



Broward County HIV Health Services Planning Council

Broward Regional Health Planning Council, Inc.
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Quality Management Committee Meeting Agenda

June 18, 2012 at 12:30 P.M

Michael Rajner, Chair
Claudette Grant, Vice Chair

1. **Call to Order**
2. **Welcome and Introductions**
3. **Moment of Silence**
4. **Ground Rules and Approvals**
 - A. Review Meeting Ground Rules and Statement of Sunshine
 - B. Review Public Comment Requirements (Please Sign-in)
 - C. Excused Absences
 - D. Approval of Today's Agenda
 - E. Approval of 05/21/12 Meeting Minutes
5. **Follow-up on Partners In+Care Campaign**
6. **HIV and the Aging Population**
7. **Review Client Level Outcomes/Indicators (WP 3A) (Handout A)**
 - A. Pharmacy
 - B. CIED
 - C. Food Bank
8. **2012-2015 Comprehensive Plan (Handout B)**
9. **Work Plan Update (Handout C)**
10. **Unfinished Business**
11. **New Business**
12. **Grantee Reports**
 - A. Part A Grantee Report
13. **Resources and Announcements**
 - A. Ryan White HIV/AIDS Program 2013 Reauthorization: Comments Requested
14. **Public Comment**
15. **Reminder:** Meeting Attendance Confirmation Required at least 48 Hours Prior to Meeting Date
16. **Request for Information/Directives**
17. **Agenda Items for Next Meeting**
18. **Next Meeting Date: Monday, July 16 2012 at 12:30 p.m.**
19. **Adjournment**

IMPORTANT NOTICE:

Please be aware this meeting and all information stated thereof is a matter of public record under FL's Government in the Sunshine Law (Florida Chapter 119.01). Acknowledgement of HIV status is not required, and if disclosed becomes a part of the public record

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Ryan White HIV/AIDS Program 2013 Reauthorization: Comments Requested

HRSA/HAB is requesting comments regarding reauthorization of the Ryan White legislation, which will take place in 2013. The Ryan White HIV/AIDS Program is the largest Federal program specifically dedicated to providing HIV care and treatment. It funds heavily impacted metropolitan areas, States, and local community-based organizations to provide medical care, medications, and support services to more than half a million people each year. Currently authorized by the Ryan White HIV/AIDS Treatment Extension Act of 2009, the program will be up for reauthorization by the U.S. Congress in 2013.

To inform that reauthorization, HRSA encourages stakeholders, including grantees, advocacy organizations, State and local administrators, and other members of the Ryan White and HIV/AIDS communities to provide comments on all aspects of the program. Comments should be organized under headings that clearly indicate which Part (Part A, B, C, D or F) the comment addresses. HRSA has established a web page with details on how to submit comments.

Comments are due July 31, 2012

HRSA will hold at least four webinar or teleconference listening sessions over the next few months, each focused on a different geographic region. Dates, times and other details will be available in near future.

In addition to the resources listed above, don't forget to check out these other HAB resources, which are updated regularly.

[HAB Web site](#)

**[TARGET Center](#), Central Source for Ryan White TA
(Not a US Government Web site)**

**[Twitter](#), Sign up using "ryanwhitecare"
(Not a US Government Website)**

The HAB Information E-mail is distributed biweekly by the HRSA/HAB Division of Training and Technical Assistance (DTTA). To subscribe or unsubscribe contact [Paula Jones](#).

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R O A H

Research on Older Adults with HIV

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ROAH ADVISORY COMMITTEE CHAIRPERSON

Marjorie Cantor, *Professor Emerita*
Fordham University Graduate School of Social Service and
Brookdale Distinguished Scholar

ROAH is a comprehensive research study of 1000 people
over the age of 50 living with HIV in New York City.

Conducted and funded by the
AIDS Community Research Initiative of America
230 West 38th Street, New York, NY 10018

Daniel Tietz, Executive Director



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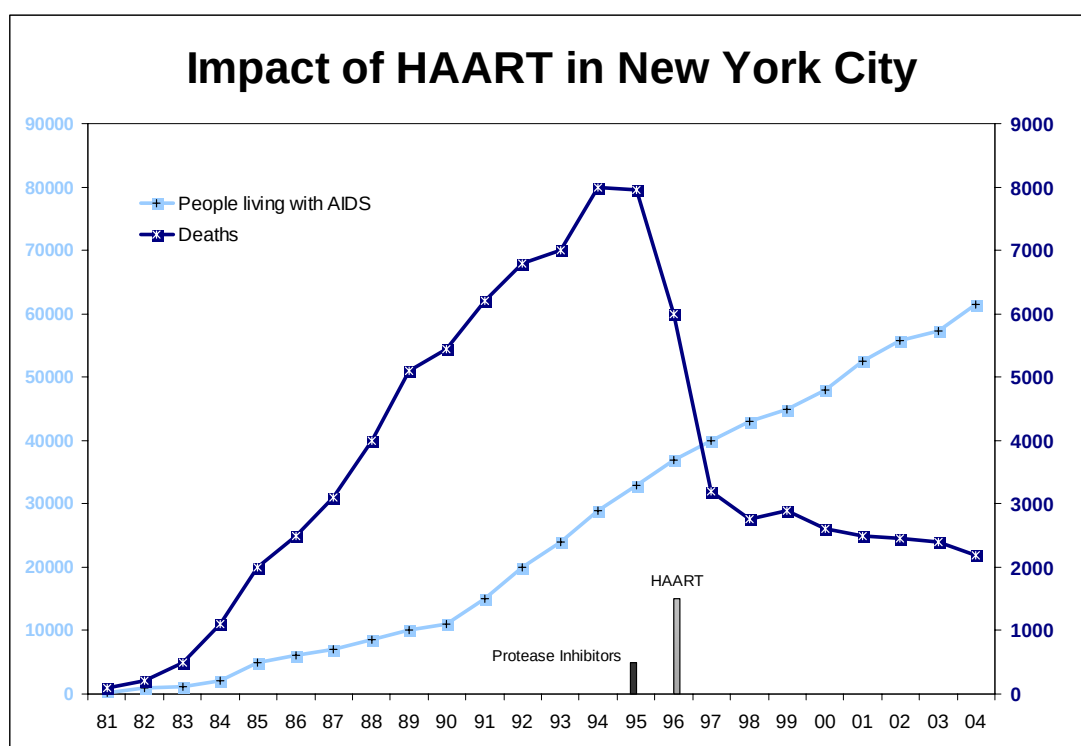
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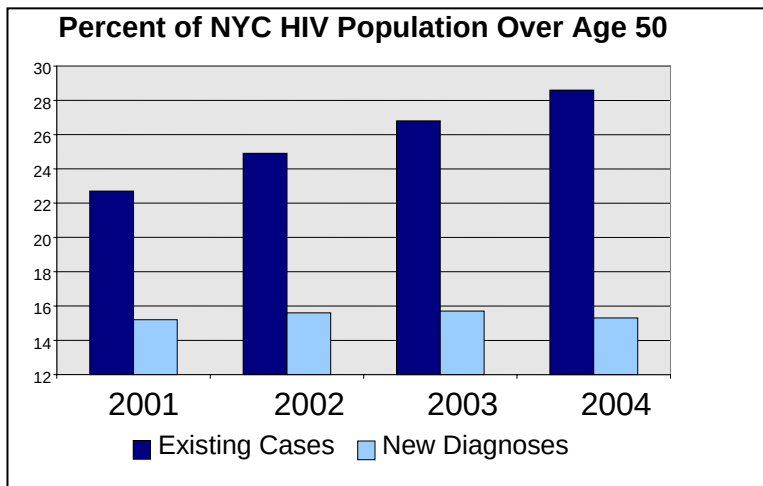
The Aging HIV Population: Growing and Invisible

One decade after the introduction of highly active antiretroviral therapy (HAART) we have witnessed a dramatic decrease in mortality rates and increased life expectancy among people living with HIV/AIDS. With new HIV infection rates remaining level, the net result is an HIV-positive population that is both graying and growing. Almost 27% of all people living with AIDS in the United States are aged over 50. In New York City, the HIV/AIDS epicenter in the United States, 30% of the almost 100,000 people living with HIV are over age 50 and 70% are over age

40.¹ Within the next decade it is probable that the majority of people with HIV in New York City will be over age 50. This pattern is seen throughout the US. Yet few have internalized this fact: there will soon be large numbers of senior citizens living with HIV and AIDS.



¹ New York City Department of Health and Mental Hygiene. (2006). HIV Epidemiology Program 1st Quarterly Report, Vol4(1). Available online: <http://www.nyc.gov/html/doh/downloads/pdf/dires/dires-2006-report-qtr1.pdf>

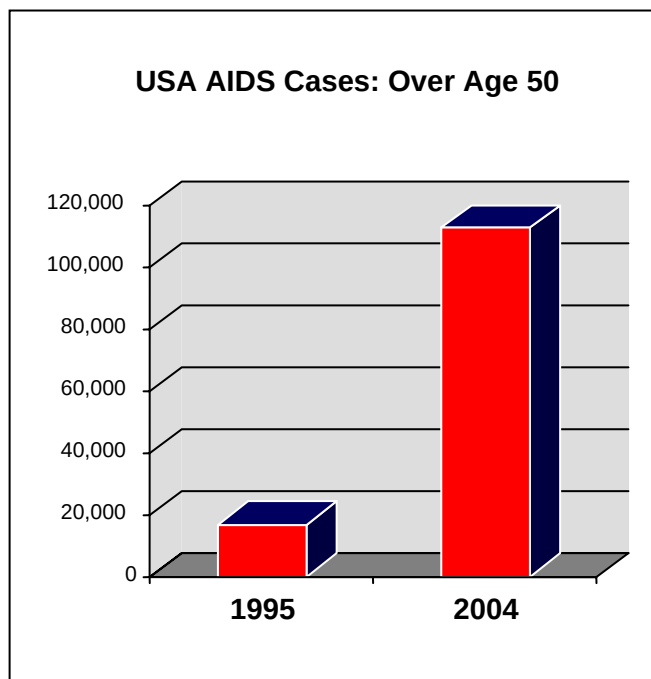


There is nothing equivocal in the New York City Department of Health (NYCDOH) HIV epidemiological data. The population of older adults with HIV is expanding. Misinformed media and public voices contend that these increases are the result of the use of erectile dysfunction drugs by older adults. Few report or know that the primary reason for the growth in the numbers of older adults with HIV is the

unparalleled success of anti-HIV drugs (HAART) that make it possible for people to live longer, healthier lives. The death sentence of AIDS has been transformed into life, albeit one with challenges.

The number of older adults infected with HIV may be even greater.² Since physicians do not perceive older adults to be at risk for HIV infection, they are less likely to test them for the virus. Consequently, underdiagnosis occurs, and HIV is detected later.³ One study of people between the ages of 60 and 79 who had died in a long-term healthcare facility found

that five percent were HIV antibody positive although none had been diagnosed with HIV.



AGING, THE IMMUNE SYSTEM, DELAYED TREATMENT

It is known that the immune system's function declines with aging. Since HIV degrades the immune system, many predicted that HIV disease would progress more rapidly in older adults. When an older person is infected with HIV, CD4 T-cell loss is more pronounced when compared with younger individuals. Studies have found that

² N C Casau. (2005). Perspective on HIV Infection and Aging: Emerging Research on the Horizon. *Clinical Infectious Diseases* 41(6): 855-863.

³ Inungu, J. N., Mokotoff, E. D., & Kent, J. B. (2001). Characteristics of HIV infection in patients fifty years or older in Michigan. *AIDS Patient Care & STDs*, 15(11), 567-573.

untreated, older HIV-positive individuals are twice as likely to die than their younger, untreated counterparts. It was thought that there would be a delayed immune response once HAART was begun in older adults. However, it is striking that three months after older adults initiate HAART, no significant differences in survival are seen as compared to younger patients. Studies have found similar rates of undetectable viral loads once HAART is initiated. This may in part be the result of older people being more adherent to drug therapy than younger individuals. Nonetheless, these data support the conclusion that older adults are at greater risk when there is a failure to diagnose HIV infection that results in delayed treatment.²

HIV AND THE COMORBIDITIES OF AGING: THE MEDICAL CARE SYSTEM IS UNPREPARED

The interaction of HIV with the aging process and common comorbidities of aging such as cardiovascular disease, osteoporosis and dementia are inevitable. Yet there is little research and even less acknowledgment or foresight anticipating this consequential commingling of HIV and aging comorbidities. Is this ageism? Is there such a need to place emphasis on youth to sustain AIDS health dollars? Or is this a failure to recognize that HIV is a manageable disease because the system does not want to engage the even more complex health and social issues that are needed to respond to a population that has been given a new lease on life?

Older adults have population-specific health challenges, such as adult-onset diabetes, Alzheimer's disease, cardiovascular disease and hypertension, menopause,

“...the agency has shifted from primarily serving the terminally ill to serving HIV-positive individuals who are living longer and presenting more *complex needs*.”

osteoporosis and prostate cancer. Little is known about how these age-related diseases and conditions will manifest in the HIV-positive population. In addition, HIV is now overwhelmingly a disease affecting poorer populations, particularly people of color and women. Individuals from lower socioeconomic strata are at higher risk for many age-related diseases. For example, Blacks are disproportionately affected by cardiovascular disease, hypertension and diabetes. Will the onset of age-related

comorbidities be earlier? Will the disease course be more severe? How will aging HIV-positive individuals tolerate the mix of antiviral medications and the powerful medications that target age-related illnesses? Moreover, the racial and ethnic groups most affected by HIV are the same people who continue to encounter endemic disparities in access to healthcare.

The NYC DOH indicates in a recent Kaisernet report – “...the agency [DOH] has shifted from primarily serving the terminally ill to serving HIV-positive individuals who are living longer and presenting more *complex needs*.” Those *complex needs* are manifest in this aging group. They include the impact of the comorbidities of aging, increased isolation from social support networks, and the negative impact of HIV stigma and ageism.”

ACRIA AND THE AGING HIV POPULATION

The AIDS Community Research Initiative of America (ACRIA) is a 15-year-old, community-based HIV research and education agency in New York City. ACRIA has

The highly visible emphasis on preventing HIV transmission in youth and younger adults suppresses the accurate picture of those who now live long lives with this virus.

developed a network of partnerships with over 100 AIDS service organizations (ASOs) and community-based organizations (CBOs) and multiple medical and hospital facilities throughout the five boroughs of New York City. The agency also maintains a HIPAA-compliant database of over 1500 older adults living with HIV/ AIDS who have expressed interest in participating in ACRIA’s clinical and behavioral research studies.

Many studies of HIV/ AIDS populations reflect a sampling bias based upon an organization’s catchment area, or are limited to rosters of patients who utilize a specific healthcare or service facility. The diversity of organizations with which ACRIA interacts ensured that participants in any large-scale study would to a large degree reflect the current demographic characteristics of those living with HIV/ AIDS in New York City.

ACRIA has recognized the critical need to understand this emerging and often obscured HIV population better. The highly visible emphasis on preventing HIV transmission in youth and younger adults suppresses an accurate picture of

those who now live long lives with the virus. ACRIA initiated studies on this aging population in 2003.⁴ ACRIA's findings and those of others began to create a picture of a population that survives and manages HIV while facing the demands of aging with marginalized resources.

Enormous resources have contributed to changing the death sentence of an HIV/AIDS diagnosis to the reality of a longer life. It is disconcerting that those who now live with HIV will face a healthcare system and communities ill-prepared to care for them as they age with the disease.

The primary findings of ACRIA's preliminary research indicate that the aging HIV population does not have access to social support networks that provide support upon which the typical aging adult relies. Without these functional informal support networks these older adults find themselves relying on costly formal care services. Enormous resources have contributed to changing the death sentence of an HIV/AIDS diagnosis to the reality of a longer life. It is disconcerting that those who now live with HIV will face a healthcare system and communities ill-prepared to care for them as they age with the disease.

⁴ Shippy, R.A., & Karpiak, S.E. (2005). The aging HIV/AIDS population: Fragile social networks. *Aging & Mental Health*, 9(3), 246-254.
Shippy, R.A., & Karpiak, S.E. (2005). Perceptions of support among older adults with HIV. *Research on Aging*, 27(3), 290-306.

ROAH: The Research Study

Developing the best strategy to sustain the health and quality of life for the aging population living with HIV/AIDS requires a rigorous assessment of this group's characteristics. ACRIA's Research on Older Adults with HIV (ROAH) is a first step in establishing a valid and comprehensive knowledge base of the unique characteristics and needs of this growing HIV/AIDS population.

This effort is guided by an experienced research team and to date has been wholly funded by ACRIA. The ROAH team has been joined by Marjorie Cantor, Professor Emerita and Brookdale Distinguished Scholar at Fordham University. Other researchers and community members have become collaborators with ACRIA, providing their expertise and perspectives to assist in directing the research project.

ROAH was designed to recruit a 1000-person cohort. As noted earlier, ACRIA is uniquely positioned to conduct a

A goal of ROAH is to give this large and growing group of older adults a needed voice and visibility. A key feature of the Ryan White CARE Act has been the inclusion of community members in decision-making processes. Unfortunately, older adults have not been integrated effectively into this process.

high-quality, community-initiated study on a large representative sample reflecting today's HIV epidemiology. It is our hope that the ROAH data will have a significant impact on the priorities for HIV/AIDS funding. For the first time there will be valid data that describe the physical and mental health, sexual behaviors, substance use, social networks, behavioral health, and quality of life in this largely unknown population. A goal

of ROAH is to give this large group a needed voice and visibility. A key feature of the Ryan White CARE Act, a key source of federal HIV/AIDS funding, has been the inclusion of community members in decision-

making processes. Unfortunately, older adults have not been integrated effectively into this process.

ROAH PARTICIPANTS AND THE SURVEY INSTRUMENT

Recruitment for ROAH did not target any specific geographic locality, neighborhood or infected group. Participants in ROAH were recruited by an ACRIA outreach coordinator utilizing ACRIA's established network of New York City-based AIDS service organizations (ASOs), public and private hospitals, and the agency's database of clients. In order to qualify for the study, participants must have been diagnosed with HIV/ AIDS, be age 50 or older, be community-dwelling (i.e., not institutionalized), and be sufficiently fluent in English to complete the survey instrument. From a sample of 1000 completed surveys, a final sample of 914 was obtained.

The survey content was determined by the ROAH research team (Karpiak, Shippy, Cantor) with input from the Research Advisory Committee. The ROAH survey instrument was constructed using existing standardized tests and encompasses six primary areas (see appendix for details):

- Demographic Profile
- Health Status
- Sexual Behaviors
- Social Networks
- Stigma
- Psychological Resources

ROAH was reviewed and approved by an independent review board (IRB) to ensure ethical treatment of participants. Its components, methodology and data collection details can be found in the appendix. This report is a summary of the outstanding findings, which provide key defining characteristics of this aging population. These data were also used to formulate a limited set of general public policy recommendations.

Questions that ROAH was designed to address include:

- Will an already overburdened healthcare system be able to meet the increased demands of the aging HIV/AIDS population?
- How can communities and individuals be mobilized to reduce the impending burden on formal care networks?
- How best can limited resources be utilized to address the needs of this aging population with HIV/AIDS?
- Are there differences in the needs of males and females, or among racial/ethnic groups?
- To what extent will the aging HIV population have access to informal support from their family and friends?
- To what extent is the older HIV population isolated by stigma? How can the effects of stigma be reduced or reversed?

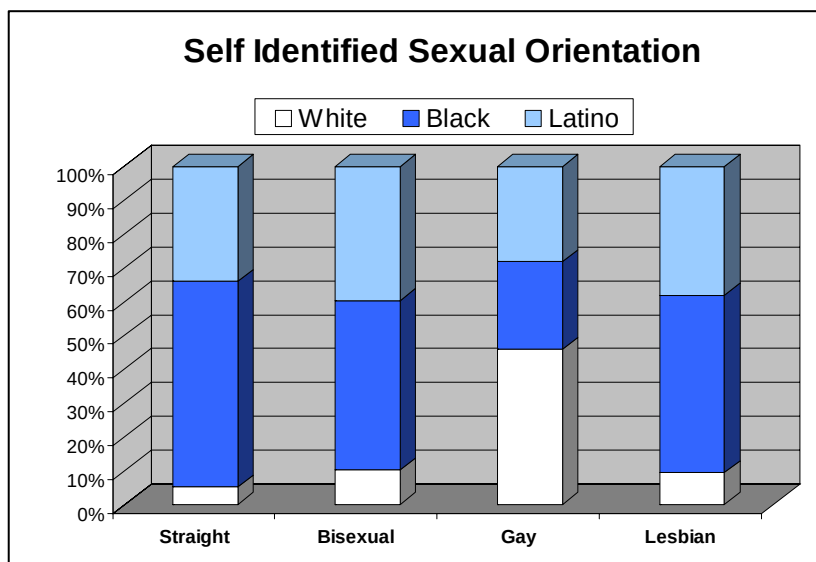
Demographic Profile: Who Are They?

Almost 67% of the participants self-identified as heterosexual.

The demographic profile of the ROAH respondents largely reflects the current demographic characteristics provided by epidemiological HIV data for New York City.⁵ The demographic variables include age, race/ethnicity, gender, education, relationship status, living arrangement, income adequacy, language, nationality/immigration status, and religion. The sample consisted of 640 men, 264 women, and 10 transgender persons.⁶ The average age was 55.5 years: 58% were 50–55, 26% were 56–60 and 16% were over

age 60. Half of the respondents were Black, a third Latino, and about 14% White. The remaining 4% identified as Asian/Pacific Islander, American Indian, or multi-ethnic⁷. The vast majority, (83%) of the participants were born in the USA. About half (47%) of participants regularly attend religious services. Christians (42% Protestant and 34% Catholic) comprised the majority, with 6% Muslim and 2% Jewish.

Regarding sexual orientation, 67% of the participants self-identified as



⁵ New York City Department of Health and Mental Hygiene. (2006). HIV Epidemiology Program 1st Quarterly Report, Vol4(1). Available online:

<http://www.nyc.gov/html/doh/downloads/pdf/dires/dires-2006-report-qtr1.pdf>

⁶ Because the number of transgender persons is low, gender comparisons will be made throughout the report on only those individuals who identified as either male or female. Where appropriate, the experiences of transgender individuals will be discussed separately.

⁷ Similarly, race/ethnicity analyses will include White, Black and Latino individuals. The number of Asian, Native American and multiethnic individuals precludes a fair and statistically meaningful comparison with other ethnicities. In all other analyses, these people are included and where appropriate, we will discuss the experience of these individuals separately.

heterosexual, 9% bisexual, and 24% homosexual. Nearly half (49%) of male participants and over a third (37%) of the females reported a history of incarceration.⁸

A substantial portion of the ROAH participants lived alone (70%). Of those who did not live alone, 15% lived with a partner, 9% lived with a relative, and the remaining 7% lived

In NYC, 70% of older adults with HIV live alone and only 15% live with a partner.

with a friend or other person. This is significantly higher than the percentage of HIV-negative people over the age of 50 who live alone (32% of people over 65 in NYC live alone).⁹ Men were more likely to live alone (75%) than women (58%); however there was

no significant difference among ethnic groups. The high proportion of people who live alone is likely to create significant implications on the need for assistance from the formal care and services system.

EDUCATION, DISABILITY AND INCOME

the education level of the study group is similar to that of the general population of NYC. Nearly 53% of the participants graduated high school, and 25% had some college experience. Over 13% of the participants were college graduates and 9% had graduate degrees.

The majority of the participants indicated that they were not working: 20% were unemployed, 54% were on disability, and 7% were retired. Nearly 8% were currently employed and an additional 3% were volunteers.

The majority indicated that they were not working: 20% were unemployed, 54% were on disability, and 7% were retired.

The responses to questions of income adequacy reflect the fact that most of this population is not working. When describing their current income, 53% reported having “just enough to get by” and 23% said stated

that they “do not have enough to make ends meet.” An examination of income adequacy, work status, and education concluded that the majority of the ROAH participants are on the lower end of the socioeconomic spectrum.

⁸ The survey question was unintentionally ambiguous, which may have resulted in overreporting.

⁹ U.S. Census, 2000. Older (55+) Population Data. U.S. Census Bureau, Washington, DC.

Health Status

The HIV population is most often defined by those parameters used to measure the delivery of medical care (e.g., office visits, lab tests, treatments received, ambulatory versus hospital care, etc.). Such analyses rarely include age as a key variable. In an effort to understand the complex health status of these older adults, ROAH assessed parameters that would provide a more complete view of this population's health. The health picture presented in ROAH is driven by the voices of the participants' self-reports.

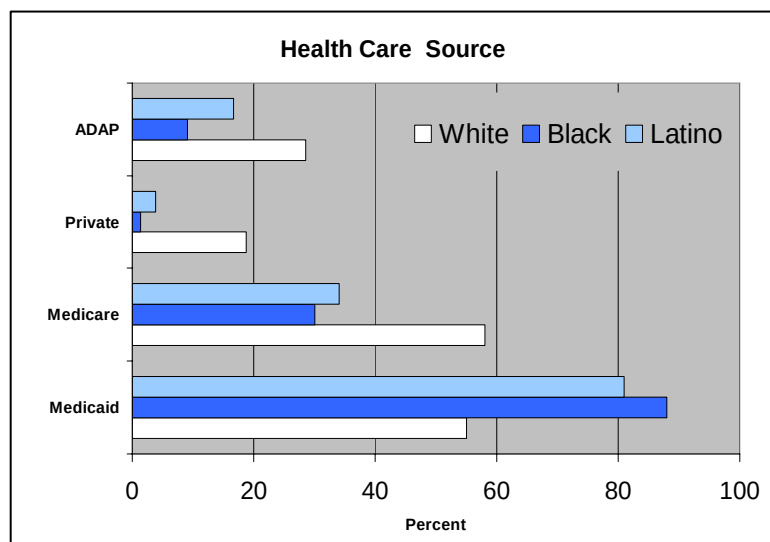
ROAH participants rated their current health on a possible scale of 0-10, with higher scores indicating better health.

Half of the older adults in ROAH have had an AIDS diagnosis. Currently only 13% report CD4 levels below 200.

Participants' scores ranged from 1 to 10, with a mean score of 6.8, slightly above the midpoint of the scale. This indicates that most consider their overall health to be at least fair or good. In many ways this measure is analogous to asking the question, "How are you feeling today?" The answer of ROAH's participants is "Not bad or pretty good." Given the tremendous challenges that these individuals face in managing HIV, as well as their own daily life activities, this suggests care, services and funding successes.

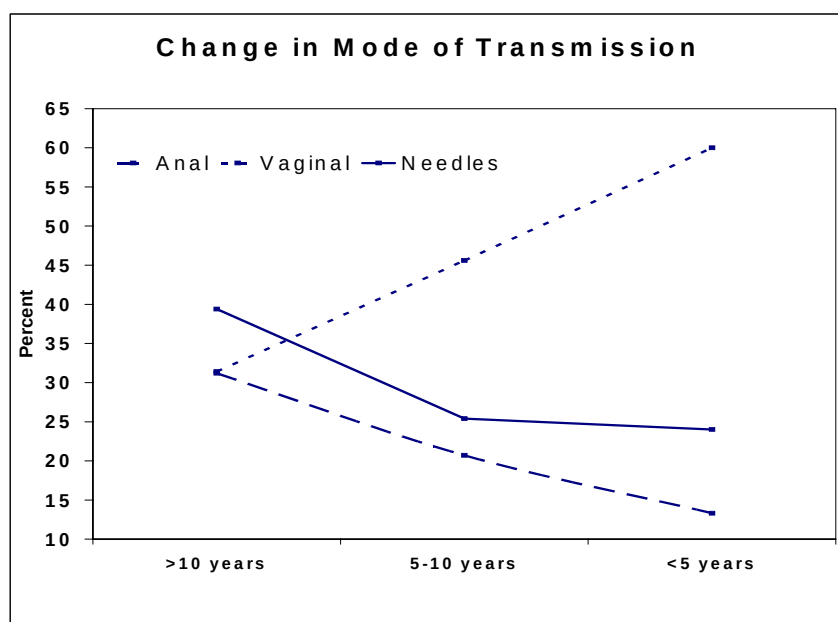
HIV-RELATED HEALTH

The older adults in ROAH have been living with HIV for an average of 12.6 years. The range from date of HIV diagnosis is 3 months to 26 years. Half have an AIDS diagnosis (51%), while only 13% currently have CD4 levels below 200. Again, the extraordinary success of antiretroviral (ARV) treatment is evident in the ROAH data set.



Consistent with New York State standards of care, the majority of participants (88%) visited their primary healthcare provider every 3-4 months.¹⁰ Nearly 85% are currently on ARV treatment. Most patients receive care in public hospitals, clinics or at ASOs (76%). There are no apparent disparities in access to treatment among the major racial and ethnic groups or between males and females. Almost one-third (29%) utilize complementary or alternative medicine (CAM).

With respect to the level of CD4 cells (a measure of disease severity and immune system status), Whites appear to have similar CD4 counts compared to Blacks and Latinos, although they have a higher rate of AIDS diagnosis (69%). Whites also have a longer history of HIV (mean 15.0 years) which may explain the higher prevalence of AIDS diagnoses. Similarly, males have a higher frequency of an AIDS diagnosis and lower CD4 levels than females. Again, gender differences may reflect the longer HIV history of the White male cohort.



When asked how they were infected with HIV, 38% reported vaginal intercourse, followed by needle sharing (intravenous drug use, or IDU, 36%) and lastly anal sex (28%). Heterosexual sex is emerging as the current dominant mode of transmission. When comparing ROAH participants who tested HIV positive in the last five years to those who tested HIV positive more than 10 years ago, vaginal sex is given as a mode of transmission in 61% of those infected in the last five years as

¹⁰ New York State Department of Health AIDS Institute. (2005). *Criteria for the Medical Care of Adults with HIV Infection, Chapter 1: Primary Care Approach to the HIV-Infected Patient.*

compared to 32% in those who were infected more than ten years ago. During the same time frame, needle sharing (IDU) and anal sex declined as modes of transmission from 41% to 24% and from 32% to 13% respectively. This change is a function of the increase in females and heterosexuals becoming HIV infected. The lower rate of HIV infection due to IDU is probably a result of needle exchange programs and targeted education for users.

Vaginal transmission of HIV is higher among Blacks and Latinos due to the proportionally higher representation of women and heterosexuals in those groups, as compared to the White sample. Infection through sharing needles is higher in Blacks and Latinos, compared to Whites, irrespective of gender.

THE CHALLENGE: MANAGING HIV AND OTHER DISORDERS ASSOCIATED WITH AGING

People with HIV infection are now living long enough to experience HIV as a chronic illness. As they age they will engage the challenges of competing health risks from aging, drug toxicity and comorbid diseases and conditions. Absent the opportunistic infections associated with AIDS and the collapse of the immune system, there is a need to focus on non-HIV-associated health needs. HIV alone does not define the health status of these individuals. As HIV-infected persons are living longer, there will be at least one if not several disease processes that will challenge them and their healthcare providers.¹¹

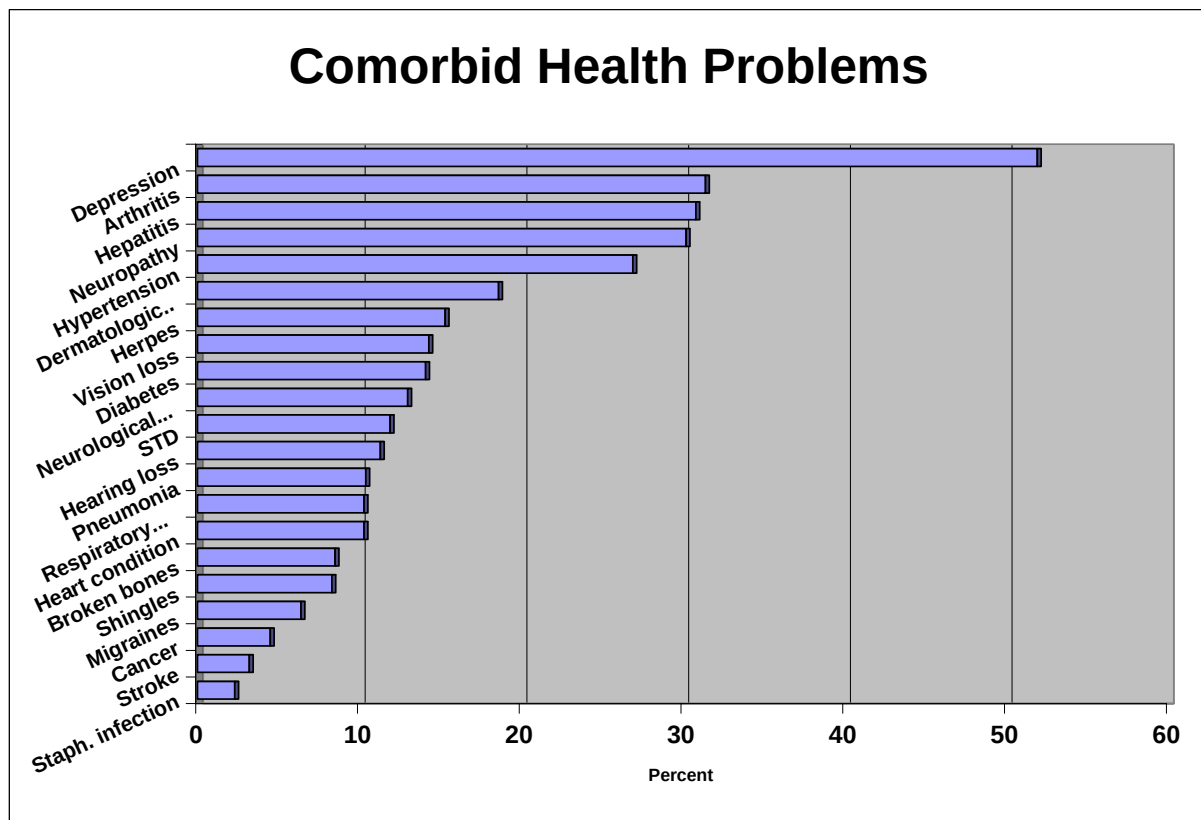
One of the most important research goals in studies of HIV/AIDS and aging is to distinguish and understand the interactions among concomitant and overlapping conditions including HIV disease, comorbidities (HIV-related and non-HIV-related), normal aging and age-related medical changes and diseases.

ROAH findings highlight several important issues that need to be considered and will be investigated in follow-up ROAH studies:

¹¹ Stoff, D. M., Khalso, J. H., & Portegies, P. (2004). Introduction: HIV/AIDS and aging. , 18(suppl 1):S1–S2

- Are the comorbidities that increase with age and with HIV infection different?
- Are these comorbidities related to aging alone or to the interaction of the aging process, HIV infection and the medications used by this population?
- What are the consequences of long-term ARV treatment?
- What is the impact of earlier and persistent substance use on the health outcomes of this population?
- What impact does treatment for comorbidities have on HIV treatment?
- Will the rate and severity of neurocognitive syndromes increase in these older adults and what impact will this have on managing care and treatment? HIV has an affinity for the brain and can lead to a host of neurocognitive problems, including HIV-associated dementia, which could be expected to have a negative impact on quality of life and adherence to HIV medications and other treatments.

Most participants experience one of the listed comorbidities (91.4%) and 77% have two or more comorbidities. The most common comorbidities were depression (52%), arthritis (31%), hepatitis (31%), neuropathy (30%) and hypertension (27%). Many medications commonly taken by older people can make the depression worse, among them steroids, anticancer drugs, tranquilizers, anti-anxiety agents, and drugs to treat Parkinson's disease, hypertension, heart disease, rheumatoid arthritis and pain.



MENTAL HEALTH: DEPRESSION

Depression afflicts people of all ages, but it can be particularly destructive for older people, who are less likely to seek treatment. Caregivers often fail to recognize the symptoms of depression in the elderly. And frequently depression is thought to be a characteristic of aging rather than an illness. Further, people can be depressed without feeling sad. Rather, the depressive disorder is expressed more by agitation and irritability, and in physical terms, like vague complaints of aches and pains or gastrointestinal upset.

Older adults continue to regard depression as shameful or a sign of weakness that should not be acknowledged, even to physicians. Physicians, in turn, often fail to ask the questions that will identify and diagnose depression in their older patients. And there is too often the belief that little or nothing can be done for people with ample reason to be depressed.

Older adults continue to regard depression as shameful or a sign of weakness that should not be acknowledged. Physicians often fail to identify and diagnose depression in their older patients. And there may be the belief that little can be done for people with ample reason to be depressed.

By suppressing the immune system, depression may render people more vulnerable to infectious diseases. Stress and depression have harmful effects on cellular immunity,

ROAH data indicate that aging HIV-positive adults experience significantly high levels of depression, at a rate at least five times higher than the general New York City population.

including those aspects of the immune system affected by HIV. Body cell mass depletion is associated with significant increases in fatigue, global distress and depressive symptomatology, and reduced life satisfaction.¹² Elevated symptoms of depression are associated with a faster progression to AIDS and a higher risk of mortality.¹³ Depressive symptoms, especially

in the presence of severe stress, are related to decreases in CD4 cell count and declines in several lymphocytes.¹⁴

Older HIV-positive adults who are depressed are more likely to have financial problems, have fewer people to turn to for support, lack critical HIV-related information, live alone, have thoughts of suicide, and experience greater levels of stigma related to HIV and aging as compared to older adults who are not depressed. Depression may

By suppressing the immune system, depression may render people more vulnerable to infectious diseases... [D]epression has harmful effects on those aspects of the immune system affected by HIV.

interfere with adherence to treatment, doctor visits, participation in social activities, and personal relationships.¹⁵

In ROAH, depression symptoms were measured by the Center for Epidemiologic Studies Depression Scale (CES-D).¹⁶ This is one of the primary standardized tools used to assess depression. The CES-D includes 20 items that are summed to obtain a total symptom score

that can range from 0 to 60. Higher scores indicate greater depressive symptoms. People with scores below 16 are not depressed. Scores between 16 and 27 indicate moderate levels of depression and would typically correspond with a clinical depression diagnosis. Scores of 28 and above indicate severe levels of depression.

¹² Wagner, Ferrando and Rabkin (2000)

¹³ Leserman (2003)

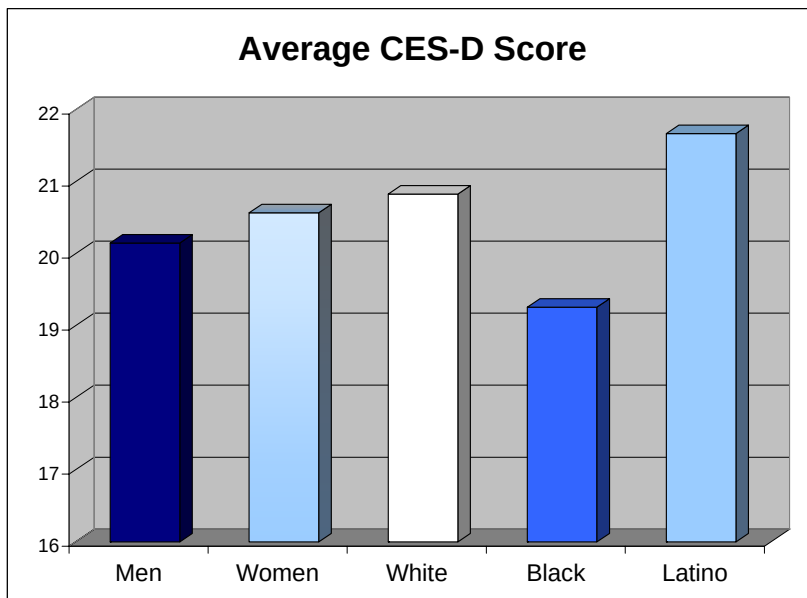
¹⁴ (Kopnisky, K., Stoff, D., & Rausch, D., 2004)

¹⁵ Heckman, T. G., Kochman, A., Sikkema, K. J. (2002). Depressive symptoms in older adults living with HIV disease: Application of the chronic illness quality of life model. *Journal of Mental Health & Aging*, 8(4), 267-279.

¹⁶ Radloff, L.S. (1977). The CES-D scale: A self report depression scale for research in the general population. *Applied Psychological Measurement*, 1, 385-401.

ROAH participants' scores ranged from 0 to 52. The mean CES-D score was 20.3: 36% of the participants were not depressed (scored less than 16), while 38% were moderately depressed (scored 16-27) and 26% could be categorized as severely depressed (scored 28+).

Even though women over age 50 are more likely to be diagnosed with depression than men, no differences between males and females were seen in ROAH. There were significant differences between the racial and ethnic groups:



Latinos reported levels of depression significantly higher than Blacks. The White group's score placed them between Latinos and Blacks. ROAH found that aging HIV-positive adults experience significant levels of depression, at a rate at least five times higher than the general New York City population.¹⁷

There is no single evident reason that these numbers are so high. The ROAH cohort is already in care and arguably has access to a myriad of support and treatment modalities for the management of

depressive disorders. One reason may be the difficulty in diagnosing depression when symptoms are not typical or are easily confused with a physical ailment. Too often, treating physicians are focused on HIV and see depressive symptomatology as an expected reaction to living with HIV. The mental health needs of this growing group of adults may be overlooked. In the era of effective antiretroviral medications, it is important for healthcare providers to be prepared to assess and treat the comorbid physical and mental health conditions that aging adults will present. In fact, the co-occurrence of HIV and depression is a formula for continued distress of the immune system. The effectiveness of ARV treatment might have also caused

¹⁷ Galea, S., Ahern, J., Resnick, H., Kilpatrick, D., Bucuvalas, M., Gold, J., & Vlahov, D. (2002). Psychological sequelae of the September 11 terrorist attacks in New York City. *New England Journal of Medicine*, 346(13), 982-987.

healthcare providers to view depression as a less significant comorbidity to aggressively treat.

SUBSTANCE USE

Substance use is a risk factor for HIV infection. Injection drug users who share needles are at high risk of infection with HIV. Substance users who do not inject are also at risk; if they are under the influence of psychoactive substances, they may engage in unsafe sex practices. The risk is not limited to substance users but also to their sexual partners.

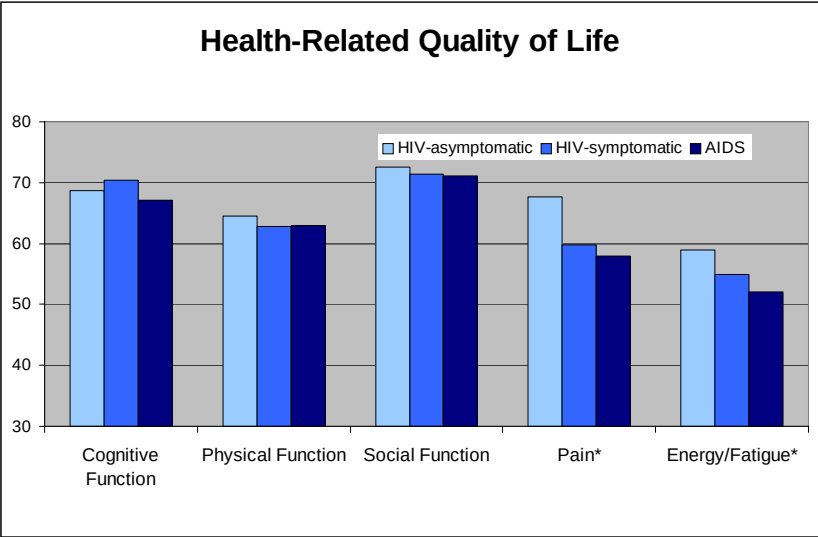
Because of its impact on health and well-being, substance use can complicate the course of HIV disease. Consequently, ROAH included a careful inquiry into patterns of substance use in this older adult population. Physical, psychological, and social problems are indicators of comorbidities that must be identified and assessed. Thoughtful dependence and addiction treatment may reduce the risk of transmission of HIV and improve quality of life for people who are HIV positive. The best outcomes occur when alcohol and other drug rehabilitation efforts are coordinated with HIV care. The challenge for caregivers of people living with HIV disease and substance use disorders is to devise a pragmatic management plan that addresses a complicated set of problems with scarce resources.

ROAH found that a majority of this older adult population used cigarettes (84%), alcohol (81%) or illicit drugs (84%) in their lifetime. Current use of illicit drugs was reported as follows: marijuana (23%), crack (16%), cocaine (15%), and heroin (7%).

Alcohol (54%) and crystal meth (5%) are used significantly more often by Whites. Crack use is significantly higher in Blacks and Latinos. Smoking is significantly higher among Blacks (63%) and Latinos (58%) compared to Whites (31%). Females have notably lower cigarette (28%), alcohol (31%) and illicit drug use (28%). More than half of those ROAH participants who were users of alcohol or illicit drugs are now in recovery (55%). Still, over one-third of the entire sample population continues to use illicit substances (37%) or alcohol (38%). More than half continue to smoke (57%).

HEALTH-RELATED QUALITY OF LIFE

Functional ability and overall health-related quality of life was evaluated using a modified version of the MOS-HIV.¹⁸ This measure was designed specifically for studies of HIV-positive individuals and has been used extensively by researchers. Five of the 10 dimensions of health (physical function, cognitive function, social function, pain and energy/fatigue) were selected for use in ROAH. Previous ACRIA research found these scales to be most relevant to older HIV-positive adults' self-rated health. Participants' scores ranged from 0 to 100 on each of the five scales, with higher scores representing better quality of life. The mean scores for each scale were: physical function 63; social function 72; cognitive function 69; pain 64; energy/fatigue 57. When we examined the differences in quality of life among participants based on their HIV status, we found that people who had never received an AIDS diagnosis [HIV-asymptomatic] scored significantly better on the pain and energy/fatigue subscales than those who had received an AIDS diagnosis, regardless of their current CD4-count. Thus, although many people today have CD4 counts that have risen from previously low levels, having once reached a disease stage that warrants an AIDS diagnosis appears to result in deleterious effects that continue to influence these individuals' health, particularly on certain domains of quality of life (e.g., pain and energy/fatigue) even if there is significant immune reconstitution.

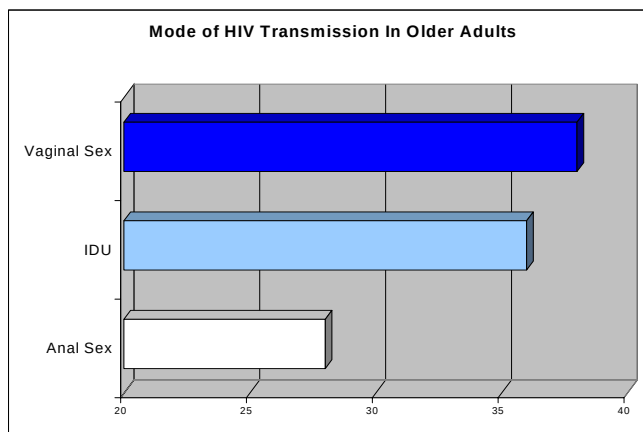


¹⁸ Wu, A.W., Rubin, H.R., Mathews, W.C., et al. (1991). A health status questionnaire using 30 items from the Medical Outcomes Study. Preliminary validation in persons with early HIV infection. *Medical Care*, 29, 786-798.

Sexual Behavior

HIV is a sexually transmitted disease (STD). ROAH is the first study to assess the sexual behaviors of an older adult population living with HIV. The data illustrate one of the notable changes in the HIV epidemic in the US inasmuch as the primary mode of transmission of HIV is no longer a result of sex between two males. The shift from homosexual to heterosexual sex as the primary mode of transmission is significant. This finding is not surprising since, in ROAH's sample, which largely reflects the present HIV epidemiology, fewer than one in four identify as homosexual (gay 21%; lesbian 3%) and 9% as bisexual. ROAH's data include assessments of sexual activity in the last three months. Half of the subjects did not have sex. This may be related to ROAH's finding that 70% live alone. Only a minority of all participants (15%) live with their sexual partner.

The shift from homosexual to heterosexual sex as the primary mode of transmission is significant.



Those engaging in sexual activities reported having oral sex (83%), vaginal sex (60%) and anal sex (39%). The type of sexual activities reflects the subjects' gender and sexual orientation, oral sex being least prevalent in straight females (63%), vaginal sex being most prevalent in heterosexual men (89%) and anal sex being most prevalent in gay men (71%).

The ROAH data illustrate a trend seen in younger HIV groups toward selection of sexual partners based on HIV status (sero-selection). More than one-third of sexually active participants (39%) had sex exclusively with HIV-positive partners. Fewer had sex exclusively with partners who had a negative or unknown HIV status (29%) and 32% had sex with both HIV-positive and HIV-negative individuals or those of unknown serostatus.

Sexual behavior involving significant risk for HIV transmission occurred in 33% of the sexually active subjects in the last three months.

Most of those who have sexual partner(s) report having one partner (77%), and one-quarter (23%) have more than one sexual partner. Women (93%) were more likely to have only one partner than men (70%). Blacks (82%) and Latinos (77%) were more likely to have one sexual partner as compared to Whites (57%). Heterosexual males (86%) were more likely to have only one sexual partner than homosexual and bisexual males (73%). Sexual behavior involving significant risk for HIV transmission (unprotected insertive or receptive anal or vaginal sex) occurred in 33% of the sexually active subjects in the last three months. Half of the time the risk behavior occurred with a partner who was not known to be infected (16%).

ROAH subjects were asked the reasons they engage in unprotected sex. Almost one-third of the subjects who had had sex in the last three months indicated that they would not have unprotected sex under any circumstance (28%). Others indicated desire for sex and partner attractiveness (32%), partner's request (32%), being high on drugs (27%), depressive feelings or neediness (19%), and conviction of low risk of STD (14%) as reasons for unprotected sex.

The use of illicit drugs during sex influenced the level of risk taken. Unprotected sex occurred more frequently when alcohol or drugs were used during sex.

Those who report current use of alcohol or drugs were more sexually active (58%) compared to those who did not use substances (42%). Almost half of sexually active people used alcohol or drugs with sex (47%). The substances most often used with sex were alcohol (32%), marijuana (20%), crack (17%), cocaine (15%) and poppers (11%). The use of illicit drugs with sex influenced the amount of risk taken. Unprotected anal or vaginal sex occurred more frequently when alcohol or illicit drugs were used with sex (40%) than when no substance was used (27%).

As expected in this older population, almost half of the women are postmenopausal (44%). One in six men (17%) reported impotence.

Social Networks

The critical role of social networks is illustrated by the impact of informal caregiving on the healthcare system.

