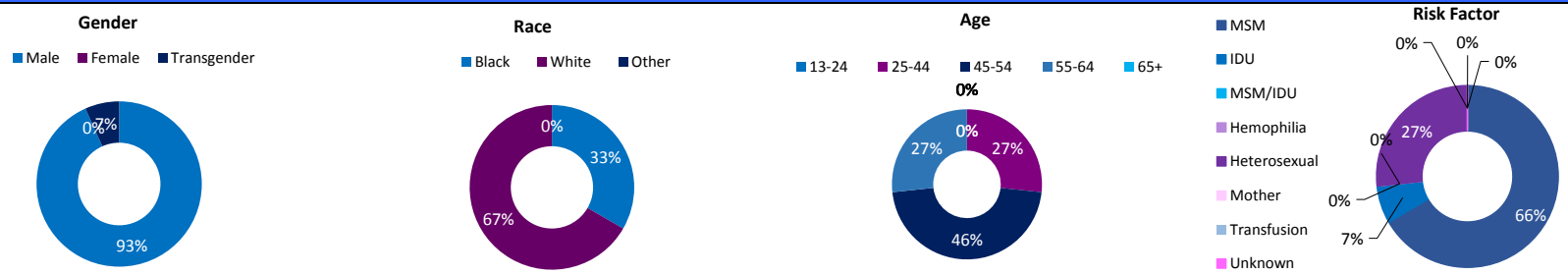
Education Level	
≤8th Grade	8.4%
8th-12th Grade	62.1%
College	29.5%
Unknown	0.0%

Hispanic	non-Hispanic	Haitian
13.6%	86.4%	13.4%

Housing Status			
Permanent	Non-Permanent	Institution	Don't Know/Other
67.1%	32.1%	0.7%	0.0%

Risk Factor							
MSM	IDU	MSM/IDU	Hemophilia	Heterosexual	Mother	Transfusion	Unknown
41.3%	1.3%	1.3%	0.4%	52.9%	1.3%	0.5%	1.3%

FY 2014-15 Demographics of Clients NOT In Care



Male	Female	Transgender
93.3%	0.0%	6.7%

Black	White	Other
33.3%	66.6%	0.0%

Age				
13-24	25-44	45-54	55-64	65+
0.0%	26.7%	46.7%	26.7%	0.0%

Education Level	
≤8th Grade	6.7%
8th-12th Grade	80.0%
College	13.3%
Unknown	0.0%

Hispanic	non-Hispanic	Haitian
33.3%	66.6%	0.0%

Housing Status			
Permanent	Non-Permanent	Institution	Don't Know/Other
80.0%	20.0%	0.0%	0.0%

Risk Factor							
MSM	IDU	MSM/IDU	Hemophilia	Heterosexual	Mother	Transfusion	Unknown
66.6%	6.7%	0.0%	0.0%	26.7%	0.0%	0.0%	0.0%

FY 2014-15 Top 10 Prescriptions					
Top 10 Formulary Dispenses			Top 10 Formulary Expenditures		
Name of Rx & Condition Treated	% of Dispenses	% of Clients	Name of Rx & Condition Treated	% of Expenditures	% of Clients
1. Lisiniopril	7.7%	19.4%	1. Lisinopril	6.4%	19.4%
Treats high blood pressure & heart failure			Treats high blood pressure & heart failure		
2. Therapeutic Multivitamins	7.2%	20.5%	2. Combivent Respimat	4.1%	1.1%
Treats or prevents low levels of vitamins in the body			Treats chronic obstructive pulmonary disease		
3. Hydrochlorothiazide	4.2%	10.8%	3. Hydrochlorothiazide	3.5%	10.8%
Treats fluid retention & high blood pressure			Treats fluid retention & high blood pressure		
4. Antioxidant Formula	3.2%	8.6%	4. Lansoprazole	2.9%	9.3%
Helps protect cells from free radicals			Treats stomach ulcers, gastroesophageal reflux disease, & helps heal damaged esophagi		
5. Lansoprazole	3.1%	9.3%	5. Atorvastatin Calcium	2.5%	10.7%
Treats stomach ulcers, gastroesophageal reflux disease, & helps heal damaged esophagi			Lowers cholesterol		
6. Atorvastatin Calcium	2.9%	10.7%	6. Nystatin-Triamcinolone	2.3%	3.1%
Lowers cholesterol			Treats fungal skin infections		
7. Amlodipine Besylate	2.8%	8.4%	7. Amlodipine Besylate	2.3%	8.4%
Treats hypertension			Treats hypertension		
8. Proventil HFA	2.6%	9.5%	8. Celebrex	2.1%	2.3%
Treats or prevents asthma, especially exercise-induced asthma			Treats pain, including pain caused by arthritis		
9. Trazodone Hydrochloride	2.5%	9.0%	9. Proventil HFA	2.1%	9.5%
Treats major depressive disorder in adults			Treats or prevents asthma, especially exercise-induced asthma		
10. Citalopram Hydrobromide	2.4%	7.8%	10. Blood Glucose Trutrack	2.1%	4.8%
Treats depression			Blood glucose monitoring system		