If the informal caregiving provided by the social networks of family, friends, and neighbors were replaced by formal (i.e., paid) caregivers, the cost would exceed \$300 billion annually.

Approximately 44 million Americans currently provide caregiving assistance to family members or friends. If the informal caregiving provided by family, friends, and neighbors were replaced by formal (i.e., paid) caregivers, the cost would exceed \$300 billion annually.¹⁹ While significant resources have been expended on understanding HIV/AIDS and its impact on individuals, groups, societies and healthcare delivery, little research

has examined how HIV/AIDS affects the ability of older adults to maintain their social networks. Few studies systematically examine the informal networks that provide critical support for the rapidly growing population of older adults living with HIV/AIDS. Therefore, we do not know who comprises their informal networks and whether those networks will be able to provide needed support for this at-risk group of older adults.

Little research has examined how HIV/AIDS affects the ability of older adults to maintain their social networks.

Life events such as retirement, illness, relocation and death of family and loved ones can result in shrinking social networks.²⁰ As one ages, a person's social network is transformed into a social care system comprised of family, friends, and formal support services (e.g., community and government agencies, hospitals, homecare services) that respond to the older adult's changing needs.²¹ Typically older adults want to receive help from those who are close to them. A common process by which older people adapt to infrequent or reduced contact with their families is to

¹⁹ National Alliance for Caregiving and AARP (April, 2004). *Caregiving in the U.S.* Bethesda, MD: National Alliance for Caregiving and AARP.

²⁰ Baltes, P. B., & Baltes, M. M. (1990). Psychological perspectives on successful aging: The model of selective optimization with compensation. In P. B. Baltes & M. M. Baltes (Eds.), *Successful aging: Perspectives from the behavioral sciences* (pp. 1-34). Cambridge, England: Cambridge University Press.

²¹ Cantor, M. H. 1979. "Neighbors and friends: An overlooked resource in the informal support system." *Research on Aging*, 1: 434-463.

Friends are the most important element of older adults' social network, more than parents, siblings and children.

augment their support networks by reliance on friends as primary sources of support. For example, research on the social networks of older gay men found that among men

who did not maintain close connections to their families of origin, friends became a chosen family, assuming many of the emotional ties and legal rights and responsibilities of biological family.²²

However, the number of people in an older adult's informal network of family and friends is not the only important factor. Research shows that a person's level of satisfaction with support from their informal social networks is more important than the actual number of individuals who are available to provide that support.²³

Previous research by the ROAH study investigators suggests that the capacity of the informal networks of older HIV-positive adults to provide needed support is inadequate.²⁴ Unlike the general population, who rely upon spouses, partners and family, many older adults with HIV rely on friends as the primary source of informal support. Many of these friends are also living with HIV and may not be able to function as caregivers. Aging adults with HIV who receive marginal social support report feelings of isolation and a decreased ability to cope with the rigors of disease management.²⁵

Social Network Composition

In order to assess the level of informal support that is available to older adults with HIV, ROAH participants were asked to complete a detailed assessment of their social networks. This assessment included the number of people, the relationship to the ROAH member and frequency of in-person and telephone contact with such persons. From these data, we designated those individuals who maintained frequent and regular contact as "functional" components

²² Shippy, R.A., Cantor, M.H., & Brennan, M. (2004). Social networks of aging gay men. *Journal of Men's Studies*, Vol 13(1), 45-66.

²³ Cantor, M. H., & Brennan, M. (2000). Social care of the elderly: The effects of ethnicity, class, and culture. New York: Springer.

²⁴ Shippy, R.A., & Karpiak, S.E. (2005a). The aging HIV/AIDS population: Fragile social networks. *Aging & Mental Health*, 9(3), 246-254.

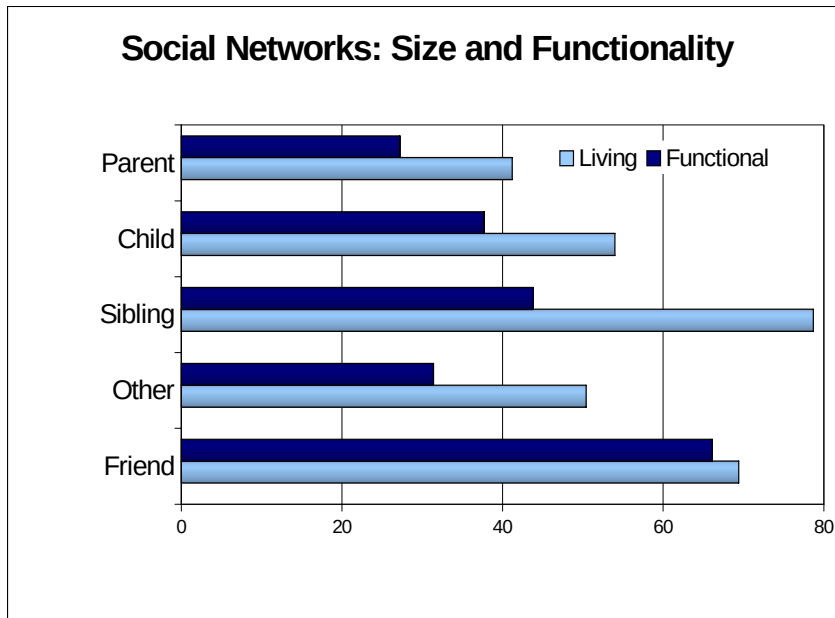
Shippy, R.A., & Karpiak, S.E. (2005b). Perceptions of support among older adults with HIV. *Research on Aging*, 27(3), 290-306.

²⁵ Heckman, T. G., Kochman, A., Sikkema, K. J. (2002). Depressive symptoms in older adults living with HIV disease: Application of the chronic illness quality of life model. *Journal of Mental Health & Aging*, 8(4), 267-279.

(e.g., parents, children, siblings, other relatives and friends), according to criteria defined by Cantor.²⁶

Approximately 40% of ROAH members had a living parent, but only 27% reported that they had regular contact with their parent(s). Of the total group, 54% had at least one child

and 38% maintained regular contact with their child(ren). Women were more likely to have children than men. Similarly, Blacks and Latinos were more likely to have children than Whites. This is a result of the greater proportion of gay men in the White sample. Eight in ten participants had a sibling, but only 44% were in regular contact with their siblings. Half of the participants had another relative (e.g., cousin, aunt, niece, etc.); 33% of the group saw or spoke to their



relatives regularly. Most participants reported that they received infrequent assistance from family members. However, the incidence of family members showing negative reactions to requests for help was very low.

Friends are an important source of support for ROAH participants, as evidenced by the fact that 69% of the

Friends were more likely than family members to provide emotional support.... 20% had no friends that were HIV positive.

participants have a close friend with whom they share confidences. More than any other informal network component, 66% of the group saw or talked to their friends regularly. While there were no differences between men and women, White participants were more likely to

report having friends than Black or Latino participants. Most participants received infrequent assistance from friends for instrumental tasks of daily living (e.g., cooking, cleaning, transportation needs) but friends were more likely than family members to provide emotional support. As with

²⁶ Cantor, M. H. 1979. "Neighbors and friends: An overlooked resource in the informal support system." *Research on Aging*, 1: 434-463. The criteria set by Cantor require either weekly telephone or monthly in-person visits to be considered "functional."

family members, few participants experienced negative reactions to requests for support from friends. An important finding was that approximately 40% of participants had friendship networks comprised of a majority of HIV-positive individuals, but almost 20% said that none of their friends were people living with HIV.

Family members and friends were the most common sources of support for these older adults with HIV. Partners were an important resource for about 25% of the participants.

However, a noticeable number of participants (25%) reported receiving assistance from paid helpers (e.g., home health aide) and 15% were assisted by volunteers.

42% said the support they had received was inadequate to their needs in the past year. An increasing number of participants (25%) reported receiving assistance from paid helpers (e.g., home health aide) and 15% were assisted by volunteers.

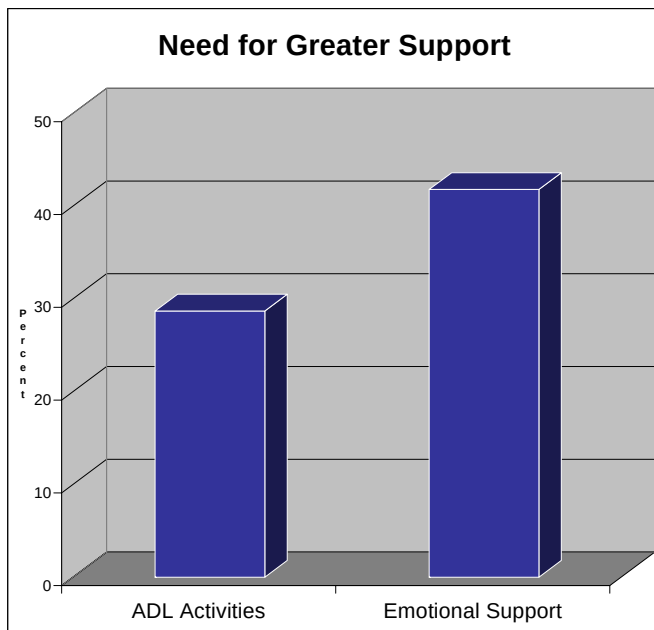
ADEQUACY OF SUPPORT

To understand the extent to which participants had readily available and adequate informal support networks, we asked four questions. The first item asked, “Do you have someone you can count on to help you with activities of daily living (ADL, e.g., shopping, cleaning, getting to the doctor)?” Slightly more than half (56%) had someone they

could rely on, but 44% had no one at all or someone only occasionally to assist with ADL tasks. Next, participants were asked, “In the past year, how much more assistance with instrumental activities of daily living did you need?” Most (71%) said they were satisfied with the level of ADL support they received, but a significant group (29%) needed more assistance during the previous year with these tasks.

When asked if they had someone to provide emotional support (e.g., someone to talk to or from whom they could get advice), a majority (74%) identified a readily available source of emotional

support. However, when participants responded to the question about how much more emotional support they needed in the past year, 42% said the support they had received was inadequate to their needs. This pattern of



unmet need is similar to studies that examined diverse groups of older adults.²⁷ However, the magnitude of need, particularly emotional support need, is higher for older adults with HIV than other older New Yorkers.

LONELINESS

In other studies of older adults, researchers found that loneliness scores are not related to frequency of contact or the social network size. But they do measure the quality of that support. Levels of loneliness have been shown to be negatively related to self-rated health and life satisfaction and positively correlated with depression in older adults.

The UCLA Loneliness Scale is designed to assess perceptions of inadequate support from a person's social network.²⁸ The scale contains both positive and negative statements about feelings of loneliness. Scores range from 20 to 80, with higher scores indicating a greater degree of loneliness.

ROAH participant responses covered the entire range of scores from 20 to 80, with an average score of 53. Thus, among older adults with HIV, loneliness is a significant issue. This level of loneliness is significantly higher than the levels found in a study of seniors (65 and older) who had a range of scores from 20-59 and an average score of 32.

Taken together, the findings from the assessment of the ROAH participants' social networks describe a population at risk. Older adults may not have access to the support they need to age in place successfully. The high levels of unmet need for emotional and instrumental support as well as significant evidence of loneliness reflect a certain distance from loved ones, either physically or emotionally. One of the possible causes for this estrangement, the stigma related to HIV/AIDS, will be discussed in detail in the following section, which examines stigma.

Among older adults with HIV, loneliness is a significant issue. This level of loneliness is significantly higher than the levels found in seniors (65 and older).

²⁷ Cantor, M. H., & Brennan, M. (2000). Social care of the elderly: The effects of ethnicity, class, and culture. New York: Springer.

Schrimshaw, E. W., and K. Siegel. (2003). "Perceived Barriers to Social Support from Family and Friends among Older Adults with HIV/AIDS." *Journal of Health Psychology*, 8: 738-752.

Shippy, R.A., Cantor, M.H., & Brennan, M. (2004). Social networks of aging gay men. *Journal of Men's Studies*, Vol 13(1), 45-66.

Shippy, R.A., & Karpiak, S.E. (2005b). Perceptions of support among older adults with HIV. *Research on Aging*, 27(3), 290-306.

²⁸ Russell, D.W. (1996). UCLA Loneliness Scale (Version 3): Reliability, validity and factor structure. *Journal of Personality Assessment*, 66(1), 20-40.

Stigma

Although HIV is treatable and manageable, the disease is chronic and incurable. HIV remains an infection surrounded by fear and myths. Many people in the US remain unaware or poorly informed about the modes of transmission and risk factors for HIV. Many people fear the mere presence of the illness. Many believe an HIV-positive person's lifestyle led to the infection. These myths contribute to the continued stigma directed against people living with HIV. HIV-related stigma exacerbates other types of stigmas faced by many older adults living with HIV, such as racism, sexism and ageism. The presence of HIV-related stigma is well documented, and appears to have increased. In 1991, 21% of the US population reported negative feelings toward HIV-positive persons, or stigma. In a similar study in 1997, HIV-related stigma increased to 28%.²⁹

Silence Equals Death...

ROAH finds that stigma causes older adults to hide from half of their friends the fact that they live with HIV.

The stigma associated with HIV is more pervasive than in most other stigmatizing health conditions. The fear of HIV is so powerful and pervasive that stigma can extend beyond those living with HIV/AIDS to their families and friends, as well as

the professionals who provide health and social care to them. HIV-related stigma can have a significant impact on the health and well-being of people living with the disease.

Individuals may experience discrimination that leads to loss of employment, estrangement from friends and family, and violence. Although some people can be supportive and accepting, others reject the HIV-positive individual or distance themselves in more subtle ways.³⁰ HIV stigma fuels the risk of spreading the virus to others because it creates a barrier to testing for HIV. Stigma can

²⁹ Herek GM, Capitanio JP, Widaman KF. (2002). HIV-related stigma and knowledge in the United States: prevalence and trends, 1991–1999. *Am J Public Health*. 92(3):371-7.

³⁰ Heckman, T. G., Kochman, A., Sikkema, K. J. (2002). Depressive symptoms in older adults living with HIV disease: Application of the chronic illness quality of life model. *Journal of Mental Health & Aging*, 8(4), 267-279.

Herek, G.M., Mitnick, L., Burris, S., Chesney, M., Devine, P., Thompson, M., et al. (1998). AIDS and stigma: A conceptual framework and research agenda. *AIDS and Public Policy Journal*, 13(1), 36-47.

influence a person's choice not to disclose her or his HIV-positive status to sexual and needle-sharing partners.

HIV AND STIGMA

ROAH data from the Berger HIV Stigma Scale³¹ provide evidence for the existence of high levels of stigma among older adults with HIV. The average total score (with a possible range of 40 to 160) was 88, well above the midpoint of 60, indicating high levels of stigma. After more detailed analyses, the data reveal that the participants scored higher on items that describe negative reactions from others (e.g., "Some people avoid touching me once they know I have HIV") as opposed to items describing internalized negative feelings (e.g., "I feel guilty because I have HIV"). This finding suggests that the impact of stigma on this population emanates from external sources, rather than negative self-appraisals. These older adults clearly see stigma as an impediment or barrier in engaging their community, family and friends. These results are similar to those of other recent studies of stigma among older adults with HIV.³²

Another indication of stigma is whether people disclose to others the fact that they have HIV. Most people with HIV

Fewer than half (46%) told all of their family members and only one-third (35%) told all of their friends that they were HIV positive. Overall, Whites were significantly more likely to disclose their HIV status than either Blacks or Latinos.

have disclosed their HIV status to someone, often with negative results. ROAH participants were asked to indicate whether they had disclosed to *All*, *Some*, or *None* of the people belonging to eight specific groups. While most ROAH members felt comfortable discussing their HIV status with others, they made careful and specific

decisions about whom they told. Not surprisingly, 91% of all respondents disclosed their HIV status to healthcare providers. ROAH respondents were more likely to disclose their HIV status to people who were closer to them than casual acquaintances. Thus, ROAH participants were most likely to disclose their HIV status to sex partners, family members, friends and drug buddies.

Nevertheless, many ROAH members were reluctant to discuss their HIV status, even with the people closest to

³¹ Berger, B.E., Ferrans, C.E., & Lashley, F.R. (2001). Measuring stigma in people with HIV: Psychometric assessment of the HIV Stigma Scale, *Research in Nursing & Health*, 24, 518-529.

³² Emler, C.A. (2006). Extending the use of the 40-item HIV stigma scale to older adults: An examination of reliability and validity. Manuscript submitted for publication to AIDS Care.

them. Over half (57%) of the participants disclosed their HIV status to all of their sexual partners. It is a startling fact that 16% did not disclose to any of their sexual partners.

Fewer than half (46%) told all of their biological family members and only one-third (35%) told all of their friends. Similarly, (30%) told all their drug buddies. Overall, Whites were significantly more likely to disclose their HIV status than either Blacks or Latinos.

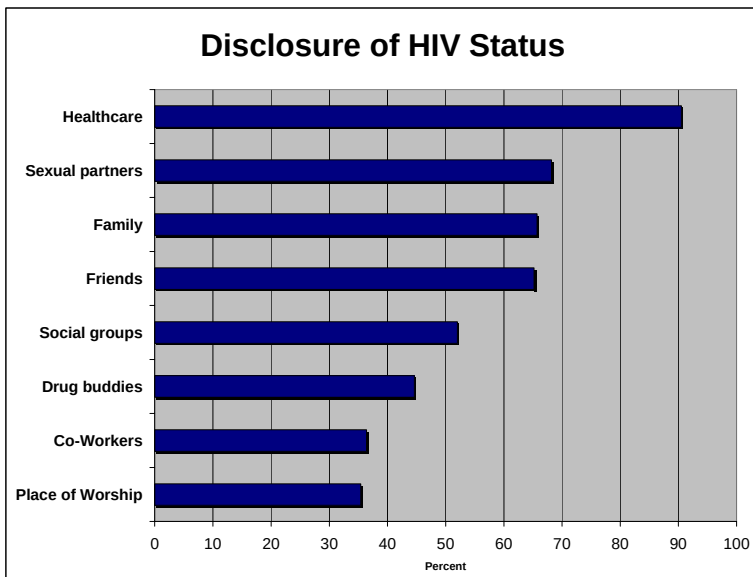
Older adults with HIV have many reasons for not disclosing their HIV serostatus to others. Responses varied from “I don’t want to worry them” to “The person might kill me.”

Members of social or political organizations, co-workers and people at places of worship were the least likely to have been told of a respondent’s HIV serostatus. About three-quarters (74%) of participants did not disclose to everyone they know in social or political organizations. Fewer than one-quarter (21%) disclosed their HIV status to all of their co-workers. Four in five (82%) did not talk to people about their HIV status at their place of worship.

REASONS FOR NONDISCLOSURE

Participants were asked if there were people who they would like to tell about their HIV status, but have not yet

done so. Two-fifths of participants reported not disclosing to people they would like to tell about their HIV status. Older adults with HIV have many reasons for not disclosing their HIV serostatus to others. Responses varied from “I don’t want to worry them” to “The person might kill me.” An examination of the responses revealed two major categories: Concern for Self and Concern for Others. The majority of respondents (61%) endorsed statements that demonstrated more concern for those individuals they did not tell rather than concern about themselves (45%).



Stigma is particularly complex as it operates at many different levels and has both social and psychological aspects. Stigma has been talked about since the beginning of the HIV/AIDS epidemic but has not been adequately

investigated or addressed in programs or policies. There are many factors surrounding stigma including denial, shame, blame, fear, rejection and discrimination.

Personal Resources

While life satisfaction and depression are often used to assess a person's quality of life, these indicators do not present a complete picture of an individual's psychological well-being. The absence of mental illness does not imply wellness.³³ Many of the ROAH participants evidenced signs of depression, but they may have psychological strengths that enable them to adapt to their illness.

PSYCHOLOGICAL WELL-BEING

Ryff's psychological well-being scales were used to understand the personal resources and assess the psychological functioning of older adults with HIV.³⁴ These scales (autonomy, environmental mastery, personal growth, positive relations with others, purpose in life and self-acceptance) have a range of 9 to 54, with higher scores indicating greater well-being. ROAH is the first HIV study in which these scales have been used. Each scale is examined below:

Autonomy: Autonomous individuals are self-determining and independent, able to resist social pressures to think and act in certain ways. They judge themselves by their own set of standards and regulate their behavior based upon these standards. Most of the ROAH participants scored higher than the midpoint of the scale ($M=40.4$), indicating that most of these older adults have a strong sense of identity and independence.

Environmental Mastery: An individual who scores high on this scale is able to adapt to or create a comfortable environment that is suitable to personal needs and values. This particular domain of well-being is integral to an older HIV-positive adult's ability to live in a society that

³³ Jahoda, M. (1958). *Current concepts of positive mental health*. New York: Basic Books.

Lawton, M. P. (1984). The varieties of well-being. In C. Z. Malatesta & C. E. Izard (Eds.), *Emotion in adult development*. Beverly Hills, CA: Sage.

³⁴ Ryff, C.D. (1989). Happiness is everything, or is it? Explorations on the meaning of psychological well-being. *Journal of Personality and Social Psychology*, 57, 1069-1081.

discriminates against people with HIV. Although ROAH participants had a slightly lower average score ($M=38.1$) than other Ryff scales, it was above the scale's median score.

Personal Growth: Older adults with HIV who are open to new experiences and see improvement in their attitudes and behaviors over time will be more likely to adhere to treatment regimens and actively seek new information about their illness. Those people can become more self-aware and realize their potential, further reinforcing positive psychosocial and physiological health. The mean score for Personal Growth was one of the highest ($M=40.0$). There were no significant differences between men and women.

Positive Relations with Others: An older HIV-positive adult who has strong relationships with others is concerned with others' welfare and is capable of empathy, affection and intimacy. That person can develop mutually beneficial

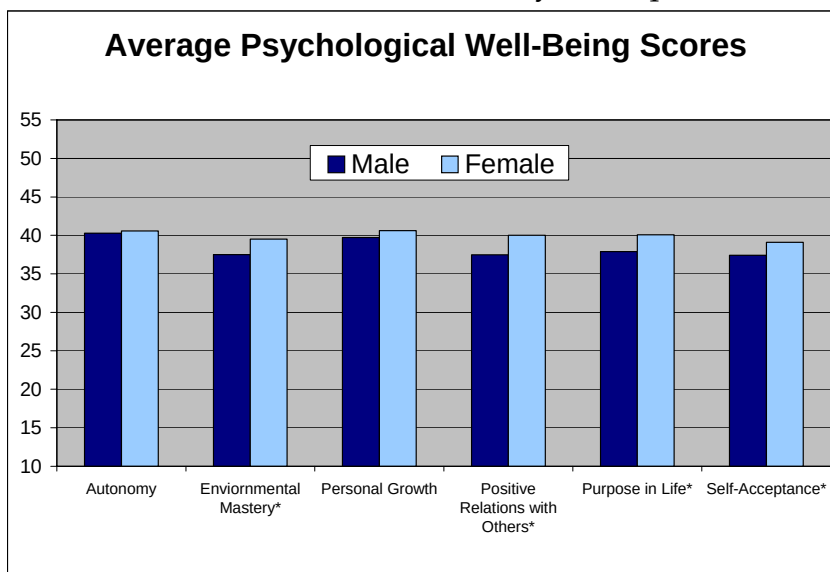
relationships, which provide needed instrumental and emotional support.

Participants' mean score in this scale was 38.2.

Purpose in Life: A sense of meaning for one's past and present life experiences assists an older adult with HIV create personal goals and objectives for living that result in positive adaptation to their illness. The person may be less likely to feel victimized and, therefore,

more proactive in seeking information and assistance with their illness. The average score was 38.5.

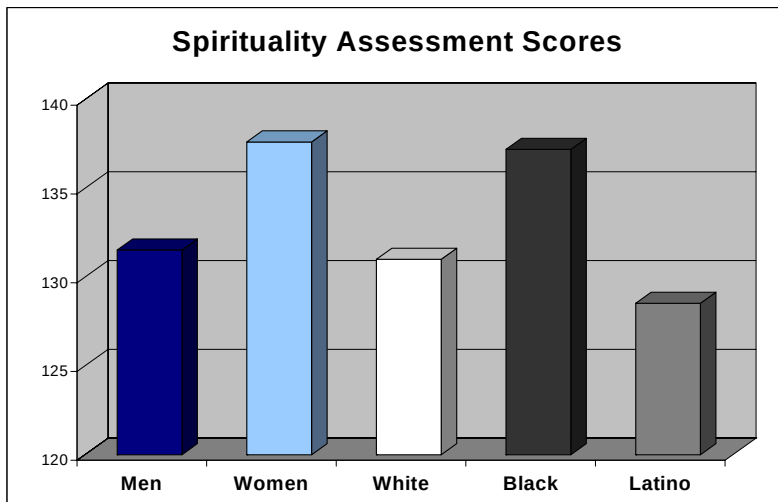
Self-Acceptance: A self-accepting person possesses a positive attitude; acknowledges and accepts both good and bad aspects of him- or herself; and feels positive about his or her past life. Although this scale had the lowest average score of the six scales ($M=37.9$), most respondents scored above the median for the scale. Given the frequently hostile attitude of society toward people living with HIV, it is important for them to achieve a high level of self-acceptance,



so that even when facing powerful stigma, they can maintain a positive outlook on life.

Average scores on each of the six scales were above the midpoint of the range, indicating that the participants have relatively high levels of well-being in each of the domains. Women reported significantly higher levels of well-being on four of the six scales (environmental mastery, positive relations with others, purpose in life and self-acceptance), suggesting that women may be better able to adapt to their illness than men and that men may need additional support to build stronger relationships with family and friends.

In addition to the Ryff scales, we used a single item to assess a global perspective of life satisfaction. The mean score was 7.3, with a possible range of 0 – 10. Women scored significantly higher than men (7.7 v. 7.1) and Whites scored lower than Blacks and Latinos (6.4 v. 7.5 and 7.3, respectively). Taken together, these measures provide a positive picture of a group of aging adults living with a chronic illness in the context of a society that is far from welcoming toward people with HIV.



SPIRITUALITY

Spirituality can be an important personal resource for some older adults, especially when adapting to a chronic illness and the demands of aging. Because churches are both a source of practical support and a significant part of the social culture for many people, an assessment of religious participation and spirituality was included in ROAH. ROAH data show that 47% attend church

services on a regular basis, yet over half (56%) say they do not receive support from their place of worship. Spirituality has been conceptualized as a different phenomenon from religiousness, or frequency of attendance at religious services.

A sense of spirituality is a positive connection in which a Higher Power is seen as a source of help in any effort to improve health. Spirituality is perceived as an inner source of

strength, power, peace, and comfort needed to live life in a healthy way. Many reports show that spirituality increases self-awareness and positive view of self. One study found that HIV-positive African-Americans' experience of HIV symptoms decreased as their level of spirituality increased.³⁵ The pivotal role of a higher being or spirituality is also a vital part of 12-step programs. ROAH finds that 51% of older adults with HIV are in recovery programs/interventions.

The ROAH instrument included The Spirituality Assessment Scale (SAS), which provides scores that range from 28 to 168 and measures various aspects of spirituality (i.e., purpose and meaning in life, inner resources, unifying interconnectedness and transcendence).³⁶ The average score among ROAH participants was 133, indicating that spirituality is a critical element for them.

There was a small minority that did not report spirituality as a source of positive support. Intergroup comparisons, however, revealed some noteworthy results. Spirituality may be a more important resource for Blacks than Whites and Latinos. Women may gain more from a sense of spirituality than men.

A constructive association is reported to exist between spirituality and health. This work affirms the need for further research into the relationship between spirituality and religion and the ability to manage health and treatment.³⁷

³⁵ Holzemer, WL, Spicer, JG, Wilson, HS, Kemppainen, JK, Coleman, C. (1998). Validation of the quality of life scale: living with HIV. *Journal of Advanced Nursing*, Vol. 28(3), p. 622-630.

³⁶ Howden, J. (1992). *Development and psychometric characteristics of the Spirituality Assessment Scale*. Unpublished doctoral dissertation. Texas Women's University.

³⁷ Popkess-Vawter, S., Yoder, E. and Gajewski, B. "The role of spirituality in holistic weight management." *Clinical Nursing Research* 14, no. 2 (May 2005): 158-174.

Policy and Practice Recommendations

Healthcare

- Conduct public education outreach campaigns to reduce and end HIV stigma, including homophobia and ageism, in healthcare, including mental healthcare services, and social care agencies that provide services to older adults.
- Increase funding for public health and mental health research into the particular needs and experiences of older adults with HIV.
- As older people live longer with HIV, reexamine and modify the HIV Standards of Care to include routine assessments for the myriad comorbid illnesses that are common among aging adults.
- Tailor and target HIV prevention messages to older adults.
- Include older men and women in clinical trials for new and current anti-HIV medications, and conduct clinical trials with older adults taking medications used to treat comorbid illnesses.

Social Policy

- The Older Americans Act (OAA) should be amended explicitly to include services, outreach, training, and research on issues of concern to older HIV-positive adults and to prohibit discrimination in services on the basis of sexual orientation and HIV status.
- Amend Title III of the Older Americans Act, which authorizes and funds the core programs of the OAA. Targeting language should be added that specifically authorizes outreach to older adults with HIV, along

with other underrepresented and underserved populations. However, new targeting should be accompanied by new funding to pay for the services, so that funds are not simply redirected away from other at-risk groups.

- Community-based organizations (CBOs) and AIDS service organizations (ASOs) should apply for demonstration funding under OAA, Part F, which provides for State and Local Innovation and Programs of National Significance, to train those who provide services to older adults with HIV. Training should lead to programs and services that are sensitive to this aging population and responsive to its needs.
- Training and education can decrease HIV stigma and create a safe environment in which HIV-positive older adults can partake fully of services offered to other elders. HIV-positive adults (peer educators) should be included as both trainers and advisors.
- Maintain the inclusive language in Part E of the National Family Caregiver Support Program that defines family caregiver as “an adult family member, or another individual, who is an informal provider of in-home and community care to an older individual.”
- Appropriate ASO staff should work with their Area Agencies on Aging (AAAs) to assess the needs of older adults with HIV, evaluate whether those needs are being met by community-based services, and influence their area plans to ensure that older adults with HIV have the services they need and deserve.
- To improve the ability of AAAs in effectively serving older adults with HIV, we recommend:
 - in-service training on issues involving aging and HIV, conducted by ASOs, to the staff of member agencies.
 - developing effective outreach strategies, including marketing strategies targeting older HIV-positive adults.

- o developing collaborations between senior centers and CBOs/ ASOs already providing services to older adults with HIV.
 - o better outreach coordination by ASOs and senior centers to HIV-positive older adults to join in the socialization activities in senior centers.
- Training for home healthcare staff on the needs of older HIV-positive people, including education aimed at eliminating stigma or other forms of prejudice.

Research

- Provide funding for targeted research aimed at treating depression and other mental health problems, including substance use and sexual risk-taking in older adults with HIV.
- Increase knowledge, through research, about how stigma continues to prevent people from disclosing their serostatus to others, thus limiting the amount and frequency of support they receive from family, friends and others.
- Funding should be made available from the National Institutes of Health (NIH) and the National Institute of Mental Health (NIMH) for:
 - o research on the needs and concerns of older HIV-positive adults.
 - o evaluation of existing health and social services and their use by older adults with HIV.
 - o development of gerontology and social work curricula at colleges and universities that train aging specialists and service providers in the particular needs of the over-50 HIV-positive population.
- Increase funding for basic research on the interaction between HIV and the common diseases of older adults, especially pertaining to drug interactions, needed to more accurately document the experiences and issues facing older adults as they become

susceptible to other common age-related illnesses. These illnesses may have an impact on both the medical and social care of older adults who are living and aging with HIV.

- Ensure that older people are included as an identifiable group at every stage of the HIV research process.

ROAH SURVEY INSTRUMENT COMPONENTS

Module 1: Demographic Profile

- Sociodemographic/background characteristics of individuals.

Module 2: Health Status

- Detailed HIV history including CD4, viral load, when diagnosed, HAART, etc.
- Past and current substance use, recovery, etc.
- Selected scales from the MOS-HIV will also be used for this module.
- The module contains the 20-item CES-D.

Module 3: Sexual Behaviors

- Sexual behavior checklist includes sexual activities, number of partners, safer sex practices, serostatus of partners, etc.

Module 4: Social Networks

- Perceived network size, functional network size, support satisfaction and support need.
- Independent measures of availability and adequacy of instrumental and emotional support.

Module 5: Stigma

- The Berger HIV Stigma Scale included in this module.
- Level of disclosure, reasons for not disclosing, and level of stigma experienced during interactions with six (biological family, friends, co-workers, social organizations, place of worship, and healthcare providers) groups of people.
- Reasons for nondisclosure

Module 6: Psychological Resources

- Psychological well-being - The absence of physical or mental symptomatology does not imply optimal health. Ryff's scales of psychological well-being encompass six domains (self-acceptance, positive relations with others, autonomy, environmental mastery, purpose in life, and personal growth) that measure positive aspects of well-being.
- Spirituality - Howden Spirituality Assessment Scale is a 28 item instrument with four subscales: 1) Purpose and Meaning in Life, 2) Inner Resources, 3) Unifying Interconnectedness, 4) Transcendence.

ROAH Methodology

Specific Aims

The primary goal of this research was to establish empirically valid normative data describing this population and to allow for the analyses of subgroups within the larger population. For example, comparisons of gender, education, health and race/ethnicity can identify potential disparities among these older adults, which will need to be addressed by healthcare providers and policy makers. New York City's HIV population, the largest and most diverse in the United States, is a gauge for changes in the HIV epidemic nationwide. This cohort of aging New Yorkers will be a benchmark against which other studies of aging adults with HIV will be compared. Pending future funding, this cohort will become the baseline data sample of a longitudinal cohort study of older adults with HIV. Before the ROAH study was undertaken, no other group representing the current demographic profile of older adults with HIV existed. Existing cohorts have limited utility because they contain highly selective groups of older adults (e.g., veterans, gay men).

Project Site

ACRIA is a well-established research entity that has completed over 80 clinical and behavioral studies on HIV, its related diseases, and side effects associated with antiviral medications. ACRIA's research program has existed since

1991, with proven procedures in place to monitor and evaluate progress of individual protocols. These procedures concern multiple aspects of a research project from timeliness and accuracy with regard to completing all study phases to compliance with HIPAA standards and other practices to protect study participants. The agency has consistently been among the most successful enrolling sites for national multicenter trials of new HIV medications, and has always been in full compliance with FDA regulatory requirements for trials of experimental therapies utilizing human subjects. In fact, a hallmark of ACRIA's work has been a strong focus on ensuring that all populations impacted by HIV have an opportunity to participate in our studies, including vulnerable populations traditionally underserved by HIV research, most prominently ethnic minorities and women.

ACRIA has one of the most extensive networks of partnerships with community-based organizations and AIDS service organizations of any not-for-profit organization in New York City. This network was used extensively in the recruitment of study participants for the proposed protocol. The agency maintains a database of over 1500 people living with HIV who are interested in receiving information about clinical and behavioral studies at ACRIA. These individuals received IRB-approved recruitment materials for this study.

Sample Selection and Recruitment

As of March 31, 2005, the last date for which data are available, there were approximately 95,707 known cases of HIV in New York City. Of this number, 28,433 (30%) were over age 50. Study participants ($N = 1,000$) were selected from this population. The ROAH study team utilized ACRIA's existing relationships with organizations in New York City to recruit individuals for the study. Recruitment occurred through on-site trainings, presentations and staff visits, as well as mail, telephone and email contacts.

Eligibility Criteria

- confirmed HIV diagnosis.
- age 50 years or older.

- reside in or receive HIV-related healthcare in New York City.
- sufficiently fluent in English to complete the measures.
- community-dwelling (non-institutionalized).
- have no significant cognitive impairment that would preclude completing the study instrument.

Instrument

The ROAH Program utilized a quantitative, self-administered instrument designed by the study investigators, composed of several standardized research measures in addition to items drawn from the investigators' previous. The instrument is designed to collect detailed information from five general conceptual areas (e.g., physical health, mental health, social support, formal care utilization, and HIV-related stigma and disclosure of HIV serostatus). The instrument has been constructed to yield empirically valid data that can be compared to population norms as well as other studies of HIV-positive individuals. These comparisons will provide a wealth of information about a group of older adults that has been heretofore invisible.

Conceptual Model

The conceptual model for the study is based on the stress and coping model (Lazarus, 1966) in combination with past empirical work by the Principal Investigator and others on the relationship between social support and well-being. The stress and coping model includes exogenous variables that are expected to affect living with to HIV and well-being, which are mediated by social support factors. Exogenous (independent) variables include sociodemographic characteristics (e.g., age, race, sex), HIV status (e.g., CD4 count, viral load, perceived stigma), and other health indicators (e.g., health-related quality of life, strain). Mediating variables in this model are measures of functional support resources, support availability and support adequacy. Outcome (dependent) variables will be quality of life (e.g., psychological well-being, life satisfaction, depression). Investigators will use innovative and sophisticated data analysis techniques such as hierarchical regression, structural equation modeling and qualitative

analysis to analyze study data. These statistical methods allow the research team to document the complex interconnections of multiple variables that affect the lives of older adults with HIV in addition to developing a model of how individuals adapt to chronic illness.

Measures

Demographic profile. Single items assessed participants' age, race/ethnicity, sex, education, health status, living arrangement, employment status, religious affiliation and participation, sexual orientation, income adequacy, history of incarceration, health coverage, and life satisfaction.

HIV status. Single items assessed date of HIV diagnosis, receipt of an AIDS diagnosis, prior history of HIV testing, CD4 count, HIV infection risk factors, use of HAART and complementary and alternative medicine use, and type of healthcare provider.

Depression. Depressive symptomatology was measured by the Center for Epidemiologic Studies Depression Scale (CES-D; Radloff, 1977). The CES-D is a 20-item self-report scale designed to assess depressive symptomatology in the general population. The CES-D includes few somatic indicators, thus reducing the likelihood of elevated depression scores due to the physical symptoms common among people living with HIV. This measure has demonstrated high internal consistency (Cronbach's α s = .85 to .90) across diverse community and clinical samples (Radloff, 1977; Ryff & Essex, 1992). Responses are summed to obtain a total symptom score with a range of 0 to 60; higher scores indicate greater depressive symptomatology. Scores below 16 suggest that a person is not depressed. Scores between 16 and 27 indicate moderate levels of depression that would likely correspond with a clinical depression diagnosis, while scores of 28 and above indicate severe levels of depression.

Informal support networks. Detailed information regarding network size and composition, as well as frequency of contact and level of affiliation with network members was collected with an assessment used in previous studies of social networks (Cantor & Brennan, 1993; Shippy, Cantor, & Brennan, 2004; Shippy & Karpiak, in press A, B). Five groups (e.g., parents, children, siblings, other relatives, and friends), or network elements, that typically comprise

informal networks will be examined. Participants indicate if they have any living members of a network element. Three additional items assess frequency of contact with the element (e.g., in-person visits, telephone conversations, and written correspondence), using a five-level, Likert-type scale (daily, weekly, monthly, several times a year, once a year or less). A final item assesses the level of affiliation with the network element (e.g., very close, somewhat close, not too close, not close at all). Assessments of contact frequency are necessary to calculate the functional status of each network element, based on criteria established by Cantor (Cantor, 1979). These criteria define the minimum level of contact as either monthly in-person visits or weekly telephone conversations.

Support availability and adequacy. Four items assessed availability and adequacy of informal network support. Two identical items provided separate ratings of emotional and instrumental support availability, “Do you have someone you can count on to help you with [type of support]?” Respondents indicated availability on a four-level scale (e.g., most of the time, some of the time, occasionally, or not at all). Adequacy of support was assessed similarly to yield independent ratings for emotional and instrumental support needs. Participants responded to the item, “In the past year, how much more help or assistance with [type of support] did you need,” by indicating one of four choices (e.g., needed a lot more, needed some more, needed a little more, or I got all the help I needed).

Frequency of ADL support. Participants indicated the frequency and types of assistance provided by family members and friends (e.g., two sets of eight positive and three negative types of support that were provided by family and friends in the past month). Each of these responses was scored on a six-point Likert-type scale anchored with ‘everyday’ and ‘not at all’. Responses were summed for each section separately to create a frequency of ADL help provided by family members and friends.

Loneliness. The UCLA Loneliness Scale (Russell, 1996) is a 20-item measure with high internal consistency (coefficient α s = .89 to .94) and acceptable test-retest reliability after one year (r = .73). There are 11 negatively worded items and nine positively worded items in the third version of the

scale. Participants responded to items with a four level scale (never, rarely, sometimes, always). The nine positively worded items are reverse coded and scores from all 20 items are summed. Higher scores indicate greater degrees of loneliness.

Substance Use. A substance use checklist assessed both past and current use of 15 different substances (e.g., tobacco, alcohol, cocaine, heroin, etc.). In addition, respondents indicated if, during the past 90 days, they engaged in sexual activities while under the influence of each of these substances.

Sexual Behaviors. Participants answered a series of gender-specific questions regarding their sexual behaviors in the past 90 days. The questions are designed to determine if respondents are involved in seroconcordant relationships or if they engage in sexual activities with HIV-negative partners and individuals who do not disclose their HIV status. In addition, participants will record the number of times they engaged in several behaviors with and without barrier protection (e.g., condoms or dental dams).

Health-related quality of life. Selected subscales (e.g., energy/fatigue, cognitive function, pain, physical function) from the MOS-HIV (Wu et al, 1991) will be used to assess health-related quality of life (HRQoL). These subscales were chosen because they assess unique domains not assessed by other measures in the instrument. In particular, the energy/fatigue subscale has been a significant indicator of functional ability in a previous study of older adults with HIV, conducted by the investigators (Shippy & Berman, 2004).

Psychological well-being. Ryff's (1989) theoretically-derived scales were used to assess psychological well-being. Each of the six 9-item scales (e.g., autonomy, environmental mastery, personal growth, positive relations with others, purpose in life and self-acceptance) utilize a 6-point scale ranging from 'strongly agree' to 'strongly disagree' to assess well-being. Internal consistency for the scales is high, ranging from .93 (self-acceptance) to .86 (autonomy). These scales provide positive indicators of mental health and quality of life, as opposed to only assessing deficits.

Spirituality. The Spirituality Assessment Scale (SAS; Howden, 2000) is a 28-item self-report instrument constructed to measure four critical attributes of spirituality

(e.g., purpose and meaning in life, inner resources, unifying interconnectedness and transcendence). The SAS employs a 6-point response format ranging from Strongly Disagree to Strongly Agree (with no neutral option). The SAS is scored by summing the responses to all 28 items; each of the four subscale scores may also be obtained by summing the responses of the subscale items. The instrument was found to have high internal consistency $\alpha = .92$. The four subscales were found to have acceptably high internal consistency, $\alpha = .71$ to $\alpha = .91$.

HIV-related stigma. The HIV Stigma Scale (Berger, 2001) is a 40-item instrument to measure the stigma perceived by people with HIV. Analyses from previous studies of diverse samples of people living with HIV have identified four factors (e.g., personalized stigma, disclosure concerns, negative self-image, and concern with public attitudes toward people with HIV) and an overall summary score. Coefficient alphas between .90 and .93 for the subscales and .96 for the 40-item instrument indicate a high level of internal consistency.

Disclosure of HIV serostatus. Disclosure was assessed with an 8-item scale used in previous studies of older adults with HIV (Shippy & Karpiak, 2005a, 2005b). Respondents indicate how many people from various groups of individuals (e.g., family, friends, co-workers, sex partners, drug buddies, social/political organizations, healthcare providers, people at place of worship) are aware of their HIV status by marking one of four (i.e., none, a few, some or all) levels of disclosure. Participants indicated reasons for non-disclosure on a checklist of common reasons for withholding information about one's HIV status from important others. Responses ranged from "I'm afraid they might kill me" to "They have too many other things to worry about now."

Biographies

Stephen Karpiak, PhD

Stephen Karpiak has a distinguished career as a research scientist. After obtaining his PhD in 1972 he joined the

faculty of Columbia University Medical School with an appointment in Neurology and Psychiatry.

At Columbia for over two decades he conducted cutting-edge NIH and NSF funded research on the Immunological Bases of Seizures and Behavioral Disorders. His work showed that antibodies were capable of entering the brain and causing epileptic activity as well as significant behavioral alterations. In 1976 he published a seminal work in *Science* in the field of neuroimmunology.

In his last decade at Columbia he achieved international recognition as a researcher by demonstrating that the brain could adapt and repair after injury. His research contributed to changing the widely held belief that in the CNS there was only limited capacity to recover after injury. His work has contributed to the development of treatments and therapies for the management of peripheral neuropathies, stroke and spinal injury.

He has given over 300 invited lectures nationally and internationally and has been a scientific adviser for the United Nations WHO as well as serving on NIH peer review committees. He has published over 100 peer-reviewed articles.

After retiring from Columbia in 1993, Karpiak did his first HIV/AIDS community work in Phoenix. He was a Program Director at *AIDS Project Arizona*, directed its buyers club, and founded the *Arizona AIDS Project Wellness Center*.

He later was the Executive Director for *A Place Called Home*, which provided congregate group housing for the homeless with HIV/AIDS using HUD/HOPWA funding.

He returned to NYC to become Executive Director for *Pride Senior Network* and for the last three years has been the Associate Director for Research at ACRIA. With ACRIA support he initiated seminal studies on HIV and the aging population, and most recently saw ACRIA launch an historic research effort to study 1000 people over the age of fifty living with HIV/AIDS in NYC.

R. Andrew Shippy, MA, PhD (c)

Shippy is a doctoral candidate in Applied Developmental Psychology at Fordham University and has conducted gerontological research since 1997. His primary research interests include social support, psychological well-being, caregiving, and personal development in middle age and older adulthood. He has studied the effects of chronic illness and stigma among many vulnerable populations.

His work with Dr. Caryn Goodman at *Lighthouse International* examined the impact of vision impairment on the marital relationship and the mental health of disabled elders and their nondisabled spouses, and his research with Dr. Mark Brennan examined the roles of spirituality and religiousness in coping with vision impairment and personal development among middle-aged and older adults. In 2000, he (with Prof. Cantor and Dr. Brennan) began work on the first large-scale study of the caregiving experiences and needs of LGBT seniors in New York City, a joint research effort of Pride Senior Network, the National Gay and Lesbian Task Force Policy Institute and Fordham University Graduate School of Social Service.

Presently, he is an Associate Research Scientist at ACRIA, where he conducts behavioral research focusing on the growing population of older adults living with HIV. This research examines the impact of personal and social support resources on the quality of life aging adults living with HIV. He has published several articles and presented his research at major national and international scientific and advocacy conferences.

Marjorie Cantor, Emerita

Professor Marjorie Cantor is Professor Emerita and Brookdale Distinguished Scholar of Fordham University Graduate School of Social Service and the Scholar in Residence of Lighthouse International. Professor Cantor is a nationally and internationally recognized leader in the field of aging. A past President of the Gerontological Society of America,

she was the first Director of Research for the New York City Department for the Aging. Professor Cantor most recently served as a Principal Investigator on the major cross-ethnic study of New York's elderly, *Growing Older in New York in the 1990's*, and has been the Principal Investigator of over nine other large scale studies during her twenty-five years in the field of aging. She is the recipient of numerous awards including a Certificate of Appreciation from the City of New York for Outstanding Service to the City and its Elderly; the Kent Award annually given by the Gerontological Society to a member who exemplifies the highest standards of professional leadership through teaching, service, and interpretation of gerontology to the larger society; and the Walter M. Beattie, Jr. Award for Distinguished Service in Aging from the State Society on Aging. She is a member of the Hunter College Hall of Fame. While at Fordham, Professor Cantor served as the Associate Director of the Third Age Center and Director of the Brookdale Research Center and Doctoral Training Program, in addition to being a faculty member of the Graduate School of Social Service. She currently continues to teach in the School and is responsible for the Doctoral Seminar in Aging as well as mentoring students involved in dissertations.

She has served as a consultant to numerous Federal, State and local agencies and boards; was a Senior Fellow of the Brookdale Foundation; and was a participant in both the 1980 and 1995 White House Conference on Aging and an Invited Participant at the International Forum on Aging hosted by the Chinese Government in Beijing. Her particular areas of research expertise include elderly in the urban setting, the effect of ethnicity and culture on elderly life styles, and the role of family and other informal supports in providing care for older people. She is the author of over 70 articles, books, chapters and papers presented here and abroad.

Giving a Voice to Those Who Are Invisible

As a research initiative, ROAH is ambitious in its size and scope. ROAH represents the voices of almost 1000 New York City older adults living with HIV who completed the study instrument. We thank them first! Listen to their voices.

The ROAH research endeavor attracted no government , foundation, or private financing. The trusting support of ACRIA's Board of Directors, and especially its former Executive Director, J Daniel Stricker, allowed this pioneering effort to move forward. They supplied both the financial support and the confidence this scientist needed to advance the effort.

ROAH is massive and comprehensive. It represents the labors of a large team of researchers and community members who unselfishly provided the insight and guidance needed to construct and execute ROAH. Their expertise, enthusiasm, and effort continue to guide the ongoing complex analyses of almost one million data points. They have been remarkable proponents of this research effort. Our continued dialogue advances the findings of ROAH. We thank them for being friends of ACRIA and those whom we serve.

ROAH has followed the rigorous demands of scientific inquiry. This adherence to established scientific process is shared by both Co-Principal Investigators. We believe that it was ACRIA's mission to use valid methodologies to begin to identify the emerging needs of these older adults living with HIV.

ROAH is a vision made real. Moving from idea to reality has been a process watched with caring eyes and a demanding intellect. Those elements best characterize the role of Professor Emerita Marjorie H. Cantor. Her firm hand has guided ROAH from inception to the ongoing publication of its findings. She has been a mentor, teacher, and friend who has influenced these investigators profoundly. ACRIA is fortunate to have counted Professor Cantor as a member of the ROAH team. She reminds us that "...teachers affect eternity". Thank you Marge.

Our personal gratitude and that of ACRIA goes to the family of professionals, community members, and study participants for making ROAH possible.

Stephen E. Karpiak, PhD, and Andrew Shippy PhD (c)
ROAH Co-Principal Investigators
ACRIA

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Quality Management Committee
Monday, May 21, 2012 at 12:30PM
Minutes



Attendance					
#	Members	Present	Absent	Guests	Grantee Staff
1	Rajner, M. Chair	X		Majcher, B.	Degraffenreidt, S.
2	Grant, C.	X		Volpitta, R.	Jones, L.
3	Johnson, K.	X			
4	Katz, H.B.	X			
5	Martin, M.	X		CQM Staff	
6	Quintana-Jefferson, M.	X		Eshel, A.	
7	Schweizer, M.		X	Smith, N.	
Quorum = 5		6			

1. Call to Order

The Chair called the meeting to order at 12:46 p.m.

2. Welcome and Introductions

The Chair welcomed everyone and attendees were notified of information regarding Government in the Sunshine Law and it was noted that a statement was added to the agenda on the Sunshine Law. Meeting reporting requirements, which include the recording of minutes, was also made known to attendees. In addition, they were advised that the acknowledgement of HIV status is not required but is subject to public record if it is disclosed.

3. Moment of Silence

4. Ground Rules and Approvals

- A. Review Meeting Ground Rules and Statement of Sunshine
- B. Review Public Comment Requirements (Please Sign-in)
- C. Excused Absences
- D. Approval of Today's Agenda

Motion #1	To "approve the 5/21/12 Meeting Agenda with the addition of item 4: Approval of 2/27/12 Minutes."
Proposed By:	H. Bradley Katz
Seconded By:	Claudette Grant
Action:	Passed unanimously

E. Approval of 03/19/12 Meeting Minutes

Motion #1	To "approve 3/19/12 Meeting Minutes."
Proposed By:	H. Bradley Katz
Seconded By:	Claudette Grant
Action:	Passed unanimously

F. Approval of 02/27/12 Meeting Minutes

Motion #1	To "approve the 2/27/12 Meeting Minutes."
Proposed By:	H. Bradley Katz
Seconded By:	Claudette Grant
Action:	Passed unanimously

5. Election of Vice Chair

The Chair explained that per the HIV PC bylaws, Part A standing committees that are not joint committees can opt to elect a vice chair. Electing a Vice-Chair ensures that in the absence of the Chair, the Committee may continue its work without disruption. The Chair explained that, according to the By-Laws, the Vice-Chair must be an HIV Planning Council (HIVPC) member; three QMC members were identified as HIVPC members. The Chair asked each of the three members if they would consider becoming Vice-Chair. Ms. Claudette Grant expressed interest and was voted unanimously as the QMC Vice-Chair.

6. Work Plan Update (Handout A)

Members were advised that the 2012-2015 Comprehensive Plan was in the process of being submitted to HRSA. The Annual QM Work Plan will be revised to reflect the goals of the Comprehensive Plan. Discussion regarding revisions to the Plan will be added to the next agenda. The Committee requested to receive the document prior to the next meeting for review.

7. Partners In+Care Campaign Overview (Handout B)

The QMC reviewed a presentation on Partners In+Care, a peer focused component of the NQC In+Care Campaign, to discuss what recommendations the QMC can make to implement the campaign, encourage JCCR participation in it, or pilot the campaign to test its impact. The QMC discussed ways to involve peers in engaging others in care and noted that training would be needed along with incentives to encourage involvement. Members inquired whether NQC had a format that the HIVPC could use to implement the program. Staff will contact NQC to discuss how other EMA's have incorporated the peer component into the overall In+Care Campaign. NQC will host a webinar "*Reaching Out to Show the Benefits of Care*" on May 24, 2012 at 2:00 P.M. A reminder of the webinar will be sent to Committee members after the meeting

8. QI Network Quarterly Update (Handout C)

Oral Health Care QI Network:

The Network is currently working on developing new Outcomes/Indicators to more accurately measure oral health care services. The Network made recommendations for revisions and is finalizing the language to be used. Members will meet independently to work on the language revisions, as well as the plan to measure the outcomes in PE; revisions will be brought forward for approval at the next Network meeting in July.

Mental Health/Substance Abuse QI Network:

The Network was asked to review data from the past year detailing the reasons why clients were discharged from MH/SA services for non-compliance. The goal of the data review was to develop a client profile of those clients who may be at increased risk for falling out of medical care. Providers found a link between non-compliance and clients with chronic mental illness, especially severe depression, drug use, and homelessness. Of all barriers to retention, depression was identified as the most significant. Transportation was initially assumed to be a barrier; however, retention did not improve as expected after clients were provided with bus passes. The MH/SA Network recommended adding a PE trigger, '*additional support needed*', for clients who suffer from severe depression that is impacting their ability to be retained in care. The trigger would prompt other providers to have additional discussion with clients suffering from depression with the goals of promoting adherence. The Network will develop: 1) a presentation that will help identify mental health issues and warning signs, and 2) language for the PE alert. The information will be presented during an All Networks meeting and a Medical QI Network meeting in July.

Members suggested adding a broader PE trigger that would encompass other barriers to retention as well. Some identified barriers were aging-related issues like memory loss and medication burnout for those clients who have been on ARVs for many years. Members asked that the conversation about HIV among the aging population continue at the next meeting to determine if the

QM Committee should develop particular activities to address the aging population's needs.

There was discussion regarding accessibility to MH/SA agencies. The Committee was advised that appointment times varied by agency. The Committee requested that all future quarterly Network reports include current appointment wait time information for each service category. It was noted that information on Medical and MCM appointment wait times is provided from the Grantee's office on a monthly basis in the Access reports. The reports will be included in the Quarterly Network updates to the QMC.

Medical QI Network:

The Network is in the process of developing a QIP to improve cervical screening rates. Site visits were conducted to identify discrepancies between cervical screening data in PE and agencies' Electronic Medical Records. A summary of findings will be presented to the Network. The Network provided feedback on Operation H.O.P.E.F.U.L. and although providers were pleased with the program, concerns were raised regarding the providers' ability to review the cards during a 15 minute medical visit. The Network noted that Medical Case Managers were the ideal users of the cards. A report of comments and concerns from the Medical Network and the Medical Case Management Network will be submitted to AETC in June. Additionally, the Network is in the process of reviewing Part A drug utilization data and recommending additions/deletions to the Local Pharmacy Advisory Committee.

Medical Case Management QI Network:

The Network is currently developing a QIP to improve retention rates. Gap Measure client level data was distributed to the agencies and providers will submit findings of the reasons why clients did not attend a medical visit in the last six months of the measurement period. The information will be analyzed in June and reviewed at the July Network meeting.

Combined QI Network:

Members noted several barriers to implementing a QIP focused on retention – 1) Inaccurate appointment records in PE; 2) Reliance of client self-reported information on attended and upcoming appointments; 3) Name/URN Change making locating the client's record difficult; and 4) Access to PE not available to all staff. Members were asked to track the following data elements over the course of one month to determine the barriers to support services' ability to reinforce retention in medical care - Last Attended OAMC Appointment, Data Source (e.g., PE, Client Self Report), If client missed appointment, reason for missed appointment, Data Source (e.g., PE, Client Self Report), Next Scheduled OAMC Appointment, Data Source (e.g., PE, Client Self Report), If appointment is scheduled, confirm it and reinforce the importance of attending the appointment, If no appointment is scheduled, document action step (e.g., Appointment made and documented in PE, client's MCM contacted for assistance, etc.)

9. Review Client Level Outcomes/Indicators (WP 3A) (Handout D)

A. Pharmacy

The Pharmacy Network met on 5.8.12 to discuss the QMC recommendations to change the medication pick up time from 'within 14 days of filling a prescription' to 7 days. Agreement was not reached. In addition, it was agreed that further discussion is needed regarding development of a better indicator for improved medication adherence. The Pharmacy Network will hold an informal meeting on 5.22.12 to continue the discussion. All recommendations will be brought to the QM Committee.

B. Medical Case Management

The Committee previously approved the Outcomes/Indicators. At this time the information is being programmed into PE to monitor compliance of the Plan of Care goals.

C. Food Bank

A meeting between Grantee and Food Bank staff will be held in June to develop outcomes and indicators that reflect the impact of Food Bank on health outcomes.

D. CIED

Following revisions to the Outcomes/Indicators, the Committee requested that additional language be added to clarify revised indicator 1. CQM support staff noted the language was changed to read: *95% of clients eligible for Part A OAMC who have not had a Part A OAMC appointment within the last 6 months **at the time of recertification** shall have an OAMC or Medical Case Management appointment scheduled within 1 business day.* Members questioned how requests for assistance for third party benefits would be monitored. The Chair requested this item be placed on the next agenda for further discussion with a CIED representative present.

Original Outcomes	Original Indicators	Revised Outcomes	Revised Indicators
Provide rapid engagement of clients into care.	95% of clients requiring Ambulatory Outpatient Medical Care or Medical Case Management services shall have an appointment scheduled within 1 business day.	Provide rapid engagement of clients into care.	95% of clients eligible for Part A OAMC who have not had a Part A OAMC appointment within the last 6 months shall have an OAMC or Medical Case Management appointment scheduled within 1 business day.
Provide access to benefits for which client is eligible.	95% of clients eligible for 3rd party benefits will receive assistance in completing applications for those benefits.	Provide access to benefits for which client is eligible.	95% of clients that meet eligibility criteria for 3rd party benefits will receive assistance in completing applications for those benefits.
Clients will have their HIV/AIDS related needs met.	95% of clients will receive referrals to both Ryan White and/or Non-Ryan White services as identified in the Intake Needs Assessment. 95% of clients receiving referrals will have a disposition follow up within 14 business days.	~~Clients will have their HIV/AIDS related needs met.~~	~~95% of clients will receive referrals to both Ryan White and/or Non-Ryan White services as identified in the Intake Needs Assessment.~~ ~~95% of clients receiving referrals will have a disposition follow up within 14 business days.~~

E. Oral Health Care

The Network is scheduled to meet informally, prior to the regularly scheduled July 11, 2012 meeting, to finalize revisions to the Oral Health Care Outcomes and Indicators.

10. Unfinished Business

11. New Business

- A. Ryan White HIV/AIDS Program 2013 Reauthorization: Comments Requested
Comments are due by July 31.

12. Grantee Reports

- A. Part A Grantee Report
None.

13. Resources and Announcements**14. Public Comment****15. Reminder:** Meeting Attendance Confirmation Required at least 48 Hours Prior to Meeting Date**16. Request for Information/Directives****17. Agenda Items for Next Meeting**

- Standing Agenda Items
- Follow-up on the Partners In+Care Campaign
- HIV and the Aging Population
- Follow Up on CIED and Food Bank outcomes and indicators
- 2012-2015 Comprehensive Plan

18. Next Meeting Date: Monday, June 18, 2012 at 12:30 p.m.**19. Adjournment**

Consent Item #1	To "Adjourn at 2:35 P.M."
Action:	Passed unanimously.



**Reaching Out to Share the
Benefits of Care:
Retention and Peer
Advocacy**

May 24, 2012

For Audio: Dial-in#: 866.394.2346 Participant Code: 3971546368#

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National Quality Center [NQC]

Welcome & Overview



Michael Hager
NQC Manager,
TA/Dissemination
New York, NY
mth02@health.state.ny.us

- This Partners in+care webinar is offered as part of the in+care Campaign.
- The in+care Campaign is a national effort to improve retention in HIV care.
- Webinars are one of many Partners in+care activities designed to engage people living with HIV/AIDS and their allies in the in+care Campaign.
- This webinar addresses how peer advocacy supports engagement in HIV care and retention. It is the third in our series. Others identified why retention is important and role of self-care.

For more information: www.incarecampaign.org

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National Quality Center [NQC]

**Welcome, Overview, Participation Guidelines
Ground Rules for Webinar Participation**

- Welcome
- This is a "public event." If you have confidentiality concerns . . .
- Your names appear on-line in the list of webinar registrants--*consider just listing to the audio or to viewing the webinar at a later time, after it is posted at www.incarecampaign.org*
- All webinars are recorded--*do not use identifying information when asking questions*

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For Audio: Dial-in#: 866.394.2346 Participant Code: 3971546368#

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National Quality Center [NQC]

**Welcome, Overview, Participation Guidelines
Ground Rules for Webinar Participation**

- Actively participate and write your questions into the chat area during the presentation; we will also have a "pop up" question exercise, and will pause for conversation during the webinar
- Do not put us on hold
- Mute your line if you are not speaking (press *6, to unmute your line press #6)
- The slides and recording of this and other Partners in+care webinars are available for playback and group presentations at www.incarecampaign.org - "Resources" tab

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For Audio: Dial-in#: 866.394.2346 Participant Code: 3971546368#

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National Quality Center [NQC]

**Welcome & Introduction
Agenda**



Bob Tracy, NQC
Peer Consultant
St. Paul, MN
bobtracyconsulting@gmail.com

- Welcome, Overview, Participation Guidelines - 5 mins
- Agenda, Learning Objectives, Introductions - 5 mins
- Characteristics of Effective Peer Advocacy, 20 mins
- Putting Peer Connections into Action, 20 mins
- Connecting through Partners in+care, 5 mins
- Wrap-up & Evaluation, 5 mins

Conversation opportunities throughout webinar

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National Quality Center [NQC]

**Welcome & Introduction
Learning Topics**

- At the end of this webinar, you will know more about . . .
- How peer advocacy can be used to support retention in HIV care
 - Key elements of successful peer advocacy
 - How to use Partners in+care to support your retention activities

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National Quality Center [NQC]

Retention & Peer Advocacy

What is retention?



- Stay in care / Return to care
- Retention –having a routine for seeing your doctor/health care provider on a regular schedule
- Doing this persistently – year-after-year-after-year

There is a relationship—a seemingly obvious relationship— between regular medical visits and improved health and reduced mortality. Research published in 2010 provides the first data to demonstrate the survival advantage of regular HIV care. [Giordano, 2010]

For more information about retention and its benefits visit www.incarecampaign.org - "Resources" tab

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7 National Quality Center [NQC]

Retention & Peer Advocacy

What are barriers to retention?



- Do not feel sick
- Need more HIV info
- "Life" gets in the way
 - Other health issues
 - Little experience with routine health care
 - Not enough help
- Clinic/system too complex
 - Processes are confusing
 - Need more help at clinic

Check out the in+care Campaign video www.incarecampaign.org - "Partners" tab

For more information about barriers to retention visit www.incarecampaign.org - "Resources" tab

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8 National Quality Center [NQC]

Retention & Peer Advocacy

How can peer advocacy improve retention?



- Peer-to-peer connections can support retention
- Can be formal [staff] or informal [volunteers]
- What can peers offer peers?
- What makes for effective peer advocacy?

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9 National Quality Center [NQC]

Characteristics of Effective Advocacy

"Positive Examples" – Experiences of Peer Educators

in+care



Marcia Dutcher
Evaluation Consultant
Kansas City, MO
marciadutcher@yahoo.com

- Peers can impact access, engagement & effective use of care and services, social support, self care & contribute to cost effectiveness
- Evaluation based on PETS/REC – Understand essential characteristics of peer-based interventions & role of peers?

"Positive Examples": A Bottom-up Approach to Identifying Best Practices in HIV Care and Treatment Based on the Experiences of Peer Educators, AIDS Patient Care & STDs, Vol. 25, April, 2011
http://www.cardeaservices.org/resources/documents/rsc_Positive-Examples-Dutcher-Phici-Goldenkranz.pdf

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10 National Quality Center [NQC]

Characteristics of Effective Advocacy

PETS/REC Overview



- Train PLWHA to serve as peers to engage other PLWHA in care and treatment
- Build capacity of organizations and communities to integrate peers into HIV care and treatment services

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"Positive Examples": A Bottom-up Approach to Identifying Best Practices in HIV Care and Treatment Based on the Experiences of Peer Educators, AIDS Patient Care & STDs, Vol. 25, April, 2011
http://www.cardeaservices.org/resources/documents/rsc_Positive-Examples-Dutcher-Phici-Goldenkranz.pdf

11 National Quality Center [NQC]

Characteristics of Effective Advocacy

"Bottom-Up" Approach to Defining Effective Advocacy



- Interviewed experienced HIV+ peers
- 23 interviewees; urban/rural; variety of demographic characteristics & peer work experience
- Describe roles, activities, strategies and elements important to success

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"Positive Examples": A Bottom-up Approach to Identifying Best Practices in HIV Care and Treatment Based on the Experiences of Peer Educators, AIDS Patient Care & STDs, Vol. 25, April, 2011
http://www.cardeaservices.org/resources/documents/rsc_Positive-Examples-Dutcher-Phici-Goldenkranz.pdf

12 National Quality Center [NQC]

Characteristics of Effective Advocacy Context for Peer Advocacy



- Relationship
 - Mutually identified as HIV+
 - Shared experience
 - Credibility; role model
 - Motivate change
- Support
 - Focus on health behaviors; access and use of care/treatment
 - Practical needs; relieving barriers
 - Flexible response to needs

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"Positive Examples": A Bottom-up Approach to Identifying Best Practices in HIV Care and Treatment
Based on the Experiences of Peer Educators, *AIDS Patient Care & STDs*, Vol. 25, April, 2011
http://www.cardeaservices.org/resources/documents/rsc_Positive-Examples-Dutcher-Phicil-Goldenkranz.pdf

13 National Quality Center [NQC]

Characteristics of Effective Advocacy Social Support Categories

Instrumental	Informational	Emotional	Affiliational
Tangible aid and services that directly assist a person in need	Communicating advice or information to assist a person in addressing problems or self-assessment	Providing empathy, love, caring and trust	Convey or assist with a connection to a social network of reciprocal help or mutual obligation

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14 National Quality Center [NQC]

Characteristics of Effective Advocacy Social Support Categories

Instrumental	Informational	Emotional	Affiliational
Directly connect to care	Support learning & understanding	Support & relieve stress	Address isolation
Provider referrals	Comprehend info from providers	Build confidence to change behavior	Connect to social networks
Research info & resources	Not replace provider; clarify in layperson's terms	Challenge to change behavior	Integrate opportunities to inform & engage care
Scheduling support [e.g. reminder calls, rides]	Understand & navigate health system/provider		Motivate change
	Prep for provider visits		

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15 National Quality Center [NQC]

Characteristics of Effective Advocacy Summary of Findings



- Unique ability to engage and motivate; power of common experience and role models
- Provide direct education and connect to care and resources [e.g. support retention]
- Also address basic needs [e.g. overcome barriers to retention]

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16 National Quality Center [NQC]

Characteristics of Effective Advocacy Summary of Findings



- Peer advocate needs to be comfortable identifying as HIV+; establish connection
- Ability to *flexibility* respond to needs
- Creating fit with clinic/organization; clearly define peer roles and fit; using social support framework can help
- Training and support are critical

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17 National Quality Center [NQC]

Characteristics of Effective Peer Advocacy Conversation

Pop-up Question

?

*In your opinion, what is the social support peers can provide **most** effectively?*

Instrumental?
Informational?
Emotional?
Affiliational?



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Additional Questions? Contact us a info@incarecampaign.org

18 National Quality Center [NQC]

Putting Peer Connections into Action Panel Discussion - Introduction



*What have we learned
from our experiences about
what makes peer advocacy
effective and useful for
promoting retention?*



Mike Maginn, Executive Director
Friends of People with AIDS
Peoria, IL
mjmaginn@mmdi.org



Steve Tift, Health Educator
MN AIDS Project / Positive Link
Minneapolis, MN
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Marcia Dutcher
Evaluation Consultant
Kansas City, MO
marciadutcher@yahoo.com

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National Quality Center [NQC]

Putting Peer Connections into Action Panel Discussion - Introduction



Central IL Friends of People
Living with AIDS

Activities include . . .

- Train peer navigators for state of Illinois
- 3-day training
- Prepare for formal or informal system support
[i.e. work employment or volunteer peer support]
- Facilitate placement & site integration
- Provide on-going supervision and support

For more information: Contact Mike Maginn – mjmaginn@mmdi.org

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National Quality Center [NQC]

Putting Peer Connections into Action Panel Discussion - Introduction



Minnesota AIDS Project –
Positive Link

Activities include . . .

- Self-care education and emotional support
- Coordinated with MCM & Quick Connect
- Peer advocacy services provided 1:1, groups,
Web/email/social networking

For more information: Contact Steve Tift – steve.tift@mnaidsproject.org

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National Quality Center [NQC]

Putting Peer Connections into Action Panel Discussion

*In your experience, what
kind of support services do
you think peer advocates are
particularly effective at
providing, especially in terms
of helping people get into or
stay in care?*



Please post your response to this question in the chat room.

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National Quality Center [NQC]

Putting Peer Connections into Action Panel Discussion

*Based on your experiences,
what makes for an effective
peer advocate?*



Please post your response to this question in the chat room.

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National Quality Center [NQC]

Putting Peer Connections into Action Panel Discussion

*Based on your experiences,
when do you know it is a
good idea for someone to be
connected with a peer
advocate?*



Please post your response to this question in the chat room.

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National Quality Center [NQC]

Putting Peer Connections into Action Panel Discussion

What needs to happen to effectively integrate peer advocacy into a professional team?



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Please post your response to this question in the chat room.

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National Quality Center [NQC]

Putting Peer Connections into Action Panel Discussion

Peer advocacy is not just a face-to-face experience. There is increased interest in social networking. What experiences have you had using social network and what have been some of your key lessons learned?



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Great resource! "Social Media and HIV," HRSA CARE Action, June 2011.
<http://hab.hrsa.gov/newspublications/careactionnewsletter/june2011.pdf>

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National Quality Center [NQC]

Putting Peer Connections into Action Panel Discussion – Wrap Up

What advice would panelists or participants like to share about using peer advocates to promote retention?



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Please post your response to this question in the chat room.

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National Quality Center [NQC]

Connect to Partners in+care An Invitation



John Spaero, Program Coordinator
Maricopa County EMA
Phoenix, AZ
johnspaero@mail.maricopa.gov

- > Join the Partners in+care network
- > Visit Partners in+care web page; **click the "Join Partners in+care" red box**
- > Encourage others to join the Partners in+care network



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Visit www.incarecampaign.org – Partners Tab

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National Quality Center [NQC]

Connect to Partners in+care How Pi+c fits into the in+care Campaign

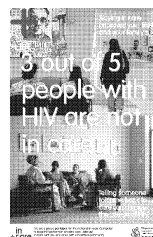


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National Quality Center [NQC]

Connect to Partners in+care Why get involved



- > Resource for planning group & advisory committee work
- > Support peer programs
- > Resources to support retention through self-care, peer connections and QM activities
- > Share "insider tips"

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www.incarecampaign.org

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National Quality Center [NQC]

COMING ATTRACTIONS

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**COMING
ATTRATIONS**

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The Health Resources and Services Administration (HRSA) Bureau together with the National Quality Center (NQC) have teamed up on a national retention campaign like no other, a campaign where you can have an immediate impact over the health and well-being of your HIV patients. We will be focusing on the simple idea that when patients stay in care they get the services that they need, leading to healthier people and stronger communities.

If you are looking for a way to make a greater difference in the lives of your patients, visit www.hivhrsa.org today.

We are currently seeking Quality Champions to organize local peer learning opportunities for HIV providers. Champions will convene two or more face-to-face or teleconference meetings with participating VAW agencies to discuss issues related to retention in HIV care and to promote peer exchanges so that we can learn regionally from each other. Quality Champions will be working closely with NQI staff/counselors to ensure the kick off of these local meetings. You can extend the reach and impact of the Campaign beyond your facility.

- + become a local quality champion

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incare@NationalQualityCenter.org
incareCampaign.org

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National Quality Center (NQC)

1. Develop 3-Year QM Plan						
	Objectives	Accountability	Outcomes	Start Date	Due Date	Status
A.	Review and make recommendations for changes to 3 Year QM Plan	Grantee Staff, CQM Support Staff & QMC	Complete Review of 3 Year QM Plan	01/2012		
B.	Update 3 Year QM Plan & Annual QM Work Plan	Grantee Staff , CQM Support Staff & QMC	Update 3 Year QM Plan	01/2012		
C.	Approve updated 3 Year QM Plan	QMC	Approve 3 Year QM Plan	01/2012		
2. Review & Analyze Annual Measures and Chart Review Data						
	Objectives	Accountability	Outcome	Start Date	Due Date	Status
A.	Select annual measures and data for tracking and evaluation	CQM Support Staff & QMC	Measures to develop Quality Improvement Projects (QIP)	03/12	03/2012	HAB Core Clinical Performance Measures and NQC In+Care Measure reviewed regularly
B.	Review and analyze annual measures and data	QMC, CQM Support Staff, Grantee Staff, QI Networks	Data analysis to determine QIP	Ongoing	Ongoing	HAB Core Clinical Performance Measures and NQC In+Care Measures reviewed regularly
C.	Review and analyze core category assessment chart review results	QMC, CQM Support Staff, Grantee Staff, QI Network	Data analysis to determine QIP	11/2011	March 2012	In Progress – Core Category is Oral Health. Final report pending.
D.	Identify service delivery deficiency and assess whether QIPs are necessary based on the measures evaluated and assessment results	QMC, QI Networks, Grantee Staff, CQM Support Staff	QIP recommendation	03/12	Ongoing	Three QIP's are in the Plan stage: - OAMC: Improvement in Cervical Screening Rates - MH/SA: Improvement in retention rates - MCM: Improvement in retention rates
E.	Develop a plan to improve system-wide service delivery deficiency (PLAN)	QMC, Grantee Staff, CQM Support Staff	Task List to complete plan	03/12	Ongoing	- OAMC: Review of PE and EMR cervical screening data for data integrity - COMPLETED

Quality Management Committee Work Plan for FY 2012/2013
Broward County HIV Health Services Planning Council

HANDOUT C

						- MH/SA: Development of PE trigger for additional support to assist clients who are depressed remain in care; Development of a presentation for all Networks on identifying signs of mental illness - MCM: Analysis of Gap Measure data
			Predict desired plan results	TBD	Ongoing	

2. Review & Analyze Annual Measures and Chart Review Data (Continued)

	Objectives	Accountability	Outcome	Start Date	Due Date	Status
F.	Implement system-wide QIP (DO)	QI Network Members	QIP Results	TBD	Ongoing	
G.	Evaluate QIP results (STUDY)	QMC, QI Networks, Grantee Staff, CQM Support Staff	Analysis of QIP results to prediction	TBD	Ongoing	
H.	Repeat another PDSA Cycle if QIP results do not meet prediction (ACT)	QMC, Grantee Staff, CQM Support Staff	See Work Plan Objectives B, C and D above.	TBD	Ongoing	
I.	Implement system-wide service delivery change if QIP results meet predication	QMC, QI Networks, Grantee Staff, CQM Support Staff	Updated Service Delivery Model	TBD	Ongoing	

3. Review & Assess Client-Level Data

	Objectives	Accountability	Outcome	Start Date	Due Date	Status
A.	Review HAB Performance Measures and Outcomes/Indicators	QMC, CQM Support Staff, Grantee Staff	Identify possible QIPs	9/2011	Pending completion of client level outcomes and	HAB Performance Measures: Reviewed regularly Outcomes/Indicators: In progress

Quality Management Committee Work Plan for FY 2012/2013
Broward County HIV Health Services Planning Council

HANDOUT C

					indicators review	
B.	Analyze HAB and Outcome/Indicator Findings	QMC, CQM Support Staff, Grantee Staff	Identify possible QIPs	Quarterly	Quarterly	
C.	Develop mechanism to share data, findings and methodologies with Part B, C, D, and HOPWA Grantees	QMC, CQM Support Staff, Grantee Staff	Data shared among EMA Grantees	09/2011	Ongoing	Recommended Data: • Client medication info • Part D wraparound info • AICP Data • Housing Info • Client contact info • Data presented at SFAN
D.	Review and modify Outcomes/Indicators as submitted by QI Networks	QMC, QI Network, CQM Support Staff	Updated Outcomes & Indicators	TBD	Ongoing	

4. Provide Quality Assurance and Quality Improvement Training to All Stakeholders

	Objectives	Accountability	Outcome	Start Date	Due Date	Status
A.	Identify and recommend trainings	QMC, CQM Support Staff, Grantee Staff	A list of prioritized trainings	Ongoing	Ongoing	
B.	Conduct QI/QA Principles trainings	Grantee Staff, CQM Support Staff	QMC & consumers will refresh and obtain new QA/QI knowledge	TBD	Ongoing	Survey other HIVPC Committees to determine topic of training and interested audience.

5. Review and Implement QM Committee Policies and Procedures

	Objectives	Accountability	Outcome	Start Date	Due Date	Status
A.	Review QMC purpose and mission statement	QMC	Updated QMC purpose and mission statement	TBD	Ongoing	
B.	Review and update policies and procedures to conform to updated QMC purpose and mission statement	QMC, CQM Support Staff	Updated QMC policies and procedures	TBD	Ongoing	
C.	Approve QMC policies and procedures	QMC	Improved	TBD	Ongoing	

Quality Management Committee Work Plan for FY 2012/2013
Broward County HIV Health Services Planning Council

HANDOUT C

			administration of QM Program policies and procedures			
6. Approve Service Delivery Model Modifications						
	Objectives	Accountability	Outcomes	Start Date	Due Date	Status
A.	Review and approve modified service delivery models as submitted by QI Networks (See CQM Monthly Update for more details)	QMC, QI Networks, Grantee Staff, CQM Support Staff, HIVPC	Updated Service Delivery Model	As Needed	As Needed	
7. Evaluate Client Survey from Needs Assessment						
	Objectives	Accountability	Outcomes	Start Date	Due Date	Status
A.	Evaluate and assess 2011 survey results	QMC, QI Networks, CQM Support Staff, Grantee staff	Data analysis to determine QIP	10/2011	2/2012	COMPLETED - 2010-2011 survey results compared.
B.	Identify service delivery deficiency and assess whether QIPs are necessary	QMC, QI Networks, CQM Support Staff, Grantee Staff	Identify possible QIPs	10/2011	Ongoing	
8. Apply QM methods to identify areas of improvement and modify processes to support EIIHA Strategy						
	Objectives	Accountability	Outcomes	Start Date	Due Date	Status
A.	Review and assess whether QIPs are necessary for rapid Linkage To Care (LTC) activities undertaken by Part A-funded outreach in collaboration with public health and health care provider HIV testing sites	QMC, QI Networks, CQM Support Staff, Grantee Staff	QIP recommendation	TBD	TBD	Pending Further Instruction
B.	Review and assess whether QIPs are necessary for the time from initial HIV+ test to the first OAMC visit with a physician	QMC, QI Networks, CQM Support Staff, Grantee Staff	QIP recommendation	TBD	TBD	Pending Further Instruction
C.	Review and assess whether QIPs are necessary for engagement and	QMC, QI Networks, CQM	QIP recommendation	TBD	TBD	Pending Further Instruction

Quality Management Committee Work Plan for FY 2012/2013
Broward County HIV Health Services Planning Council

HANDOUT C

	retention in OAMC in the first year following initial HIV testing	Support Staff, Grantee Staff				
D.	Review and assess whether QIPs are necessary for linkage and retention methods tailored to the unique needs of racial, ethnic, and sexual minority men and racial and ethnic minority women	QMC, QI Networks, CQM Support Staff, Grantee Staff	QIP recommendation	TBD	TBD	Pending Further Instruction
E.	Inform Outreach QI Network of QIP recommendations	QMC, QI Networks, CQM Support Staff, Grantee Staff	Improved service delivery	TBD	TBD	Pending Further Instruction

9. Conduct Annual QM Plan Evaluation

	Objectives	Accountability	Outcomes	Start Date	Due Date	Status
A.	Describe QM Committee Annual Accomplishments (HRSA Conditions of Award)	QMC	Submit to Grantee for inclusion in RW Progress Report HRSA COA	TBD	TBD	*Dates contingent upon release of grant guidance from HRSA
B.	Define QM Committee challenges (HRSA Conditions of Award)	QMC	Submit to Grantee for inclusion in RW Progress Report HRSA COA	TBD	TBD	*Dates contingent upon release of grant guidance from HRSA
C.	Review Grantee Annual Contract/Program Evaluation Findings	Grantee	Develop potential QIP	TBD	TBD	
D.	Review 3-Year QM Plan progress	QMC	Update 'rolling' 3-Year QM Plan	12/2011	02/2012	COMPLETED

10. Participate in the development of the Clinical Quality Management section of the Ryan White Grant Application

	Objectives	Accountability	Outcomes	Start Date	Due Date	Status
A.	Review and compare Annual Work Plan to criterion for QM section of Ryan White Grant Application.	QMC, CQM Support Staff, Grantee Staff	Integration of QM Committee input into QM Section of grant application	TBD	TBD	*Dates contingent upon release of grant guidance from HRSA

Quality Management Committee Work Plan for FY 2012/2013
Broward County HIV Health Services Planning Council

HANDOUT C

B.	Provide data and information to the Joint Priorities Committee to assist in the PSRA process.	QMC, CQM Support Staff, Grantee Staff	Data summary report	03/12	06/12	
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FY 2012-2015

Broward County Comprehensive HIV Health Services Plan

2012 - 2015

Fort Lauderdale/Broward County EMA

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INTRODUCTION

The Ryan White Treatment Modernization Act provides HIV-related core medical and support services for low income and uninsured persons living with HIV/AIDS (PLWHA). The Ryan White Program is funded by the Treatment Modernization Act and is operated by the HIV/AIDS Bureau (HAB) of the Health Resources and Services Administration (HRSA). Ryan White Part A funds provide direct financial assistance to Eligible Metropolitan Areas (EMA) or Transitional Grant Areas (TGA) that have been severely affected by the HIV epidemic. Broward County was designated as one of the first 11 EMAs and has continued to qualify as an EMA for the last two decades due to its consistently high HIV/AIDS prevalence. To qualify as an EMA, an area must have reported at least 2,000 AIDS cases in the most recent 5 years and have a population of at least 50,000.

Part A grants to EMAs include formula and supplemental components as well as Minority AIDS Initiative (MAI) funds, which support services targeting minority populations. Formula grants are based on reported living HIV/AIDS cases as of December 31 in the most recent calendar year for which data are available. Supplemental grants are awarded competitively on the basis of demonstrated need and other criteria. MAI funding is awarded using a formula that is based on the distribution of living HIV/AIDS cases among racial and ethnic minorities. Grants are awarded to the chief elected official (CEO) of the city or county that provides health care services to the greatest number of people living with AIDS in the EMA. In Broward County, the grant is awarded to the Broward County Board of County Commissioners and administered by the Human Services Department.

Per HRSA, The Ryan White Part A Program Grantee is responsible for planning and organizing a comprehensive continuum of HIV care that includes core medical and support services. Ryan White Grantees are required to spend at least 75% of the award on core medical services. These are limited to outpatient and ambulatory medical care (OAMC); AIDS drug assistance program (ADAP); AIDS pharmaceutical assistance (APA); oral health; early intervention services (EIS); health insurance premium and cost sharing assistance for low-income individuals; medical nutrition therapy; hospice services; home and community-based health services; mental health services; substance abuse outpatient care; home health care; and medical case management (MCM), including treatment adherence services. Grantees are required to spend no more than 25% on support services. These services must be linked to medical outcomes and may include outreach, medical transportation, linguistic services, respite care for caregivers of people with HIV/AIDS, referrals for health care and other support services, case management, and substance abuse residential services. In Fiscal Year

(FY) 2011-2012, over 7,000 clients received core and/or support services through the Part A program in Broward County.

Planning is central to developing HIV/AIDS care systems. Section 2602 (4) (D) of the Ryan White legislation requires EMAs/TGAs to develop a comprehensive plan for organizing and delivering health and support services described in section 2604. The Plan includes strategies to:

- Identify individuals who know their HIV status and are not receiving such services, and to inform the individuals of and enable the individuals to utilize the services. The strategies give particular attention to eliminating disparities in access and services among affected subpopulations and historically underserved communities, and include discrete goals, a timetable and an appropriate allocation of funds
- Coordinate the provision of services with programs for HIV prevention (including outreach and early intervention) and for the prevention and treatment of substance abuse (including programs that provide comprehensive treatment services for such abuse)

The Plan must be compatible with State or local plans for the provision of services to individuals with HIV/AIDS.

Per this legislation, HAB expects EMAs to develop multi-year comprehensive plans that:

- Address disparities in HIV care, access, and services among affected subpopulations and historically underserved communities
- Ensure the availability and quality of all core medical services within the EMA
- Address the needs of those who know their status and are not in care as well as the needs of those who are currently in the care system
- Address clinical quality measures.

These plans should include strategies that:

- Identify individuals who know their HIV status but are not in care and inform these individuals of services and enable their use of HIV-related services
- Eliminate barriers to care and disparities in services for historically underserved populations
- Provide goals, objectives, and timelines
- Coordinate services with HIV prevention programs including outreach and EIS
- Coordinate services with substance abuse prevention and treatment programs
- Are compatible with existing State and local service plans including and in particular the Statewide Coordinated Statement of Need (SCSN)

The Part A Grantee works in partnership with the Broward County HIV Health Services Planning Council (HIVPC) to plan, prioritize, and assess the HIV/AIDS service system. The HIVPC is guided by a vision directing a coordinated and effective community response to the HIV epidemic to ensure access to a high quality system of care.

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 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, 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

Each grant year, the HIVPC establishes service priorities and a plan for resource allocations through the Priority Setting Resource Allocation (PSRA) process. The 2012-2015 Fort Lauderdale/Broward County EMA Comprehensive HIV Health Services Plan (referred to for brevity as the 2012-2015 Comprehensive Plan) goes beyond the annual process and provides a road map for developing a broad and responsive system of care over time. It provides an opportunity for the EMA to review the current system of care, envision an ideal system, and develop a three-year work plan towards achieving its goals.

The 2012-2015 Comprehensive Plan includes several new components that the EMA has addressed in this document:

1. Monitoring and Evaluation

Evaluation of the 2009-2011 Comprehensive Plan to identify successes and challenges experienced in the implementation of the plan and the strategy to meet those challenges.

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

A legislative requirement that focuses on individuals who are unaware of their HIV status, and how best to link HIV+ individuals into care and refer HIV negative individuals into services that will keep them negative.

3. The National HIV/AIDS Strategy (NHAS)

The Strategy includes four primary goals: 1) Reducing the number of people who become infected with HIV, 2) Increasing access to care and optimizing health outcomes for People Living with HIV (PLWH), and 3) Reducing HIV-related health disparities and health inequities, and 4) Achieving a

more coordinated response to the HIV epidemic. The NHAS recognizes that new prevention methods must be recognized and put into place. Moreover, the NHAS recognizes the importance of getting PLWH into care early after infection to protect their health and reduce the potential of transmitting the virus to others.

4. Healthy People 2020 (HP 2020)

HP 2020 is a national initiative led by the Department of Health and Human Services (HHS) that sets priorities for all HRSA programs. HP 2020 establishes new 10-year national objectives for improving the health of all Americans. The initiative has two major goals: 1) To increase the quality and years of a healthy life, and 2) To eliminate health disparities. The program consists of 28 topic areas, one of which is HIV, and 467 objectives.

5. Affordable Care Act (ACA)

The Patient Protection and Affordable Care Act (referred to as health reform law) aims to expand health insurance coverage while also reforming the health care delivery system to improve quality and value. It includes provisions to eliminate disparities in health care, strengthen public health and public health access, invest in the expansion and improvement of the health care workforce, and encourage patient wellness in the community and workplace. The law aims to increase coverage to approximately 94% of Americans.

Development of the 2012-2015 Comprehensive Plan included review of various sources of data including epidemiological, needs assessment, utilization, performance measures and evaluation data; consumer needs and priorities; and analysis of the cost and outcomes effectiveness of services. In addition, input from HIVPC and Committee members, service providers, funders, and other key stakeholders as well as the community, including PLWHA and specifically consumers of Ryan White Part A services, was elicited through a series of full day retreats staged in environments that promoted open dialogue on various Comprehensive Plan related topics such as identified special populations, EIIHA strategy, continuum of care, and quality of care. The input of all participants in the process has been invaluable.

The Comprehensive Plan aims to satisfy federal requirements while also providing an important and useful resource for planning, service delivery, and evaluation. The Comprehensive Plan may serve as a resource for several entities. The HIVPC will utilize the Comprehensive Plan to guide decision-making related to annual service prioritization and resource allocation processes over the next three years. Other stakeholders, such as service providers, may also use the Comprehensive Plan in the development and enhancement of their HIV service delivery planning.

The Comprehensive Plan has four chapters designed to answer the following questions:

Where are we now? (What is the EMA's current system of care?)

This section describes the status of the HIV epidemic, the needs of PLWHA, and available HIV services. The following subsections are included: epidemiologic profile and emerging populations; EMA response to the epidemic; health care needs of both those in and out of care, estimated unmet need, gaps in care, and prevention needs; the current continuum of care; available core and support services; provider capacity and capability; and service gaps and barriers to care.

Where do we need to go? (What is the EMA's vision of an ideal system?)

This section of the plan describes how the EMA would like its system of care to function including an operational definition of 'continuum of care', reflecting the context in which the HIVPC works, and a description of how Part A services will be coordinated with other services available to PLWHA. This section also includes an evaluation of the 2009-2011 Comprehensive Plan and proposes solutions to identified challenges.

How will we get there? (What steps can the EMA take to develop an ideal system of care?)

This section outlines goals for developing a comprehensive continuum of care and activities to help achieve these goals. These include system, planning, evaluation, and service-related goals and objectives and outcomes and the strategies and activities needed to implement the plan.

How will we monitor our progress? (How will we evaluate its success in meeting its goals?)

This last section outlines a plan to assess progress in achieving goals and objectives and to update the Comprehensive Plan. The monitoring and evaluation plan describes the process for tracking changes using client-level data and measurement of clinical outcomes.

1. WHERE ARE WE NOW?

The purpose of this chapter is to identify populations in most need of HIV care and services, provide an overview of the current state of HIV healthcare and service delivery, as well as identify progress and shortfalls. The chapter includes a description of the local HIV/AIDS epidemic, HIV/AIDS incidence and prevalence, demographics, estimated unmet need (HIV+ persons in the EMA who know their HIV status but do not receive primary care), methods to identify and address gaps in care, the current continuum of care, description of prevention and service needs, and barriers to care.

A. Description of the Local HIV/AIDS Epidemic

This section describes the rapidly evolving HIV/AIDS epidemic in the EMA, disproportionately impacted subpopulations, groups under-represented in the Ryan White-funded primary medical care system, and estimated service gaps.

Broward County is Florida's (FL) second largest metropolitan area, with 1.7 million residents and 670,472 households. The US Census reports that among the 1.7 million Broward residents in 2010, 43% were White non-Hispanics (compared to 58% of all FL residents and 64% nationally), 25% Black non-Hispanic (compared to 16% of all FL residents and 13% nationally), 25% are Hispanic (compared to 23% of all FL residents and 16% nationally), and 7% other. That makes Broward a "majority of minorities" with the rate of racial and ethnic minorities exceeding that of White non-Hispanics. About 30% of Broward residents are foreign-born, a higher rate than the state average (19%) and national average (13%). The US Census reports that Broward County has 9,125 same-sex households, or 1.3% of the total number of households. That is the largest number of same-sex couples in the state. Fort Lauderdale and Wilton Manors claim 150 gay-owned shops and establishments. The area hosts the largest PrideFest in the state, with more than 40,000 attendees and 250 vendors. By 2006, Fort Lauderdale ranked number six nationally for gay travelers, according to the Greater Fort Lauderdale Convention and Visitors Bureau, surpassing Miami. The following year, gay vacationers accounted for approximately \$800 million in tourist dollars – 11% of the city's annual tourism-based income.

The HIV/AIDS epidemic has severely affected Broward. At least one in every 104 Broward residents is HIV+. A cumulative 27,549 HIV+ Broward residents were reported through 2010, including 358 children and youth. HIV prevalence through 2010 included 8,628 AIDS cases and 7,378 HIV (not AIDS) cases or 16,006 prevalent HIV/AIDS cases living with HIV/AIDS. In FY 2011, for the first time, the FL Department of Health (DOH) added an additional 814, totaling 16,820 living with

HIV/AIDS regardless of where reported (persons tested elsewhere but currently residing in Broward County).

In the first nine months of 2011, newly reported AIDS cases increased 14% and newly reported HIV cases rose 35% over the same period in 2010 (an average of three new HIV/AIDS cases per day). The CDC reports Broward and two additional South Florida EMAs rank highest in population-adjusted AIDS cases in the US. Broward HIV+ residents experience an average of five deaths per week. One-half of PLWHA in Broward County are non-Hispanic Blacks, 34% are non-Hispanic Whites, and 14% are Hispanic. Non-Hispanic Blacks are impacted disproportionately, representing 27% of Broward residents, but 50% of HIV+ persons in the County. Non-Hispanic Black women account for nearly 76% of all living HIV+ women in Broward. Men who have sex with men (MSM) represent 47% of living HIV+ cases. One-half of HIV+ residents live in Broward's East-Central section, home to one of the largest population-adjusted gay communities in the US and many of Broward's poorest minority neighborhoods. HIV services are located in these communities to ensure accessibility.

The FDOH generated the HIV/AIDS epidemiologic data used in this section as well as in later sections describing Unmet Need and the Early Identification of Individuals with HIV/AIDS (EIIHA). References to newly reported AIDS cases include the number of new AIDS cases reported in the CDC Electronic HIV/AIDS Reporting System (eHARS) as of 12/31/2010 and exclude FL Department of Corrections (DOC) AIDS cases. AIDS, HIV, and HIV/AIDS prevalence data include the number of diagnosed cases in eHARS as of 5/2011, and include cases whose current residence is the Broward County EMA, regardless of where they were diagnosed. Inclusion of AIDS and HIV (not AIDS) data for current residents affords the EMA the opportunity to assess the needs of and plan for HIV+ individuals that relocated to the EMA.

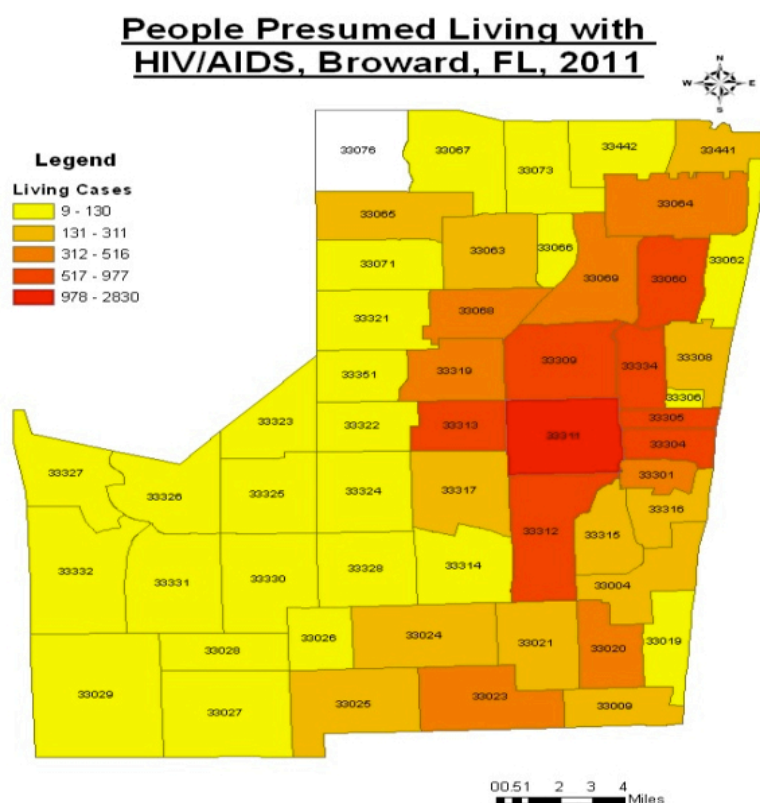
HIV/AIDS Incidence and Prevalence

Eight hundred and forty one (841) new AIDS cases were reported in 2008, 763 in 2009, and 631 in 2010. Additionally, 1,278 new HIV (not AIDS) cases were reported in 2008, 864 in 2009, and 882 in 2010. In the first nine months of 2011 alone, newly reported AIDS cases increased 14% (489 new cases) and newly reported HIV cases rose 35% (822 new cases) over the same period in 2010, or an average of 3 new HIV/AIDS cases per day. This rate of growth significantly exceeds the other five FL EMAs and FL as a whole.

The true magnitude of the HIV/AIDS epidemic may be even greater due to the immigration of HIV+ individuals from other states and countries. FDOH estimates that 19% of Broward residents living with AIDS and 18% of HIV (not AIDS) cases immigrated to the EMA, rates that far exceed those of

any other FL EMA. FDOH reports that seeming decreases in new HIV (not AIDS) and AIDS cases reported are likely to be misleading due to a significant delay in entering of paper lab reports submitted in the last two years.

The EMA's HIV/AIDS epidemic must be considered within its geographic context. According to the CDC, the Metropolitan Statistical Area (MSA) made up of Broward, Miami/Dade, and Palm Beach Counties ranked highest in the US for population-adjusted AIDS and HIV (not AIDS) rates in the US in 2009, with a population-adjusted case rate of 37.2 (or 37.2 cases per 100,000 population). The CDC does not separately report population adjusted case rates for the counties in the MSA. Broward's population-adjusted AIDS case rate (36.2) is exceeded only by St. Lucie (42.5) in FL. Broward's population-adjusted HIV (not AIDS) rate exceeds all other FL counties and is higher than the State at 50.6 compared to 27.7.