FY 2014-2015 Pharmacy Service Category – Key Points

- 3,145 clients served, slight increase from the previous FY
    - 21.8% of clients were new
- Expenditures decreased approximately 18% since 2010, may be due in part to ADAP no longer having a waiting list
- Utilization indicates clients seeking care for long-term, chronic conditions, such as diabetes and heart disease
- About 18% of Pharmacy clients not virally suppressed, and about 9% of Pharmacy clients were not retained in care. It is important to keep in mind that these numbers are relatively small. Subpopulations not achieving health outcomes include:
    - Black non-Hispanic Women – 19.1% not virally suppressed, versus 16.5% of white non-Hispanic women and 12.8% of Hispanic women
    - Black non-Hispanic men – 21.0% not virally suppressed, versus 17.0% white non-Hispanic men and 11.6% Hispanic men
    - Although 18-28 year olds made up the smallest portion of pharmacy clients (only 6%), they were far more likely not to be virally suppressed than all of the other age categories (26.9%). Younger clients were more likely to be retained in care, however
    - Pharmacy clients who were non-permanently housed were less likely to be virally suppressed (22%)
    - Clients with less than an 8th grade education were less likely to be virally suppressed (20.0%) but clients with an 8th-12th grade education were less likely to be retained in care
    - Clients who identified heterosexual sexual contact as a risk factor were slightly more likely to not achieve outcomes (18.2% not virally suppressed)
    - The difference between genders for clients who identified heterosexual sexual contact as risk factor was minimal (50.3% of women not virally suppressed versus 49.6% men)
        - Blacks were more likely than whites not to be virally suppressed (19.4% versus 13.1%), but whites were slightly less likely to be retained in care (46.7%)
    - Black MSM were far more likely not to be virally suppressed (23.2%) than both Hispanic and white MSM (14.9% and 14.4%, respectively)

Recommendations for Formulary Additions and Deletions
The Committee began reviewing the Medical QI Network's recommendations for additions to the Formulary. The recommendations were: ***Add -*** *Januvia (Sitagliptin)*
Januvia (Sitagliptin) by Merck Recommendation: Members reviewed the Medical QI Network recommendation to add Januvia to the formulary. The Medical Network's justification to add Januvia is to provide another option for the treatment of diabetes. Januvia must be used in conjunction with other diabetes medications (Metformin and Glipizide), and the number of estimated clients who will use the medication is low. Januvia has a Patient Assistance Program (PAP) and there is currently no diabetes medication on Tier 3. Estimated Cost: Januvia is $73.49 for a 100 mg 30 day supply (the usual dosage). The Medical QI Network estimates that less than 1% of clients will use Januvia (based on FY 2014 clients who used Metformin and Glipizide, approximately 3 clients). $73.49 per prescription * 12 prescriptions per year * 3 clients = $2,645.64 estimated cost.

LPAC Motions			
Motion #1	To add Januvia to Tier 3 of the Ryan White Part A Formulary.		
Proposed by:	Leverence, S.	**Seconded by:**	Ehren, M.
Justification:	Accept Medical Network recommendation		
Action:	Passed Unanimously		