Disclaimer: Map is for BCHD use. Map by Lashawnda White, 2/21/2012.
Source: FL DOH HIV/AIDS Surveillance Program

Demographics

KEY POINTS

- Age
 - FL ranks second only to New York in cumulative pediatric AIDS cases
 - No known births to HIV+ mothers were identified in the EMA in 2010
 - Younger and older adults are the fastest growing segments of Broward's HIV+ population
 - Population-adjusted HIV (not AIDS) case rate was higher among residents 20 to 24 than any other age group in 2010
 - In 2010, 44% of newly reported AIDS cases were 45 years or older
- Gender
 - 70% of Broward PLWA in 2010 were men and 30% were women
 - 1 in 72 Broward male residents is HIV+ compared to 1 in 140 Florida men
 - 1 in 178 Broward female residents is HIV+, compared to 1 in 327 Florida women
 - 45% of Broward HIV+ males were White, 37% were Black, 16% Hispanic, and 2% were 'other'
 - 80% of Broward HIV+ females were Black, 11% were White, 7% were Hispanic, and 2% were 'other'
- Race/Ethnicity
 - HIV/AIDS disproportionately impacts Broward's racial/ethnic minorities especially Black, non-Hispanics
 - 53% of PLWA in 2010 were Black non-Hispanics, 12% Hispanic, 33% White non-Hispanic, 2% 'other'
 - 47% of PLWH in 2010 were Black non-Hispanics, 15% Hispanic, 37% White non-Hispanic, 1% 'other'
- Exposure Category
 - MSM HIV exposure category:
 - 41% of newly reported AIDS cases in 2010
 - 61% of prevalent male AIDS cases through 2010
 - 73% of HIV (not AIDS) male prevalent cases through 2010
 - Heterosexual exposure category:
 - 50% of new AIDS cases in 2010
 - 26% of prevalent male AIDS cases through 2010
 - 18% of prevalent male HIV (not AIDS) cases through 2010
- Mortality
 - HIV-related mortality disproportionately impacts Broward racial and ethnic minorities
 - The rate of Broward HIV/AIDS-related deaths has leveled in recent years
 - Mortality rates may be impacted by barriers to access to HAART due to the ADAP waitlist
- Homelessness
 - Homelessness has grown significantly in Broward County
 - Contributing factors: insufficient affordable rental units, increased cost of living, and a sharp increase in foreclosures
 - The 2011 Consumer Survey indicated the following:
 - Heterosexual Black men and women reported the highest rates of homelessness
 - The homeless were more likely to report exchanging sex for drugs, a place to sleep, or money
 - The homeless were six times more likely to not have enough food to eat, and seven times more likely to not have a safe place to sleep or to feel unsafe in their neighborhoods
 - Through 2010, approximately 58 HIV+ residents were homeless at the time of their HIV/AIDS diagnosis
- Formerly Incarcerated
 - 7% of the inmates released in 2010 were HIV+
 - Broward has the highest jail HIV test rates of any FL county
 - The EMA developed protocols to help link and engage inmates to care upon release

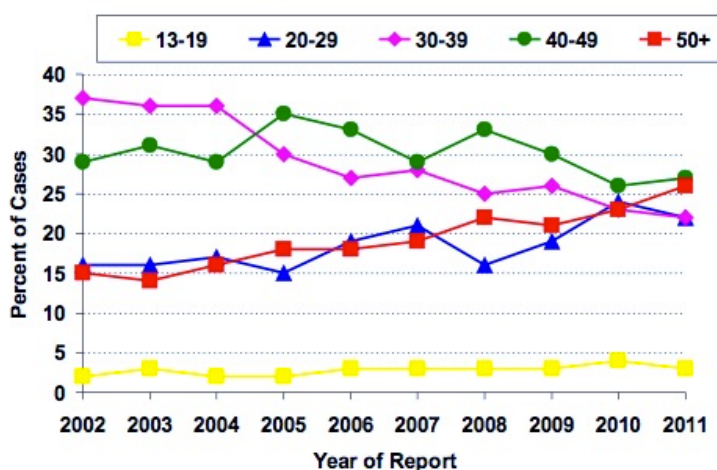
HIV/AIDS disproportionately impacts demographic and economic groups in the EMA, as demonstrated by trends in the age of HIV+ residents. Florida ranks second only to New York in cumulative pediatric AIDS cases, with Miami/Dade and Broward Counties contributing more cases than other FL counties. To address the pediatric AIDS epidemic, the Broward HIV care system

created effective systems to prevent perinatal HIV infection. Ryan White Program grantees, community obstetricians, and hospital labor and delivery departments implemented a task force to ensure the rapid identification of HIV+ pregnant women. Intensive clinical and psychosocial interventions are undertaken with HIV+ pregnant women. Task force members also educate HIV+ men who have sex with women about secondary HIV prevention techniques. Due in large part to these interventions, no known births to HIV+ mothers were identified in the EMA in 2010. Among the 58 Broward perinatally infected children and youth under 20 years of age prior to the taskforce's efforts, 15% had AIDS and 85% had HIV (not AIDS).

Age

FDOH trend analyses demonstrate that younger and older adults are the fastest growing segments of the Broward adult HIV+ population. About one-third (31%) of HIV+ adults between 20 and 29 years of age have AIDS and 69% HIV (not AIDS). The 2010 US Census reports that 13% of Broward residents were in their twenties; while 5% of AIDS cases and 11% of HIV (not AIDS) cases were in their twenties.

Adult HIV Infection Cases, by Age Group at Diagnosis, and Year of Report, 2002–2011, Broward County

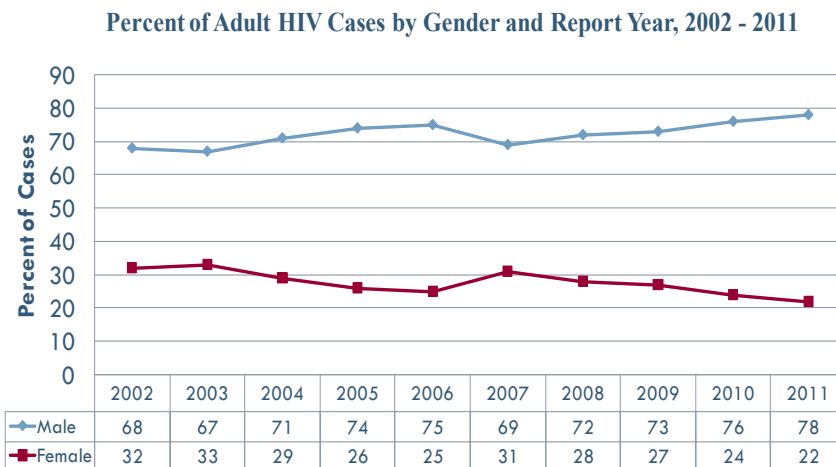


The population-adjusted HIV (not AIDS) case rate was higher among Broward residents 20 to 24 years of age (113.1) than any other age group in 2010. Younger age and gender are not associated, with about one-quarter of HIV+ men and women between the ages of 20 and 29 years. In contrast, older age was associated with gender, with 62% of HIV+ males 45 years or older compared to 48% of HIV+ women. Aging of HIV/AIDS cases, immigration of MSM, and Broward's popularity as a retirement community contribute to the rate of HIV+ residents in their middle or older years. In 2010, 44% of newly reported AIDS cases were 45 years or older and 43% of Broward residents with AIDS were 50 years of age or older compared to 30% of residents with HIV (not AIDS). For individuals 50 years of age or older, age and gender were not associated, with about one-quarter of HIV+ men and women in that age bracket. It should be noted that HIV+ Broward residents tend to be younger than residents in general with 34% of Broward residents 50 years or older.

Gender

By the end of 2010, 70% of adults living with AIDS in Broward County were men and 30% were women. The ratio of male to female AIDS cases (i.e., total male cases/total female cases) has narrowed significantly in the last decade. While the ratio of men to women was 2.6 men to 1 woman in 2001, the gap between men and women decreased to 2.2 men to 1 woman by 2010.

In contrast, the gap between men and women with HIV (not AIDS) has widened. The ratio of men to women rose from 2.1 men to 1 woman in 2002, to 3.5 men to 1 woman in 2011. Broward male residents were almost twice as likely to be HIV+ as Florida male residents with 1 in 72 Broward male residents HIV+ compared to 1 in 140 Florida males. Broward female residents were 1.8 times as likely to be HIV+ than Florida women with 1 in 178 Broward female residents HIV+, compared to 1 in 327 Florida women.



M:F Ratio* CY 2002 = 2.1:1 CY 2011 = 3.5:1

Transgender have been identified by HRSA as a Special Population, a term that encompasses populations that may not have the greatest burden of disease but have unique, individual, social, or community conditions that impact their risk and access to services leading to high vulnerability for HIV infection and being out of care. They have also been identified as an emerging population by the EMA, a term used to describe priority populations with high unmet need. The Centers for Disease Control and Prevention (CDC) do not systematically collect data regarding transgender populations. This absence of accurate data significantly impairs the EMA's ability to plan for the needs of Broward HIV+ transgender residents. However, the Part A program is supplementing data on transgender Part A clients with data collected through the Provide Enterprise (PE) system, the data and billing system used to collect client level information including demographics. PE allows for the documentation of gender as Male, Female, Transgender Male-To-Female, and Transgender Female-To-Male. In FY 2011-2012, 27 Part A clients identified as transgender during their intake process as documented in PE. It is estimated that the actual number of transgender clients is higher. The HIVPC has also reviewed data regarding unmet need and client satisfaction from the 2011 Countywide Needs Assessment which included input from 34 PLWHA who self-identified as transgender. Other sources

of data used to provide additional insight into the needs the EMA's transgender population include results from the BCHD transgender survey.

FDOH reports that HIV+ Broward male residents are significantly more diverse racially and ethnically than HIV+ women. Among Broward HIV+ males living in 2010, 45% were White non-Hispanic (White), 37% were Black non-Hispanic (Black), 16% Hispanic, and 2% were other race. Among HIV+ women, 80% were Black, 11% were White, 7% were Hispanic, and 2% were other races. Population-adjusted AIDS case rates demonstrate the significant disparity among gender, racial, and ethnic groups. Black men had an AIDS case rate of 123.3, compared to 43.2 for White men and 43.5 for Hispanic men. There were 2.8 Black men for every 1 White non-Hispanic man, and there was approximately a 1 to 1 ratio between White men and Hispanic men. The AIDS case rate was sharply higher for Black women (93.3) than Hispanic women (8.6) or White women (3.6). There were 25.9 Black women for every 1 White woman, and 2.4 Hispanic women for every 1 White woman.

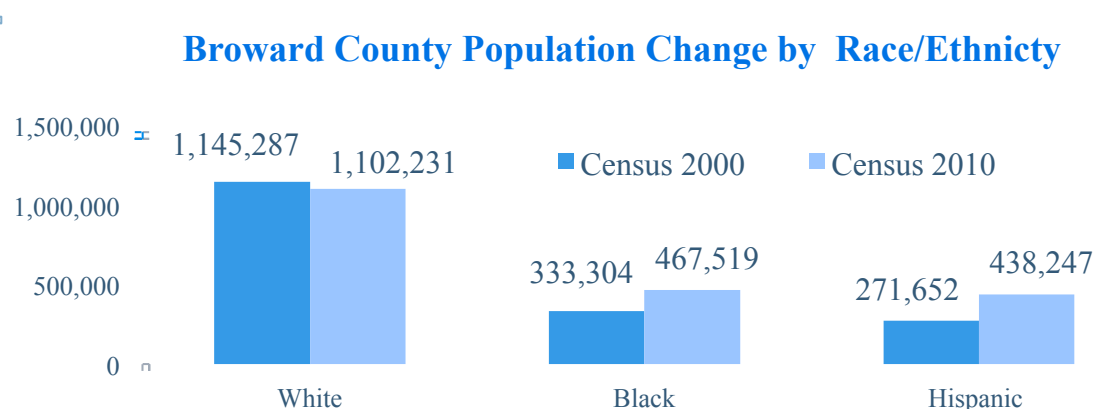
Population-adjusted HIV (not AIDS) case rates showed a similar pattern. In 2010, Black males had an HIV (not AIDS) case rate of 161.3 compared to 86.7 for White males and 67.9 for Hispanic males. There were 1.8 Black men with HIV (not AIDS) for every 1 White man, and a 1 to 1 ratio between White men and Hispanic men. Among women, the HIV (not AIDS) case rate ranged from 85.1 for Black women, 4.8 for White women and 12.4 for Hispanic women. There were 7.7 Black women for every 1 White woman, and 2.6 Hispanic women for every 1 White woman.

Race and Ethnicity

Broward County is racially and ethnically diverse. Since 1990, Broward has risen from the 16th to the third most racially diverse FL County (US Census computes a diversity index as the percentage of times two randomly selected people differ by race/ethnicity). Broward ranked 13th in diversity among US MSAs. Broward's diverse population is reflected in Broward's HIV+ residents' race and ethnicity.

About 30% of Broward residents are foreign-born, with 70% from Latin America, Haiti, or other Caribbean country. The US Census notes that in 2009, 35% of the County's population reported speaking a language other than English at home compared to 26% of Florida residents overall. Shifts in Broward's demographics are fueled by immigration of foreign-born minorities, decreased White non-Hispanic birth rates, out-migration of White non-Hispanics due to the County's worsening economy, and increased White non-Hispanic death rates. Broward's diversity is shifting so rapidly, it is projected to be the second most diverse county in the US by 2030.

The 2010 US Census reports that Broward's Hispanic population is growing at a faster rate than Black non-Hispanics. The Hispanic population grew by 61% between 2000 and 2010, compared to a gain of 38% for non-Hispanic Blacks and a decrease of 19% for non-Hispanic Whites.



The EMA's Hispanic population continues to grow more diverse, as new residents from Central and South America and the Caribbean immigrate to Broward. They have settled in large numbers in the county's newer southwestern suburbs, including Pembroke Pines, Miramar and Weston, as well as Fort Lauderdale and older eastside cities. Less than one-half (48%) of HIV+ Hispanic Broward adult residents were born in the US (including 11% born in Puerto Rico). The remaining HIV+ adult residents were born in other countries. Haitian immigrants make up a growing portion of the EMA's population especially in Fort Lauderdale and older central-county neighborhoods. Likewise, new residents from Caribbean islands have found homes in cities such as Lauderhill, Lauderdale Lakes, North Lauderdale and Margate. Broward County planners estimate 62,000 Broward residents have Haitian ancestry. Among this group, approximately 53,000 speak French-Creole. Broward has experienced a 2,466% growth in the Haitian-born population from 1980 to 2000 (the most recent data available). Among the 6,747 Haitian-born HIV+ Floridians reported through 2009, 21% resided in Broward. Adult HIV+ Broward residents born in Haiti make up 21% of HIV+ Black adults in the EMA, while 70% of Blacks were born in the US, 5% in Jamaica.

HIV/AIDS disproportionately impacts Broward's racial/ethnic minorities. The prevalent HIV/AIDS case data through 2010 demonstrate the disproportionate impact of the HIV epidemic on Black residents, with 1 in 52 living with HIV/AIDS compared to 1 in 137 Whites and 1 in 191 Hispanics. Among living AIDS cases in 2010, 53% were Black, 12% Hispanic, and 33% White. Among living HIV (not AIDS) cases in 2010, 47% are Black, 15% Hispanic, and 37% White. There is a strong association between gender, race, and ethnicity. Among men, the HIV/AIDS case rate varied from 1,986.5 for Black men to 1,220.7 for White men, 819.1 for Hispanic men, and 788.3 for other men. There were 1.6 Black men for every 1 White man, and 0.7 Hispanic men for every 1 White man.

Among women, HIV/AIDS case rate varied from 1,654.7 for Black women to 123.8 for White women, and 150.8 for Hispanic women. There were 13.4 Black women for every 1 White woman, and 1.2 Hispanic women for every 1 White woman.

Table 1. HIV/AIDS Epidemiology by Race and Ethnicity through CY 2010

Race/Ethnicity	Newly Reported AIDS		AIDS Prevalence Through CY 2010		HIV/not AIDS Prevalence		HIV/AIDS Prevalence	
	#	%	#	%	#	%	#	%
White	362	25.97%	2,807	32.53%	2,723	36.91%	5,530	34.55%
Black	813	58.32%	4,560	52.85%	3,448	46.73%	8,008	50.03%
Hispanic	185	13.27%	1,063	12.32%	1,070	14.50%	2,133	13.33%
Asian/Pacific Island	8	0.57%	36	0.42%	43	0.58%	79	0.49%
American Indian	0	0.00%	4	0.05%	11	0.15%	15	0.09%
Not Specified	26	1.87%	158	1.83%	83	1.12%	241	1.51%
Total	1,394	100.00%	8,628	100.00%	7,378	100.00%	16,006	100.00%

Sexual Preference

As noted earlier, according to the 2010 Census report, Broward County has 9,125 same-sex households, or 1.3% of the total number of households. That is the largest number of same-sex couples in the state. Fort Lauderdale ranked first among mid-sized cities for population-adjusted rates of same-sex couples per 1,000 households. Hollywood ranked 24th among same-sex couples. Wilton Manors ranked second and Oakland Park ranked tenth for population-adjusted rates of same-sex couples per 1,000 households among small cities with populations below 100,000. County government officials estimate that 10.4 million tourists visit Broward annually, including 1 million gay and lesbian visitors.

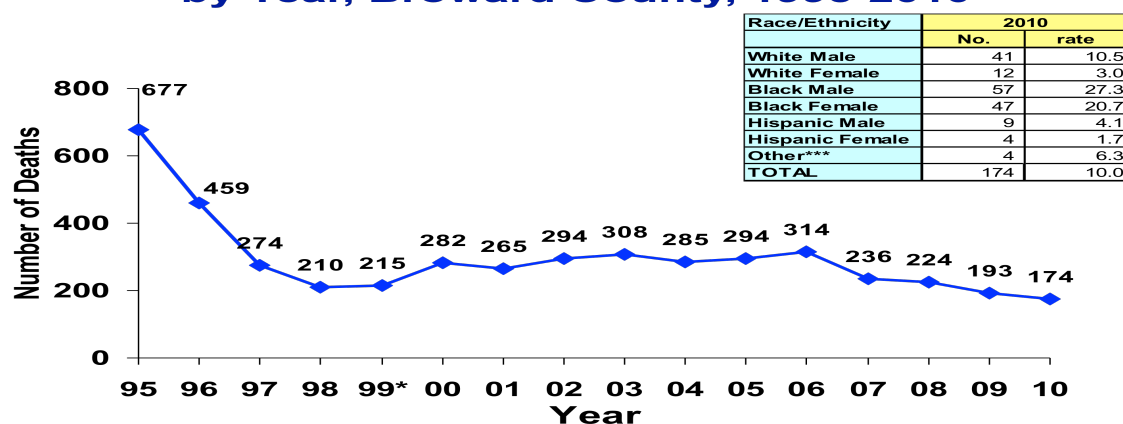
The MSM HIV exposure category was associated with 41% of newly reported AIDS cases in 2010, 61% of prevalent male AIDS cases through 2010, and 73% of HIV (not AIDS) male prevalent cases through 2010. In contrast, the heterosexual exposure category was associated with 50% of new AIDS cases in 2010, 26% of prevalent male AIDS cases, and 18% of prevalent male HIV (not AIDS) cases. Among HIV+ men, race, ethnicity, and exposure category are strongly associated. Among White males, 89% reported MSM as their HIV exposure category compared to 5% injecting drug use (IDU), 3% MSM/IDU, and 3% heterosexual. Among Blacks, 51% reported heterosexual exposure, 34% MSM, 9% IDU, 4% MSM/IDU, and 2% other category. Among Hispanics, 76% reported MSM, 11% heterosexual, 7% IDU, 5% MSM/DU, and 1% other.

Mortality

Due to increased use of highly active antiretroviral therapy (HAART) and expanded virologic monitoring, the rate of Broward HIV/AIDS-related deaths reached a plateau in recent years. In 2010, 266 Broward HIV+ residents died, compared to 355 in 2009 signifying a 25% decrease. However, the

impact of HIV/AIDS-related mortality cannot be discounted as Broward HIV+ residents experienced an average of five deaths per week.

Resident HIV/AIDS Deaths by Year, Broward County, 1995-2010*



Source: Office of Vital Statistics, Death Certificates

HIV-related mortality disproportionately impacts Broward racial and ethnic minorities. Mortality rates for Black residents are particularly high, representing 53% of all deaths among Broward HIV+ residents in 2010. Black non-Hispanics had 1.7 times the number of deaths than White non-Hispanics, who accounted for 31% of deaths among HIV+ Broward residents. HIV+ Broward male residents accounted for 67% of deaths, or twice the death rate of HIV+ female residents. Among HIV+ males, HIV exposure category was highly associated with death rates. MSM accounted for 52% of deaths, compared to 30% for heterosexual men, 11% for IDUs, and 7% for MSM/IDUs. Among HIV+ females, heterosexual women accounted for 74% of deaths and IDUs for 23%. Notably, female IDUs experienced the only increase in death rates between 2009 and 2010 for men and women of any exposure category (an 8% increase).

While Hispanics, White non-Hispanics, and Black non-Hispanics living with AIDS experienced significant gains in life expectancy during the course of the AIDS epidemic, White non-Hispanics achieved significantly longer median life expectancy than Hispanics and Black non-Hispanics. Median life expectancy for White non-Hispanics was 55 months from AIDS diagnosis to death for individuals first diagnosed between 1998 and 2007 (the most recent data available), compared to 32 months for Black PLWHA and 51 months for Hispanics. When comparing median survival time between men and women, concerning differences were identified. Among White PLWHA between 1998 and 2007, women had a median of 47 months of survival, compared to 56 months for men. Similarly, among Hispanics, women had a median of 47 months of survival compared to 52 months for men. Among Black non-Hispanics, women had a median of 36 months compared to 29 for men.

While rates have leveled in recent years as a result of HAART, a concern for Broward County has been the potential impact of the Florida ADAP crisis on these rates. In 2010, the Florida ADAP began facing serious funding shortfalls that threatened the drug supply for 6,500 uninsured PLWHA. In response, the state collaborated with pharmaceutical companies that agreed to donate drugs to non-profit Welvista to deliver at ADAP distribution sites. While this solution ensured that nearly two-thirds of Florida's 10,000 ADAP clients would not be dropped from the program, a large number of clients remained on the state's waiting list despite cost-cutting measures such as reducing the ADAP formulary and changing the ADAP income eligibility criteria to 300% of Federal Poverty Level (FPL). Broward has had the second highest number of waitlisted and terminated FL ADAP clients. Mortality rates may increase due to barriers and delays in access to HAART and other HIV drugs due to ADAP termination or placement on the waitlist. However, the number of individuals on the waitlist has been greatly reduced and stands at 111 as of April 2012.

Homeless HIV+ Individuals

KEY POINTS

- Homeless HIV+ Individuals
 - Homelessness in Broward has grown significantly
 - Lack of affordable rentals; cost of living and foreclosures increased
 - Heterosexual Black men and women reported highest homeless rates
 - Homeless are more likely to:
 - Exchange sex for drugs, place to sleep or money
 - Not have enough food to eat
 - Not have a safe place to sleep
 - Feel unsafe in their neighborhoods
 - Approximately 58 HIV+ residents were homeless at time of diagnosis
 - HOPWA and HIP are the two central homeless programs in Broward

Homelessness has grown significantly in Broward County. Contributing factors include insufficient affordable rental units, increased cost of living, and a sharp increase in foreclosures. The FL Department of Children and Families (DCF) estimates that 3,801 Broward residents were homeless in 2011, a 66% increase over 2005. About 35% of homeless Floridians reported being homeless for more than one year. Over one-half of respondents (53%) reported that they were homeless for the first time. Almost one-half (49%) of respondents reported that they were homeless due to employment or financial problems and 18% because of medical issues or disability. Florida's economic crisis has increased the risk for becoming homeless. The foreclosure crisis among homeowners has created a new group of homeless individuals, and added to the demand for affordable rental housing. The Mortgage Bankers Association reported recently that one in five Florida homeowners are seriously

delinquent or in foreclosure, making FL first nationally for failed or seriously delinquent home loans. FL ranks second in the US in the number of foreclosures, and Broward County ranks second in foreclosures among FL counties. Broward County experienced a dramatic decline in home values, with Broward's Property Appraiser reporting an historic 12% drop in property value that resulted in 44% of Broward home loans becoming "underwater." Crowd-out of low-income residents from affordable housing is increasing due to new demand for rental units by homeowners in foreclosure.

FDOH reports that, through 2010, approximately 58 HIV+ Broward residents were homeless at the time of their diagnosis with HIV or AIDS, for a 362.4 prevalence rate. This rate significantly underestimates the likely number of HIV+ homeless in Broward. The Part A client-level data system, PE, identified 689 HIV+ Part A clients who were homeless or domiciled in temporary housing (e.g., temporarily living with family or friends or in a transitional housing program). The rate of homeless or temporarily housed HIV+ individuals identified in PE rose 17% between 2008 and 2009.

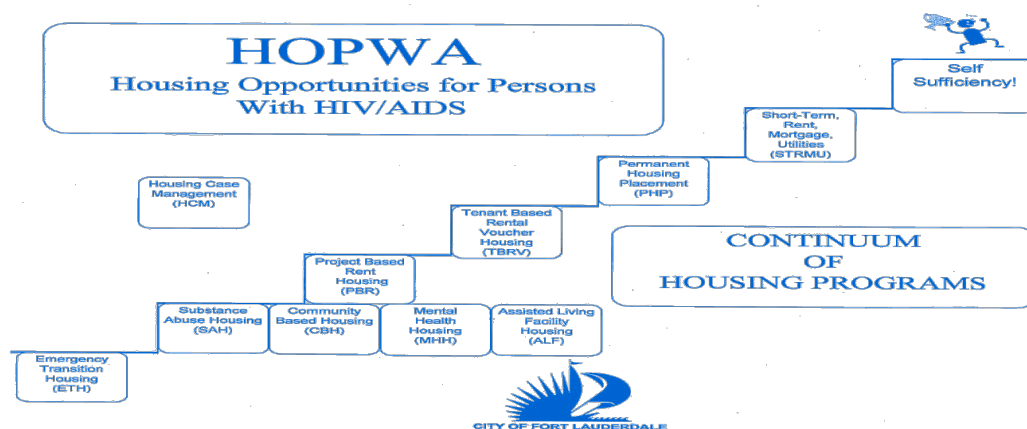
Until recently, little was known about HIV+ Broward residents who become homeless after diagnosis with HIV or AIDS. A countywide assessment of HIV+ Broward residents was commissioned in 2011 by the Part A grantee, Part B administrative agent, and the City of Fort Lauderdale Housing Opportunities for Persons with HIV/AIDS (HOPWA) grantee. Surveys were distributed by ethnically and racially diverse survey workers who targeted HIV clinics, infectious disease practices, gay and lesbian community agencies, homeless shelters, soup kitchens, community-based organizations (CBOs), residential treatment programs, and housing programs for HIV+ residents (the survey was also available online). Among 1,161 survey respondents, 99 (6%) were homeless in the six months before the survey. Heterosexual Black men and women reported the highest rates of homelessness. The homeless were significantly more likely than others to live with friends, family, or in temporary housing because they had nowhere else to live. The homeless were also significantly more likely than others to report exchanging sex for drugs, a place to sleep, or money. The homeless were six times more likely to not have enough food to eat, and seven times more likely to either not have a safe place to sleep or to feel unsafe in their neighborhoods. The homeless were over four times more likely than others to report difficulty finding affordable housing, five times more likely to have a bad credit history, and 10 times more likely to have not had transportation to look for a place to live. Homeless respondents were also significantly more likely than their counterparts to have a criminal record, physical disability, and substance abuse problem.

There are two central programs in place to address the needs of the homeless population in Broward County: The HOPWA program, a Federal program dedicated to the housing needs of people living

with HIV/AIDS, and The Broward County Homeless Services Section, responsible for homeless services planning and coordination.

Under the HOPWA program, the Housing & Urban Development Department (HUD) provides grants to local communities, states, and nonprofit organizations for housing projects that benefit low-income persons medically diagnosed with HIV/AIDS. In Broward County, the HOPWA program receives approximately \$8 million per year to provide a variety of housing options that assist persons living with HIV/AIDS. The Continuum of Housing Programs span across Broward County and offer Emergency Transitional Housing, Assisted Living Facilities, Mental Health Housing, Substance Abuse Housing, Community-Based Housing, Project-Based Rent, Tenant-Based Rental Vouchers, short-term, rent, mortgage and utilities assistance, move-in assistance and Housing Case Management with the long-term goal of helping clients achieve self-sufficiency.

The Broward County Human Services Department Homeless Services Section serves as staff to the



Homeless Initiative Partnership (HIP) Advisory Board, Broward County's focal point for planning and coordination for, and on behalf of, homeless families and individuals in Broward County. HIP staff assists with the formation of policies, programs and procedures related to homeless services. HIP Administration is responsible for administering multi-million dollar homeless programs funded by Broward County, the State of Florida, and HUD, in a collaborative effort with other Human Services Department divisions, community service providers, business leaders, and government officials, to maintain a countywide Continuum of Care of homeless services. Broward's Continuum of Care addresses all aspects of homelessness including prevention, outreach, emergency shelter, transitional and permanent affordable housing, and supportive services.

Formerly Incarcerated HIV+ Individuals

KEY POINTS

- **Formerly Incarcerated HIV+ Individuals**
 - 7% of inmates released were HIV+
 - Broward's jail HIV test rates are highest of any FL county
 - Protocols are in place to ensure engagement and linkage to care upon release

Two populations make up the formerly incarcerated HIV+ population in Broward County: 1) Inmates released from FL state prisons and 2) Inmates released from the Broward jail system. The FL DOC reports more than 95% of prison inmates are re-released to Broward, including 2,485 in 2010. DOC must test each inmate for HIV within 60 days of release. One hundred and sixty nine (169) HIV+ inmates were released in Broward in 2008, 176 inmates in 2009, and 165 inmates in 2010. HIV+ individuals made up 7% of the inmates released in 2010. An estimated 63,000 prisoners are booked annually into the Broward Sheriff's Office (BSO) jail system, the 12th largest jail system in the US. The BSO supervises 8,000 individuals on any given day, including an average daily population of 4,600 inmates in its four jails. CDC funds from FDOH support the African American Testing Initiative (AATI) that provides the jail HIV screening program.

FDOH reports Broward has the highest jail HIV test rates of any FL county, with 20% of HIV tests conducted in BSO facilities. In 2010, 5,851 male inmates received HIV tests, with 29 HIV+ inmates newly identified (0.5% HIV+ rate). Among the 1,203 women inmates tested for HIV, 11 HIV+ inmates were newly identified (0.9% HIV+ rate). An additional 55 inmates were aware of their HIV+ status before incarceration. A total of 99 inmates received HIV treatment from an HIV-experienced physician, HIV medications, and lab monitoring. Additional discussion of incarcerated individuals is included in this chapter under Section G-Barriers to Care.

In recognition of the importance of linking and engaging inmates upon release, the HIVPC established the Ad Hoc Reentry Committee in 2011. The Committee was comprised of representatives from Part A, Part C, Part B Jail Linkage Program, Broward Sheriff's Office, and Department of Corrections. The Committee established a re-entry protocol for HIV+ individuals residing in Broward. It includes pre-release planning 90 days prior to release, pre-scheduling of rapid intake by ADAP and the Part A-funded Central Intake Eligibility Determination (CIED), forwarding of necessary client eligibility documents and health records upon the inmate's release, scheduling of OAMC visits, and monitoring of OAMC appointment compliance. The work of the Committee under Part A ended in the Fall of 2011 but continues under the South Florida AIDS Network with many of the same members remaining on board.

2010 Unmet Need Estimate

KEY POINTS

- **Unmet Need**
 - Unmet need refers to individuals aware of their HIV status but not in medical care
 - In Broward, the estimated unmet need is 49%, or 8,325 individuals
 - Within the group with unmet need, 3,635 were HIV+ and 4,690 had AIDS
 - Unmet need data utilized in priorities, allocations, and decision-making
 - Unmet need is particularly high among Broward County White non-Hispanic MSM, Black non-Hispanic heterosexuals, Black heterosexual homeless men, Haitian-born men and women, and Black non-Hispanic heterosexual women
 - Efforts are being made to collaborate with prevention programs to identify, engage, link, and treat HIV+ Broward residents who are not in care

Comparing available services to identified needs reveals unmet needs and service gaps in Broward's HIV population. This includes an examination of unmet needs for HIV+ individuals who know their status but are not in care; service gaps for those who are currently in care; disparities in care; and capacity development needs of providers and the overall system of care. Analysis of unmet needs and service gaps includes not only a determination of overall needs but also identification of particular service needs for specific PLWHA populations. This will be discussed in detail within this section.

The CDC estimates that over 1 million Americans are living with HIV/AIDS, 21% of whom do not know their status. As such, they are not getting care for their HIV disease. Other estimates suggest that about one-third of those who know their status are not receiving regular HIV-related primary health care. The Ryan White CARE Act Amendments of 2000 directed HRSA grantees to assess the needs of PLWHA, particularly those from disproportionately affected and historically underserved populations who are aware of their HIV status but who have yet to receive HIV-related health services. This targeting is intended to keep Ryan White HIV/AIDS Program resources focused on early intervention and care delivery to fill gaps in care and away from expansion into such prevention areas as general outreach and HIV counseling and testing for non-infected populations.

In 2003, HRSA introduced a framework developed by the University of California, San Francisco, for grantees to use to estimate met and unmet need. The framework called for the integration of two types of data: 1) data on a jurisdiction's population of HIV-infected people who are aware of their infection, and 2) data on the number of HIV-infected people receiving care, based on laboratory reports of CD4 count and HIV viral load or the prescription of antiretroviral medications. Beginning in 2005, receipt of Ryan White funding required an assessment of HIV medical care utilization.

The EMA utilized the HAB Unmet Need Framework and calendar year (CY) 2010 data to estimate unmet need. The unmet need methodology focuses on reported AIDS and HIV (not AIDS) cases who were alive through CY 2010 and whose last known residence was in FL, regardless if the case was initially reported in FL or out of state. Cases known to be living outside of FL by December 31, 2010 and not in care in FL were not included in these analyses. These data are generated from the eHARS database, which documents cases living and in care in FL, regardless of the state in which the case was initially reported. This revised process of excluding cases known to be living outside of FL and including cases reported outside of FL but obtaining care in FL provides a more complete and accurate picture of those individuals in need of care, as well as the in- and out-migration of cases. Although the eHARS dataset is used as the primary tool for estimating unmet need, it must be noted that the database has limitations. HIV cases were not reportable in FL until July 1, 1997. From July 1997 through November 2006, HIV reporting was limited to HIV confirmatory tests performed in a confidential setting and only via diagnostic HIV tests. Mandatory lab reporting of all viral load and CD4 results was enacted in law in November 2006. Only detectable viral tests are reportable as a new case in eHARS. Therefore, patients testing “undetectable” will not be reported as HIV+ until they have a detectable viral load and/or develop AIDS. Thus, the data for HIV (not AIDS) underestimate the true number of diagnosed and in-care clients who are not yet reported. Paper reports received at the FDOH from labs not currently reporting electronically are entered into an Access database, not linked with eHARS. With the reporting laws in place for over four years and the continued expansion of electronic lab reporting (ELR), HIV lab reporting has become more complete (approximately 75%). All cases with a lab report from FL, but reported out-of-state are entered into eHARS. Due to the sheer volume of out-of-state cases, there is a backlog of over 1,000 cases to be entered into eHARS. Thus, the total number of cases and their care status are under-reported.

To compute unmet need, FDOH matches eHARS data with Medicaid, ADAP, and Health Management System (HMS), a FDOH county health department electronic health database used for patient-based services, as well as CAREWare, the ELR database, and paper lab database. Cases identified as in-care by some other source that used lab verification, are NOT identified as “in care” using these matching algorithms. This method artificially deflates the percentage of cases in care. Therefore, a multiplying factor of “those estimated in care via other sources” is used to quantify those cases. Adjusted estimates also help to account for those who migrated out and are no longer in care.

Since eHARS implementation in January 2009, FDOH tracks and updates current residence, and adds cases to eHARS reported by other states but in care in FL. For 2010, the AIDS and HIV (not AIDS) data reflect the current county of residence rather than county of initial report. This process more

accurately reflects where a case lives and, if in FL, if the case is in care. The 2010 unmet need estimate for each EMA is NOT directly comparable to previous years due to inclusion of data to account for in-migration of previously reported HIV+ cases.

Per CDC guidance, FL re-assigned several thousand cases previously reported in FL but identified as being initially reported elsewhere. Cases were omitted from the total count of HIV+ persons if they no longer lived in FL in 2010 and were no longer in care. As a result, they will no longer negatively affect the in-care data since they are no longer living in FL. This adjustment accounts for a smaller increase in HIV+ persons from the previous year. Table 2 describes the method used by FDOH to generate EMA-level Unmet Need estimates.

Table 2. Unmet Need Population - CY 2010

Population Size		#	
A	Persons living with AIDS (PLWA)	8,971	
B	Persons with HIV (PLWH)/non-AIDS	7,849	
C	Total number of persons living with HIV or AIDS	16,820	
Care Patterns		#	%
D	PLWA who <u>did</u> receive specified HIV primary medical care services	5,336	62%
E	PLWH/non-AIDS who did receive specified HIV primary medical care	3,159	38%
F	Total # of HIV+ who did receive specified HIV primary medical care	8,495	51%
Calculated Results		#	%
G	# of PLWA who <u>did NOT</u> receive primary medical services	3,635	44%
H	# of PLWH/non-AIDS who did NOT receive primary medical services	4,690	56%
I	Total HIV+ who did NOT receive specified primary medical care	8,325	49%

FDOH staff conducts ongoing matches with the death certificate database maintained by the FDOH Office of Vital Statistics to ensure the most accurate statistics on vital status. FDOH receives ongoing reports of death certificates on cases with a known HIV-related cause of death. Additionally, FDOH routinely matches living eHARS case data with death certificate data to identify deaths due to unrelated causes. Annually, FDOH matches deaths data from the SSA Death Master File with eHARS data. In 2010, FDOH also matched AIDS case data with the National Death Index and identified over 700 new deaths not previously recorded. This matching is best done annually to show the mortality trend. Due to budget constraints, FDOH has not been able to do this annually. What appears to be a sharp decline is actually a product of the delay in the matching process.

Trends in Unmet Need

FDOH estimates that through 2010, 8,325 HIV+ Broward residents were aware of their HIV status but were not receiving specified primary medical care services. Within this group with unmet need, 3,635 were HIV

(not AIDS) (44%) and 4,690 had AIDS (56%). Table 3 summarizes the percent of unmet need for Broward residents with AIDS and HIV (not AIDS) for CY 2008, 2009, and 2010. The estimated unmet need among Broward residents with AIDS increased 65% from 2008 to 2009 and 43% between 2009 and 2010. The estimated unmet need among Broward residents with HIV (not AIDS) rose 44% from 2008 to 2009 and 39% from 2009 to 2010. Among HIV+ Broward residents, estimated unmet need rose 52% from 2008 to 2009 and 41% from 2009 to 2010. FDOH estimates that unmet need among Broward residents with AIDS increased 140% from 2006 to 2011, 156% for residents with HIV (not AIDS), and 149% for all HIV+ residents.

Table 3. Estimated Unmet Need/% of AIDS, HIV Not-AIDS, and Total HIV+ Cases

	2006	2007	2008	2009	2010
AIDS	20%	19%	19.0%	30%	41%
HIV/Not-AIDS	32%	22%	33.0%	47%	60%
Total HIV+	25%	20%	25.0%	38%	49%

Unmet need increased steadily between 2008 and 2010 due in part to the refinement of FDOH unmet need estimation methods to account for immigration of persons initially diagnosed with HIV in other states or countries. These increases are attributable to Broward's unabated HIV/AIDS epidemic, as well as steady immigration of HIV+ individuals from other FL counties, US states and territories, and other countries. These increases may also be attributable to the stagnation of funds for the Broward HIV care continuum since 2008, with stagnation defined by economists as a growth rate less than 2 to 3% per year. Funds have been unavailable to expand significantly the capacity of HIV clinics to meet the needs of HIV+ Broward residents with unmet need. As mentioned earlier, Part A funds increased 0.1% between 2008 and 2009 and decreased 2.5% between 2009 and 2010. It should be noted that despite insufficient funding, the Part A Grantee has actively promoted referral and linkages between Counseling and Testing (CTS) and Part A, C, and D-funded HIV clinics through capacity building and performance monitoring. Sharply increased funds are essential to adequately address the estimated unmet need.

Methods to Identify Gaps and Apply Data for Planning and Decision Making

Unmet need data are used in priorities, resources allocation, and decision-making. On an annual basis, the HIVPC uses unmet need data to establish service priorities and make recommendations to the Grantee about allocations of Part A funds to core and support services. The HIVPC and its committees review unmet need estimates annually by demographic characteristics and estimate the percent of clients not currently in care that would likely qualify for Ryan White based on the percentage of the population currently in care and served by Part A. The HIVPC then estimates the number of new clients that the system has the capacity to engage in care. The 2010 unmet need estimate that 49% of aware HIV+ Broward residents are not in care (or 8,325 persons), presents a daunting challenge to the HIVPC and Grantee as the Ryan White-funded HIV care continuum has the

capacity to serve only about 10% to 15% of that group. The Joint Priorities Committee also reviews unmet trend data to identify other funding sources that might address the growing number of HIV+ Broward residents with unmet need. In recent years, efforts to effectively address sharply increasing unmet need have been difficult since most federal and state funders supporting the HIV care continuum have flattened or decreased their awards.

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 and trend analyses, service gap analyses, identification of emerging populations, HIV provider surveys, Broward HIV+ resident assessments, monthly reporting of appointment waiting times, and quarterly HIVPC-sponsored community meetings. The Grantee also conducts an annual in-depth assessment of a service category to ensure that Part A funds are used cost-effectively, barriers to care are addressed and eliminated, and client satisfaction is high. In recent years, the Grantee assessed OAMC, prescription drugs, oral health care, MCM, and mental health/substance abuse services. Subpopulation and core service assessments use 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). Service planning and funding allocations are informed by synthesized findings and recommendations.

Demographics and Location of People Aware of Their HIV+ Status and Not in Care

FDOH estimates the demographic characteristics of people who are aware of their HIV+ status but are not in care, including race, ethnicity, gender, age group, and HIV transmission mode. Characteristics are estimated by comparing prevalence and in-care data by demographics and reported risk groups. The demographic analyses identify subpopulations needing additional efforts to improve access to care. Demographic analyses concluded unmet need to be particularly high among Broward County White non-Hispanic MSM, Black non-Hispanic heterosexuals, Black heterosexual homeless men, Haitian-born men and women, and Black non-Hispanic heterosexual women.

Aggregated ZIP Code data do not inform unmet need assessments because they are not updated as individuals move. eHARS case reports from 2010 and the first half of 2011 are more informative, as they identify the geographic distribution of cases more recently identified as being HIV+. Geo-mapping identified the central northern and southern communities of Broward County as the location where newly identified HIV+ Broward residents tend to reside. The central northern area has high rates of MSMs and heterosexual Black non-Hispanics. The southern area is adjacent to a high incidence area of Miami-Dade County.

Efforts to Assist People Who Know Their Status and are Not in Care

Considerable effort is being made to collaborate with FDOH HIV prevention programs to identify, engage, link, and treat HIV+ Broward residents who are aware of their status but not in care. These new efforts were launched in September 2011 with a formative meeting of healthcare leaders and a think tank of Broward HIV prevention and treatment experts. In addition to these new efforts, the Grantee, HIVPC, and HIV providers have undertaken several other noteworthy efforts:

- The Part A Grantee sponsored a Consumer Forum and HIVPC retreat in late 2008 to obtain input on the 2009-2011 Comprehensive Plan. These activities reaffirmed efforts to address unmet need as a central component of the Plan. The activities conducted encouraged participation of HIV+ persons not in care, conducting special focus groups and planning sessions, and refining core and support service strategies targeting HIV+ persons' engagement in care.
- The EMA conducted three focus groups in 2010 – with transgender men-to-women, women and young males. Three focus groups were done in 2011 – with homeless, MSMs and recently released individuals. These groups identified factors that contribute to unmet need, and methods to identify, engage, and link individuals to care. A countywide survey of over 1,300 individuals in 2010 and over 1,100 individuals in 2011 provided detailed information regarding service needs among specific subpopulations.
- In preparation for the development of the 2012-2015 Comprehensive Plan, several retreats were held with the HIVPC, Grantee, committee members, PLWHA, and consumers.
- Performance among Part A subgrantees in addressing and preventing clients lost to care has been included by the Grantee in Part A performance measures. Those include waiting time for new OAMC, oral health care, Mental Health/Substance Abuse, and MCM visits; and the number of new clients engaged in care, clients lost to care or follow-up but later re-engaged in care, and clients retained in care.
- The PE client-level data system has been modified to include detailed information regarding the disposition of clients who have not had an OAMC visit in six months. These data are helpful in understanding if a client is lost to health care generally, or is now receiving care from a public or commercially funded provider, incarcerated, relocated to another jurisdiction, or deceased.
- The EMA elected to participate in the National Quality Center's (NQC) In+Care Campaign, a national retention initiative to bring clients back to care and keep others from falling out of care.
- The Grantee and HIVPC collaborate to identify trends and unmet need estimates. An annual presentation integrates key quantitative and qualitative client needs data, epidemiologic trends and service utilization data. A user-friendly summary is reviewed prior to the PSRA to identify priority areas needing increased allocations and changes to service delivery models.

- Part A contract language requires coordination between subgrantees and agencies providing Counseling and Testing Services (CTS), Early Intervention Services (EIS), and other HAB-recognized points of entry into care. These requirements include establishing linkage agreements and Memoranda of Understanding (MOU) that clearly define referral and follow-up roles, with language requiring documented referrals and response time.
- Part A Service Delivery Models (SDM) encourage client enrollment in OAMC and compliance with medical care. Support services assist HIV+ persons to engage and be retained in OAMC. Subgrantee contract language requires all agencies to determine at intake and review periodically, client engagement in OAMC, as well as provide medical referrals for, and follow-up of, consenting clients not in care. Food banks are a common point of entry into the EMA's HIV care continuum. The Food Bank subgrantee engages newly diagnosed and lost-to-care HIV+ individuals and refers them to a core service.
- The Part A and CDC outreach providers find and engage HIV+ individuals who are aware of their HIV status but are not in care and reengage clients who have dropped out of care. The EMA has undertaken significant efforts to increase the efficiency and effectiveness of outreach. The Part A outreach subgrantee is contractually required to coordinate its efforts with CDC-funded prevention programs to avoid duplication of activities.

Early Identification of Individuals with HIV/AIDS/Unaware Estimate

The Grantee developed a comprehensive EIIHA Strategy in close coordination with other Ryan White, prevention, counseling and testing, healthcare, and community stakeholders. The Strategy is designed to identify, counsel, test, and inform Broward residents of their HIV status, link, and engage HIV+ Broward residents in OAMC, and link HIV negative Broward residents to appropriate prevention services. The Strategy focuses on reducing barriers to HIV screening and addressing disparities in the availability of HIV screening for minorities and historically underserved populations. Building on the initial Strategy developed in FY 2009, the FY 2012 Strategy further formalizes relationships and jointly planned activities among HIV prevention, public and private sector HIV screening, and health and support services. The Strategy is aligned closely, but does not duplicate, the HIV prevention, screening, and treatment efforts funded by the CDC, FDOH, health insurers, and other funders. The Strategy is designed to integrate further the key stakeholders including HAB-funded grantees and subgrantees, public health prevention, disease control/intervention, healthcare system, CBOs, correctional system, faith-based community, HIV+ Broward residents, and community leaders.

The EIIHA Strategy Goals focus on increasing the number of: 1) individuals who are aware of their HIV status, 2) HIV+ individuals who are in OAMC, and 3) HIV negative individuals referred to

services that contribute to keeping them HIV negative.

Specifically, the EMA's EIIHA Strategy targets the groups below:

- Tested Confidential/Tested Anonymously
- Received Preliminary HIV+ Result Only No Confirmatory Test
- Not Tested in the Past 24 Months/Not Tested in the Past 48 Months
- Recently Incarcerated/Released
- MSM (Black MSM (BMSM), Hispanic MSM (HMSM), White MSM (WMSM))
- Black Heterosexuals (Black Women and Substance Users)
- Hispanic Heterosexuals (Hispanic Women and Substance Users)

The Strategy increases awareness among Broward residents about their HIV status by implementing evidence-based, coordinated, and targeted countywide activities that identify target populations disproportionally impacted by HIV. The Strategy is based on an already highly coordinated HIV prevention, screening, care, and financing system. The Strategy's goals are designed, implemented, and evaluated to ensure that unscreened individuals become aware of their status.

An estimated 3,996 living HIV+ Broward residents were unaware of their status in CY 2009. Table 4 summarizes the estimation method. A total of 49,499 HIV tests were conducted using Federal, State, or local funds in CY 2010.

Table 4. HIV Tests Using Federal, State, and Local Funds, CY Ending 12/31/10

49,499 =	Total number of HIV tests conducted
+ 38,654	Total number informed of their HIV status (positive and negative)
+ 10,813	Total number NOT informed of their HIV status (positive & negative)
643 =	Total number of HIV positive tests
+ 625	Total number of HIV positive informed of their HIV status
+ 18	Total number of HIV positive NOT informed of their HIV status
625 =	Total number of HIV positive referred to medical care
+ 484	Total number of HIV positive linked to medical care
+ 141	Total number of HIV positive NOT linked to medical care
48,824 =	Total number of negative tests
+ 38,029	Total number of HIV negative informed of their HIV status
+ 10,795	Total number of HIV negative NOT informed of their HIV status
Not Collected	Total number of HIV negative referred to services

B. Current Continuum of Care

KEY POINTS

Continuum Of Care

- Continuum refers to integrated system of care made up of medical and social services
- Integrated planning process engages representatives of stakeholders in planning, decision-making, implementation, and evaluation to maximize resources
- Limited funding jeopardizes the HIV continuum for those in care, and cannot support the estimated 8,325 residents aware but not in care
- The EMA considers all other funding sources to ensure "payor of last resort"

HAB defines a continuum of care as: “an integrated service network that guides and tracks clients through a comprehensive array of clinical, mental, and social services in order to maximize access and outcomes.” Reflecting its large and growing HIV/AIDS epidemic, the EMA has received Part A and MAI funds for 20 years. The EMA provides a highly accessible, culturally sensitive, HIV experienced, high quality continuum of HIV services. In FY 2011, 6,865 clients received some or all Part A core or support services. There are five Part A OAMC sub grantees, with eight 8 clinic sites. Services are available from 24 medical case management and support service sites located throughout Broward. A network of 39 counseling, testing and EIS sites offers outreach targeting minority, low income, and uninsured communities. The map illustrates the geographic distribution of Part A clients served in FY 11-12 and the location of Part A subgrantees by zip code and the table shows services provided by each Part A subgrantee.

The FY 2012 Implementation Plan addresses core medical and support services and anticipated increases in demand resulting from focused outreach efforts to identify and engage individual unaware or aware of their HIV+ status in care and reengage individuals who have dropped out of care. The proposed budget targets core services funding at 86%, exceeding the 75% requirement.

Part A Clients and Provider Locations FY 11-12

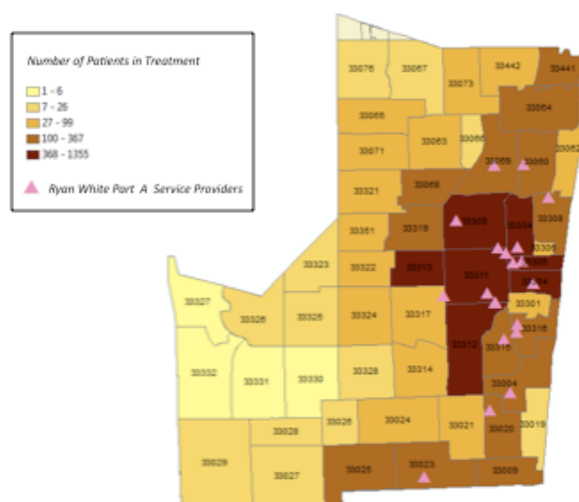
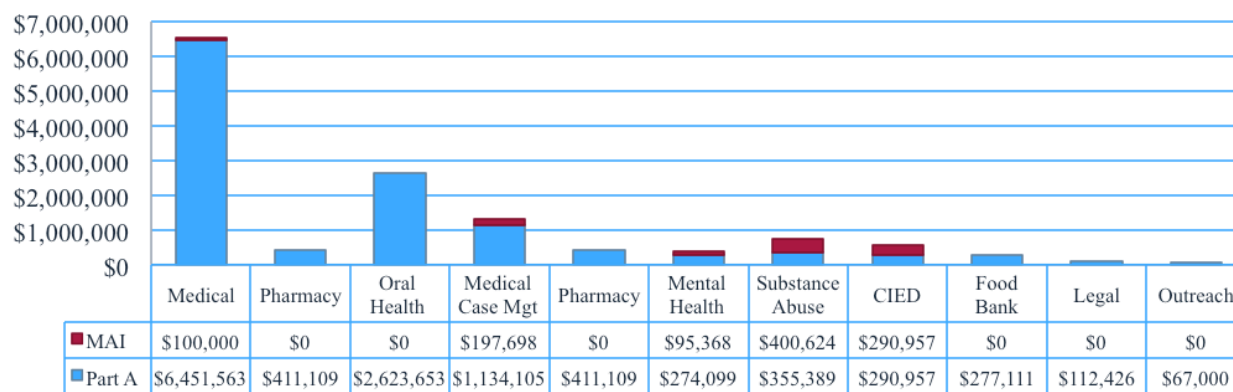


Table 5. Ryan White Part A Funded Service Providers By Service Category

Funded Agency	Medical	Medical Case Mgt	Oral Health	Pharmacy	Mental Health	Substance Abuse	Case Mgt (CIED)	Outreach	Food Bank	Legal
AIDS Healthcare Foundation	X	X		X				X		
Broward Community & Family Health	X	X								
Broward County Health Department			X	X						
Broward Health	X	X		X						
Broward House					X	X				
Broward Regional Health Planning							X			
Care Resource	X	X			X					
Legal Aid of Broward County					X					X
Minority Development		X			X					
Nova Southeastern			X							
Poverello Center									X	
Memorial Healthcare System	X	X			X	X				

FY 2012/13 Part A and MAI Allocations

Ryan White-Funded Services Interaction with Non-Ryan White to Ensure Continuity

Services funded by Federal, State, and local sources (including other Ryan White Programs) are taken into consideration in planning for the Broward HIV care continuum during the priority setting and resource allocation processes. The EMA considers the HIV and non-HIV specific services funded by local, State, and Federal resources to maximize funds, avoid duplication, and ensure Ryan White funds are 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; 2) Social Security Administration (SSA); 3) State Children's Health Insurance Program; 4) Veteran's Administration (VA); 5) HOPWA Grantee; 6) BCHD (lead agency for Part B, ADAP, and CDC prevention); 7) Children's Diagnostic and Treatment Center (CDTC) (Part D grantee for women, infants, children, and youth or WICY); 8) FL DCF (Federal and State SAMHSA funds); 9) Broward Health (Part C grantee); 10) Nova Southeastern University (Part F Grantee); 11) Broward Community and Family Health Centers (federally qualified health center FQHC); 12) Memorial Healthcare System; 13) United Way and

Community Foundation; and 14) Broward County government, represented by the Part A Chief Executive Officer and the Grantee who oversee the distribution of County funding for health and human services (including Part A and MAI funds). Broward Health and Memorial Healthcare System provide the majority of publicly funded inpatient services in the EMA.

Table 6 summarizes the availability of public funds for HIV/AIDS services in FY 2011 and anticipated in FY 2012. This table includes the actual dollar amounts and the percentage of total available funds from each source. The numbers were calculated using data obtained from Ryan White grantees for the most recent period available. Grantees have slightly different grant periods; the data from the different “parts” were not adjusted to align with the Part A grant year. FDOH provided data regarding FL general revenue allocated to Broward. Data regarding local funds were obtained from the two tax-assisted hospital districts operating in Broward - Memorial Healthcare System and Broward Health.

Table 6. Total Public Funds: Fort Lauderdale/Broward County EMA Awarded FY 2011								
Service	Ryan White Part A		Other Federal		State		TOTAL	
Minority AIDS Initiative	\$1,025,383	8%	\$344,074	2%	\$0	0%	\$1,369,457	4%
Outpatient Medical Care	\$5,920,360	46%	\$1,216,154	6%	\$259,518	14%	\$7,396,032	21%
State ADAP	\$0	0%	\$652,585	3%	\$0	0%	\$652,585	2%
Counseling and Testing	\$0	0%	\$319,634	2%	\$402,091	21%	\$721,725	2%
Home/Community Health	\$0	0%	\$991,737	5%	\$371,782	20%	\$1,363,519	4%
Other Outpatient Medical	\$0	0%	\$24,007	0%	\$158,976	8%	\$182,983	1%
Oral Health Care	\$2,155,150	17%	\$234,747	1%	\$0	0%	\$2,389,897	7%
Substance Abuse /Mental H	\$584,487	5%	\$451,976	2%	\$2,326	0%	\$1,038,789	3%
Other Core Services	\$2,112,489	16%	\$2,554,680	13%	\$636,970	34%	\$5,304,139	15%
Other Support Services	\$1,042,785	8%	\$13,172,776	66%	\$68,765	4%	\$14,284,326	41%
Total	\$12,840,654	100%	\$19,962,370	100%	\$1,900,428	100%	\$34,703,352	100%

During FY11, Part A served 7,022 unduplicated clients. Service utilization for all Part A services is described in Table 7; client demographics are provided in Table 8.

Table 7. Part A Service Utilization per Service Category FY11-12		
Service Category	Total Clients	New Clients
Health Insurance Continuation Program	137	79
AIDS Pharmaceutical Assistance (local)	2,061	482
Outpatient Ambulatory Health Care	3,506	1,354
Non-Medical Case Management (Centralized Intake and Eligibility)	6,333	4,062
Food Bank	2,019	519
Legal Services	164	97
Medical Case Management	3,554	1,130
Mental Health Services	419	167
Oral Health Care	2,768	879
Outreach Services	118	111
Substance Abuse Services (Outpatient)	124	49
Medical Transportation Services	124	12

Table 8. Part A Client Demographics FY 2011-2012	
Race	%
American Indian /Alaskan Native	0.1%
Asian	0.5%
Black	52.0%
Native Hawaiian or Other Pacific Islander	0.1%
More than one race	0.3%
White	44.2%
Other Race	2.9%
Ethnicity	%
Haitian	9.9%
Hispanic	14.4%
Non-Hispanic	75.7%
Gender	%
Male	70.1%
Female	29.5%
Transgender	0.40%
FPL	%
0-100	58.5%
101-200	31.1%
201-300	9.2%
301-400	1.0%
400-449	0.2%

FY11 reporting of expenditures for other Ryan White grantees and HOPWA indicates that Part B expended approximately \$1,030,000 serving 2,842 unduplicated clients. Specific Part B expenditures include: Medication Co-Payment - \$621,548; Home Delivered Meals - \$1,050; Home Health Care - \$6,550; Non-Medical Case Management - \$143,681; and Medical Transportation - \$149,930. Part B FY12 allocations are: Medication co-payment - \$610,000; Home delivered meals - \$2,479; Medical Transportation - \$150,971; and Non-Medical Case Management - \$228, 287.

In FY11, Part C was awarded \$952,729 and served 825 clients for medical care (excluding labs and prescription drugs), 808 for MCM, and 1,049 for treatment adherence. In addition, Part C collaborated with the DOH by dedicating approximately \$130,000 of the Part C award to DOH for counseling and testing activities and treatment of TB/HIV co-infected individuals with Directly Observed Therapy (DOT). Under this service category, Part C performed 874 HIV tests (among them 19 were positive) and provided DOT to 130 clients. A majority of Part C clients in FY 11 were males (61% of total clients), Black/African American (71%), in the 45-64 age range (61%). Part C had a surplus of \$154,700 at the end of FY11 due to staff changes; Part C has requested that HRSA authorize the use of the surplus towards purchasing testing kits.

In FY11, Part D received an award of \$2,240,740 and served 1,349 HIV infected and 203 HIV indeterminate WICY clients, approximately 95% of whom were minorities. The Part D objective for FY12 is to test 300 new patients; identify 85 newly infected patients and 215 who know their status but are not in care; provide medical care to 1,534 patients; track 210 exposed infants; provide prenatal services to 105 women; provide adherence education to 800 patients; and arrange 2,300 specialty referrals. Core medical and support services that will improve access to and retention in care for WICY clients, such as medical care coordination, childcare and transportation will be provided to 1,852 clients.

In FY11, Part F expended \$234,000 serving 443 unduplicated clients, and HOPWA expended \$8,460,000 serving 2,501 clients.

Trends in Part A Funding and Impact of Declining Funds

The EMA's Parts A and D funds are the sole sources of support for uninsured HIV+ indigent adults receiving HIV/AIDS MCM, outpatient substance abuse, mental health, food, and legal services. Part A also supports most primary and specialty services for HIV+ indigent uninsured adults. Despite a 14% increase in newly reported AIDS cases in the first nine months of 2011 and a 35% increase in newly reported HIV cases, the EMA experienced a 2.5% net decrease in FY 2011 funds. As summarized in Table 7, the EMA's FY 2011 award was 1.1% lower than its FY 2008 award. In FY12-13, the EMA was awarded \$15,390,658 (\$14,171,538 Part A and \$1,219,120 in Minority AIDS Initiative). This amount represents an increase of \$384,397 or 2.6%. Although the EMA's award was increased, the Part A-funded HIV care continuum cannot address the estimated 8,325 HIV+ individuals with unmet need.

Table 9. Broward EMA Part A Program Award Trends, FY 2008-2011 (In Millions)

Award	FY 2008	FY 2009	% Change FY 08-09	FY 2010	% Change FY 09-10	FY 2011	% Change FY 10-11	FY 2012	%Change FY 11-12
Formula	\$9.4	\$9.4	0.0%	\$10.1	7.1%	\$10.1	0.1%	\$10,118,051	-0.1%
Supplemental	\$4.6	\$4.6	0.3%	\$4.2	-8.9%	\$3.7	-12.7%	\$4,053,487	10.4%
MAI	\$1.1	\$1.1	0.5%	\$1.1	-4.9%	\$1.2	12.6%	\$1.2	1.1%
Total	\$15.2	\$15.2	0.1%	\$15.4	1.4%	\$15.0	-2.5%	\$15.4	2.6%

Average annual per capita Part A expenditures were computed to assess the impact of increased living HIV/AIDS cases on Part A funds over time. Per capita funds represent the average amount of funds spent per Part A-funded client per year. In the EMA, average per capita funds dropped from \$2,326 in FY 2008, to \$2,300 in FY 2009, and \$2,186 in FY 2010. This represents a 6% decrease between FY 2008 and FY 2010, or a loss of \$140 per client served by Part A. The loss of Part A

funds coupled with a serious decrease in ADAP funds and flat Part C and Part D funding in Broward County has created a dire situation.

Inadequate Part A funding persists at a time when the prevalence of new HIV/AIDS cases in the EMA is high and growing. The life expectancy of HIV+ individuals continues to increase due to high quality OAMC services and the benefits of HAART. Part A OAMC subgrantees are experiencing sharply increased demand for visits, medications, and other services. Steady in-migration of HIV+ individuals, for which HAB does not adjust for its Part A formula awards, also contributes to the already stressed system. Increased demand for services has resulted in sharply longer appointment waiting times for OAMC and MCM visits. To address this issue, the Grantee requires monthly reporting by Part A-funded OAMC, mental health, oral health and MCM subgrantees regarding the waiting times for new and ongoing clients. The Grantee synthesizes the information and distributes an Access to Care Schedule to Broward Part A and other HIV providers to ensure that clients are referred to providers with the shortest waiting times for appointments.

The Needs Assessment (including special population assessments) along with the unmet need framework estimates, are the basis for developing objective targets for access, retention, and adherence. HIV+ patients of Part A clinics are less likely than patients in commercial or publicly funded HIV care to report unmet need for OAMC. However, they are more likely to report barriers to care and dissatisfaction with services (e.g., wait time to get an appointment, getting a medical provider on the phone when they had a medical question or problem, and receiving an explanation regarding aspects of their treatment from their medical provider).

C. Description of Need

Minorities disproportionately impacted by HIV/AIDS and those with additional co-morbid conditions are targeted for service delivery. The HRSA Bureau of Health Professions (BHP) designated the EMA as a federally underserved area. In addition, BHP also designated the EMA as a Medically Underserved Area and a Health Professional Shortage Area. Due to the high prevalence of HIV/AIDS and limited access to HIV clinical services, expansion of core services is a critical need in this geographic area. The HIVPC allocated the largest portion of funds to four core services and two support services that effectively facilitate and engage clients in care to ensure that minority and other populations have access to the HIV care continuum. Part A-funded MCM, outreach, and food bank services are specifically designed and funded to link minority clients to culturally and linguistically competent core services.

Assessment of Emerging Populations with Special Needs

KEY POINTS

- **Emerging Populations With Special Needs**
 - Emerging populations Homeless, Black Women, White MSM, Black MSM & Hispanic MSM
 - Each population presents unique challenges to the Broward HIV care continuum in terms of service gaps and estimated costs associated with service delivery

The Grantee tracks the percentage of Part A funds that serve specific racial/ethnic minorities, analyzes service utilization data for possible discrepancies, and funds Part A and MAI subgrantees located in Broward cities and neighborhoods where HIV prevalence is high, minorities are disproportionately impacted by the HIV epidemic, and where the highest concentration of HIV+ individuals reside who are aware and unaware of their status and not in care. The Grantee also ensures that Culturally and Linguistically Appropriate Standards (CLAS) are incorporated in all the SDM's (which serve as the official Part A standards for service delivery) and are integrated in subgrantees' contracts and clients' service plans. The HIVPC and Grantee address the needs of racial/ethnic minorities by ensuring the percentage of clients from each of these groups meets or exceeds the rates proportionate to their prevalence in the local HIV epidemic. Minorities disproportionately impacted by HIV/AIDS and those with additional co-morbid conditions are targeted for service delivery.

Disparities Among Affected and Underserved Subpopulations

Disparities in Access

The EIIHA Strategy addresses disparities in access to HIV screening and linkage services among affected subpopulations and underserved communities by promoting expanded HIV screening and adoption of rapid HIV testing in communities where affected subpopulations and underserved communities reside. The Strategy ensures culturally and linguistically appropriate HIV screening is available to diverse HIV+ populations based on race, ethnicity, gender, sexual orientation, age, behavioral risk factors, and immigration status. Cultural norms and concerns about stigma and disclosure are taken into consideration: for example, in HIV mobile testing unit placement. HIV screening programs meet routinely to share their experiences in optimizing the location of mobile test units or incorporating HIV screening in broader community health screening events to address concerns that HIV disclosure might occur if an individual's family, friends, or community members observe them entering an HIV screening site or mobile testing unit. Specific cultural barriers and priority needs that obstruct awareness have been and are included in Tables 10 and 11.

Table 10. Target Group Specific Cultural Challenges That Obstruct Awareness of HIV Status

Tested Confidentially or Anonymously: Fear of learning HIV result and stigma may lead individuals to provide false information or to change their contact information prior to receiving their results

Preliminary Result Only: Fear of learning one's HIV result, denial, HIV phobia, and stigma.

Not Tested in Past 24 Months/Past 48 Months: Lack of perception of being at risk for HIV.

MSM: Internalized homophobia may impact the ability to make healthy choices, including decisions about sex and substance use. Stigma and homophobia may limit the willingness of MSM to access HIV prevention and care.

Black MSM: Resistance to disclose MSM behaviors. Insufficient culturally appropriate interventions. Religious/cultural stigma
Hispanic MSM: Fear of discrimination if HIV+, homophobia (e.g., traditional gender roles/cultural norms such as machismo), and perception that anal-insertive sex does not result in HIV transmission or represent homosexuality.

White MSM: Belief that HIV is no longer a serious health threat, due to availability of ARVs and decreased mortality.

Black Heterosexual: Disproportionate HIV risk due to cultural barriers. Racism, stigma, isolation, fewer social networks, fatalism, and distrust of government programs. Need for basic information in both Creole and English.

Hispanic Heterosexuals: Cultural insensitivity and racism. Reluctance to be tested. Lack of access to OAMC. Fear of discrimination and deportation. Few prevention interventions specifically designed to meet needs of Hispanics. Hispanic women may be unaware of male partner's risk factors or incorrectly assess them.

Table 11. Priority Needs That Obstruct Awareness of HIV Status

Tested Confidentially: CTS staff cannot verify identity or contact info. Partner notification cannot be conducted if identity is unknown. Rapid testing is not universal. Some CTS do not meet standards for storing rapid tests.

Tested Anonymously: It is impossible to identify and inform individuals whose names are not recorded. Partner notification cannot be conducted if the tested individual's identity is unknown. Rapid HIV testing is not universally adopted, thereby reducing likelihood of immediate receipt of results. CTS must receive a CLIA waiver to conduct HIV rapid testing. Some CTS do not have the physical resources necessary to store HIV rapid tests.

Preliminary Results Only: BCHD Disease Intervention Specialists (DIS) have insufficient capacity to conduct partner notification and active case finding. Part A outreach workers cannot legally obtain contact information from CTS for case finding, since these individuals have not consented to receive Part A-funded services.

Not Tested 24/48 Months: May perceive low HIV risk. System barriers include lack of health insurance payment for HIV tests, lack of testing funds for uninsured, and clinician resistance to conduct HIV screening. Lack of awareness among tested individuals about how to find CTS. Testing rates are highly variable among hospital departments.

Incarcerated: Following release, previously incarcerated persons may be homeless, indigent, uninsured, addicted, have mental health problems, and have no telephone or transportation. Lack of knowledge about CTS resources.

Black MSM: BMSM may be unaware of their HIV infection. Lack of awareness of HIV status among young BMSM may reflect recent infection, underestimation of personal risk, fewer opportunities to get tested, or belief that HIV treatment minimizes the burden of HIV. Racism, poverty, being uninsured, and lack of access to healthcare serve as barriers to testing. Low level of knowledge of, or access to, community resources.

Hispanic MSM: Few evidence-based interventions available to target HSM. Highly diverse and vary in income, education, citizenship or legal residency, health insurance, English proficiency, and acculturation. Belief that use of public services makes them ineligible for residency/citizenship. Social and religious stigma about being gay and HIV+.

White MSM: Disproportionately high HIV rates. Relatively higher rates of uninsured. Perception that HIV is inevitable.

Black Heterosexuals: Stigma, denial, social ostracism, and fear of discrimination. Socioeconomic barriers: poverty, access to high quality healthcare, and housing. Among immigrant Blacks, fear of deportation and unstable housing make case finding difficult. Among women, financial dependency upon HIV+ partners, fear of partner violence, stigma and denial.

Hispanic Heterosexuals: Lack of awareness of CTS. Highly diverse and vary in income, educational, citizenship or legal residency status, housing stability, health insurance rates, English proficiency, and acculturation. Immigration status, fear of deportation, and belief that use of public services will make them ineligible for legal US residency status or citizenship.

Disparities in Services

The HIVPC identified five emerging populations with special needs: Homeless adults, Black non-Hispanic women, White non-Hispanic MSM, Black non-Hispanic MSM, and Hispanic MSM. These populations are consistent with high priority groups identified in the Broward County HIV Prevention Plan, and have the greatest percentage of unmet need identified by FDOH. It should be noted that while IDUs constitute a significant percentage of HIV+ persons in other EMAs, IDU contributes to a much small portion of HIV+ Broward residents (7%) and, thus, unmet need. This section describes

unique challenges that each population presents to the continuum, the service gaps they experience, and estimated costs associated with delivering services to each population.

Homeless Adults

In CY 2010, \$30,749 in Part A funds were expended for homeless adults, a per capita average expenditure of \$1,337. A total of \$11,184 in OAMC expenditures were made for HIV+ homeless clients, a per capita average expenditure of \$860. FDOH reports that there were 58 HIV+ homeless Broward residents through 2010, with 28 homeless residents aware of their HIV status but not in care. As was discussed earlier, it is likely that the number of HIV homeless in care and out of care is larger suggesting that it will be important to screen carefully and persistently for homelessness as the EMA plans for, and addresses, the unique needs of homeless HIV+ individuals.

Non-Hispanic Black Women (NHBW)

In CY 2010, \$2,397,305 in Part A funds were expended for NHBW adults, an average per capita expenditure of \$1,522. A total of \$1,037,752 in Part A OAMC expenditures were made, a per capita expenditure of \$1,304. The FDOH reports that 2,143 HIV+ NHBW resided in Broward through 2010. NHBW include US-born Black women, as well as women born in Haiti or other Caribbean nations. It is important to keep the differences within this group during planning and delivering services, as their customs, linguistic needs, stigma experiences, and economic and legal status vary.

The characteristics of the 132 NHBW participating in the 2011 Consumer Survey were compared to 161 other women. Among other women, about one-half were Hispanic and one-half NHWW. NHBW were significantly younger on average than other women. NHBW were significantly less likely than other women to have been diagnosed with AIDS (25% versus 37%). Most (83%) NHBW first tested HIV+ in Broward County, compared to 78% of other women. NHBW and other women did not differ significantly in their employment status, or the number of hours they worked per week. NHBW were significantly less likely to live alone than other women, with NHBW reporting a significantly larger average household size than other women did. NHBW were twice as likely to be uninsured than other women (20% versus 10%).

Service use was compared for NHBW and other women. NHBW were significantly more likely than other women to have received outreach. While most NHBW and other women had a usual source of OAMC (89% versus 94%), NHBW were significantly more likely than other women to receive OAMC at a Part A subgrantee. On average, NHBW received 4.1 OAMC visits in the six months before the survey, compared to 3.7 visits for other women. NHBW and other women did not differ

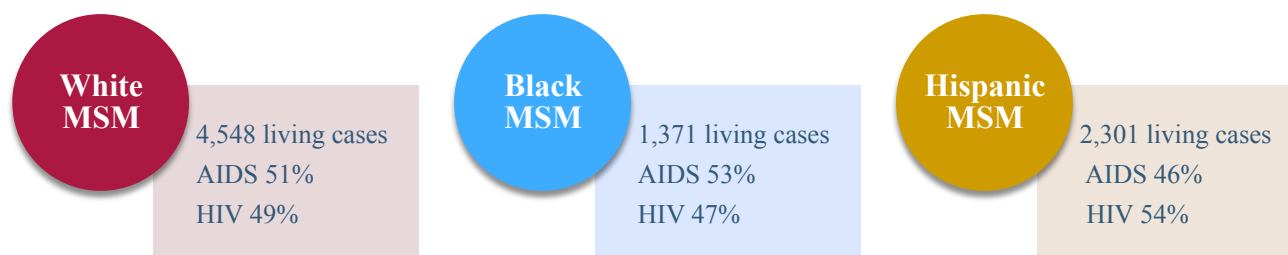
significantly in their use of ARVs (66% versus 71%), while another 20% of each group reported that they had never taken ARVs. Among women taking ARVs, NHBW and other women did not differ significantly in the frequency in which they took ARVs, or most dimensions of access to OAMC.

The use of, and unmet need for, other services were assessed. NHBW were significantly more likely than other women to be referred to a medical specialist. Conversely, other women were significantly more likely than NHBW to report unmet need for referral to a medical specialist. NHBW were significantly less likely than other women to have received dental care and significantly more likely than other women to report unmet need for dental care. NHBW were significantly less likely than other women to have received outpatient substance abuse services. While there was no significant difference in use of mental health services by NHBW and other women, other women were significantly more likely than NHBW to report unmet need for mental health services. While NHBW were significantly less likely than other women to have received HIV drug assistance, there was no significant difference reported between the two groups in unmet need for HIV drug assistance. NHBW were significantly less likely than other women to receive legal services, but there was no significant difference between the two groups in unmet need for legal services. NHBW and other women did not differ significantly in the rate of use of, or unmet need for, MCM, transportation, food bank, health insurance assistance, or HIV drug assistance.

White MSM (WMSM), Black MSM (BMSM), and Hispanic MSM (HMSM)

This section summarizes challenges that HIV+ Broward adolescent and adult WMSM, BMSM, and HMSM residents present to the Broward HIV care continuum, the service gaps they experience, and their estimated costs. Summary comparison data are presented for brevity.

Broward County HIV/AIDS Prevalence among MSM by Race/Ethnicity



The characteristics of the 328 WMSM participating in the 2011 Consumer Survey were compared to 87 BMSM and 119 HMSM. MSM respondents were identified by self-report, with a respondent assigned to this group if he reported that he was gay, bisexual, or had sex with men in the past. WMSM were significantly older on average and had been HIV+ a significantly longer number of years than HMSM and BMSM. There was no significant difference between the three groups in rates of employment, average number of hours worked if employed, or average monthly income. There

was a significant difference between the three groups in the rate of first testing HIV+ in Broward; 51% of BMSM first tested HIV+ in Broward, 49% of WMSM, and 46% of HMSM. In contrast, 35% of HMSM first tested HIV+ in another FL county vs. 21% of BMSM, and 10% of WMSM. Over one-third (39%) of WMSM were first tested HIV+ in another State/US territory, 26% of BMSM, and 23% of HMSM. About one-tenth (7%) of HMSM were first tested HIV+ in another country, 2% of BMSM, and 2% of WMSM. Twenty seven percent (27%) of WMSM reported being uninsured, 22% of HMSM, and 14% of BMSM. The three groups did not significantly vary in receiving help to pay for HIV drugs or health insurance premiums, co-payments, or deductibles, or reporting unmet need for those services.

There were significant differences between the three MSM groups in their use of OAMC and ARVs and their satisfaction with OAMC. WMSM were significantly more likely to report having a usual source of OAMC (95%) than HMSM (92%) and BMSM (86%). There was no significant difference reported by the three groups in the average number of OAMC visits in the six months before the survey. HMSM were significantly more likely than the other two groups to report always getting the medical services they need (84%), compared to 72% of WMSM and 69% of BMSM. WMSM reported the highest rate of current use of ARVs (89%), compared to 87% of HMSM and 78% of BMSM. In contrast, BMSM were significantly more likely to report never having taken ARVs (18%), compared to 9% of HMSM and 7% of WMSM. Among MSM currently taking ARVs, HMSM were significantly more likely than the other MSM to report always taking their ARVs as prescribed (97%), compared to 91% of WMSM and 89% of BMSM. While there was no significant difference between the three groups in the rates of referral to medical specialists, BMSM were significantly more likely than other MSM to report unmet need for medical specialty referral (27%), versus 17% for HMSM and 15% for WMSM.

Significant differences were found in several dimensions of access to OAMC. HMSM were significantly more likely than the other two groups to report that they always think about leaving their medical provider to find better care (24%), compared to 16% of BMSM and 10% of WMSM. BMSM were significantly more likely than the other two groups to report that the staff always lets them know about wait times when they check in for their appointments (43%), compared to 42% of HMSM and 33% of WMSM. BMSM were also significantly more likely to report that they can always schedule an appointment in the evening or weekends (43%), compared to 27% of HMSM and 17% of WMSM. BMSM were significantly more likely to report that their medical provider always asks if they use condoms during sex (63%), compared to 60% of HMSM and 45% of WMSM. WMSM were significantly more likely than the other two groups to report always feeling comfortable talking about

personal issues with their medical provider (85%), compared to 77% of HMSM and 68% of BMSM. WMSM were significantly more likely than the other two groups to report that their medical provider is always non-judgmental about their life (78%), compared to 57% of both HMSM and BMSM. WMSM were significantly more likely than the other two groups to report that they always know the process to make a complaint about their medical care (67%), compared to BMSM (60%) and HMSM (48%). These differences were consistent, for the most part, after analyzing the responses of MSM served specifically by Part A OAMC subgrantees.

WMSM were significantly more likely than the other groups to report getting mental health services in the six months before the survey (34%), compared to 25% of HMSM, and 20% of BMSM. HMSM were significantly more likely to report unmet need for mental health services (22%), versus 16% of BMSM, and 9% of WMSM. BMSM were significantly more likely to report getting transportation assistance to medical services (32%), compared to 19% of HMSM, and 10% of WMSM. BMSM were also significantly more likely to have received Part A-funded transportation services (21%), compared to 8% of HMSM and 6% of WMSM. There was no significant difference between the three groups, however, in reporting unmet need for transportation services.

A significantly greater rate of BMSM (40%) reported receiving outreach services in the six months before the survey, 29% of HMSM, and 27% of WMSM. There was no significant difference in use of dental, outpatient substance abuse, MCM, or food bank services between the three groups from either a Part A or non-Part A funded provider. No significant differences were found in their rates of unmet need for these services.

In summary, while White non-Hispanic, Black non-Hispanic, and Hispanic MSM share a common sexual preference, cultural and linguistic difference among these groups must be recognized in designing and providing services. In CY 2010, \$2,646,063 in Part A funds were expended for WMSM, \$1,594 per capita. Part A OAMC expenditures totaling \$872,077 were made for HIV+ WMSM, \$1,356 per capita. In CY 2010, \$896,285 in Part A funds were expended for BMSM, or \$1,572 per capita. A total of \$337,707 in Part A OAMC expenditures were made for HIV+ BMSM clients, \$1,189 per capita. In CY 2010, \$1,046,930 in Part A funds were expended for HIV+ HMSM, or \$1,863 per capita. A total of \$454,382 in Part A OAMC expenditures were made for HIV+ HMSM clients, or \$1,309 per capita.

D. Description of Allocation Priorities based on Size, Demographics and Needs

KEY POINTS

Allocation Priorities

- Joint Priorities Committee recommends service priorities and resource allocations
- Members review multiple data sources including demographics and needs assessments

The Joint Priorities Committee recommends service priorities and resource allocations to the HIVPC and/or South Florida AIDS Network (Consortia) for the disbursement of Ryan White Part A and Ryan White Part B funds in Broward County. The Committee recommends language to the HIVPC and Consortia on how best to meet each priority and additional factors that the Grantee should consider in disbursing funds 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 Committee reviews client needs and other data presented in the Needs Assessment, Comprehensive Planning documents, the Statewide Coordinated Statement of Need, client utilization data and spending patterns as provided by the Grantee, and other data as applicable and available. This ensures that service priorities set by the Committee are being addressed and conform to a comprehensive continuum of care.

The funding formula utilized when estimating resources is as follows: # of clients (based on surveillance data) x cost (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. The Committee must assign language on how best to meet the needs to each prioritized category.

E. Description of Gaps In Care

KEY POINTS

Gaps In Care

- Budget cuts have destabilized the care continuum
- A major concern for Broward County has been the impact of the ADAP crisis

Broward has experienced serious, negative impact from State and local budget cuts, with changes made in ADAP resulting in grave destabilization of the HIV continuum. FDOH instituted an ADAP

waiting list in June 2010 due to a projected deficit of \$18 million. In 2009, 2,838 Broward HIV+ residents were enrolled in ADAP. Enrollment rose to 3,097 in 2010, a 9% increase, before the institution of ADAP cost-containment policies. ADAP enrollment dropped to 1,857 in the first half of 2011, a 40% decrease. The EMA experienced the second greatest proportionate drop in ADAP enrollment among FL EMAs and TGAs, second only to the Jacksonville TGA. Broward had the second highest percentage of ADAP waitlisted individuals. Remaining ADAP clients have experienced a contraction of benefits. As noted earlier, Part B cost-containment efforts implemented since June 2010 included reduction of ADAP formulary to ARVs and Opportunistic Infection (OI) medications only, lowering of the FPL, and termination of clients not picking up their medication within 30 days of the refill date. Not all ADAP terminated clients have attempted to reenroll and are therefore not waitlisted. Some HIV+ consumers receive medications through pharmaceutical Patient Assistance Programs (PAPs), while others have discontinued their medication. Broward HIV clinicians report some patients who have lost ADAP enrollment have experienced serious clinical complications due to interruption of ARVs and other medications previously covered by ADAP. Depression and fatalism are reported to be common among individuals who were terminated from ADAP, while anxiety is reported to be common among ADAP clients who fear that their benefits will be terminated.

F. Description of Prevention and Service Needs

KEY POINTS

- **Prevention Needs**
 - Needs identified in SCSN impact Part A and its efforts to collaborate with counseling and testing and prevention programs in implementing the EIIHA Strategy
 - Prevention providers desire more far-reaching initiatives using new technologies
 - EIIHA Strategy addressed prevention barriers by identifying, counseling, testing, and informing residents of their HIV status, linking and engagement in OAMC
- **Service Needs**
 - Various service needs were identified for the following service categories:
 - Medical Care, Specialty Services, Oral Health Care, Medical Case Management, Mental Health, Substance Abuse, Health Insurance Premium, HIV Drug Assistance, Transportation, Food and Legal
 - Service needs vary by age, gender, race, and ethnicity

Prevention Needs

The 2012 Part B Statewide Coordinate Statement of Need (SCSN) lists the findings from the State's Prevention Planning Group's (PPG) assessment of prevention and service needs. The needs identified have an impact on Part A and its efforts to collaborate with counseling and testing and prevention programs in the implementation of the EIIHA Strategy.

The PPG conducted a community needs assessment survey between April and May of 2010. The survey consisted of 26 questions and offered HIV prevention service providers an opportunity to describe prevention and service needs in their community. Questions assessed a range of variables, including respondent demographics, agency information, delivery of prevention services, and community and agency needs. There were 158 agencies who responded to the survey; approximately half (51%) of agencies estimated they provided HIV prevention services (e.g., interventions, HIV testing, outreach) to at least 1,000 people in the last 12 months; one-fourth (25%) estimated serving 250-999 clients, and approximately another one-fourth (23%) estimated serving less than 250 clients. The majority (85%) of agencies reported providing clients with HIV prevention walk-in services or same-day appointments and 67% reported offering services during weekends or evening hours.

Respondents were asked to select from a list any significant barriers or difficulties their agency has faced when providing HIV prevention services. Insufficient funding represents the most (71%) reported barrier. The two other most prevalent barriers reported include increasing workloads (44%) and inadequate transportation (43%). Respondents selected from a list the three most important unmet needs for HIV prevention services in their area. The top three prevention needs selected were media campaigns (30%), community mobilization (26%), and group support (25%). Other services needs include community-level interventions (23%), Internet-based outreach, interventions, or campaigns (23%), rapid HIV testing (20%), HIV/STD education (19%), linkage to care (18%), STD testing (17%), individual and group-level interventions (16%) and cell phone-based interventions or campaigns (16%).

Findings suggest that most providers have expertise and capacity for providing HIV prevention services to Florida's at-risk populations. While most agencies reported a services program in which HIV/AIDS is not the sole focus, the majority had an established history (≥ 10 years) of providing HIV/AIDS services. Respondents reported diverse funding sources for HIV prevention, which support sustainability of programs. The vast majority of agencies ensure prevention staff receives important trainings on HIV/AIDS, cultural competency, and confidentiality.

Responses suggest broad implementation and reach of HIV prevention services, including HIV testing, behavioral interventions, and condom distribution. Agencies appear to target a vast range of populations and implement practices that help increase access to and use of services (e.g., walk-in services, non-traditional hours). Reported barriers to services underscore the need to explore further ways of addressing issues such as transportation, mental health issues, substance abuse, and homelessness. Such barriers may be lessened by linking clients to psychosocial and health services,

as well as local efforts to implement structural interventions (e.g., new public transportation routes, policies limiting alcohol advertising).

Responses suggest that providers desire more far-reaching initiatives in their areas (e.g., media campaigns, community mobilization initiatives, community-level interventions). A variety of other prevention service needs were reported (e.g., group support, rapid HIV testing, linkage to care, and individual- and group-level interventions), including an interest in the use of new technologies for HIV prevention (e.g., Internet- and cell phone-based initiatives). Provider responses suggest that numerous populations, particularly the black and MSM communities, have unmet service needs. Areas use these findings with other data (e.g., epidemiologic and funding data) to help assess and meet the service needs of Florida's at-risk populations.

To address prevention barriers in Broward County, the EIIHA Strategy has been designed to identify, counsel, test, and inform Broward residents of their HIV status, link, and engage HIV+ Broward residents in OAMC, and link HIV negative Broward residents to appropriate prevention services. The Strategy focuses on reducing barriers to HIV screening and addressing disparities in availability of HIV screening for minorities and historically underserved populations. It formalizes relationships and jointly planned activities among HIV prevention, public and private sector HIV screening, and health and support services. As mandated, the Strategy is aligned closely with, but does not duplicate, the HIV prevention, screening, and treatment efforts funded by the CDC, FDOH, health insurers, and other funders.

Service Needs

Information about specific service needs has been elicited through the Consumer Surveys conducted between 2009 and 2011. The 2011 Consumer Survey provided information from both Part A clients and the general PLWHA population in Broward County regarding service use, unmet need and barriers to care. The trend analysis for use of core and support services between 2009 and 2011 indicates a pattern of precipitous drop in utilization rates from 2009 to 2010, and then slight drops between 2010 and 2011. Taking these trends in mind, rates of unmet need were compared only between 2010 and 2011. Unmet need for Oral Health Care was over three times higher in 2011 than in 2010, while unmet need for legal services was over eight times higher. Unmet need for MCM was slightly higher in 2011 than in 2010. Unmet need was lower in 2011 than in 2010 for health insurance assistance, referral to medical specialists and outpatient substance abuse services. Unmet need was not assessed in 2010 for emergency food bank, legal services, and transportation services.

Table 12 lists services that survey respondents reported that they needed but were not receiving.

Table 12. Client Reported Service Needs						
<i>(*=No Data Available)</i>	2009		2010		2011	
Health Insurance, Co-Pay, Deductible Assistance	57	10%	151	18%	92	12%
HIV Drug Assistance	412	70%	105	.1%	65	9%
Medical Case Management	429	73%	110	12%	86	13%
Medical Specialty Referral	440	75%	179	18%	131	15%
Mental Health Services	448	77%	707	12%	83	12%
Oral Health Care	459	78%	126	10%	240	32%
Substance Abuse Services	432	74%	55	6%	23	3%
Emergency Food Bank	*	*	*	*	102	15%
Legal Services	*	*	*	*	67	9%
Transportation To Medical Services	*	*	*	*	114	16%

2011 Consumer Survey

Medical Care

Most respondents (92%) reported having a usual source of medical care, with 38% receiving that care at a Part A-funded medical provider. Younger adults were significantly less likely than older adults to have a usual source of care. Gender and race were associated with having a usual source of medical care, with White men reporting the highest rate. On average, respondents reported having 3.8 medical visits in the six months before the survey, significantly exceeding a federal performance measure. A comparison of 2010 and 2011 patient satisfaction with Part A medical care is provided in Table 13.

Table 13. Client Satisfaction With Ryan White Medical Care	2010	2011
Getting needed medical services	17.8%	72.2%
Waiting room staff is friendly	41.0%	74.1%
Ability to see the same medical provider	47.6%	89.0%
Want to be more involved in making decisions about care	13.1%	68.2%
Clinic staff keeps HIV status confidential	12.9%	94.6%
Medical provider asks how they feel emotionally	37.8%	46.3%
Comfortable talking about their personal issues	19.2%	79.2%
Easy to understand medical provider's answers regarding their HIV care	71.3%	81.3%
Ability to get a medical provider on the phone	35.5%	42.1%
Medical provider asks if condoms are used during sex	52.3%	60.7%
Medical provider speaks the language you feel most comfortable with	57.3%	90.8%
Awareness of how to make a complaint about medical care	52.0%	62.6%
Staff informs of wait time when checking in for appointment	92.0%	34.7%
Ability to schedule appointment in the evenings or weekends	69.4%	31.1%
Wait time for appointments is acceptable	73.7%	47.5%
Medical provider asks about living situation	77.2%	27.5%
Medical provider explains HIV drugs side effects	75.1%	67.0%
Medical provider suggests ways to remember to take HIV drugs	87.2%	70.8%
Medical provider asks about eating habits	55.2%	46.9%
Staff informs of wait time when checking in for appointment	92.0%	34.7%
Medical provider never judgmental about personal lives	66.0%	59.0%

Medical Specialty Care Services

Over one-third (36%) of respondents reported receiving referrals to medical specialists. Age was associated with specialty referral with older respondents more likely to be referred to specialty services. Gender and ethnicity were significantly associated with specialty referral, with Hispanic women reporting the highest rate of referral. Similarly, referrals rates were associated with gender and race, with Black women reporting the highest rate of specialty referral. Insured respondents were 1.6 times more likely than uninsured respondents to have received specialty referral. Over one-tenth (15%) of respondents reported having unmet need for medical specialist referral. Common reasons reported for unmet need included being unable to afford specialty care (27%) and the wait for an appointment was too long (9%). Gender and race were significantly associated with unmet need for specialty referrals, with White women reporting the highest rate of unmet need.

Oral Health Care

Over one-half (54%) of respondents reported receiving oral health care, with 69% of those patients receiving care at a Part A-funded program. Gender and ethnicity were significantly associated with the use of oral health care, with Hispanic women having the highest utilization rate. Race and gender were also associated with the use of oral health care services, with White men having the highest utilization rate. Older respondents were significantly more likely than younger respondents to receive oral health care. About one-third (32%) of respondents reported needing but not getting oral health care. Common reasons for having unmet need for oral health care included being unable to afford help (40%), the wait to obtain services was too long (16%), and fear of pain (14%). Unmet need was associated with ethnicity, gender, HIV+ but not having AIDS, and younger age.

Medical Case Management

About one-half (49%) of respondents reported getting MCM, with 62% of those respondents receiving services from a Part A-funded MCM provider. Gender and race were significantly associated with use of MCM, with White women reporting the highest utilization rate. Respondents using MCM had significantly lower average monthly income than respondents not using this service. Over one-tenth (13%) of respondents reported an unmet need for MCM.

Mental Health

Over one-quarter (27%) of respondents reported getting mental health services, with 20% of respondents receiving those services at a Part A-funded provider. Gender and race were significantly associated with the use of mental health services, with White women reporting the highest utilization

rate. Average monthly income was significantly higher among respondents getting mental health services, compared to other respondents. Slightly more than one-tenth (12%) of respondents reported that they had unmet need for mental health services. Common reasons given for unmet need included being unable to afford help (34%), not knowing where to get help (29%), the wait for an appointment was too long (16%), and not wanting anyone to know they had a mental health problem (8%). Gender, ethnicity, race, and AIDS diagnosis were significantly associated with unmet need for mental health services.

Outpatient Substance Abuse Services

Less than one-tenth (8%) of respondents reported getting outpatient substance abuse services, with 3% of respondents receiving those services at a Part A-funded provider. The relationship between respondent characteristics and service use could not be assessed due to the small number of respondents using this service. Only 3% reported that they needed but did not get this service.

Health Insurance Premiums, Co-Payments, or Deductibles Assistance

Over one-tenth (13%) of respondents reported receiving assistance to pay for health insurance premiums, co-payments, or deductibles. Gender, ethnicity, and race were significantly associated with getting assistance, with non-Hispanic and White men having the highest utilization rates. Respondents with AIDS diagnosis were significantly more likely to get assistance. Over one-tenth (12%) of respondents reported an unmet need for assistance, with the most common reasons including not knowing where to find help (61%), not having transportation to get help (11%), and not wanting anybody to know that the respondent was HIV+ (8%).

HIV Drug Assistance

Over one-third (37%) of respondents reported that they received assistance to pay for HIV drugs. Gender and race were associated with getting assistance, with White women having the highest utilization rate. Less than one-tenth (9%) of respondents reported that they needed but did not get this service. It should be noted that unmet need for HIV drug assistance is likely to be significantly underreported by respondents, as 63% of respondents reported that they do not have health insurance.

Medical Transportation Services

Over one-fifth (21%) of respondents reported getting transportation to medical services, with 63% of those respondents receiving those services at a Part A-funded provider. Gender, race, being insured, and monthly income were significantly associated with use of this service, with the lower the average

monthly income the more likely the service was used. Over one-tenth (16%) of respondents reported that they needed but did not get transportation services.

Food Bank

Over one-third (36%) of respondents reported getting emergency Food Bank services, with 79% of those respondents receiving services at a Part A-funded provider. Average monthly income was significantly associated with use of Food Bank services, with lower income respondents more likely to have used the service. Being insured was significantly associated with using Food Bank services, with 38% of insured respondents using this service versus 29% of uninsured respondents. Over one-tenth (15%) of respondents reported an unmet need for Food Bank services. Gender and ethnicity were significantly associated with unmet need for this service, with non-Hispanic women reporting the highest rate of unmet need.

Legal Services

Less than one-tenth (7%) of respondents reported getting legal services, with 5% of respondents receiving those services from Part A-funded providers. The relationship between use of legal services and respondent characteristics was not assessed due to the small number of respondents. Less than one-tenth (9%) of respondents reported an unmet need for legal services. The most common reasons given for unmet need included not knowing where to find help (55%), being unable to afford the help (33%), and not getting transportation to get the service (13%). Respondents with HIV (not AIDS) were significantly more likely than others to have unmet need for legal services.

G. Description of Barriers To Care

KEY POINTS

- **Description Of Barriers To Care**
 - There are program, provider, and client barriers to care
 - Program barriers include lack of ADAP data sharing, multiple eligibility processes, and coordination with prevention planning
 - Routine testing is not currently permitted under FL law
 - Provider barriers include lack of sufficient prevention staff to provide partner notification or locate those unaware of status, availability of rapid HIV test kits does not meet the need, multiple eligibility processes across funders cumbersome and costly
 - Client barriers vary by population

Routine testing (including any state or local legislative barriers)

A significant systemic barrier was identified and addressed to further the EIIHA Strategy of FL Part A and B Grantees. Opt-out, or routine, testing is not currently permitted under FL law. FDOH legal

counsel reports, however, that the FL statute allows for verbal or other types of informed consent for HIV testing, and that the statute is not a barrier to routine HIV testing. FDOH reports that the consent process can be limited to informing patients of their right to confidentiality that HIV+ test results must be reported to FDOH, and that anonymous testing is available. Another significant systemic and programmatic barrier to making individuals aware of their HIV+ status results from a FL statute which states that Disease Intervention Specialists (DIS) are the only FDOH personnel authorized to provide partner notification services or conduct community case finding to locate HIV+ individuals who did not return for their post-test counseling and HIV test results. BCHD staff currently employs 15 DIS for all communicable disease partner notification and community case finding. FDOH has applied for CDC funds to support additional BCHD DIS in FY 2012. To ameliorate inadequate DIS staffing, FDOH has significantly increased the number of rapid HIV test kits to further efforts to identify HIV+ persons who are unaware of their status. Hospitals and other CTS report, however, that those funds are insufficient to meet demand for rapid testing. Co-location of HIV screening, CIED, and OAMC services has addressed earlier long-term challenges to the Strategy.

Program Related Barriers

Sharing of ADAP Data

The Part A and B Grantees have been collaborating to implement a data sharing process specifically to track information on clients who receive core and support services through Part A and medications through ADAP. The historical lack of data sharing has presented many barriers to ensuring clients' medication needs are addressed consistently to prevent interruption in access to medications. Sharing of data should allow both programs to better track clients' medications, medication pick-ups and subsequent adherence to medications, and recertification dates. Ensuring timely recertification and medication pick-up has become especially important since the ADAP "No Tolerance" policy went into effect in April 2012. The policy calls for immediate disenrollment of clients who are not recertified within six (6) months. Clients who are disenrolled are put on a waiting list, are not eligible to receive any prescription medication through ADAP and must enroll in a PAP. In addition, because many clients receive medications from various funding sources, data sharing will provide clients' complete and current medication lists which should prevent drug interactions and medication duplication.

Multiple Eligibility Processes Across Funding Sources

There is an overall need to increase collaboration between various programs, including other Ryan White programs, to serve a growing number of clients with less funding. The Part A program has

been working to streamline the eligibility process by developing agreements with Part B and HOPWA to utilize the PE database to share client information.

Part A clients generally receive services from multiple funding sources. Eligibility requirements (e.g., income limits), required frequency of eligibility screening (e.g., once or twice a year), and acceptable documentation to support eligibility may vary between funding sources. The result is a cumbersome process for providers and clients as well as a duplicative and costly endeavor for program administrators and grantees. The Part A data system has allowed for the sharing of client level information between the Part A and HOPWA programs, although the eligibility requirements and process remain different and separate. Most ADAP eligibility is performed at community-based organizations and AIDS service organizations in the community. In the Ryan White Part A areas, they often work together to determine eligibility for clients accessing services under both Parts. The Bureau of HIV/AIDS funds eligibility services from the Non-medical Case Management category. In FY 2010-2011, contracted providers and county health departments reported expenditures of \$2,155,132 in this category. CIED currently provides intake and recertification services at multiple locations with the goal of being available at all medical sites to ensure efficient and timely linkage to care for newly diagnosed as well as re-engagement of clients who have fallen out of care. CIED intake can occur in the hospital, clients' homes (if home bound), or at CIED offices throughout Broward. Further assisting coordination efforts, both Broward Health and Memorial Healthcare System are Part A-funded OAMC and MCM subgrantees. CIED staff is out posted at their clinics.

Coordination with Prevention Planning

There have been historical cuts in CDC prevention and HAB-funded support services, leading to a small number of Broward CBOs operating HIV prevention and HIV screening services. Two CBOs funded to provide HIV prevention and screening are Part A subgrantees of MCM, outreach, and other support services. These CBOs actively participate on the HIVPC, its committees, and Quality Improvement (QI) Networks. Previous Part A efforts to coordinate the EIIHA Strategy with other CBOs have been challenging as CDC prevention planning efforts had slowed considerably in Broward County. New BCHD staff revitalized the Broward Community Prevention Planning Group (BCPPG), and applied to the CDC in FY 2012 to increase awards to CBOs for HIV prevention and screening. In anticipation of increased CBO HIV prevention and screening activities, the Part A Grantee expanded its collaborative activities to engage all CBOs offering HIV prevention and screening. Integration and alignment of the comprehensive HIV prevention and care plans, including annual action-oriented work plans, were initiated. Collateral integration of HIV care could not be integrated into the Broward Prevention Plan, however, because the CDC reorganized its HIV

prevention planning process through the FY 2012 FOA. Through the award of FY 2012 CDC prevention funds, FDOH will initiate a new Broward HIV Prevention Plan in mid-FY 2012 to be integrated with the Comprehensive Plan.

Provider Related Barriers

HIV Provider Assessment

HIV providers were surveyed in 2011 to assess service capacity and identify factors contributing to service gaps. All Ryan White-funded providers completed the survey, with one survey submitted per agency. Core service providers were queried about the extent to which core and support services had changed in the year before the survey. Over three-quarters of core service providers reported that help to pay for prescribed medications not on the ADAP formulary has worsened. One-half of core service providers reported that health insurance premiums, deductibles, and co-payments assistance has worsened. One-third of providers reported that access (defined as the ability to obtain needed services without barriers created by the provider, healthcare system, or consumer) to OAMC and specialty care had worsened and one-quarter reported that access to mental health services had worsened. All providers reported that access to outpatient drug or alcohol addiction treatment had stayed the same; 89% reported that access to MCM had stayed the same. Access to support services was reported by 37% of core and support providers to have worsened. Core service providers reported that it was hard to make a referral to critical services: AIDS Insurance Continuation Program (AICP) (by 100% of responding core providers); health insurance, premiums, deductibles, or co-payments assistance (71%); medical transportation (67%); ADAP (63%); specialty medical (50%); and housing assistance (50%).

The most common factors identified by providers as impeding HIV+ clients from starting OAMC include lack of transportation, cost of care, and lack of knowledge among clients about available services. The most common factors impeding HIV+ clients from staying in OAMC include client co-morbidities (e.g., substance abuse and mental illness), lack of transportation, unstable housing, negative behavior of HIV clinic staff, appointment waiting times, cost of care, and the enrollment processes for Ryan White and health insurance.

Among core service providers, 13% reported that at the time of the survey in June 2011 they did not have enough funds to meet demand for HIV services, compared to 67% of support service providers. Among core service providers, almost one-quarter reported that their HIV program does not have the capacity to increase the number of HIV+ clients served and one-third reported that they could only expand capacity by 10%. Providers reported heavy dependence on Part A funds. On average, Part A

funds made up 55% of the monthly HIV program revenue of core service providers and 93% of non-core providers. All providers reported applying for other funds in the last year, but only 17% reported being very successful in those efforts.

Broward HIV providers reported structural barriers that impeded them from expanding to serve the sharply growing number of HIV+ Broward residents. Only 22% of providers increased the amount of space available for HIV services in the last year and 11% expanded the number of HIV services sites. Almost one-half of providers reported that their full-time equivalent (FTE) staff employed to serve HIV+ clients had stayed the same or decreased, and almost one-quarter reported that turnover of front-line service employees had increased in the last year among core service providers. If additional funds were available all core service providers would increase the number of clients served, 89% would hire more direct service staff, 44% would establish linkage services with HIV CTS to ensure rapid enrollment in HIV care, and 44% would expand outreach to individuals who know their HIV status but are not in care.

Client Related Barriers

The 2011 countywide Consumer Survey assessed the service utilization experiences and service gaps of 1,161 respondents reporting being out of care, served by Part A, or served in private infectious disease or primary care practices. Almost all respondents (92%) reported receiving OAMC; among them, 38% received OAMC from a Part A subgrantee. Service utilization rates varied from 49% for MCM, 46% for medical specialty referral, and 37% for drug assistance. Most (81%) respondents reported taking ARVs at the time of the survey, while 14% reported never having taken ARVs and 5% reported having stopped taking them. Over one-half (54%) of respondents reported receiving Oral Health Care, of them 69% reported receiving Oral Health Care from a Part A subgrantee. One-third (32%) of respondents reported that they needed but did not get Oral Health Care in the six months before the survey. Unmet need was reported to be relatively lower for all other service categories. Service utilization patterns and service gaps varied significantly among respondents as noted earlier.

Focus Groups Findings

The HIVPC Joint Planning Committee identified three specific groups within the emerging populations for focus groups in 2011: MSM, individuals recently incarcerated in jails or prisons, and homeless or unstably housed individuals. The focus groups allowed for in-depth discussion regarding the specific barriers to care experienced by members of these groups.

MSM Focus Group

The 12 participants discussed current barriers to starting HIV care once MSM learn that they are HIV+. Staying in HIV care was reported to be a challenge. Participants reported that while they generally had excellent experiences with their HIV physicians, receptionists' customer service was poor. Several participants recounted the problems they had with staying on ADAP in the last year. They reported that their physicians had to intervene to ensure that they obtained refills. Frequent changes in ADAP policies were described as highly confusing. The group identified the need for greatly improved information about the availability of HIV services, including medication and health insurance premium assistance. They also asked for clarification about changes in eligibility.

Homeless Focus Group

The 15 participants reported being homeless at least once in the last year. Almost all participants reported that they had moved at least several times in the last year, with some participants moving numerous times. Participants reported that homelessness seriously impairs HIV+ individuals from starting and staying in HIV care. They described experiencing no regular source of food or a safe place to store their HIV and other medications. Participants stated that homeless individuals must know where to go to get sheltered, or have to stand in a certain spot for pick-up. They must constantly keep on the move or be arrested for loitering. They must travel with a small number of personal possessions that must be kept with them at all times to prevent theft. Depression is reported to set in, leading to drug and alcohol use. Taking ARVs and keeping medical appointments become a low priority. Affordable housing was reported to be extremely difficult to find in Broward, particularly for the participants on a fixed income, with most of their monthly income consumed by rent. Several participants stated that their rent exceeded their disability payments, making it necessary to find roommates to share the rent. Finding affordable housing was reported to be highly challenging. While the group reported that there were some low rent options, these properties are in unsafe neighborhoods. The process for getting low-cost housing and housing assistance was reported to be slow and entailed considerable bureaucratic barriers. While they agreed that there were many programs available in Broward, they reported that it was difficult to find a single source of information to help them. While HIV programs are located in high HIV prevalence communities, long bus rides are necessary due to Broward's long travel times and densely traveled streets. Reduction in bus passes created a significant barrier to staying in medical care.

Recently Incarcerated Focus Group

The five participants reported that they were aware that they were HIV+ prior to being incarcerated.

Four of the five participants were incarcerated within the last year, with several participants reporting long jail sentences. HIV+ DOC inmates were reported to have access to medical care and medication. Seeking those services, however, was likely to result in disclosure among other inmates and DOC employees. The DOC pre-release program was reported to be excellent, with the DOC worker arranging for transfer of medical records, scheduling community-based HIV clinic visits, issuing bus passes, and making referrals to CBOs. Several participants reported that they wandered the streets of downtown Fort Lauderdale for several days before they could find a shelter. Participants incarcerated in BSO jails reported that it was difficult to maintain confidentiality about their HIV status. Participants reported that DOH jail linkage workers were helpful in transitioning into the community. Transition from DOC and BSO facilities to community services was significantly hindered by the loss of identification documents during their stay in jail or prison. Participants reported that they commonly were released without their identification documents and were afraid that they might be rearrested if stopped by law enforcement personnel. The participants reported that the process for gaining identification documents was lengthy and expensive, as they had to get a bus pass to go obtain their Social Security number and driver's license before becoming Ryan White certified.

H. 2009 Comprehensive Plan Evaluation

As required by HRSA, the table below contains a summary of the evaluation of the 2009-2011 Comprehensive Plan goals including progress, successes, and challenges in implementing the goals, objectives, and strategies. The next chapter addresses in depth the challenges and proposed solutions to the implementation of the 2009-2011 Plan. Chapter 3 provides the new goals, objectives, and strategies to be implemented over the next three years.

Goal 1. Increase access to HIV outpatient/ambulatory medical care and other core services

- Evaluate identification, engagement, and retention in medical care, training evaluation, subgrantee reports, inter-agency collaborative workgroup, and Memoranda of Understanding with hospitals.
- Complete baseline assessment, number of MMP guidelines distributed, training and capacity development events with AIDS Education and Training Center and randomized chart audit.

Ongoing: Service-related outcomes to be evaluated using PE data

Achieved: OAMC Cost Effectiveness Assessment, CIED implementation and Hospital MOUs

- The OAMC Cost assessment identified recommendations to maximize funds, minimize duplication, and ensure Part A funds are used as the payer of last resort. The study focused specifically on quality of medical care and treatment, access and adherence to medications, patient level outcomes, access to and engagement in care, cost of medical and pharmaceutical services,

and patient satisfaction. In addition, an OAMC Performance Measures study provided a comparison of the rates of five Broward County Part A OAMC providers on grantee and HAB performance measures with Institute for Healthcare Improvement (IHI) and HIVQUAL mean performance scores, based on a review of a random sample of health records for the 2009 measurement year.

- Part A contract language requires coordination between subgrantees and agencies providing CTS, EIS, and other HAB-recognized points of entry into care. These requirements include establishing linkage agreements and MOU's 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 OAMC. Support services assist PLWHA to engage and be retained in OAMC. Subgrantee contract language requires all agencies to determine at intake and review periodically, client engagement in OAMC, as well as provide medical referrals for and follow-up of consenting clients not in care. Part A has coordinated with Broward hospitals to ensure newly diagnosed HIV+ hospitalized patients are linked to OAMC funded by Part A or health insurers. The Part A CIED subgrantee has established MOUs with the hospitals in which discharge staff schedule expedited CIED appointments on behalf of HIV+ inpatients. CIED intake can occur in the hospital, clients' homes (if home bound), or at CIED offices throughout Broward. Further assisting coordination efforts, both Broward Health and Memorial are Part A-funded OAMC and MCM subgrantees. CIED staff is out posted at their OAMC clinics. The Part A outreach subgrantee has MOUs with substance abuse clinics to ensure rapid engagement in OAMC for persons with HIV+ test results.

2. Reduce the rate of secondary HIV infection

Complete baseline assessment, number of MMP guidelines distributed, training and capacity development events with AIDS Education and Training Center and randomized chart audit.

Ongoing: Service-related outcomes to be evaluated using PE data

Not Implemented: While baseline assessment and training have not been implemented, secondary prevention (early detection and prompt treatment of disease) with the goal of slowing disease progression and preventing additional complications are in place. For example, Ryan White Program grantees, community obstetricians, and hospital labor and delivery departments implemented a task force to ensure the rapid identification of HIV+ pregnant women. Task force members also educate HIV+ men who have sex with women about secondary HIV prevention techniques. Emphasis will be placed on understanding the dynamics of risky behavior among PLWHA and on designing, implementing, and evaluating a limited number of interventions to promote safer sexual and drug use behavior among this population.

3. Expand geographic availability of outpatient medical care and other core services

Ongoing: Complete annual written analyses, request for proposals language and subgrantee reports.

Achieved: Expanded OAMC with AIDS Healthcare Foundation (North Point) and CIED out-posting

The 2011 HIV inventory identified a significant loss of capacity to provide HIV OAMC, MCM, and mental health services when a large OAMC subgrantee abruptly terminated those services on March 1, 2011. Services were terminated for 741 Broward HIV+ clients. The Part A grantee coordinated with other Part A subgrantees to transfer rapidly clients to avoid loss to care. Many clients required immediate medical visits to reassess their clinical status and medications, as they had not had recent medical visits. Fortunately, a physician previously employed by the closed clinic transferred most of her patients to another OAMC clinic. A psychiatrist transferred her patients to another Part A-funded mental health subgrantee. Total OAMC clients increased an average of 17% among the four remaining HIV clinics in the first six months following the HIV clinic closure with increases ranging from 2% to 57%. Contract with a new provider in 2011 will help increase access to OAMC, MCM, Outreach, and Pharmacy services.

CIED was implemented in FY 2010 and co-located at 11 provider sites offering prevention, CTS, OAMC, and other services. CIED conducts post-referral verification to ensure that appointments are kept. CIED staff contacts clients who missed their appointments to identify and overcome barriers to appointment keeping.

4. Increase access and adherence to FDA-approved HIV-related pharmaceuticals.

Achieved: (with cost savings due to LPAC)

Ongoing: Service-related outcomes evaluated using PE data.

The Local Pharmacy Advisory Committee responded to ADAP funding shortfalls by proactively revising the Part A Formulary as a cost savings measure. Part A-funded MCMs, patient navigators, physicians, and pharmacists assist patients to complete PAP applications. PE was modified to provide subgrantees with easy access to PAP applications. Other Part A efforts were undertaken to ameliorate the impact of ADAP shortfalls, including intensive chart audits conducted by the Grantee to identify and move insured ADAP clients off the program.

5. Ensure retention and engagement through culturally and linguistically competent services

Achieved: Implemented Cultural Competency Plan and NQC In Care/Retention Initiative

- The EMA joined the In+Care Campaign in October 2011 illustrating its commitment to improving retention in OAMC. All QI Networks have since been active participants in identifying barriers and developing strategies to increase retention.
- The 2009-2011 Implementation Plan ensured culturally and linguistically specific services. The Grantee organized several cultural competency trainings in conjunction with community partners, including the AIDS Community Research Initiative of America (ACRIA) and FL/AETC. These trainings address the multi-focal aspects of cultural and linguistic competency and the varied roles of the care team, including reception and other support staff.
- Subgrantees are contractually required to have a cultural competency plan to ensure clients receive high quality, appropriate care. Annual monitoring visits by the Grantee assess subgrantee cultural competency and implementation of their cultural competency plans. For example, subgrantees must demonstrate that they provide multilingual services and use linguistically appropriate forms and signage. Subgrantees employ multilingual staff (i.e., Spanish, Creole, and English) who reflect the characteristics of Broward's HIV+ residents.

In addition, a three-year health literacy plan has been developed. Year 1 will focus on assessing client and providers' health literacy levels. Year 2 will focus on QIP implementation. Year 3 will focus on evaluating Year 2 activities. All health literacy activities will begin with the newly formed Combined Network that includes CIED, outreach, legal services, food bank, pharmacy, and HOPWA.

6. Increase access, retention, and adherence to culturally a competent high quality oral health

Ongoing: Service-related outcomes evaluated using PE data.

Achieved: Two Part A funded oral health care subgrantees now collaborate to provide culturally competent, high quality routine and complex oral health care. A Cost Effectiveness and Quality Assessment was planned in 2011 and implemented in 2012 to determine areas for improvement.

7. Increase access and reduce barriers to outpatient/ambulatory care, mental health, substance abuse, and oral health by providing peer and/or near peer outreach services that are culturally and linguistically competent.

Ongoing: Service-related outcomes evaluated using PE.

Achieved: Adding peers to MAI MCM

- The Joint Priorities Committee reviews MAI-funded service category utilization, expenditure, and client demographic data, summarized on MAI service category scorecards, during the Part A and MAI planning process to enhance services to racial/ethnic minorities. The Joint Priorities

Committee recommended that peers be incorporated in delivery of MCM and the HIVPC approved the recommendation.

- To address retention in care and systemic barriers to care in the HIV care continuum, the HIVPC proposed implementation of a new intensive case management service category modeled after the CDCARTAS-II evidence-based model incorporating peers and near peers. The Grantee implemented the model intervention to enhance client familiarity with the complex service system and to increase retention in care. The implementation will assist newly diagnosed individuals and patients at risk of falling out of care by using an evidence-based model of linkage and retention.

8. Eliminate or decrease disparities related to racial or ethnic minorities

Short to mid-term: Training evaluation and subgrantees reports.

Achieved: Decreased disparities with MAI services

- The EMA uses MAI funds to enhance the quality of care and health outcomes in communities of color disproportionately impacted by the HIV epidemic. MAI-funded services are an integral part of the overall continuum of HIV care and focus on improving quality of care and health outcomes by increasing access to, retention in, and adherence to care.

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

Ongoing: Service-related outcomes evaluated using PE data.

Achieved: The EMA has implemented a Cultural Competence Work-Plan; QM, HAB Performance Measures are monitored regularly; AETC and NQC Training has been provided to all subgrantees; Technical Assistance is available to all subgrantees by request; Selected service category Chart Reviews help identify areas for improvement; Participation in the NQC In+Care Campaign provided an opportunity to develop system-wide methods to identify barriers to retention and implement strategies to address identified barriers.

2. WHERE DO WE NEED TO GO?

The purpose of this section is to provide an opportunity to discuss the EMA's vision for an ideal, high quality, comprehensive continuum of care and the elements that shape this ideal system. The section includes the plan to meet challenges identified in the evaluation of the 2009-2011 Comprehensive Plan, goals for proposed care, goals regarding individuals Aware of their HIV status but not in care, goals regarding individuals Unaware of their HIV status (EIIHA), proposed solutions for closing gaps and addressing overlaps in care, and proposed coordinating efforts with other community programs to ensure optimal access to care.

A. Plan to Meet 2009 Comprehensive Plan Evaluation Challenges

KEY POINTS

- **Plan To Meet Challenges**
 - Accomplished many goals; however challenges and solutions were identified during the evaluation
 - Development of a new Plan provides an opportunity to examine HIVPC operations
 - 2012-2015 goals and objectives provide the roadmap for the EMA and address both local and national priorities

The EMA was successful in addressing many of the goals outlined in the 2009-2011 Comprehensive Plan with many being achieved and others either ongoing or in the development stage.

Development of a new Comprehensive Plan provides the HIVPC an opportunity to examine many of its functions and operations. Several factors necessitate this examination: 1) Shrinking resources, 2) Fragmentation of committee work, and 3) Focus on day-to-day HIVPC activities at the expense of ultimate goals and a bigger picture.

The challenges identified in the implementation of the 2009-2011 Comprehensive Plan were discussed during a series of HIVPC and Committee retreats and proposed solutions were developed.

Challenge: Plan goals are not woven into Committees' work or prioritized on their work plans

Proposed Solutions

- The HIVPC has tasked the Joint Planning Committee with developing the Comprehensive Plan work plans on the committee level, ensuring goals and activities are appropriately matched to each Committee's function
- Work plans must be updated to actively address EIIHA, Special Populations, and the impact of the Affordable Care Act (ACA) on the service delivery system.

- Work plan activities must be reviewed regularly as a standing agenda item for all Committees and addressed early in the meeting. Committees must ensure agendas are outcome- and goal-oriented.

Challenge: Minimal to no oversight or evaluation of the Comprehensive Plan

Proposed Solutions

- Progress made towards achieving work plan goals should be reported to Joint Executive quarterly
- Monitoring and evaluation guidelines must be developed to help the HIVPC self-assess planning process and measure progress towards achieving Comprehensive Plan goals and objectives

Challenge: Committees operate separately instead of collaborating to address common themes

Proposed Solution

- The Comprehensive Plan provides a road map for the EMA's activities and as such requires the participation and collaboration of all HIVPC Committees and consumers. Committee work plans must address common themes such as EIIHA, Special Populations' needs, and response to ACA, as noted above, to ensure a cohesive approach to achieving goals

Challenge: At a time of shrinking resources, it is essential to ensure collaboration and coordination between all service providers, regardless of funding source. To facilitate this coordination, detailed reports on cost, utilization, and need will be provided by HIVPC members representing Ryan White Parts and other funding sources

Proposed Solution

- Request service and funding information based on membership categories. Each HIVPC membership category meets a specific need. Involvement of consumers ensures crucial input from persons closest to care delivery. Other membership categories comprising government and health professions are intended to enhance service delivery. This includes coordination of funding streams to better address gaps in care, service overlaps, and comprehensive service delivery systems.
- Define roles and responsibilities of HIVPC member categories
- Ryan White Parts B, C and D as well as HOPWA representatives provide reports at HIVPC meetings.

Challenge: Ensuring a productive Needs Assessment cycle to inform PSRA

Proposed Solutions

- Needs Assessment and PSRA are two of the most important HIVPC functions. The Needs Assessment should utilize a timeline that ensures completion before the PSRA and should result in recommendations for use in PSRA
- The Joint Planning Committee informs the Needs Assessment process by selecting the most important and useful data sets for the process as well as identifying Special Populations. Directing

data collection and ensuring the data is presented in a ‘user-friendly’ format will ensure the best possible data is used for PSRA and encourage participation of HIVPC members and consumers

- The Quality Management (QM) Committee is responsible for monitoring, evaluating, and continuously improving the quality and appropriateness of Part A and MAI services. Recommendations made as a result of reviewing performance measures and clinical outcomes should provide insight during the PSRA process

Along with the challenges and proposed solutions, several improvements and successes over the course of the 2009-2011 Comprehensive Plan were noted as well. For example, the Joint Committees improved their collaborative processes, HIVPC activities are more data driven than ever before, the Part A Grantee has implemented a data sharing agreement with HOPWA and ADAP, and an increased number of consumers has been attending HIVPC and Committee meetings.

B. 2012 Proposed Care Goals

The proposed care goals reflect both local and national priorities. Local priorities are informed by the mission of the HIVPC to 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; findings from the Consumer Survey; unmet need estimates; local changes in funding and service availability; and, national priorities such as EIIHA, NHAS, and HP 2020. The specific goals proposed for 2012-2015 are as follows: 1) Reduce new HIV infections and increasing the percentage of individuals who are aware of their status, 2) Reduce HIV-related health disparities, and 3) Increasing access to care and improving health outcomes for PLWHA.

C. Goals Regarding Individuals Aware Of Status, But Not In Care

KEY POINTS

- **Goals Regarding Aware But Not In Care**
 - Address special population needs identified in Surveys and Focus Group
 - Improve data utilization
 - Assess impact of health literacy on disparities in access and retention
 - Improve collaboration with prevention and CTS including referral and linkage
 - Utilize outreach to locate lost to care and return them to the service system
 - Continue to participate actively in the NQC In+Care Campaign

The needs of several populations have been studied in the EMA; each population presents unique challenges to the Broward HIV care continuum, in terms of the service gaps they experience, and estimated costs associated with delivering services to each population. The specific barriers to

accessing and remaining in care must be considered when planning developing goals regarding individuals aware of their status but not in care.

As noted in Section 1, the Joint Planning Committee identified three HIV+ groups for focus groups in 2011: MSM, individuals recently incarcerated in jails or prisons, and homeless or unstably housed individuals. In addition, five emerging populations with special needs were identified: Homeless adults, Black non-Hispanic women, White non-Hispanic MSM, Black non-Hispanic MSM, and Hispanic MSM. These populations were identified as having the greatest percentage of unmet need by FDOH. The graphics summarizes Consumer Survey and/or Focus Groups findings.

White MSM • More Likely Than BMSM & HMSM To Report • Regular medical care source • Comfortable talking about personal issues with medical provider • Medical provider is non-judgmental • Knowing process to complain about care • Receiving mental health	Black MSM • More Likely Than HMSM & WMSM To Report • Facilitators: • Evening/weekend appointments • Doctor asks about condom use • Unmet medical specialty need • Informed about wait time upon arrival at appointment • Transportation assistance • Receiving outreach • Barrier: Never have ARVs	Hispanic MSM • More Likely Than BMSM & WMSM To Report • Facilitators: • Getting needed medical service • Taking ARVs as prescribed • Barriers: • Thinking of leaving medical provider to find better care • Unmet Need for Mental Health
Black Women • More Likely Than White Women To Report • Service Use In Past 6 Months • Outreach services • Part A medical care • Oral Health • Higher number of medical visits • Medical specialist referrals • <u>Unmet Need:</u> Oral Health	Recently Incarcerated • Facilitators • FDOC pre-release program helpful in facilitating access • FDOH programs helpful for community re-entry • Barriers • Difficulty finding shelter • Loss of identification documents hinders access to care	Homeless/At-Risk • Needs • Food • Transportation • Safe medication storage • Barriers • Substance abuse • Homelessness impairs OAMC care • Depression • Medical care not a priority • Sex for drugs/money

Utilization of Data to Address the Needs of Individual Aware of Their Status

- Identify clients at risk for falling out of care (e.g., through triggers in PE for clients who have missed two medical appointments in a row)
- Identify clients who have fallen out of care as well as the reasons they fell out of care
- Develop an 'at risk' client profile to help target those clients who may be most at risk of falling out of care (e.g., mental health or substance abuse issues)

- Continuous, in-depth analysis of the NQC Retention In+Care Performance Measures
- Identify unmet need trends and estimates using both Part A analysis and the SCSN
- Measure and reinforce the impact of support services on retention in care

Assess the Impact of Health Literacy on Retention in Care

- Measure health literacy levels to determine their correlation to health disparities and retention
- Develop and implement strategies to address health literacy related disparities in retention in care
- Assess the impact of using AETC's Operation HOPEFUL cards on health outcomes

Improve Collaboration Among Part A, Prevention, and CTS

- Obtain regular updates and reports on referrals from prevention programs and CTS to CIED
- Measure outreach's performance in engaging HIV+ individuals who are aware of their HIV status but are not in care and reengaging clients that have dropped out of care

D. Goals Regarding Individuals *Unaware Of HIV Status (EIIHA)*

KEY POINTS

- **Goals Regarding Individuals Unaware Of Status**
 - The EMA has implemented a comprehensive EIIHA Strategy in close coordination with other Ryan White, prevention, CTS, healthcare, and community stakeholders
 - EIIHA Strategy goals are consistent with ensuring that individuals who are unaware of their HIV status become aware
 - Part A administrative funds are utilized to support the majority of the EIIHA Strategy's coordination and planning efforts
 - Counseling and testing efforts to identify individuals unaware of their status are provided by multiple entities and are coordinated with Part A to ensure linkage to care

The EIIHA Strategy is designed to identify, counsel, test, and inform Broward residents of their HIV status, link, and engage HIV+ Broward residents in OAMC, and link HIV negative Broward residents to appropriate prevention services. The Strategy focuses on reducing barriers to HIV screening and addressing disparities in availability of HIV screening for minorities and historically underserved populations. The EIIHA Strategy goals are directly aligned with NHAS goals and are listed below:

EIIHA GOALS	NHAS GOALS	HP 2020
Increase the number of individuals who are aware of their HIV status	Reduce number of people who become HIV+	To increase quality and years of a healthy life
Increase number of HIV+ individuals in OAMC	Increase access to care and optimize health outcomes Reduce HIV-related health disparities	To eliminate health disparities.
Increase the number of HIV negative individuals referred to services that contribute to keeping them HIV negative	Achieve a more coordinated response to the HIV epidemic	

The goals are aimed at addressing the needs of both those who are aware of their status and those who are not. The next two sections address the EMA's goals for both populations. As noted in Section 1, the EMA continually assesses service needs, gaps, and barriers to care of people who know their HIV/AIDS status and are not in care. However, there is certainly room for improvement in how the EMA addresses the needs of special populations; ensures services are culturally and linguistically sensitive and account for clients health literacy levels; utilizes data to promote retention; and ensures outreach services coordinate with CTS and prevention programs to refer and link individuals aware of their status, whether newly diagnosed or lost to care, to care.

The Grantee has developed a comprehensive EIIHA Strategy in close coordination with other Ryan White, prevention, counseling and testing, healthcare, and community stakeholders. It is the goal of the EMA that the Strategy continue to ensure jointly planned activities among HIV prevention, public and private sector HIV screening, and health and support services. The Strategy will continue to align closely with, but not duplicate, the HIV prevention, screening, and treatment efforts funded by the CDC, FDOH, health insurers, and other funders. The Strategy will continue to integrate key stakeholders including HAB-funded grantees and subgrantees; public health prevention, disease control and intervention; healthcare system; CBOs; correctional system; the faith-based community; HIV+ Broward residents, and community leaders.

The EIIHA Strategy's goals are consistent with ensuring that individuals who are unaware of their HIV status become aware. Strategy-related activities are conducted to increase the number of individuals who are aware of their HIV status, their newborns, and their untested children, as well as increase their sexual partners' awareness of their status. Evidence-based, coordinated, and targeted countywide activities have been implemented to identify target populations disproportionately impacted by HIV.

The use of Part A-funded services to facilitate routine HIV testing in Broward has been carefully planned, as mandated, to supplement but not supplant CDC prevention. Part A administrative funds are utilized to support the majority of the EIIHA Strategy's coordination and planning efforts. The Part A Grantee and subgrantees collaborate closely with EIS, CDC-funded HIV CTS including the BCHD and BSO jails, Part A OAMC subgrantees and other healthcare systems, and CBOs to ensure HIV+ individuals are referred rapidly to OAMC. These collaborative efforts identify individuals who are unaware of their HIV status through targeted interventions and outreach activities, including case-finding efforts for HIV+ individual that do not return for their results.

All Part A, C, and D-funded OAMC providers routinely offer HIV testing in their HIV clinics (Part B does not fund OAMC.) Along with OAMC, Part A funds outreach (focused on identification, referral, and linkage to care) and CIED (focused on linkage and engagement in care). The Part A-funded outreach subgrantee identifies HIV+ Broward residents who are not in care and coordinates their entry into care. An FY 2010 Broward Part A outreach effectiveness evaluation noted that HAB key points of entry must be targeted to ensure efficient and effective outreach.

The Part A Grantee's fully integrated planning process will continue to engage representatives of key funders and stakeholders in all levels of planning, decision-making, implementation, and evaluation of the continuum of identification, linkage, engagement, and retention in HIV care. Through the HIVPC and recently established Broward is Bigger than AIDS (BIGA) planning initiative, representatives include BCHD; RW Parts B, C, D, and F; BCHD CDC prevention, CTS, communicable disease, DIS, and outreach programs; SAMHSA grantees; FL and BSO correctional facilities; FQHCs; hospitals, and other healthcare systems. An important component of the effort to facilitate HIV testing and rapid Linkage to Care (LTC) will be the integration of information systems to track newly tested HIV+ individuals to ensure their timely entrance into OAMC.

E. Proposed Solutions for Closing Gaps In Care

KEY POINTS

- Closing Gaps In Care
 - Collaboration between Part A and ADAP ensures clients remain in ADAP or PAPs
 - SCSN-reported barriers to services underscore the need to explore ways of addressing issues such as transportation, mental health issues, substance abuse, and homelessness
 - EIIHA goals will be achieved through continued and improved collaboration

Gaps in care depend on several factors, such as the availability of other funding and service providers, which may change throughout the three years of this Comprehensive Plan. Solutions for planning and implementing strategies to address gaps in care must consider ensuring access and availability of services, reducing disparities, linking individuals aware of their status but not currently in care with appropriate care and treatment, coordinating with counseling and testing and prevention to facilitate linkage to care and treatment, and evaluating and responding to upcoming changes as future aspects of the ACA impact services for PLWHA.

The HIV continuum of care has been impacted by State and local budget cuts most noticeably as a result of the ADAP crisis. An addition of \$2.5 million in state General Revenue dollars is expected to clear the waitlist by July 2012. However, the economic downturn continues and as an increasing

number of residents become unemployed and require the assistance of social services, the demand for ADAP services will continue to increase and impact the service system.

Increased collaboration between ADAP adherence managers and Part A MCMs and medical providers will help ensure that, until the waitlist is eliminated, clients will be recertified timely to ensure they are not removed from ADAP. It is essential that clients are recertified timely since 1) a missed recertification will lead to immediate removal from ADAP or the waitlist (as stated in ADAP's No-Tolerance policy), and 2) being on the waitlist is a pre-requisite for PAP eligibility. It is important to note that medications received through Welvista, a program available only to clients on the ADAP waitlist, are more likely to arrive as complete regimens as opposed to medications obtained through individual PAP applications. Individual applications may result in receipt of medications at different times, thereby impacting clients' access to their complete regimen. To reduce gaps in care, Part A will continue to provide a 10-day supply of ARVs (with the option of requesting additional overrides) to any Part A eligible client who is awaiting ADAP or PAP eligibility determination or shipment of medications. A Part A pharmacy also provides a free 10-day supply of ARVs while clients await medication shipment or eligibility determination. In addition, the HIVPC's Local Pharmacy Advisory Committee (LPAC) will continue utilization and cost analysis of drugs on the Part A Formulary as well as implementing timely solutions to ensure access to medications that are becoming increasingly difficult to access through ADAP or a PAP.

The needs identified in the State's PPG assessment have an impact on Part A and its efforts to collaborate with counseling and testing and prevention programs in the implementation of the EIIHA Strategy. As noted earlier, the Part B SCSN reported barriers to services underscore the need to explore further ways of addressing issues such as transportation, mental health issues, substance abuse, and homelessness. Such barriers may be lessened by linking clients to psychosocial and health services, as well as local efforts to implement structural interventions (e.g., new public transportation routes). Additionally, new and far-reaching methods for HIV prevention such as media campaigns, community mobilization initiatives, community-level interventions, and use of new technologies are essential to address prevention barriers. The EIIHA Strategy aims to also address prevention barriers by identifying, counseling, testing, and informing residents of their HIV status, linking and engaging HIV+ residents in OAMC, and linking HIV negative residents to prevention services. Continued and improved collaboration and coordination between Part A, prevention programs, and CTS will help reduce gaps in access to, and retention in, care.

As described earlier, the specific needs of various special populations have been identified through the findings of the Consumer Surveys conducted from 2009-2011. Various service needs were

identified for the following service categories: Medical Care, Specialty Services, Oral Health Care, Medical Case Management, Mental Health, Outpatient Substance Abuse, Assistance for Health Insurance Premiums and other costs HIV Drug Assistance, Transportation, Emergency Food Bank and Legal Services. The service needs vary by age, gender, race, and ethnicity. The EMA will continue to use these findings to respond to the identified needs of emerging and special populations including the four mandated special populations (Adolescents, IDU, Homeless, and Transgender).

F. Proposed Solutions For Addressing Overlaps In Care

KEY POINTS

- Addressing Overlaps In Care
 - Part A providers are monitored to ensure Part A is payer of last resort
 - All Ryan White Parts as well as other funding streams are HIVPC members
 - EIIHA Strategy requires collaboration to eliminate duplication of services

The EMA has several activities in place to address overlaps in care. All Part A providers are regularly monitored to ensure Part A is the payer of last resort as well as coordination and collaboration with other Ryan White and non-Ryan White providers in the community. In the context of limited resources and increased need for collaboration, the EMA will continue to emphasize the importance of ensuring representation and reporting from all Ryan White Parts as well as other funding streams at all HIVPC Committee meetings.

The EIIHA Strategy is based on a strong collaborative model that ensures that Part A and Part B services are jointly designed, implemented, and evaluated to avoid duplication and optimize available resources. SFAN and the Part A HIVPC, under the guidance of the Part A and B Grantees, have a long history of coordinated planning, funding allocations, and service delivery through the HIVPC Joint Planning and Joint Priorities Committees. In FY 2010 and FY 2011, this collaboration expanded to include the development of a comprehensive Part A and Part B EIIHA Strategy. The HIVPC and SFAN, Part A and Part B Grantees' respective planning bodies, have incorporated EIIHA data collection and reporting, planning, implementation, and evaluation into the work plans of Joint Part A and B HIVPC Committees. Part B EIIHA activities are also closely coordinated with CIED and Part A OAMC subgrantees to ensure rapid linkage to OAMC, engagement, treatment, and retention.

The Part A Grantee has also incorporated the EIIHA Strategy in its FY 2011 RFPs, and subgrantee contracts for all Part A service categories. Among other reporting requirements, Part A subgrantees

must provide detailed quarterly reports to the Grantee about coordination with all Ryan White-funded agencies, ADAP, BCHD, and other community EIIHA efforts to support the Strategy.

G. Proposed Coordinating Efforts to Ensure Optimal Access To Care

KEY POINTS

- Optimal Access To Care
 - Part A services are well coordinated to ensure access to care
 - The collaborative efforts between the different Ryan White Parts as well as other funders include coordination to implement EIIHA, ensuring access to care for WICY, and providing linkage to housing services

Ryan White Part A services are well coordinated with other programs and funding streams to ensure optimal access to care. Part B, C, D, and F Grantees are also Part A subgrantees and serve many of the same clients. Part A clients receive services from various other programs that enhance the range of needed service. For example, housing assistance is available through the HOPWA program, Part D provides services to women, infants, children and youth, Part C provides CTS, Part B provides transportation services and HICP, and ADAP provides ARV and OI medications. Stakeholders such as public health agencies, correctional facilities, and FQHCs participate in the HIVPC and its Committees, provide data about their efforts, and work collaboratively with the HIVPC to ensure coordinated efforts and promote uninterrupted and cohesive care.

Part B Services, Including ADAP

The long-standing FL ADAP funding crisis has presented challenges to implementing the EIIHA Strategy. The Part A Grantee has undertaken coordination, programmatic, and financing efforts to offset the impact of ADAP shortfalls and expanded APA coverage to accommodate newly identified HIV+ individuals. For example, the Grantee has spearheaded efforts to coordinate Part A OAMC and MCM subgrantees to enroll newly HIV+ identified individuals in ADAP and APAs to ensure immediate access to ARVs and other needed medications. The Part A-funded APA has historically provided wrap-around coverage for ADAP-eligible clients pending enrollment, when ADAP funds are unavailable, or when PAP applications are pending. Due to the continued ADAP waitlist and reduced formulary, the HIVPC approved APA funds to individuals placed on the ADAP waitlist or who need medications that were removed from the ADAP formulary. Part A-funded MCMs, peer navigators, physicians, and pharmacists assist clients to complete PAP applications. PE was modified in response to provide subgrantees with easy access to PAP applications. Other Part A efforts were undertaken to ameliorate the impact of ADAP shortfalls, including intensive chart audits conducted

by the Grantee to identify and move insured ADAP clients off the program. Subgrantees received extensive Grantee-sponsored training regarding assisting clients to enroll in health insurance and working with the Social Security Administration (SSA) to enroll clients in disability programs, efforts designed to open ADAP slots. Florida Part A Grantees have also worked with the Florida DOH to identify vulnerable populations who must be immediately enrolled in ADAP: HIV+ pregnant women, children, or adolescents who are ineligible for other programs; postpartum HIV+ women needing to continue ARVs (with clinician approval); and other extreme medical conditions (with clinician approval). Florida DOH also funded patient navigators to assist ADAP waitlisted individuals to enroll in PAPs. In recognition of the critical importance of accessible HIV medications, the Part A Grantee continues to meet at least monthly with Florida DOH ADAP staff to identify ways to ensure access to medications for newly identified HIV+ Broward residents. In addition, any barriers to ADAP access reported by Part A clinicians are reported directly to the ADAP Medical Director to ensure immediate resolution and uninterrupted access to medications.

Part C Services

Part A efforts to make individuals aware of their HIV status are closely coordinated with Part C EIS activities. The Part C Grantee (Broward Health) has implemented a measurable, time-specific plan to expand HIV screening through the Part C funds. Confidential HIV screening is conducted in outpatient departments, inpatient departments, labor and delivery rooms, ERs, school health centers, teen pregnancy programs, and the Part D service provider (CDTC). The Part C HIV clinics also strongly encourage their HIV+ patients to bring in their partners for HIV screening; HIV+ individuals are immediately linked into care, while HIV negative individuals are counseled on how to remain negative while living with an HIV+ partner. Pregnant women at all prenatal centers receive HIV screening, are strongly encouraged to receive HIV antibody testing twice during their pregnancies (once at intake and once again between weeks 28-32 of their pregnancies). To protect their unborn children, HIV+ women are voluntarily treated with ARVs. Through subcontracted Part C funds, BCHD promotes testing among individuals unaware of their HIV status. This effort focuses on minority women and adolescents, and is conducted at health fairs in minority communities, homeless shelters, and community and church events. The Part C Grantee also receives Part A funds and actively participates on the HIVPC, its Committees, and QI Networks. The Part A and C Grantees have worked closely to ensure that Part C EIS funds are used optimally to screen as many individuals as possible and ensure their rapid linkage to care.

Part D WICY Services

The Part A and Part D Grantees collaborate closely to assess and address the needs of the WICY population. In 2011, the Part D grantee, CDTC, was instrumental in offsetting some of the impact of the BCHD HIV clinic closure. CDTC organized the transfer of HIV+ women served previously by BCHD to ensure access to HIV clinical and MCM services. The Grantee and HIVPC assess the needs of, and trends in utilization, of Part A-funded services to determine allocation of funds to WICY. WICY allocations are proportional to the EMA's WICY AIDS case percentages. WICY account for nearly 33% of Broward's total AIDS cases, with women accounting for 29% and infants, children, and youth accounting for about 4%. In 2011, WICY accounted for 32% of expenditures, with 29% allocated to women, less than 1% to infants, less than 1% to children, and 3% to youth. Part A WICY expenditures complement Part D, Medicaid, and Medicare WICY expenditures. The Part D Grantee holds an HIVPC mandated seat, is active in HIVPC Committees and QI Networks, and provides monthly updates to the HIVPC and QI Networks to share information and coordinate services. The Grantee facilitates this process by reviewing Florida DOH epidemiologic data as well as service utilization, expenditure, quality, and performance data comparing WICY and other populations to identify disparities. Subgrantees are contractually required to serve WICY in proportion to at least their prevalence in Broward.

The CDC and American College of Obstetricians and Gynecologists (ACOG) National Fetal and Infant Mortality Review funded the Fetal Infant Mortality Review (FIMR) in Broward to improve perinatal HIV prevention systems. The FIMR HIV prevention methodology identifies community-level factors associated with the individual cases of fetal or infant mortality. Sentinel events are reviewed (e.g., infants exposed to HIV) to identify healthcare system deficiencies and potential improvements. Based on the data gathered, community actions are initiated to achieve system change to improve outcomes for HIV+ women and their children and prevent future perinatal HIV cases.

Part F Services

Nova Southeastern University is the Part F Community-Based Dental Partnership Grantee as well as a Part A subgrantee. Nova staff participates in the HIVPC Oral Health Care Network and HIVPC Committees. Part A also collaborates with the Part F funded Florida/Caribbean AETC on various activities including chart reviews, MCM training, Technical Assistance (TA), and most recently, a Health Literacy pilot study.

Private Providers (Non-Ryan White Funded)

Clients receiving private medical care who are eligible for Ryan White may access other Part A core and support services as well as ADAP and HICP. The EMA has identified several activities to form

and maintain relationships with private HIV medical providers to verify that private care patients have accessed HIV treatment. The BCHD CTS Program DIS staff is responsible for verifying that persons referred to a private physician have initiated care. Both Part A and DIS staff have established strong relationships with community private HIV practices in Broward, and routinely contact practice managers to conduct verification. Part A and FDOH will continue to collaborate with the FL Medical Association on educational opportunities regarding reimbursement, community collaboration on patient linkage, and post referral follow up. HIV-related information is disseminated on the Association website and newsletters, including articles underscoring the importance of HIV screening, initiating HIV treatment, and HIV treatment topics. FDOH also partners with the FL/Caribbean AETC to train private providers. The FL/Caribbean AETC provides an educational forum for staff at identified clinical sites throughout FL. Training topics include racial and ethnic minority health disparities, HIV stigma, acute and chronic HIV infection signs and symptoms, FL laws related to HIV screening such as informed consent, CDC HIV screening recommendations, PHS HIV guidelines, and Ryan White funded services.

STD and Prevention Programs - Partner Notification and Prevention with Positives

While relationships have been established with private providers, there is room for improvement in the degree of collaboration. For example, MCM's are required to track and monitor clients' CD4 and Viral Load results as well as other tests and screenings required for compliance with PHS guidelines. Access to results is often difficult as private providers do not necessarily operate under the same standards of care. In addition, strategies to ensure referral of newly diagnosed and lost-to-care clients to the Part A system must be expanded to ensure timely linkage and retention in care.

BCHD is the Broward Part B and HIV prevention lead agency. It manages the Community Prevention Partnership, and designs and implements the Broward HIV Prevention Plan. BCHD staff and Partnership members also participate in the HIVPC and its Committees. The CDC-funded BCHD ensures that public funds are available for HIV screening, partner notification, outreach, and LTC. CDC funds support HIV screening, including the AATI, Expanded Testing Initiative (ETI), and Targeted Outreach for Pregnant Women Act (TOPWA). MAI and FL General Revenue funds also support HIV screening and LTC.

All BCHD HIV screening activities are consistent with the CDC 2006 recommendations and adhere to FL statutes pertaining to partner notification, confidentiality, and content of counseling sessions. Opt-out, or routine, testing is available only to pregnant women at their initial prenatal care visit, again at 28-32 weeks gestation, and at labor and delivery for women with an undocumented HIV status. Providers must notify women that testing will occur and that they can refuse any or all tests.

HIV screening is provided confidentially at five BCHD sites in high HIV prevalence areas of Broward County. Anonymous HIV screening is permitted by FL statute at several BCHD sites and three CBOs. HIV+ individuals tested at anonymous sites are counseled about the importance of rapid engagement in OAMC and are offered the option of giving identifying information so that linkage to OAMC can be initiated.

BCHD has collaborated in the last two years with Part A and HOPWA to plan and implement countywide surveys of HIV+ Broward residents. BCHD has also collaborated with Part A to identify strategies for increasing HIV screening rates in STI, TB, and HCV clinics, improving linkage and outreach processes to ensure engagement and retention in OAMC for HIV+ persons, and mechanisms for integrating BCHD HIV screening and linkage data into PE. BCHD has applied for FY 2012 CDC prevention funds to implement BIGA and is collaborating with the Part A Grantee to ensure that BIGA is fully integrated into the EIIHA Strategy.

Previous Part A efforts to coordinate the Strategy with other CBOs have been challenging as CDC prevention planning efforts had slowed considerably in Broward. New BCHD staff revitalized the Broward Community Prevention Planning Group (BCPPG). In anticipation of increased CBO HIV prevention and screening activities, the Part A Grantee expanded its collaborative activities to engage all CBOs offering HIV prevention and screening.

Substance Abuse Treatment Programs/Facilities

The erosion of public substance abuse and mental health treatment funds continues to impair the already limited capacity of those systems. Continued demand for substance abuse treatment has resulted in waiting lists for detox and residential treatment. Due to funding shortfalls, public mental health services are limited to only the most severely mentally ill and/or addicted. Part A continues to allocate substance abuse and mental health treatment funds for HIV+ clients to assist access, retention, and adherence to OAMC, to the extent that new Part A and MAI funds are available. A recently completed review of Part A-funded OAMC health records identified the need to increase screening for mental illness and substance abuse, which suggests a need to expand access to these services. Part A has closely coordinated the EIIHA Strategy with substance abuse prevention and treatment programs. Conventional and rapid HIV testing is offered at publicly funded drug treatment programs, including methadone clinics. The Part A outreach subgrantee has MOUs with substance abuse clinics to ensure rapid engagement in OAMC for persons who receive an HIV+ test results.

Broward County has seen an increase in the use of pain medication and resulting fatalities. Florida has become the prescription pain medication capital of the nation. According to the Florida Medical Examiners Commission Reports From 2000 to 2010, opiate-related deaths by heroin and/or opiate

medications in Florida increased from 869 to 3,986. The Broward Addiction Recovery Center (BARC) has seen changes with the primary admitting diagnosis switching from alcohol abuse/addiction (32.6%) to opiates such as heroin or oxycodone (52.1%). Young adults between 18-35 years old are the majority age group abusing these drugs. BARC offers a comprehensive range of services for Broward County residents over the age of 18 who are affected by substance abuse and/or co-occurring disorders. BARC collaborates with a variety of health care providers and referral sources to ensure clients, especially from underserved populations, receive services that will support their recovery. 4,500 clients each year are admitted to BARC and benefit from residential or outpatient treatment and support services. 1,800 clients per year benefit from medically supervised drug and alcohol withdrawal treatment offered by the professionals at BARC's detoxification unit. 800 residents per year participate in non-residential day treatment programs.

Medicaid

The Agency for Health Care Administration (AHCA) is responsible for administering Medicaid in Florida. AHCA is also the lead agency for the Children's Medical Insurance Programs (SCHIP), the state's health insurance program for uninsured children.

Medicaid is funded by both federal and state contributions. Florida's federal contribution was temporarily increased from 55.4% to 68.8% due to federal stimulus funds provided for in the American Recovery and Reinvestment Act of 2009 (ARRA). The enhancement expired June 30, 2011, despite continued high need due to ongoing heightened unemployment and lack of insurance rates combined with state budget shortfalls.

Medicaid is available to pregnant woman, disabled adults, caretakers of children under age 18 years, adults over age 65 years, and children under age 19 years who meet low-income requirements. Supplemental Security Income (SSI) recipients typically automatically receive Medicaid. Beginning on January 1, 2014, the ACA is scheduled to expand Medicaid eligibility to children, parents, and childless adults who are not entitled to Medicare and who have family incomes up to 133% FPL.

Florida does not have a waiver in place to provide Medicaid coverage to nondisabled people living with HIV/AIDS. Therefore, applicants must demonstrate disability before applying for Medicaid. Florida Medicaid enrollees who have been diagnosed with AIDS may be eligible to enroll in the Project AIDS Care (PAC) Medicaid waiver program for home- and community-based services (HCBS). To be eligible, an individual must be otherwise eligible for Medicaid, must show documentation of an AIDS diagnosis and the presence of AIDS-related opportunistic infections, must have been determined to be at risk of hospitalization or institutionalization in a nursing facility, must not be enrolled in another Medicaid HCBS waiver program, and be capable of remaining safely in the

home and community. Florida originally received federal approval for this program in 1990; the current waiver is set to expire December 31, 2012. The program is capped at 5,900 enrollees.

Medicaid and the Department of Children and Families (DCF), another agency that helps operate Florida Medicaid, are represented on the HIVPC. AHCA provides detailed Medicaid enrollment and expenditure data to the Part A Grantee to assist in planning and resource allocation activities. The Part A PE Medicaid interface has been helpful in ensuring that CIED and Part A-funded providers comply with HAB's payer of last resort policy, by linking automatically to Medicaid using clients' Social Security numbers to determine if clients are enrolled, what Medicaid program they are enrolled in (which indicates the extent of benefits they are receiving), and obtain their Medicaid numbers. CIED and Part A medical case managers have been trained to ensure that potential clients are screened for Medicaid and PAC Waiver.

Medicaid Managed Care Pilot Program

In addition to the state's traditional Medicaid program, in 2006 FL obtained a waiver to launch an experimental Medicaid pilot program in Duval and Broward counties. Through this program, traditional Medicaid was replaced with a managed-care model, in the hopes of reducing costs and improving efficiency by allowing beneficiaries to enroll in any available plan, including capitated managed care plans (HMOs) and provider-sponsored networks (PSNs). The managed care program was expanded to additional counties, enrolling over 288,000 consumers, about 10% of statewide Medicaid enrollment. While research shows that the pilot program's efficiency and cost-saving impacts have been mixed, the Legislature passed a bill in 2010 directing AHCA to seek approval of a three year waiver extension for the pilot program. The Legislature passed a sweeping Medicaid reform bill during the 2011 session that allows statewide expansion of the waiver.

As Florida moves in this direction, and as additional low-income adults, including many with disabilities, obtain Medicaid under the ACA, a set of special concerns for this high-need population – related to outreach and education, system navigation, access to services, and beneficiary protection and oversight – warrants careful consideration. Managed care offers potential to increase access and improve the coordination of care, particularly for those with the most complex needs. At the same time, it has the potential to disrupt access and care and to compromise the well-being of beneficiaries if they are unable to navigate the system or health plans are not equipped to meet their needs.

Medicare

Medicare is a federally funded program that provides health insurance to people over age 65 years who are eligible for Social Security. Disabled adults who are under age 65 and who have worked

enough years to be eligible for Social Security Disability Insurance (SSDI) also automatically qualify for Medicare after receiving their SSDI benefit for 2 years. It is possible for a person to qualify for both Medicaid and Medicare (“dual eligibility”). Medicare covers an estimated 100,000 people living with HIV/AIDS in the United States, representing approximately one-fifth of people living with HIV/AIDS who are in care. In FL, 3.3 million individuals were enrolled in Medicare in 2010 (18% of the state’s total population). Approximately 86% of Medicare enrollees in FL are aged (over 65 years), while about 13% are disabled.

Medicare Part D

Originally launched in 2006 and intended to help beneficiaries pay for prescription drugs, Medicare Part D requires an additional premium that varies by plan. Part D plans are required to equal or exceed a defined standard benefit, which currently has a \$310 deductible, then coinsurance of 25% up to \$2,830 in total drug costs, followed by a gap in coverage that starts when total drug costs reach \$2,830 and ends at approximately \$6,100 in total costs (the donut hole). The donut hole ends after recipients have spent \$4,550 out of pocket in deductibles and co-payments toward their drugs. After passing the donut hole, they qualify for “catastrophic coverage,” and pay 5% of drug costs for the rest of the year, with the federal government paying the other 95%.

The donut hole affects Medicare beneficiaries with income over 150% FPL (\$16,245 per person). Individuals with income below 150% FPL who meet the requirements for the Low Income Subsidy (LIS) program do not have a donut hole. Low-income individuals who are not enrolled in a Part D drug plan may receive assistance through the Florida Discount Drug Card Program, which helps to lower the cost of prescriptions.

Historically, Part D enrollees who entered the donut hole were required to pay 100% of the cost of their prescription drugs until they reached catastrophic coverage; third-party payments to assist with drug costs could not count toward an enrollee’s “true out-of-pocket” (TrOOP) spending requirement. For Part D enrollees taking HIV medications, who are typically covered for about two months worth of medications before falling into the donut hole, this meant that contributions by ADAP to help people pay for medications in the donut hole could not count toward TrOOP. Consequently, these individuals could not reach catastrophic coverage and ADAP paid for their drugs until the next year, when their plan was reset. However, under the ACA, ADAP contributions now count toward TrOOP, helping more people reach catastrophic Part D coverage. Beginning in January 2011, ADAP clients were notified that they would be allowed to remain in ADAP during the time they are accessing Medicare Part D, as long as their ADAP enrollment remained current. Clients could return to ADAP

with appropriate proof that the donut hole in their plan was reached and ADAP would pickup coverage of the medications and coordinate pharmaceutical benefits.

Income Subsidy (Extra Help)

The Extra Help/LIS program provides financial support for people with especially limited income and resources. The program pays for all or part of the monthly premiums and annual deductibles and provides lower prescription copayments for Medicare prescription drug plans. LIS beneficiaries with income between 135% and 150% FPL pay a sliding-scale-based Part D premium and have a \$60 annual deductible. Individuals who are dual-eligible are automatically enrolled in LIS. Non-duals with income less than 135% FPL also receive LIS automatically if they receive SSI. Individuals who are not dual-eligible, do not receive SSI, and have income less than 135% FPL must apply for LIS.

Social Security Administration

Part A subgrantees' have been trained on SSA eligibility determination processes and benefits. The Part A Grantee worked closely with SSA field staff to develop processes for verification of enrollment in SSA disability and retirement programs by Part A-funded CIED staff. SSA staff has also provided SAMHSA-funded SSI/SSDI Outreach, Access and Recovery (SOAR) training to CIED and MCM staff to provide tools for completing SSA applications and helping enroll clients in SSA disability programs. SSA staff collaborates with CIED to facilitate enrollment of clients in SSA programs. SSA policies have created substantial challenges for the HIV care continuum that have had to be addressed by Part A Grantee, HIVPC, providers, and clients. The process for applying for disability benefits is complex, requires substantial clinical documentation, and commonly results in denial of benefits. Part A Legal Services are available to assist with following up on denials as well as initiating the application process.

Children's Health Insurance Program

The State Children's Health Insurance Program in FL is called KidCare and is administered by DCF. It includes four partners: MediKids which covers kids ages 1-4, Florida Healthy Kids which covers kids ages 5-18, Children's Medical Services Network which covers kids from birth through 18 who have special health care needs and Medicaid for Children which covers kids from birth through 18 whose families qualify for the low-income eligibility requirement. DCF administers the FL KidCare Program, which offers affordable, low-cost health insurance for the uninsured children of FL. Routine programmatic updates are provided to the HIVPC by DCF.

Community Health Centers

Federally Qualified Health Centers (FQHCs) are “safety net” providers such as community health centers, public housing centers, outpatient health programs funded by the Indian Health Service, and programs serving migrants and the homeless. The main purpose of the FQHC Program is to enhance the provision of primary care services in underserved urban and rural communities. Broward’s two FQHCs are also Part A subgrantees, and fully participate in HIVPC Committees and QI Networks. One FQHC is represented on the HIVPC. The Florida DOH actively collaborates with the FQHCs to enhance and expand HIV prevention, train staff to perform rapid HIV tests, and encourage HIV screening of all patients. Florida DOH also funds HIV screening at one of the clinics. One FQHC provides extensive prevention and testing services targeting MSM and minority communities

Veterans Affairs

The US Department of Veterans Affairs (VA) provides patient care and federal benefits to veterans and their dependents. HAB’s VA policy is considered in Part A planning and care coordination. In July 2011, Broward Part A-funded MCMs participated in a mandatory training sponsored by the Part A Grantee in which HAB’s VA policy was reviewed. They were trained regarding specific activities that they must undertake to adhere to the policy, including advising clients regarding the voluntary use of VA services and coordinating VA benefits with services obtained from the Ryan White-funded HIV care continuum. Clients potentially eligible for VA may be referred to one of several VA sites in South FL. The HIVPC is currently in the process of recruitment to fill an available HIVPC seat with a VA representative.

HOPWA

The HOPWA program was described in detail earlier. The City of Fort Lauderdale HOPWA Grantee participates actively in the HIVPC and several of its committees. HOPWA staff also collaborates with the Part A Grantee and the Part B administrative agent to conduct planning and assessment activities, including the consumer and provider surveys described earlier. The HOPWA Grantee collaborated with the Part A Grantee to integrate HOPWA client-level data into the Part A-funded PE System. HOPWA subgrantees, including housing case managers, are required to enter client-level assessment and services data into PE. They, in turn, are able to review MCM assessment and services data, health utilization data, and clinical status data. The utility of integrated HIV clinical and housing data was demonstrated in a series of previous HOPWA-funded studies.

3. HOW WILL WE GET THERE?

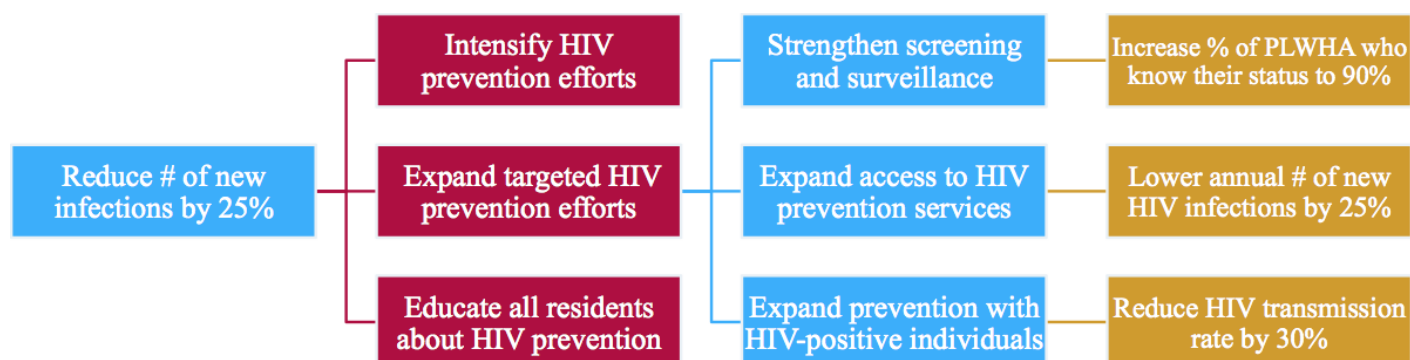
This section describes the specific strategy, plan, activities, and timeline associated with achieving specified goals and meeting identified challenges. The Comprehensive Plan is a living document and the Part A Grantee and HIVPC may revise, amend, and/or include additional goals, objectives, and activities throughout the implementation period to improve the health outcomes and quality of life for PLWHA in Broward County as needed. Implementation and oversight of this Plan are the responsibility of the Grantee, HIVPC, Committees, and QI Networks. Proper oversight will require the development of Committee work plans that incorporate the goals into their regular activities.

The NHAS goals are the foundation of the Broward County Comprehensive Plan and are listed below along with corresponding activities and anticipated outcomes. This section also illustrates how the Comprehensive Plan will address Healthy People 2020 objectives, plan for, and adapt to, changes resulting from the ACA, and reflect the SCSN.

The NHAS vision calls for collaboration and targeted funding so that: “New HIV infections will be rare and when they do occur, every person, regardless of age, gender, race/ethnicity, sexual orientation, gender identity or socioeconomic circumstance, will have unfettered access to high quality, life-extending care, free from stigma and discrimination.” Along with the three overarching goals, the NHAS lists measures to be met by 2015.

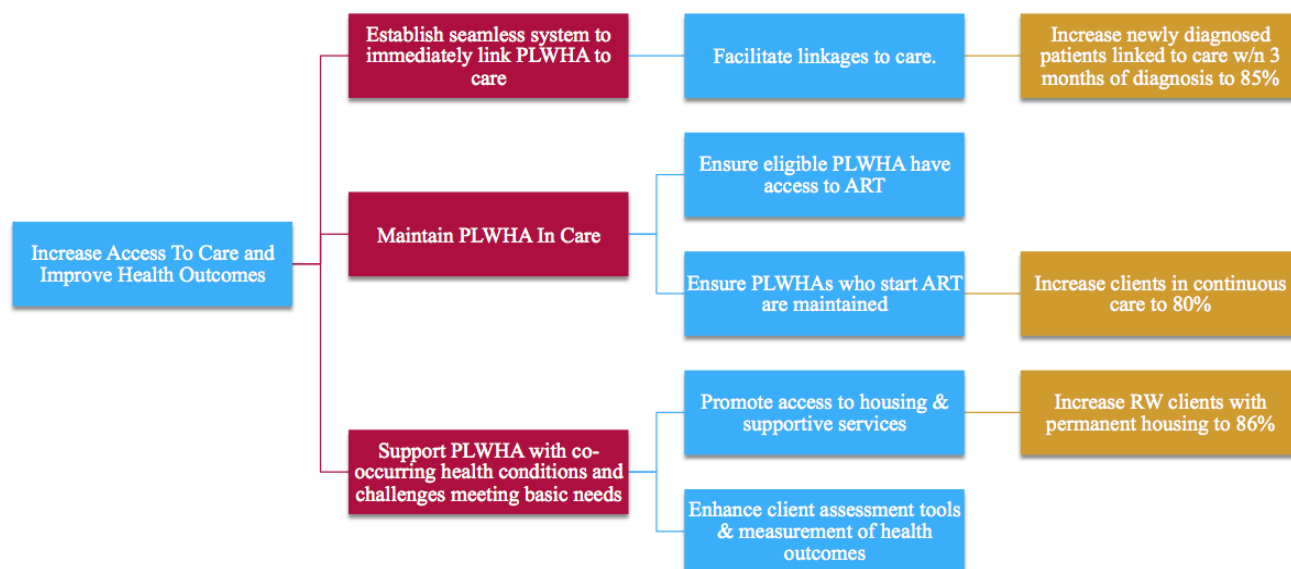
NHAS Goal #1 Reduce the number of people who become infected with HIV

- Lead efforts to lower the number of new infections by 25%
- Reduce the HIV transmission rate by 30%
- Increase the number of people who know their serostatus from 79% to 90%



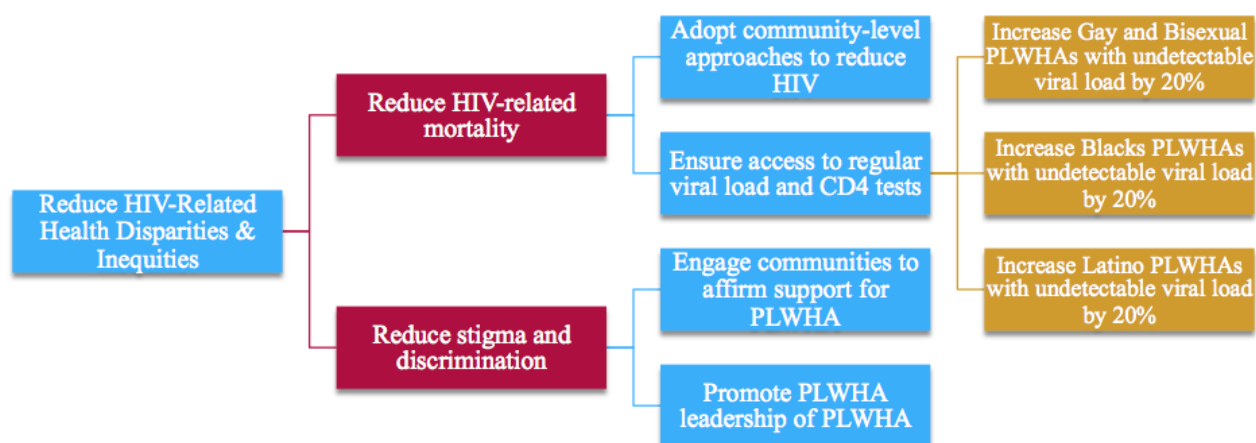
NHAS Goal #2 Increase access to care and improve health outcomes for PLWHA

- Increase to 85% the number of newly diagnosed receiving clinical care within 3 months of diagnosis
- Increase to 80% the proportion of Ryan White clients in continuous care, defined 2 routine HIV medical care visits in 12 months, with each taking place at least 3 months apart
- Increase the number of PLWHA in permanent housing to 86%



NHAS Goal #3 Reduce HIV-related health disparities

- Increase access to prevention and care services
- Increase number of gay and bisexual men, Blacks, and Latinos with undetectable viral loads by 20%



HRSA recently provided recommendations on how the Ryan White Program might best respond to achieve the NHAS outcomes. Those include concentrating resources where the epidemic is most severe through coordination and resource maximization; increasing and improving HIV prevention, care, and treatment strategies; utilizing the Needs Assessment process to tailor services to high-risk populations; collaborating with CDC-funded prevention programs; utilizing AETC for training and resources on all aspects of care and performance improvement.

The primary target population for the NHAS and EIIHA - individuals unaware of their status - is the same: “any individual who has not been tested for HIV in the past 12 months, or any individual who has not been informed of their HIV test result (HIV positive or HIV negative), or any HIV positive individual who has not been informed of their confirmatory HIV test result”. Secondary target populations include individuals aware of HIV status but not in care, individuals receiving medical care but not HIV care, individuals lost to follow-up, and sporadic users of HIV care.

The desired outcomes for the activities described in the EMA’s Comprehensive Plan are: improved access to and retention in HIV care for target populations, timely entry into HIV care, and prevention of vulnerable clients from dropping out of care. The activities will help the EMA identify PLWHA, link them to care, and retain them in treatment. It is the goal of the NHAS and the Broward EMA that these activities will help improve health, reduce HIV transmission, and reduce community viral load.

NHAS Goal 1: Reduce New HIV Infections by 25% by 2015



NHAS Objective 1.1 Intensify HIV prevention efforts in communities where HIV is most heavily concentrated

1.1.1. Target high-risk populations: gay/bisexual men; transgender; Blacks; Latinos; substance users

Responsible: Prevention Grantee, BCPPG, Broward AIDS Partnership

Timeframe: Ongoing

Activities

1. Link couples where at least one partner tests positive or is currently living with HIV to appropriate counseling
2. Train HIV Counselors to conduct HIV Prevention counseling sessions and STI screening with couples.
3. Train Community Health Workers/Peers to work with the target populations
4. If serving HIV-negative MSM, promote routine testing every six months.

NHAS Objective 1.2 Expand targeted efforts to prevent HIV using effective evidence-based approaches

1.2.1 Strengthen HIV screening and surveillance to identify populations at greatest risk

Responsible: FL Bureau of HIV and AIDS

Timeframe: Ongoing

Activities

1. Identify and address issues that impede ability of surveillance staff to track and report data regarding linkage
2. Design and implement performance measures to assess number receiving HIV testing, HIV+ individuals identified, and individuals receiving LTC services, engaged, receiving adherence counseling, and partner notification referrals to BCHD.

1.2.2 Expand access to prevention services for population-level impact for high-risk populations

Responsible: Prevention Grantee, BCPPG, BAP

Timeframe: Ongoing

Activities

1. Target individuals at high risk
2. Select venues frequented by high-risk individuals and/or communities at greatest risk for HIV infection
3. Integrate CD program activities within other community-level intervention approaches to promote condom use and other risk reduction behaviors
4. Conduct community-wide mobilization efforts to support and encourage condom use aligned with Florida DOH Programs

1.2.3 Expand prevention with HIV+ individuals for avoidance of transmitting HIV to others

Responsible: Part A Grantee, Quality Management Committee, QI Networks**Timeframe:** FY12/13**Activities**

1. Educate and counsel patients about reducing HIV transmission risk behaviors, such as risky sexual activities and sharing syringes, and encourage safer-sex practices among all patients
2. Become familiar with the evidence-based prevention interventions that are offered at community-based settings so that patients' referrals to these interventions are properly matched according to specific patient risks
3. Identify women who wish to become pregnant and provide preconception counseling; refer HIV-infected pregnant women for early prenatal care and antiretroviral therapy (ART)
4. Screen for, diagnose, and treat other STIs
5. Conduct substance abuse screening and make appropriate referrals for the management of substance use
6. Conduct mental health screening and make referrals for treatment
7. Promote adherence to ART treatment to ensure maximal viral suppression and to reduce transmission risk
8. Implement AETC Prevention with Positives trainings (Core Medical QI Networks)
9. MCM continue AETC Operation HOPEFUL pilot to assist risk and prevention assessments with patients
10. Identify available prevention with positives services and document in client services inventory

1.2.3 Evaluation Measures	HAB HIV Core Clinical Performance Measures
HIV Risk Counseling	Percentage of clients who received HIV risk counseling within the measurement year
Adherence: Assessment and Counseling	Percentage of clients on ARVs assessed and counseled for adherence 2 or more times in measurement year
Syphilis Screening	Percentage of adult clients who had a test for syphilis performed in the measurement year
Chlamydia Screening	Percentage of clients at risk of STIs who had a test for chlamydia in the measurement year
Gonorrhea Screening	Percentage of clients at risk of STIs who had a test for gonorrhea in the measurement year
Hepatitis/HIV Alcohol Counseling	Percentage of clients hepatitis B or C infection with alcohol counseling in measurement year
MAC Prophylaxis	Percentage of clients with CD4 <50 prescribed MAC prophylaxis in measurement year
Mental Health Screening	Percentage of new clients with HIV infection who have had a mental health screening
Substance Use Screening	Percentage of new clients screened for substance use (alcohol & drugs) in measurement year

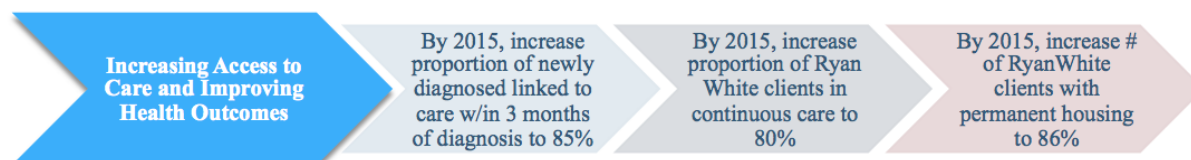
1.3.1 Utilize evidence-based social marketing and targeted education campaigns**Responsible:** Prevention Grantee, BCPPG, BAP, Part A EIIHA ***Timeframe:** Ongoing**Activities**

1. Integrate CDC program activities within other community-level intervention approaches to promote condom use and other risk reduction behaviors
2. Conduct community-wide mobilization efforts to support and encourage condom use aligned with Florida DOH Programs
3. Social Marketing and Media in connection with a Counseling and Testing Program
4. Locally developed interventions (must have minimal data showing effectiveness evidence)
5. Peer Programs

1.3.2 Promote age-appropriate HIV and STI prevention education for all residents**Responsible:** Prevention Grantee, BCPPG, BAP, Part A EIIHA ***Timeframe:** Ongoing**Activities**Update EIIHA Plan utilizing Prevention, Testing Activities **Source:** Broward Jurisdictional Plan

1. Train HIV counselors to conduct HIV prevention counseling sessions and STI screening with couples.
2. Condom Distribution and sexual health, HIV/STI education
3. Behavioral/sexual risk screening and social service referrals (substance abuse, mental health, etc.)
4. Education about and linkage to Partner Services provided by BCHD's STI Program

NHAS Goal 2. Increase Access To Care and Improve Health Outcomes



Objective 2.1 Establish seamless system to immediately link PLWHA to continuous/coordinated quality care

2.1.1 Facilitate linkages to care (including coordination in health and social services setting for at-risk)

Responsible: RW Grantees, Prevention Grantee, Outreach, OAMC, CIED, QMC, QI Networks

FY 2012/2013 Activities

1. Implement Ryan White/Prevention Grantees Collaborative Work Group to Ensure Seamless Care System
 - a. Design client flow processes to ensure seamless system from test sites to Part A OAMC engagement
 - b. Define and provide training regarding linkage roles and responsibilities
 - c. Design and/or modify reporting and MIS to track HIV+ individuals receiving their diagnosis at confidential testing sites to LTC, and engagement and retention in OAMC
 - d. Develop aggregate reports regarding key processes, performance measures and outcomes
2. Ensure the following strategies are incorporated into Outreach through SDM revisions and training
 - a. Mobilize Part A-funded outreach workers to provide services at CDC and FDOH tests sites
 - b. Ensure application of motivational techniques to engage newly diagnosed and encourage immediate care
 - c. Ensure orientation about available services, and eligibility documentation assistance
 - d. Compute OAMC engagement rates three months or greater following HIV+ test and long-term retention

FY 2013/2014 Activities

1. Utilize engagement reports to identify areas of improvement. Reports include sub-analyses to assess EIIHA strategy impact on rates of racial, ethnic, and sexual minorities, and WICY
2. Apply quality management (QM) methods to identify areas of improvement and modify processes
3. Undertake QIPs to identify, test, and adopt effective methods for improving: Rapid LTC activities undertaken by outreach in collaboration with testing sites, hospitals and physician
 - a. Compute time from initial HIV+ test to the first OAMC visit with a physician; Engagement and retention in OAMC in the first year following initial HIV testing; Tailor Linkage and retention methods to unique needs of racial, ethnic, and sexual minority men and women
 - b. Develop QIPs by Outreach QI Network to design, test, and implement the new LTC model

Objective 2.2 Promote Collaboration Among Providers

Responsible: RW Grantees, Prevention, ADAP, Jail Linkage Staff, Re-Entry Coordinator

FY 2012/2013 Activities

1. Continue efforts to recruit Prevention Grantee to join the HIV Planning Council
2. Assess feasibility of combining HIV planning efforts required by prevention and care grants including: Client/Provider Needs (surveys, focus groups, community forums); Funding/Services Inventories/Directories
3. Increase linkage collaboration activities between Part A, testing, mental health, substance abuse and housing
4. Ensure MOUs between testing and Part A-funded outreach, CIED, and OAMC are implemented
5. Request quarterly linkage updates from all funders
6. Utilize data to evaluate effectiveness and program planning

2.3.1 Ensure that all eligible HIV-positive persons have access to antiretroviral therapy.

Responsible: Part B ADAP Grantee

Timeframe: Ongoing

1. Decrease or eliminate the ADAP wait list
2. Create a system to obtain real time information for all ADAP clients

Responsible: Part A Grantee

Timeframe: Ongoing

1. Ensure linkage to PAP – Educate MCMs, pharmacists, and Part A clinicians on changes to PAP requirements and eligibility guidelines to ensure that barrier to access to ART are addressed; Continue to monitor changing

PAP guidelines through the Medical Network ensure clinicians' recommendations for additions to Part A Formulary are brought before LPAC for consideration

2. LPAC Emergency ART – Continue to provide emergency ART through Part A and other community resources to ensure clients do not experience interruption in treatment; Educate MCMs, pharmacists, and Part A clinicians about the availability of emergency ART
3. Ensure MCMs and clinicians discuss importance of ADAP 6-month recertification

2.3.2 Ensure PLWHA who start therapy are maintained on regimen, per HHS guidelines

Responsible: Part A Grantee **Timeframe:** Ongoing

1. Increase the percentage of clients with a viral load less than 200 copies/mL by monitoring NQC viral load suppression and developing strategies to improve suppression rates

Evaluation Measures: HAB and NQC Viral Load suppression measures

Objective 2.4 Support PLWHA with co-occurring conditions and challenges to meet basic needs, such as housing

2.4.1 Enhance client assessment tools and measurement of health outcomes

Responsible: Part A Grantee, HIVPC, PSRA, QMC, QI Networks

Timeframe: 2012 – 2015

1. Develop tools to measure the impact of all Core and Support Services on client level health outcomes
2. Program revised client level outcomes in PE MIS
3. Monitor the impact of non-medical services on retention in medical care
4. Integrate the two core group 1 viral load performance measures added 12/11 into PE system and SDMs

2.4.1.1 Provide case management and clinical services that contribute to improving health outcomes

1. Ensure Part A/MAI OAMC service category funding allocation is sufficient to serve all eligible PLWHA
2. Ensure Oral Health service category funding allocation is sufficient to serve all eligible PLWHA
3. Ensure AIDS Pharmaceutical Assistance service funding allocation is sufficient to serve eligible PLWHA
4. Ensure Mental Health funding allocation is sufficient to serve eligible PLWHA needing services
5. Ensure Substance Abuse funding allocation is sufficient to serve eligible PLWHA needing treatment
6. Ensure Medical Case Management service funding allocation is sufficient to serve all eligible PLWHA
7. Develop QIP's based on review of HAB Measures
8. Analyze client level data to develop strategies to improve retention
9. Develop a baseline measure of client Health Literacy levels

2.4.1.2 Increase access to non-medical services as critical elements of an effective HIV care continuum:

Including Centralized Intake and Eligibility Determination, Food bank/vouchers, Legal services and Outreach

Evaluation Measures

Medical Case Management Performance Measures focus on two key issues: care plans and medical visits. HAB encourages MCM programs to utilize core clinical performance measures as appropriate.

Indicator	How Measured
Dental and Medical History	Percentage patients with dental & medical history (initial or updated) at least once in year
Dental Treatment Plan	Percentage of patients with a treatment plan developed or updated at least once in year
Oral Health Education	Percentage of oral health patients who received oral health education at least once in year
Periodontal Screen Exam	Percentage of oral health patients with a periodontal screen or exam at least once in year
Phase 1 Treatment Plan	Percentage of oral health patients with a Phase 1 treatment plan completed within 12 months

2.4.2 Address policies to promote access to housing and supportive services for PLWHA

2. Provide housing assistance and other services that enable PLWHA to obtain and adhere to HIV treatment

Responsible: A Grantee, HOPWA, PSRA

Timeframe: 2012-2015

1. Continue to provide joint MCM trainings to Ryan White and HOPWA case managers
2. Review utilization of SOAR in assisting HOPWA clients access benefits, thereby reducing the financial burden on HOPWA and opening housing slots for clients with no income
3. Identify barriers to care related to supportive services and develop QIP's to address barriers

NHAS Goal 3. Reduce HIV-related Health Disparities and Inequities by 2015



NHAS Objective 3.1 Reduce HIV-Related Mortality in Communities at High Risk for HIV Infection

3.1.1 Ensure high-risk groups have access to regular viral load and CD4 tests

FY 2012/2013 Activities

Responsible: RW Grantee, QMC, QI Networks

1. Ensure access to high quality HIV-related OAMC services including access to regular VL and CD4 tests
2. Improve retention in HIV Primary Care
3. Ensure OAMC meets or exceed HHS guidelines as measured by HAB Performance Measures (Group 1)
4. Apply HAB performance measurement model to QI Network. Measures national benchmark; outcomes
5. Conduct PM quality assessment to ensure data are timely, complete, accurate and meet goals

FY 2013/2014 Activities

Responsible: RW Grantees, QMC, QI Networks

1. Develop QIPs to address data reporting and data quality/reporting issues and/or performance deficiencies

FY 2014/2015 Activities

Responsible: RW Grantees, QMC, QI

1. Review progress annually, identify remediation steps to achieve goals and key action steps for coming year.

Evaluation Measures: HAB HIV Core Clinical Performance Measures

Viral Load Monitoring: % of patients with a viral load test performed at least every six months

Viral Load Suppression: % of patients with viral load below limits of quantification at last test

NHAS Objective 3.2 Adopt community-level approaches to reduce HIV infection in high-risk communities

3.2.1 Establish pilot programs utilizing community models that reduce risk in high prevalence communities*

Timeframe: Ongoing

Responsible: Prevention Grantee, BCPPG, BAP

3.2.2 Measure and utilize community viral load

FY 2012/2013 Activity

Responsible: State ADAP

1. Assess comprehensiveness of viral load data contained in eHARS, ADAP, CAREWare and Provide Enterprise

FY 2012/2013 Activity

Responsible: Grantees, Support Staff, Joint Planning

1. Assess reliability of estimate based on proportion of cases with known viral load
2. Ensure OAMC and MCM (regardless of funder) electronically document VL and CD4 at least every 6 months
3. Implement VL/CD4 lab documentation as a required recertification component those not in Part A OAMC

FY 2013/2014 Activity

Responsible: Prevention Grantee, RW Grantees, Joint Planning

1. Assess viral load data for accuracy, completeness and quality
2. Develop a quality improvement plan for improving incomplete or inaccurate data
3. Develop undetectable community (Part A) VL baseline and subpopulations (gay/bisexual, Black, Latino)

NHAS Objective 3.3 Reduce stigma and discrimination against people living with HIV

3.3.1 Engage communities to affirm support for people living with HIV

Timeframe: Ongoing

1. HIVPC planning efforts, materials and events will "Engage communities and affirm PLWHA support"

3.3.2 Promote public leadership of people living with HIV

1. Promote public leadership of PLWHA through actively recruiting PLWHA to serve as HIVPC members and council leadership positions; providing training; and disseminating national training opportunities

A. Closing Gaps In Care

KEY POINTS

■ CLOSING GAPS IN CARE

- Several mechanisms are already in place to address gaps in care
- Part A goals for closing gaps in care require collaboration and are aligned with the SCSN

Several methods to close gaps in care are in place in the EMA. These include but are not limited to: representation of all Ryan White Parts on the HIVPC and its Committees; a wide array of core and support services; a centralized intake and eligibility process; data sharing agreements between Part A and HOPWA as well as ADAP; mechanisms to identify, inform, refer, link, and engage newly diagnosed clients as well as identify clients who have either fallen out of care or are at risk for falling out of care, and return them to the service system, and a system that facilitates and monitors efforts to retain clients in care.

The EMA will continue to collaborate with the State and local stakeholders to consider modification of some goals and activities to ensure federal, state, and local gaps in care are identified and addressed. Aligned with many of the Part A goals, the 2012-2015 SCSN and Comprehensive Plan include a clear plan for addressing gaps in care. The SCSN lists the need to stretch limited resources to help close gaps in care and to decrease or eliminate the ADAP waitlist as two central goals for 2012-2015. Several strategies to address these goals are aligned with, and have an impact on, the goals of the EMA:

- Assess cost benefit of Pre-existing Condition Insurance Program (PCIP) and determine plan to expand if PCIP proves a cost effective option
- Continue to refine and monitor eligibility screening process
- Develop one comprehensive Consortia client level dataset capable of reporting data for services utilized in their geographic area with the payer sources identified
- Work towards a statewide reporting format that allows external providers to submit their service utilization data in a format that will ensure compatibility with FL CAREWare system
- Encourage Part A and Part B database to capture client level data within their service area
- Adjust resource allocation methodology to ensure fair and equitable distribution of Part B funds
- Facilitate the enrollment and participation of PLWHA in clinical trials and other research
- Increase timely dissemination of information with Part A EMAs and Part B Consortia
- Streamline ADAP eligibility and enrollment processes
- Create a system to obtain real time information for all ADAP clients
- Improve access to care by preparing clients for transitions with the full implementation of ACA

B. Retention Needs Of Individuals Aware Of Status, But Not In Care

KEY POINTS

- Retention Needs of Aware But Not In Care
 - Culturally competent and linguistically appropriate LTC and referral services
 - Outreach and CIED conduct referrals and follow up to ensure linkage. The EMA is participating in the NQC In+Care Campaign aimed at retaining clients in care, and helping those who have fallen out of care, return to care

Broward County has well developed LTC activities that rely on collaboration between CTS, prevention, outreach programs, and Part A subgrantees. In addition, the EMA has elected to participate in the NQC In+Care Campaign to ensure individuals aware of their status are retained.

Culturally competent and linguistically appropriate LTC activities and referral services were undertaken by Part A subgrantees using well defined protocols that reflect the Part A outreach service delivery model. Part A-funded outreach workers serve as the bridge between HIV CTS and the care continuum for individuals recently made aware of their HIV+ status or who were engaged but dropped out of care. The Part A Outreach QI Network uses HIV CTS data, stratified by key points of entry and ZIP Code, to target outreach to CTS with highest HIV+ rates. The Part A outreach subgrantee is contractually required to coordinate efforts with BCHD prevention and outreach programs to avoid duplicative activities at key points of entry and to ensure recently diagnosed individuals are rapidly linked to care.

Part A-funded outreach supplements CDC-funded prevention activities by targeting hard-to-reach populations (e.g., African-Americans, Haitians, Hispanics, homeless, adolescents, MSM, and the recently incarcerated). Part A outreach workers provide newly identified HIV+ persons with intensive one-on-one linkage to OAMC, medication assistance, MCM, and other needed services. Outreach workers are required to coordinate their activities with MCMs to ensure follow-up with clients. The Part A Outreach subgrantee has applied for a grant funded through prevention dollars awarded to the State and administered by the BCHD. The purpose of the grant is to provide HIV/AIDS prevention, Counseling and Testing, linkage to care, and intervention services to HIV-infected and high-risk negative populations of all races and ethnicities with the goal of: 1) increasing knowledge of HIV status among people living with HIV and their partners; 2) reducing the risk of HIV transmission by people living with HIV; and 3) reducing HIV acquisition among persons at high risk for infection.

CIED recently implemented a process requesting clients who receive medical care through a non-Part A provider to bring copies of current CD4 and Viral Load results in order to help 1) monitor clients' retention in care regardless of funding source, and 2) establish an accurate measure of community Viral Load.

In 2012-2015, Part A and Part B will continue to collaborate to decrease the number of individuals aware of their status but not in care and to reduce overall infectiousness and community viral load by:

- Establishing a true baseline of individuals aware but not in care
- Capturing community viral load
- Developing a referral and linkage system between prevention and care
- Developing and implementing contact protocols for individuals aware of status but not in care
- Developing linkage project for undocumented
- Identifying barriers and obstacles to engagement in care
- Reducing identified barriers

Part A and Part B will continue to collaborate to increase the number of individuals aware of their status who are linked to medical care by:

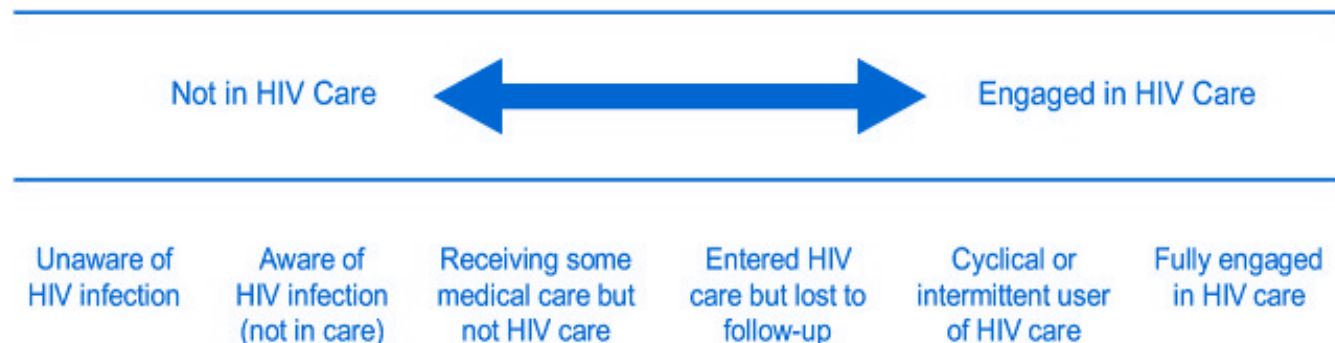
- Expanding rapid testing
- Measuring OAMC visit rates in the OAMC engagement period (3 months following HIV seropositive test) and long-term retention period
- Incorporating testing data into care reporting systems to track referrals and linkages

In addition to the efforts above, and in line with the EMA's commitment to ensuring and improving retention in care, the EMA elected to participate in the NQC In+Care Campaign. The In+Care Campaign is designed to facilitate local, regional and state-level efforts to retain more HIV clients in care and to prevent HIV clients falling out of care. The campaign aims to improve providers' ensure efforts are aligned with the NHAS to provide greater access to, and retention in, quality care that will help lower individual and community viral loads.

Retention in care has been identified as a critical challenge for HIV providers nationally and aligns with local HIV priorities as well as the NHAS. According to NQC, in the US, 1 in 5 individuals are not aware of their HIV status; 2 in 5 are aware of status but have not seen an HIV primary care doctor; 3 in 5 are aware of status do not regularly see their HIV doctor; and 4 in 5 are not viral load suppressed. The EMA elected to participate in the In+Care Campaign as it has the potential to impact a significant number of consumers and to improve their overall health outcomes.

Research has shown that retention in care leads to better health outcomes and lower costs as regular appointments with a provider are shown to result in improved CD4 count, suppressed viral load, and

fewer hospital admissions/emergency room visits. Additionally, mortality rates are significantly lower among patients seen three or four times per year versus once or twice annually. Attending all medical appointments during the first year of HIV care doubled survival rates for years afterwards, regardless of baseline CD4 cell count or use of ART. The EMA aims to transition clients along the HRSA developed continuum of HIV care model to full engagement in HIV care



Participation in the year-long Campaign requires routine reporting of performance data on four uniform Campaign-related measures as well as submission of progress reports to highlight improvement strategies and challenges. The EMA reports to NQC on the campaign's four performance measures on a bi-monthly basis in aggregate reports that capture the data for all Part A subgrantees. In addition, the QI Networks analyze the measures at the client and service category levels to identify barriers and challenges to retention and develop strategies to address them. The goals of the campaign are listed below and are also addressed in the next chapter. The EMA also participates in monthly webinars and has communicated with NQC to recommend the creation of special reports to allow comparison with other EMAs that are submitting aggregate data.

National Quality Center In+Care Campaign Retention Measures

Gap Measure

Percentage of patients, regardless of age, with a diagnosis of HIV/AIDS who did not have a medical visit with a provider with prescribing privileges in the last 6 months of the measurement year.

Medical Visit Frequency

Percentage of patients, regardless of age, with a diagnosis of HIV/AIDS who had at least one medical visit with a provider with prescribing privileges in each 6-month period of the 24-month measurement period with a minimum of 60 days between medical visits.

Patients Newly Enrolled in Medical Care

Percentage of patients, regardless of age, with a diagnosis of HIV/AIDS who were newly enrolled with a medical provider with prescribing privileges who had a medical visit in each of the 4-month periods in the measurement year.

Viral Load Suppression

Percentage of patients, regardless of age, with a diagnosis of HIV/AIDS with a viral load less than 200 copies/mL at last viral load test during the measurement year.

C. EIIHA: Identifying, Informing, Referring, and Linkage Needs

KEY POINTS

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EIIHA

- BCHD and EIS are responsible for identifying individuals in public settings
- DOH funds outreach, prevention, and education activities
- CIED and JLP refer and link clients to care and follow-up to ensure engagement
- Strategies must be reinstated to ensure HIV negative individuals remain negative

Broward's system for identifying, screening, LTC, engaging, treating, and retaining individuals in care has had to be as efficient as possible since demand for these services has greatly exceeded funding. The HIV care continuum, for which identification and screening are the initial steps, strives to avoid redundancy and gaps in services by carefully planned, coordinated, implemented, and evaluated strategies.

Design and implementation of the EIIHA Strategy in FY 2009 were the first steps to integrating the HIV screening, identification, linkage, engagement, treatment, and retention strategy. CDC, FDOH, BCHD, and HAB grantees have worked closely with subgrantees, CBOs, consumers, and other stakeholders to raise community awareness about HIV, HIV screening, early identification of HIV+ persons, LTC, engagement, treatment, and retention. This collaboration has crossed disciplines and funders to achieve a planning process that aims to avoid duplication of activities.

The BCHD HIV/STI Prevention Director is responsible for identifying HIV+ unaware individuals receiving HIV screening in public settings, with an anticipated 50,000 HIV tests to be conducted annually. This responsibility is shared with Broward Health, the Part C Grantee, which will continue to use Part C EIS funds for identification activities in their health care system and supplement BCHD HIV screening funds. CDC funds will continue to be used by BCHD to conduct the BIGA Initiative, a comprehensive community education, prevention, and media campaign targeting high-risk Broward populations. FDOH will continue to fund HIV awareness, outreach, screening, LTC, and prevention interventions in community settings including FQHCs, hospital ERs, and CBOs (including agencies that focus on the Hispanic, African-American, Haitian, and MSM communities).

Persons tested for HIV in BCHD CTS are informed of their test results by CTS staff authorized to conduct post-test counseling services following a preliminary rapid HIV test or conventional test. Individuals who do not return for their conventional test results are referred to DIS to be located and informed of the results. The current 15 DIS FTEs are reported by BCHD to be insufficient to conduct tracking and notification services, as they are also assigned STI and partner notification services. FDOH has requested that CDC fund additional DIS in FY 2012.

A key component of the EIIHA Strategy is adoption of an LTC model, in which Part A-funded outreach and peer/near-peer workers directly assist newly identified HIV+ persons to navigate rapidly in Part A CIED and OAMC. Components of successful LTC strategies adopted in the EIIHA Strategy include: effectively targeting individuals most at risk, using existing public health resources and evidence-based interventions (targeted by population/community), and developing innovative ways to optimize LTC for newly diagnosed HIV+ persons and those lost to care. LTC includes strategies to simplify entry into OAMC. These strategies include streamlining appointments, co-locating CTS and OAMC, physically escorting clients to OAMC and other services, and intervening with patients who have dropped out of care or have low appointment adherence rates. In refining the Strategy, the Part A Grantee has carefully examined the results of recent HAB-funded SPNS and LTC best practices studies to identify areas of improvement for LTC.

Part A subgrantees have established well-coordinated collaborations with CDC-funded CTS, including BCHD, health care sector, and CBO CTS. MOUs define these collaborative relationships and participating agencies' roles and responsibilities. Representatives involved in all levels of planning, decision-making, implementation, and evaluation of the EIIHA Strategy include BCHD, Parts B, C, D, and F grantees and subgrantees, CDC prevention and CTS subgrantees, SAMHSA grantees, FQHCs, Memorial, Broward Health, consumers, and other stakeholders. Part A subgrantees expanded the number of formal MOUs with CTS to verify linkage and engagement in OAMC. CIED is co-located at 11 provider sites offering prevention, CTS, OAMC, and other services. CIED conducts post-referral verification to ensure that appointments are kept. CIED staff contacts clients who missed their appointments to identify and overcome barriers to appointment keeping. Part A medical case managers address adherence to OAMC appointments and medications through psychosocial assessment and care planning. The objective of Part A outreach is to assist clients to be engaged in OAMC, with outreach completed when the client has demonstrated engagement and retention in care. Outreach workers are also deployed if clients are not retained in care, through home visits and other case finding methods. CIED workers undertake intensive Part A intake, linkage to OAMC and other services, arrange appointments, and verify that their clients have successfully engaged in OAMC and other needed services. The EMA has identified several activities to form and maintain relationships with private HIV medical providers to verify that private care patients have accessed HIV treatment; however, additional CDC funds are needed to expand the capacity of DIS to verify referrals to private practices result in initiation of medical care.

Part A-funded outreach, Part B-funded BCHD outreach workers, or JLP workers are available to assist HIV+ individuals to schedule their CIED and OAMC appointments and accompany them if needed. Part A and BCHD designed a protocol to ensure rapid CIED screening of newly identified

HIV+ persons for Part A-funded services. CIED workers are out-posted at key CTS sites. CIED staff conduct intake, assess Part A eligibility, and schedule OAMC appointments. CIED workers give HIV+ clients a directory of OAMC providers and inform them about the wait time for each provider (based on data gathered monthly by the Part A Grantee). Part A requires that CIED link HIV+ clients to OAMC within 48 hours. For individuals newly diagnosed during hospitalization, CIED must schedule an intake appointment at the hospital or at the client's home within two weeks of discharge. The current Florida statute no longer requires tracking of HIV negative persons. The Part A Grantee will work with Florida DOH staff to develop a strategy to reinstate the practice of tracking HIV negative persons to ensure that they are offered CDC-funded comprehensive risk counseling services. The Part A Grantee will continue to meet monthly with BCHD CTS, prevention and disease control/intervention, and Part B staff to identify ways to increase the rate of HIV+ persons referred to private providers (if insured) or CIED for Part A intake and immediate linkage to OAMC. The group will assess and address barriers to immediate referral, including CTS staff training about the referral protocol. Part A and BCHD staff will standardize the protocol in pocket-sized laminated brochures for all CTS staff, and update referral materials given to CTS clients. Part A outreach funds will be used to complement, but not substitute for, CDC and FL general revenue funds for referring HIV+ persons to care.

The Part A Grantee initiated integration of BCHD data into PE to allow tracking of HIV+ CTS and DIS clients to CIED for intake and linkage to OAMC. Expanded PE data will allow computation of the rate of referral, linkage, and engagement of newly identified and other HIV+ persons. Well-established Part A QM processes will be used to identify and address areas of improvement to ensure that 100% of persons referred to Part A medical care are linked and engaged.

Addition Identification and Linkage Activities to be Implemented in 2012-2015

Identification Activities

- Shift from current HIV testing strategies to high yield, targeted screening activities
- Identify and address structural and policy barriers to implementing routine HIV screening
- Implement CDC-funded community mobilization initiatives, media campaigns, and other evidence-based models
- Use strategies such as social marketing, fact sheets, web-based information, and other resources to maintain the timeliness of and distribute HIV testing messages
- Reduce HIV stigma and discrimination experienced by HIV+ racial, ethnic, and sexual minority men and women through an evidence-based community education campaign
- Increase the number of providers who routinely offer HIV screening in public health and

health care settings, as well as voluntary HIV screening in community settings

- Increase the provision of voluntary HIV screening for incarcerated persons
- Ensure practices that engage unaware individuals are consistent with CDC testing recommendations and FL statutes by monitoring policy changes and modifying program design as needed to ensure rapid identification of HIV+ persons and their timely linkage to the HIV continuum of care
- Increase collaboration among programs conducting targeted culturally competent outreach

Informing Activities

- Conduct outreach to Broward health care settings to increase the number of CTS adopting rapid HIV testing, as well as serologic testing where rapid testing is infeasible or unfunded
- Increase the number of HIV CTS funded by FDOH, to the extent funds are available
- Intensify rapid testing to increase the rate of HIV+ who receive their test results
- Obtain CDC TA regarding methods for rapid serologic testing using new HIV test equipment, and design of lab policies and practices to implement rapid test results for serologic HIV testing
- Adopt new HIV testing procedures in hospitals, FQHCs, and other health care settings

Linking Activities

- Design a system for effectively linking newly identified HIV+ persons at HIV CTS with Part A-funded OAMC or other care systems. Client flow processes are designed to ensure a seamless system of services from HIV CTS to LTC, treatment, and retention. Refine roles and responsibilities for HIV screening staff and Part A-funded outreach workers, peer educators, CIED workers, physicians, MCM, and reception staff
- Train staff at HIV screening and OAMC sites about refined LTC system and roles and responsibilities
- Increase rate of newly diagnosed and linked to OAMC within 3 months of learning HIV status
- Increase secondary prevention services, including HAART adherence and partner notification
- Increase rate of HIV+ inmates incarcerated > 30 days who are receive OAMC and HAART
- Increase rate of HIV+ inmates who are linked to Part A CIED and OAMC upon their release

D. Addressing The Needs Of Special Populations

KEY POINTS

- Addressing Needs of Special Populations
 - HRSA has identified four populations that require special consideration - Adolescents, Homeless, IDU, and Transgender
 - Five emerging populations with special needs - Homeless adults, Black non-Hispanic women, White non-Hispanic MSM, Black non-Hispanic MSM, and Hispanic MSM - present challenges to the care continuum
 - EIIHA target populations also require special consideration to ensure access to screening and linkage to care

HRSA has identified four specific population groups (Adolescents, Homeless, Injection Drug Users and Transgender) to receive special consideration during 2012 comprehensive HIV planning. The Comprehensive Plan requires the EMA to: 1) Identify needs and barriers for special populations including but not limited to; adolescents, injection drug users, homeless, and transgender, and 2) Develop strategy for addressing special populations needs including but not limited to; adolescents, injection drug users, homeless, and transgender.

The Comprehensive Plan guidance asks the EMA to describe how the Comprehensive Plan addresses the National HIV/AIDS Strategy and Healthy People 2020 HIV specific objectives. The comprehensive plan also requires the EMA to include the strategy to address Early Identification of Individuals Living with HIV and AIDS.

NHAS	HP 2020Adolescents	Comprehensive Plan	Emerging Populations	EIIHA Populations
• African Americans • Alaska Native • Asian Americans • American Indians • Hispanics • Gay/Bisexual Men • Substance Users • Transgender	• Adolescent MSM • Heterosexuals • MSM • Injection Drug Users • Pregnant Women • Substance Users	• Adolescents • Homeless • Injection Drug Users • Transgender	• Black Females • Homeless • Black MSM • Hispanic MSM • White MSM	• MSM • Black MSM • Hispanic MSM • White MSM • Black Hetero • Females • Substance Users • Hispanic Hetero • Females • Substance Users • Recently Released

Adolescents

The Comprehensive Family AIDS Program (CFAP), one of five programs at CDTC, has provided family centered, culturally competent care to children, youth and women living with HIV/AIDS since 1991. Through CFAP, HIV infected and affected children, youth and women receive quality medical care with access to the most effective HIV treatments available. These clients have also received

dental care, mental health and substance abuse treatment, nutritional guidance, linkage to research, health education and emergency assistance. The Part D funded CDTC CFAP serves four groups of infected people and their families, including: HIV infected women; HIV infected and exposed infants; HIV infected children; and HIV infected youth. Fathers of HIV positive children or youth are also served by CDTC and male children or youth are allowed to continue being served by CDTC as adults and are transitioned into the adult “Healthy Living Clinic.”

The majority (94%) of clients served by CDTC are members of racial and ethnic minorities, most living below the FPL. Over the past 20 years, the number of CDTC clients has increased an average of 4% annually. CDTC has had consistent numbers of new referrals among youth.

Primary medical care is generally available in Broward County through Ryan White providers (Parts A, C, & D), with the WICY population being served predominately by CDTC. CDTC clients are the primary referral services to bring individuals into care who are aware of their HIV status and are not receiving care. CIED staff are outposted at CDTC to allow for quick and efficient linkage to care. All eligibility documentation is scanned into the PE data system, which tracks all HIV+ individuals who are eligible for any Part A service. PE provides information about the available community services, including Part D, for women, youth and children. When a client selects CDTC to receive their medical care and MCM, a referral is made directly to the program manager to conduct linkage and entry into care. The Part D program has been provided access to the PE system to ensure that individuals who receive medical care and MCM services with CDTC have access to other services provided by Part A, specifically food services and wraparound dental care. Access to patients in the PE system ensures that there is no duplication of services provided.

The Part A Grantee collaborates with CDTC and the HOPWA Administrator to create trainings for all Ryan White MCMs and HOPWA housing case managers regarding the services provided through these entities, and to ensure that Part A MCMs are referring women and youth to the Part D provider.

Injection Drug Users

Seven percent of Broward’s HIV+ adults or adolescents have IDU as their HIV exposure category, and 3% have MSM and IDU as their exposure category. Based on reported HIV+ cases, Florida DOH reports that there are 1,647 IDUs in Broward (including 499 MSM IDUs). It should be noted that while IDUs constitute a significant percentage of HIV+ persons in other EMAs, IDU contributes to a much small portion of HIV+ Broward residents (7%) and, thus, unmet need.

Homeless

Many of the needs identified by homeless PLWHA have been discussed earlier. Homelessness has grown significantly in Broward County, contributed to by insufficient affordable rental units,

increased cost of living, and a sharp increase in foreclosures. DCF estimates that 3,801 Broward residents will be homeless in 2011, a 66% increase over 2005. About 35% of homeless Floridians reported being homeless for more than one year.

FDOH reports that approximately 58 HIV+ Broward residents were homeless at the time of their diagnosis with HIV or AIDS, for a 362.4 prevalence rate. This rate significantly underestimates the likely number of HIV+ homeless in Broward. Over one-half of the 2011 Consumer Survey respondents (53%) reported that they were homeless for the first time. Heterosexual Black men and women reported the highest rates of homelessness. The homeless were significantly more likely than others to live with friends, family, or in temporary housing because they have nowhere else to live. The homeless were also significantly more likely than others were to report exchanging sex for drugs, a place to sleep, or money. The homeless were six times more likely not to have enough food to eat, and seven times more likely to not have a safe place to sleep or not feeling safe in their neighborhoods. The homeless were over four times more likely than others to report that it was hard to find affordable housing, five times more likely to have a bad credit history, and 10 times more likely to have not had transportation to look for a place to live. Homeless respondents were also significantly more likely than their counterparts were to have a criminal record, physical disability, and substance abuse problem.

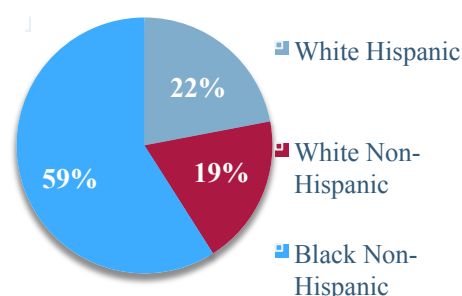
Participants in the homeless focus group noted that homelessness seriously impairs HIV+ individuals from starting and staying in HIV care. Ensuring that homeless clients are assisted with accessing and remaining in care will be a priority for the EMA.

Transgender

FDOH does not systematically collect data regarding transgender populations. This absence of data significantly impairs the EMA's ability to plan for the needs of Broward HIV+ transgender residents. Nationally, the size of the population is unknown as surveillance data often excludes or miscounts

transgender populations. However, it is estimated that HIV rates are higher among transwomen than any other subpopulation, and a significant proportion of HIV+ transwomen are unaware of their status. Lack of national and local data affects funding for prevention, outreach, testing, and health care focused on transgender populations. In addition, transgender health is traditionally taught under the umbrella of psychiatry or psychology, not core primary health, and some physicians may feel ill equipped to adequately address the needs of their transgender clients.

FY 11/12 Part A Transgender Clients



Several aspects must be taken into account when developing strategies to address the needs of transgender clients including stigma which may lead to depression and suicidal ideation, substance abuse, or risk-taking behaviors such as unprotected sex or silicone injection parties; social marginalization may lead to unemployment, lack of stable housing, or incarceration; lack of medical providers able, or willing, to address transgender needs may impact access to care; hormone therapy and sex reassignment are often excluded by insurers and are not funded through Ryan White; substance abuse treatment may be impaired by gender segregation requirements, or requirements to refrain from hormone use; legal issues such as identification documents that do not match appearance may serve as a barrier to accessing services; Electronic Medical Records (EMRs) often lack transgender specific options and changing sex designation may be difficult. In addition, providers may require training to ensure sensitivity and understanding of transgender culture and use of culturally appropriate language. Physicians may have to collaborate with specialists outside the Ryan White system to ensure hormone therapy is not contraindicated with ARV therapy.

An analysis of PE data suggests the estimated number of transgender clients served by Part A in FY2011-2012 was 27, or 0.40% of the total client population. A majority of Part A clients who identified as transgender are Black non-Hispanic.

The Part A OAMC SDM has been revised to address transgender care. The SDM includes a definition of the term transgender (*Individuals whose gender identity, expression, or behavior is not traditionally associated with their birth sex*) and transgender specific Standards of Care. Revision of the SDM to include these standards indicates the importance the EMA has placed on ensuring that the medical needs of transgender clients are addressed in a manner that ensures high quality and culturally appropriate routine care, is appropriate for clients' birth sex as anatomically permitted, and considers additional medical and mental health needs not inherent in birth sex and including those incurred from additional anatomical changes in a culturally appropriate manner.

EMA's Emerging/Special Populations

The five emerging populations with special needs (Homeless adults, Black non-Hispanic women, White non-Hispanic MSM, Black non-Hispanic MSM, and Hispanic MSM) were discussed earlier, including the unique challenges that each population presents to the Broward HIV care continuum, the service gaps they experience, and estimated costs associated with delivering services to each population. These emerging populations are consistent with high priority groups identified in the Broward County HIV Prevention Plan, and have the greatest percentage of unmet need identified by FDOH. The needs of the four mandated Special Populations (Adolescents, Homeless, Transgender,

and IDU) were discussed during the HIVPC retreat with the goal of informing Comprehensive Plan activities. It was noted that many of the Special Populations included subpopulations with special needs. It was also noted that these subpopulations overlapped with each other as well as with the mandated Special Populations and there were themes that linked them together.

Adolescents	Homeless	Transgender	IDU
Young Adults	Adolescents/Young Adults	Homeless	General Substance abuse
MSM	Substance Use/Mental Health	Adolescents/Young Adult	MSM
Homeless	Transgender	IDU/SA/Hormone Therapy	Homeless
Substance Abuse	Recently Released	Mental Health	Transgender
Transgender	Sex Worker	Sex Worker	Recently Released

EIIHA Target Populations

The EIIHA Strategy addresses disparities in access to HIV screening and linkage services among affected subpopulations and underserved communities by promoting expanded HIV screening and adoption of rapid HIV testing in communities where affected subpopulations and underserved communities reside. The Strategy ensures culturally and linguistically appropriate HIV screening is available to diverse HIV+ populations based on race, ethnicity, gender, sexual orientation, age, HIV behavioral risk factors, and immigration status. The cultural norms and concerns about HIV stigma and disclosure are taken into consideration, for example, in the placement of HIV mobile testing units. HIV screening programs meet routinely to share their experiences in optimizing the location of mobile test units or incorporating HIV screening in broader community health screening events to address concerns that HIV disclosure might occur if an individual's family, friends, or community members observe them entering an HIV screening site or mobile testing unit. Section 2b identifies priority target groups, specific cultural barriers and priority needs that obstruct awareness for each target group, and activities to address those barriers and needs.

The Parent Groups targeted through EIIHA are: (1) all unaware individuals in Broward, (2) individuals tested in the past 12 months, and (3) individuals not tested in the past 12 months. The specific Target Groups are: Tested Confidential, Tested Anonymously, Received Preliminary HIV+ Result Only No Confirmatory Test, Not Tested in the Past 24 Months, Not Tested in the Past 48 Months, Recently Incarcerated/Released, Non-Hispanic Black MSM (BMSM), Hispanic MSM (HMSM), Non-Hispanic White MSM (WMSM), Black (Including Haitian) Heterosexuals, and Hispanic Heterosexuals. The EMA adopted the BCPPG's Target Groups which were selected based on an algorithm weighted based on prevalence, new cases and special considerations. Several barriers, activities, methods, and means used to implement the EIIHA Strategy are described below for all Parent and Target Groups.

2012-15 Planned Activities Addressing Priority Needs Obstructing Awareness of Status

Tested Confidentially or Anonymously:

- Reduce structural and policy barriers to implementing routine HIV screening.
- Increase routine HIV screening in clinic settings and voluntary screening in non-clinical settings.
- Improve access to HIV screening and increase case finding in high HIV seroprevalence areas.
- Target populations with high rates of undiagnosed HIV infection.
- Expand universal opt-out testing to all BCHD communicable disease clinics.
- Expand HIV screening in FQHCs and promote universal opt out screening.
- Increase routine testing and use of rapid HIV tests in hospital obstetrics and gynecology, outpatient, labor and delivery, inpatient units and ERs.

Preliminary Result Only: Respect Yourself, Check Yourself, Protect Yourself Movement.

Recently Incarcerated/Released: Increase opt-out universal rapid HIV testing for all BSO inmates.

Not Tested Past 24/48 Months: Reduce structural and policy barriers to routine HIV screening. Increase the number of providers who routinely provide HIV screening. Expand HIV screening in hospital settings. Integrate routine HIV screening in both public and private sector. Increase use of effective, evidence-based methods to identify individuals unaware of their status. Continue to expand HIV communications efforts by developing and delivering messages for the public, health care sector, HIV prevention providers, and the populations they serve. Expand BIGA media campaign. Continue FDOH's active partnership with FQHCs and efforts to enhance and expand efforts by training staff to implement rapid HIV testing and encourage universal opt-out screening. Increase routine HIV screening and use of rapid HIV tests in the 17 Broward hospitals, including labor and delivery departments, outpatient departments, inpatient units, and ERs.

BMSM: Targeted media campaigns and testing events, including interventions targeting Caribbean communities. Increased use of evidence-based prevention interventions.

Hispanic MSM: Targeted media campaigns and testing events, including materials in Spanish. Increased use of evidence-based prevention interventions.

White MSM: Targeted testing using evidence-based prevention and media campaigns.

Black Heterosexuals: Increase targeted media campaigns and evidence-based interventions.

Hispanic Heterosexuals: Increase voluntary HIV testing among Hispanics, increase targeted media campaigns, targeted HIV awareness and screening events, increase use of Spanish language materials.

2012-15 Activities Addressing Cultural Challenges Obstructing Awareness of Status

Tested Confidentially or Anonymously: Expand HIV screening in hospital settings, including HIV rapid testing. Ensure rapid identification of HIV+ persons and timely linkage to OAMC. Ensure testers are trained to ensure services are culturally and linguistically appropriate. Increase CDC and

FDOH-funded programs to expand HIV communications efforts by developing and delivering messages for the public, health care sector, HIV prevention providers, and the populations they serve. Expand Broward's Bigger Than AIDS (BIGA) media campaign.

Preliminary Test Result Only: Utilize social marketing and education to distribute testing messages.

Incarcerated: Increase rapid HIV screening in BSO jails.

Not Tested 24/48 Months: Use social marketing strategies and expand BIGA media campaign.

BMSM: Increase partnerships with the faith-based community to mobilize HIV awareness and screening initiatives. Targeted media campaigns, events and prevention interventions.

HMSM: Hispanic AIDS Awareness Program campaign targets Spanish-speaking persons. Targeted testing events, outreach, and prevention interventions focusing on Hispanic MSM.

WMSM: Social media campaigns. Targeted prevention interventions/testing events.

Black Heterosexuals: Stop the Spread HIV testing media campaign targets African-American and Haitian/Caribbean populations and funds the Haitian-Creole HIV/AIDS hotline. Promote routine testing by health providers serving this group, including women. Increase faith based partnerships.

Hispanic Heterosexuals: Culturally specific strategies such as Stop the Spread media campaign.

Increase targeted HIV screening events. Increase collaboration with Latino HIV/ Leadership Summit participants. Promote routine HIV screening by health care providers that serve this population.

E. Coordinating Efforts To Ensure Optimal Access To Care

KEY POINTS

- Ensuring Optimal Access To Care
 - Access to care requires coordination of efforts across funding streams
 - Stakeholders across all funding streams participate in HIVPC activities to promote access to care
 - Coordination includes response to state and local budget cuts

Ensuring access to care depends on coordination efforts across funding streams to maximize available resources and access to services. Coordinating efforts include: optimizing coordination across Ryan White Parts B-F, non-RW funded entities, prevention programs, substance abuse treatment programs and other federally and state funding programs; inviting and including stakeholders across all funding streams to participate in HIVPC and QI activities; requesting reports from all funding streams to HIVPC and Networks; developing linkage and data sharing agreements (e.g., HOPWA and Part A); providing training and presentations across all Networks and non-RW funded providers to increase knowledge of available resources; conducting regular review of client eligibility to ensure RW is payer of last resort; coordinating efforts with aforementioned community stakeholders in event of

state/local budget cuts; reviewing periodic updates regarding available public and private community resources (e.g., PAPs).

Part B Services, including ADAP: Part A will coordinate with Part B on all EIIHA-related planning and activities, HICP, transportation, and home health care. The Part B Grantee and ADAP representative will continue providing detailed reports on cost and utilization to the HIVPC and its Committees. In addition, data sharing between Part A and ADAP will be improved to promote timely ADAP recertification as well as provide a clearer picture of clients' complete regimens to avoid medication duplication and multi-drug interactions.

Part C Services: Part A will continue to ensure that EIS activities are coordinated with Part A outreach, CIED, and OAMC to promote identification, referral, and linkage to care. Part A will also ensure that funds are not used to supplant services provided through Part C.

Part D Services: Part A will continue working with the Part D Grantee to provide quality care to WICY. Part D MCMs will continue attending quarterly MCM training provided by Part A to promote coordination and collaboration between the Parts.

Part F Services: Part A will continue collaborating with both the Part F Grantee and the Florida/Caribbean AETC in the provision of high quality Oral Health Care and QM activities respectively.

Providers (Non-Ryan White Funded, including private providers): Part A service will continue to be available for Part A eligible clients who receive primary medical services from a private physician. Services may include support services as well as assistance with co-pays and deductibles. In addition, relationships with private physicians will be expanded to promote the EIIHA Strategy.

Prevention Programs including, Partner Notification Initiatives and Prevention with Positives Initiatives: Part A will collaborate with BCHD and EIS to ensure partner notification and to reinforce adherence and safer sex among PLWHA and their partners.

Substance Abuse Treatment Programs/Facilities: Part A will continue funding Substance Abuse treatment programs to ensure and expand access to address the need and ensure comprehensive care for the dually diagnosed.

STD Programs: Part A will coordinate with prevention and disease control programs by ensuring: 1) linkage to care services are available at testing sites, 2) DIS, Part A Outreach, CIED, and Part A

OAMC coordinate to ensure linkage to care and partner notification, 3) Obtain regular epidemiological data on STD rates in the EMA to promote prevention.

Medicare: Part A CIED and MCMs will continue to screen clients for Medicare eligibility and assist them with their application using the SOAR method as well as referring clients to Legal Services for assistance with applications or denials.

Medicaid: Part A CIED and MCMs will continue to screen clients for Medicaid eligibility and assist them with their application. The PE system runs automatic verification of clients' Medicaid status to ensure Ryan White is accessed as the payer of last resort.

State Children's Health Insurance Program: Part A will ensure referral to SCHIP or Part D as appropriate, ensuring the role of Ryan White as payer of last resort.

Community Health Centers: Part A will continue collaborating with the two Part A-funded FQHCs.

Hospitals: Testing rates are highly variable among hospital departments of the 17 Broward acute care hospitals: labor and delivery (90%), inpatient (65%), Emergency Departments (ED) (59%), and outpatient clinics (29%). Representatives from three of the largest hospital systems in Broward (Broward Health, Memorial Healthcare System, and Holy Cross Hospital) participate actively in the HIVPC and its Committees. They conduct confidential HIV screening in their outpatient departments, acute care inpatient hospitals, labor and delivery rooms, and emergency rooms (ERs). These systems and other Broward hospitals have not fully adopted the CDC 2006 HIV testing recommendations. An important aspect of the BIGA initiative will be to implement fully HIV screening in all Broward acute care hospitals. Part A has coordinated with Broward hospitals to ensure newly diagnosed HIV+ hospitalized patients are linked to OAMC funded by Part A or health insurers. The Part A CIED subgrantee has established MOUs with the hospitals in which discharge staff arrange expedited CIED appointments on behalf of HIV+ inpatients. CIED intake can occur in the hospital, clients' homes (if home bound), or at CIED offices throughout Broward. Further assisting coordination efforts, both Broward Health and Memorial are Part A-funded OAMC and MCM subgrantees. CIED staff is out-posted at their OAMC clinics.

Correctional Facilities: The EIIHA Strategy reflects closely coordinated efforts between Part A, Florida DOC prison system, and BSO jail system. As discussed earlier, the HIVPC formed an ad-hoc Reentry Subcommittee in 2010 to ensure uninterrupted access to HIV OAMC and medications for HIV+ inmates released from jails or prisons. The Subcommittee identified barriers to OAMC and access to medications, and designed protocols to streamline enrollment in Part A OAMC, ADAP, and

PAPs. In the DOC Prison Re-Entry Protocol, the Part B-funded Prison Pre-release Coordinator assists all HIV+ inmates prior to their release to assess and arrange for post-release OAMC, medication, and transportation. HIV+ inmates receive a copy of their medical records documenting their HIV treatment while incarcerated, and a 30-day medication supply upon release. Through the Florida DOH-funded JLP, linkage workers conduct pre-release planning to ensure rapid transition to community HIV OAMC and support services. A Part A-funded CIED worker is posted at the BSO to conduct Part A eligibility and schedule medical appointments at the Part A-funded HIV clinic selected by the client. In 2010, the Broward JLP was successful in ensuring 100% of released HIV+ inmates were engaged in HIV medical services, a significantly higher rate than the program statewide (84%). DOC and BSO HIV+ inmates sign the Part A combined consent form prior to release, allowing the Coordinator to send medical records and eligibility documents to CIED and arrange a CIED Part A intake appointment within one week of release. Part A OAMC and support service appointments are made during the CIED intake. The Coordinator and CIED staff provide follow up to ex-offenders for one month after release to ensure that CIED, OAMC, and support service appointments are kept. In the BSO Jail Protocol, CIED staff is co-located at the BCHD JLP to ensure rapid Part A intake upon release. The Reentry Subcommittee also developed a protocol describing the collaborative efforts of the BCHD JLP, CIED, and Part B ADAP staff to ensure medication adherence and linkage to OAMC within 30 days of release.

F. Comprehensive Plan and EIIHA Strategy Reflect HP 2020 Goals

Healthy People (HP) 2020 is a national initiative led by HHS that sets priorities for all HRSA programs and establishes new 10-year national objectives for improving the health of all Americans. The initiative has two major goals: (1) to increase the quality and years of a healthy life; and (2) to eliminate our country's health disparities. The program consists of 28 topic areas and 467 objectives. One of the topic areas is HIV and it includes specific objectives we have broken into three categories: HIV Prevention, HIV Testing, and Treatment and Quality Management Activities.

Addressing Healthy People 2020

KEY POINTS

- **EIIHA and Healthy People 2020 Goals**
 - HP 2020's goals aim to increase quality and years of life and eliminate disparities
 - The Comprehensive Plan was created to strengthen the delivery of medical care
 - The state and EMA continue efforts to determine a baseline community viral load

The Part A Comprehensive Plan was created with the intent to strengthen the accessibility and delivery of critical medical care to newly diagnosed individuals, as well as those aware of their status but out of care. Through enhancement, expansion, and continued HIV education of the medical provider network, increasingly sensitive and timely care will be provided to consumers to improve health outcomes for PLWHA. The Parts A and B Grantees will enhance collaboration with Prevention to support efforts to educate the community about HIV, refer high-risk HIV-negative individuals to appropriate interventions to help them remain negative, as well as link HIV+ individuals to medical care, and more importantly, retain them in care.

Numerous studies emphasize the importance of adherence to decrease the likelihood of HIV transmission and improve the health outcomes of PLWHA. FL will continue efforts to determine a community viral load baseline at the state and local level where possible. After achieving a valid, verifiable, and reliable baseline, FL will formulate a strategy to reduce the community viral load by increasing the proportion of consumers with undetectable levels, which will mean retaining people in care and educating them about the importance of adhering to their medical regimen. The Part B Grantee will continue to work towards increased data sharing and integration to decrease the delay in service and accelerate the provision of a high-quality, coordinated service delivery system.

The Implementation Plan's services, goals, and objectives relate directly to the HP 2020's overarching goals of increased quality and years of a healthy life, eliminating health disparities, and promoting good health behaviors. The EMA's outreach and food bank services serve as a point of entry and facilitate engagement in OAMC through direct linkages with OAMC providers. APA, Oral Health Care, and MCM ensure that clients have access to services and medications consistent with PHS guidelines. Specifically, the Plan addresses the following objectives: HIV-1 (*reduce the number of new HIV diagnoses among adolescents and adults*), HIV-8 (*reduce the number of perinatally acquired HIV and AIDS cases*), HIV-10 (*increase the rate of HIV+ adolescents and adults who receive HIV care and treatment consistent with current standards*), HIV-11 (*increase the rate of persons surviving more than three years after AIDS diagnosis*), HIV-12 (*reduce deaths from HIV infection*), HIV-14 (*increase the rate of adolescents and adults tested for HIV in the past 12 months*), and HIV-16 (*increase rate of substance abuse treatment facilities that offer HIV/AIDS education, counseling, and support*).

Part A Coordination With Other Funder Activities - Prevention (HP 2020 Objectives 1-3, 17-18)

1. Reduce the number of new HIV diagnoses among adolescents and adults
 2. Reduce new (incident) HIV infections among adolescents and adults
 3. Reduce the rate of HIV transmission among adolescents and adults
 17. Increase proportion of sexually active persons who use condoms
 18. Decrease proportion of MSM who reported unprotected anal sex in the past 12 months
-

Coordination With Other Funders Testing, Substance Abuse, Health Center (HP 2020 4-7, 9, 13-16)

4. Reduce the number of new AIDS cases among adolescents and adults
 5. Reduce the number of new AIDS cases among adolescent and adult heterosexuals
 6. Reduce number of new AIDS cases among adolescent and adult men who have sex with men
 7. Reduce the number of new AIDS cases among adolescents and adults who inject drugs
 9. Increase the proportion of new HIV infections diagnosed before progression to AIDS
 13. Increase proportion of people living with HIV who know their serostatus
 14. Increase proportion of adolescents and adults tested for HIV in past 12 months
 15. Increase proportion of adults with tuberculosis (TB) who have been tested for HIV
 16. Increase proportion of substance abuse treatment facilities offering HIV education, counseling, and support
-

Part A Service, Treatment and Quality Management Activities (HP 2020 Objectives 8, 10-12)

8. Reduce the number of perinatally acquired HIV and AIDS cases
 10. Increase proportion of HIV+ who receive HIV care and treatment consistent with current standards
 11. Increase proportion of persons surviving more than 3 years after a diagnosis with AIDS
 12. Reduce deaths from HIV infection
 12. Reduce deaths from HIV infection
-

G. Plan Reflects Statewide Coordinated Statement of Need

KEY POINTS

▫ **Comprehensive Plan Reflects The SCSN**

- SCSN and Comprehensive Plan ensure a high quality comprehensive continuum
- SCSN and Comprehensive Plan reference Part A and B collaborative activities
- Both Plans address NHAS, HP 2020, and ACA goals

HRSA requires that the Comprehensive Plan be compatible with existing State and local service plans including the SCSN. All 2012-2015 Comprehensive Plan goals align with and reflect the SCSN. Moreover, Part A HIVPC Support staff played an essential part of multiple statewide calls to develop the 2012-2015 goals as well as strategies to address gaps in care.

Florida's 2012-15 SCSN and Comprehensive Plan has been an incredibly successful collaboration between the Part B grantee; the Patient Care Planning Group (PCPG); Ryan White Parts A, C, D, and F; and various other stakeholders. The Part B grantee invited the grantees from all of Florida's Ryan White programs, Lead Agency staff, contract managers, HIV/AIDS Program Coordinators (HAPC), PCPG members, providers, and consumers to participate in a SCSN web conference in February 2011 to allow as many stakeholders to offer input as possible. A face-to-face meeting for this SCSN took place in March of 2011 in Tampa, Florida. The PCPG, an advisory work group specifically charged with assisting the Part B grantee in the development of the Comprehensive Plan for Patient Care services, attended, as well as representatives from other Ryan White parts, Lead Agency staff, contract managers, HAPC, providers, and consumers.

The State 2012-2015 SCSN and the Part A Comprehensive Plan address the components deemed most critical to cultivate a high quality, comprehensive continuum of care for all PLWHA in the state. The goals and corresponding strategies, activities, and timelines delineated in the SCSN demonstrate

collaboration between the Part B Grantee, Comprehensive Plan writing workgroup, and Part A Grantees. The PCPG reviewed the plan to substantiate that the proposed methods responded to Florida's crucial needs and identified challenges. The SCSN also addresses the NHAS goals, HP 2020 objectives, and ACA goals.

FL incorporated the SCSN within the Comprehensive Plan to evidence its commitment to address the identified, needs, gaps, barriers, and challenges. As resources constrict and demand for services expand, the SCSN and the Part A Comprehensive Plan recognize and advance the importance of coordination and collaboration between Patient Care and Prevention, maximizing the collective effort and streamlining care, while serving more people with less resources. Both plans prioritize core medical services, including OAMC and medications, as the foundation for optimal care. The strategy to expand medical care networks and increase their capacity to reach more people and retain them in care advanced an access to care gap identified as a core issue in the SCSN. FL intends to address this issue by identifying areas with inadequate capacity, assessing the needs, creating an education plan, and collaborating with Part A grantees and the F/C AETC to implement the plan.

H. Coordination and Adaptation with the Affordable Care Act

KEY POINTS

- **ACA Coordination And Adaptation**
 - It is expected that as of 2014 most Ryan White clients will have health insurance
 - The Comprehensive Plan includes the goal of preparing for the impact of ACA
 - It is anticipated that the Part A program's role will change
 - Many PLWHA are uninsured; some features of the law went into effect in 2010 and have already begun to help PLWHA find and keep health insurance
 - Both the State and the EMA will continue their commitment to a high quality, comprehensive continuum of care regardless of the ultimate configuration of the ACA

The intent of the Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the Reconciliation Act of 2010 (P.L. 111-152) (collectively referred to as the health reform law) is to expand health insurance coverage while also reforming the health care delivery system to improve quality and value. It also includes provisions to eliminate disparities in health care, strengthen public health and health care access, invest in the expansion and improvement of the health care workforce, and encourage consumer and patient wellness in both the community and the workplace. According to the Congressional Budget Office, the law increases coverage to about 94% of Americans. The Comprehensive Plan outlines how efforts are coordinated with and adapt to changes that occur with the implementation of ACA.

Beginning in 2014, most Ryan White clients are expected to have health insurance coverage. The impact of the ACA is not known at this time; however, it is expected that changes will be made to the mission of, and services provided by, the Ryan White program. In anticipation of the changes that are due to occur in 2014, the EMA's Comprehensive Plan includes a goal of preparing a response for the impact of the ACA on the system of care. It has been recommended by the Joint Executive Committee that Health Care Reform become a standing agenda item on all Committee work plans and that regular updates on impending changes be shared with all stakeholders. The EMA must develop recommendations to assist with Ryan White system modifications as needed. Recommendations must include a plan for the continued collaboration with state, federal, and local partners.

Ryan White programs offer an important blueprint for the expansion of comprehensive health and support services for people with chronic illnesses. In many ways, Ryan White programs serve as a best-practices model for comprehensive and holistic provision of care and treatment. As major health care reform provisions go into effect; however, the role of Ryan White is expected to undoubtedly change. Advocacy around integration of Ryan providers into Medicaid and state exchange provider networks, for instance, will be crucial to ensure seamless access to care for the thousands of people newly eligible for Medicaid and private insurance coverage. Integration of Ryan White programs and models of care into Medicaid and private insurance models is also important to ensure a smooth health care reform transition for those currently receiving care.

The ACA helps address coverage issues and provides new protections for patients and consumers. Many important features of the law went into effect in 2010 and have already begun to help PLWHA find and keep health insurance. Insurance companies can no longer deny coverage to children because of HIV/AIDS or any other pre-existing condition. Insurers cannot rescind coverage except in cases of fraud or intentional misrepresentation of a material fact. Insurers can no longer impose a lifetime dollar limit on essential health benefits. ADAP benefits now count as contributions toward a Medicare beneficiary's True out of Pocket (TroOP) spending limit for drug coverage. This will continue to provide considerable savings to Florida's ADAP. Beginning in 2011, Medicare beneficiaries who reached the "donut hole" began to receive a 50% discount on covered brand name drugs while in the "donut hole." Discounts for brand name and generic drugs will grow over the course of the decade until the donut hole is closed.

When the ACA achieves full implementation, additional changes in health insurance options will make it more accessible. In 2014, the ACA is to ensure that Medicaid coverage is available to all low-income Americans (less than 133% of the FPL), including adults with no children. As a result,

low-income adults living with HIV would no longer have to wait for an AIDS diagnosis to become eligible for coverage. Insurers could not deny coverage or charge more for anyone who has a pre-existing condition or impose annual dollar limits on essential health benefits. People without access to employer-sponsored insurance or Medicaid would be able to buy private coverage from Affordable Insurance Exchanges, designed to make buying health insurance easier and more affordable. People with low and middle incomes would have access to Federal premium tax credits, which would ensure that this coverage is affordable for them.

The ACA seeks to ensure that people with public or private coverage can find high-quality health care. Health insurance plans would need to provide information in a user-friendly way, clearly explaining covered and non-covered services. Individuals and small business that purchase insurance, including people who buy coverage in the Affordable Insurance Exchanges, would have access to a benefit package that equals the scope of a typical employer plan. The package would offer coverage to meet the health care needs, including prescription drugs, preventive care, chronic disease management, and substance abuse and mental health treatment. Medicare and many private insurance plans are now required to cover many recommended preventive services, including screening for HIV, mammograms and other cancer screenings, with absolutely no cost sharing for patients, which will help PLWHA stay healthy. The ACA calls for new investments to help providers manage chronic disease. The law also recognizes the value of patient-centered medical homes to strengthen the quality of care, especially for people with complex chronic conditions such as HIV. Medical homes provide a way to offer coordinated, integrated, and comprehensive care that has proven to be particularly effective for treating people living with HIV.

While health care coverage is a key issue for PLWHA, other economic, social, and physical factors influence their overall health. The ACA acknowledges the importance of these other factors. The law makes critical investments in prevention, wellness, and public health activities to improve public health surveillance, community. It expands initiatives to strengthen cultural competency training for all health care providers to ensure the equitable treatment of all populations. The ACA also bolsters the Federal commitment to reducing health disparities. The law helps improve access to comprehensive quality health care, thereby improving the health and wellbeing of all PLWHA.

Both the State and the EMA will continue their commitment to a high quality, comprehensive continuum of care regardless of the ultimate configuration of the ACA.

I. How The EMA's Comprehensive Plan Addresses NHAS Goals

KEY POINTS

▫ Addressing NHAS Goals

- NHAS goals aim to reduce the number of people who become infected with HIV, increase access to care and optimizing health outcomes for people living with HIV, and reduce HIV-related health disparities
- The Plan extends a statewide strategy to ensure these goals are achieved

As noted earlier, the EMA's Comprehensive Plan, including the EIIHA Strategy, is designed to address all three NHAS primary goals: 1) Reduce new HIV infections, 2) Increase access to care and improve health outcomes for People Living with HIV, 3) Reduce HIV-related health disparities and health inequities.

The NHAS states that more must be done to ensure that new prevention methods are identified and that prevention resources are more strategically deployed. Further, the NHAS recognizes the importance of getting people with HIV into care early after infection to protect their health and reduce the potential of transmitting the virus to others. HIV disproportionately affects people who have less access to prevention and treatment services and, as a result, often have poorer health outcomes. Therefore, the NHAS advocates for the adoption of community-level approaches to reduce HIV infection in high-risk communities and to reduce stigma and discrimination against people living with HIV.

The NHAS goals are the foundation of the Part A Comprehensive Plan. They are also directly aligned with the Part B SCSN, which extends a statewide strategy to ensure the implementation of community-level approaches to reduce HIV infection, to increase access to care, and to reduce HIV-related health disparities, particularly in high-risk communities. Ryan White providers will continue to encourage risk reduction strategies and treatment adherence, as well as provide education to consumers and those affected by HIV about the threat of infection. By expanding medical care provider networks and increasing their capacity, FL will simultaneously increase access to care and reduce health disparities throughout the state. Since this strategy will provide consumers increased options for medical care, it will also encourage their retention in care.

The Part A and B Grantees recognize the importance of rapid testing, an effective method of engaging people to identify and inform them of their status and refer and/or link them to appropriate services. Part A and B Grantees will continue to improve the referral mechanism between HIV testing functions in Prevention and the Ryan White HIV service delivery systems across the state as well as

actual linkage from testing through care by implementing peer programs. By adopting the primary goals of the NHAS as the 2012-15 proposed care goals, Broward County and FL as a whole emphasize the commitment to align the response to HIV/AIDS with the NHAS. As FL and Broward County strive to meet proposed goals, they will also be contributing to the national coordinated effort to achieve the NHAS' vision of a nation committed to stopping the HIV epidemic and supporting all infected persons with dignity, and access to high-quality care.

J. Response To Changes In The Continuum – State and Local Budget Cuts

KEY POINTS

- **Response To Changes In The Continuum of Care**
 - EMA has several mechanisms in place to plan for core and support services funding
 - The HIVPC reviews monthly updated Part A and MAI expenditure data to ensure that over- or underutilization of Ryan White funds is minimized
 - Part A PSRA activities are closely coordinated with other Ryan White Grantees, as well as other funders
 - Key stakeholders and funders meet monthly to discuss policy, legislative, cost, and funding issues that influence the EMA's care continuum

Changes in Federal, State, and local program policies and funding 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 on the HIV care continuum.

The EMA has established several mechanisms through which the funding of core and support services is considered:

- Ryan White Program Grantees and key funders provide the HIVPC with monthly funding and utilization reports. The HIVPC reviews monthly updated Part A and MAI expenditure data to ensure that over- or underutilization of Ryan White funds is minimized. The EMA has successfully addressed unexpected service needs by rapid reallocation of funds. Grantee staff conducts three “sweeps” and reallocation processes annually to address service shortfalls in core services.
- The HIVPC adopted a process that is similar to the SCSN to maximize funds. Part A PSRA activities are closely coordinated with other Ryan White Grantees, as well as other funders. Core services are prioritized as essential to supporting the HIV care continuum. To the extent feasible, they are “held harmless” if funds are reduced or “flat.” While this policy ensures access to core services, access to support services is subject to reductions based on decreased funding. The Grantee evaluates Part A-funded services to ensure that they are cost-effective, achieve their aims, and are of high quality. The Grantee also has provided considerable technical assistance (TA) and

capacity development to subgrantees to enhance capacity, ensure retention of clients in care, and achieve improved quality.

- Key stakeholders and funders meet monthly to discuss policy, legislative, cost, and funding issues that influence the EMA's care continuum. Program, service, and utilization trends, as well as emerging issues also are discussed. These ongoing discussions assist policymakers in the EMA to respond proactively to changes that may affect the HIV care continuum. Press releases, forums, presentations, TA, and training needs are jointly developed and provided in the EMA.
- The Part A Grantee collaborates with the Part B lead agency and HOPWA grantee in conducting countywide consumer needs assessments. The HIVPC takes the results of these assessments into consideration in PSRA.

The Part A grantee and HIVPC undertake funder-specific activities, in addition to the overarching activities described above:

Medicaid: Covered benefits, budgetary changes, and reform activities are major considerations in planning for a comprehensive HIV care continuum, priority setting, and allocations. DCF and AHCA representatives sit on the HIVPC and provide detailed Medicaid enrollment and expenditure data to the Part A Grantee to further planning and resource allocation activities. Medicaid policies have created substantial challenges for the HIV care continuum.

State Children's Health Insurance Program (SCHIP): DCF administers the FL KidCare Program, which is represented on the HIVPC and provides routine programmatic updates.

Medicare: The Grantee and HIVPC closely monitor changes in Medicare medication benefits due to serious ADAP cost containment efforts, which have resulted in some Medicare beneficiaries with Part D coverage terminated from ADAP enrollment.

Social Security Administration: Part A CIED and MCM staff have been trained to ensure Ryan White is payer of last resort by verifying clients' enrollment in SSA disability and retirement programs. They also ensure that potentially eligible clients are assisted in applying for benefits and/or are referred to Legal Services if their application is denied.

Veterans Affairs: HAB's VA policy is considered in Part A planning and care coordination. Eligibility is assessed at intake and if eligible referrals to one of several VA sites are made.

HOPWA: The City of Fort Lauderdale HOPWA grantee participates actively in the HIVPC and several of its committees. HOPWA staff also collaborates with the Part A Grantee and the Part B administrative agent to conduct planning and assessment activities, including the consumer and

provider surveys described earlier as well as MCM trainings. HOPWA client-level data has been integrated into the PE system.

CDC Prevention: BCHD is the Broward Part B and HIV prevention lead agency, manages the Community Prevention Partnership, and designs and implements the Broward HIV Prevention Plan. BCHD staff and Partnership members also participate in the HIVPC and its Committees. The Part A Grantee regularly collaborates with BCHD and FDOH prevention initiatives.

WICY Services: The Part A and Part D Grantees collaborate closely to assess and address the needs of the WICY population. In 2011, the Part D Grantee, CDTC, was instrumental in offsetting some of the impact of the BCHD HIV clinic closure.

Local, State, and Federal Public Health Programs: The Part A Grantee collaborates closely with the Florida DOH and BCHD staff. Participating programs include the DOH staff responsible for operating the HIV prevention, STI, TB, oral health care, and other programs.

Local and Federal Funds for Substance Abuse and Mental Health Treatment Services: Due to funding shortfalls, public mental health services are limited to only the most severely mentally ill and/or addicted. Part A continues to allocate substance abuse and mental health treatment funds for HIV+ clients to assist access, retention, and adherence to OAMC, to the extent that new Part A and MAI funds are available.

Part B: Florida has one of the largest Ryan White Part B funded programs in the country. The majority of the grant received from HRSA goes towards funding ADAP, the largest and most costly part of the programs, largely due to the size and scope of the epidemic in the state. The Part B grantee allocates the funds to the local Consortia, who then prioritize service categories. There is a statewide standardized eligibility criteria and determination process for all programs administered through the Part B grantee: Consortia, General Revenue, Patient Care Network funds, ADAP, AICP and HOPWA. The current income cap for all Part B Grantee programs is 400% of Federal Poverty Level (FPL), with the exception of HOPWA, which is 80% of local median income as directed by HUD. All other programmatic requirements are enforced as well, including documentation of HIV disease.

The Part B Grantee and PCPG both appreciate the uncertainty with respect to federal funding for Ryan White services, as well the potential for further erosion of state general revenue funding for HIV programs. Florida's largest challenge to closing gaps in care directly relates to the level of funding allocated at both the federal and state levels. Florida, as many other states, has struggled with multi-billion dollar deficits for the past five years. The Part B grantee plans to reconvene the

allocation methodology workgroup to ensure fair and equitable distribution of funds based on static or increases in HIV and AIDS cases who are actually engaged in Ryan White-funded care. With the full implementation of CAREWare for Part B reporting, there is much improved access to client-level data, and the possibility to apply utilization data as an input in the allocation process. The Part B grantee's strategy to respond to future budget cuts will be to focus primarily on critical core medical services.

Part F: Nova Southeastern University is a Part A subgrantee, and a Part F Community-Based Dental Partnership Grantee. Nova staff participates in the HIVPC Oral Health Care Network and HIVPC.

4. HOW WILL WE MONITOR OUR PROGRESS?

The purpose of this section is to describe the methods and/or means by which progress in achieving goals and meeting challenges will be monitored. Monitoring and evaluation will ensure that the activities implemented to achieve the goals are prioritized, analyzed, and adapted as needed to align with shifts in resources and priorities. This section of the Comprehensive Plan describes how progress in achieving goals, meeting challenges and barriers, and adapting over time will be monitored. It also provides a detailed description of the well established Quality Management (QM) process already in place designed to promote quality services and improved health outcomes.

KEY POINTS

- **Monitoring Progress**
 - The Comprehensive Plan provides the foundation for each HIVPC Committee's work plan
 - The EMA has a well established CQM program in place
 - Four interconnected bodies oversee the CQM program: Grantee CQM staff, subcontracted CQM support, QMC, and QI Networks
 - All QM activities TARGET increased access, adherence, and retention in care
 - Client-level, administrative, and utilization data are collected to meet HAB RSR reporting requirements, assess HAB clinical performance measures, and measure EMA-specific client-level outcomes and indicators.
 - Performance measurement is continuously adapted to changes in treatment guidelines
 - The HIVPC uses QM data in the priority setting and resource allocation process
 - Local outcomes and indicators are being revised to ensure that service categories are measured by their impact on reinforcing and improving retention in medical care

A. Plan to Monitor and Evaluate Progress Achieving Goals and Identified

Challenges

The Comprehensive Plan functions as the foundation for each HIVPC committee's work plan. As appropriate, committees will be tasked with coordinating the implementation and monitoring of activities, tracking the progress of specific activities, providing regular status updates, including challenges and proposed solutions, and suggesting revisions to better achieve the goals. While the process of implementing, reviewing, and reporting on the Comprehensive Plan goals will be revised to ensure participation and accountability from all committees, many monitoring activities are already included in the work of committees as shown below.

The Joint Executive Committee, Joint Planning, Quality Management (QM) Committees and the HIVPC have reviewed accomplishments and challenges in implementing and monitoring the 2009-2011 Comprehensive Plan goals and have made recommendations towards the development of 2010-2014 goals and activities. While the HIVPC assumes overall responsibility for monitoring progress to implement the goals, objectives, and activities of the Comprehensive Plan, a coordinated approach will be needed to implement, monitor, and evaluate the Plan and its goals. The approach:

- The HIVPC and its committees, Grantee, and support staff will define roles, responsibilities, tasks, timeline, evaluation measures, and indicators for each plan goal, objective, and strategy.
- Each HIVPC committee will develop an annual work plan that includes monitoring and evaluation of Comprehensive Plan goals. Review of the Plan goals will be a standing agenda item for all committees.
- The annual work plans will be modified as needed to reflect: 1) Identified successes and challenges achieving plan goals, 2) Changes in resources and priorities, 3) Changes in the implementation process of each goal and activity, and 4) Roles and responsibilities.
- Each committee will report progress achieving Comprehensive Plan goals as well as identified challenges, barriers, and next steps to the HIVPC on a monthly/bi-monthly/quarterly basis. An annual review of the Comprehensive Plan goals will identify system-wide accomplishments, challenges, barriers, and next steps to be reported to the HIVPC.
- Client-level data and clinical outcomes will be used to assess the EMA's success in promoting access to and retention in care.

Joint Executive	Joint Planning	Quality Management	Joint Priorities
Oversee committee goals and objectives	Ensure coordinated services	Develop and monitor system level outcomes and indicators	Analyze utilization
	Increase access to care	Develop standards of care	Address changes in priorities and resources
	Decrease disparities	Improve client health outcomes	
	Decrease unmet need	Standards of care and client satisfaction	

The Joint Executive Committee and HIVPC planning retreats resulted in recommendations for each committee to help monitor progress towards achieving Comprehensive Plan goals. These recommendations have been informing the development of annual committee work plans focused on the implementation and evaluation of the Comprehensive Plan.

HIV Planning Council

- Review progress achieving Plan goals
- Add standing 'Health Care Reform' item to HIVPC agenda to prepare for changes in the continuum of care
- Appoint a committee to focus on Health Care Reform as it impacts HIV care and treatment

Part A/Joint Executive Committee
• Committee Chairs and staff to define roles and responsibilities and collaborative process for planning meeting agendas and goals including Comprehensive Plan goals • Information sharing and reporting from representatives of all funding streams to ensure the Plan adapts to changes in community resources and priorities • Mentor new PC members to encourage comfort with procedures and participation in planning and evaluation • Monitoring committee-specific Plan activities and timeframes • Identify common themes among all committees and incorporate into annual work plans • Consider revising committee meeting cycles to improve efficiency and productivity • Prioritize review of committee work plans
Joint Planning Committee
• Recommend relevant Plan-related work items for each Committee • Select most important and useful Needs Assessment data and other data sets early in the calendar year to ensure data are organized in “user-friendly” format for use in PSRA • Conduct Client Needs Survey every 2 years with annual data assessment reports • Conduct a baseline Needs Assessment on all Part A clients through the CIED intake process • Define activities to address needs of special populations and specific subgroups
Joint Client Community Relations Committee
• Define JCCR role in implementing Plan and corresponding work-plan activities related to NHAS and EIIHA • Develop and implement strategies targeting special populations to facilitate linkage to care • Identify and implement targeted recruitment and engagement strategies • Encourage participation of special population representatives on JCCR • Identify better ways to market the system of care and improve consumer knowledge • Use linkage specialists, navigators and peers to find those who have fallen out of care
Joint Priorities Committee
• Improve utilization and funding data • Quarterly data updates from Ryan White Parts B, C, D & F programs • Request County Commissioners invite all other funders to participate in HIV Planning

Plan to Assess the Impact of the EIIHA Initiative

The EIIHA initiative is an integral component of a high quality, comprehensive continuum of care. The EMA developed a comprehensive EIIHA strategy in close coordination with other Ryan White, prevention, counseling and testing, healthcare, and community stakeholders. The strategy was developed to address the following: Identifying individuals unaware of their HIV status, informing individuals of their HIV status, referring individuals recently informed of their status, and linking newly identified HIV+ persons to OAMC.

The EIIHA strategy goals include increasing the number of:

- Individuals who are aware of their HIV status
- HIV+ individuals enrolled in HIV-related medical care within three months of HIV diagnosis
- HIV negative individuals referred to services that contribute to keeping them HIV negative

The Part A Grantee has collaborated with key stakeholders to refine and implement the strategy, optimize other public and private sector resources, increase rates of HIV screening, linkage, and

engagement in HIV care among HIV+ Broward residents, and enhance primary and secondary prevention activities to reduce new HIV infections.

The HIVPC Joint Planning Committee is tasked with monthly monitoring of the EIIHA strategy objectives. Key stakeholders, as noted above, are members of the committee and/or invited guests, who provide input into the progress and challenges in the completion of each objective. BCHD provides monthly surveillance and prevention data to the committee informing of the progress toward achieving the strategy's objectives. Additionally, Part A subgrantee contracts contain a requirement to provide detailed quarterly reports to the Grantee about EIIHA activities, which will be reported to the committee. The Committee will continually update progress and challenges throughout the year. A final status report will be compiled annually. Proposed activities to be reviewed and monitored by the Joint Planning Committee are below.

Joint Planning Committee

Goal 1. IDENTIFY: Increase by 10% annually the rate of HIV+ persons who are aware of their HIV+ status, with specific focus on voluntary testing among African-Americans, Hispanics, MSM, recently incarcerated, and substance users.

Goal 2. INFORM: Increase by 10% the annual rate of HIV+ persons who know their status, through rapid HIV testing and rapid serologic testing in community and healthcare settings

Goal 3. REFER: Increase the rate of HIV+ persons who are referred to OAMC and other core services

Goal 4. LINK: Increase the rate of newly identified HIV+ persons linked to OAMC who initiate HAART

RECOMMENDATIONS FOR ADDITIONAL WORK PLAN ACTIVITIES

- Ensure HIVPC prevention seat is filled; have BCPP representation on HIVPC and vice versa
- Identify prevention and testing barriers
- Develop a high risk negative data system and identify resources for those who test negative
- Develop a taskforce to work specifically on requesting ER's increase HIV testing
- Increase communication between prevention and treatment related to EIIHA
- Develop plan to locate those who tested positive and not linked to care

In addition to the Joint Planning Committee's review, the QMC is also be tasked with monitoring EIIHA activities to determine the need for QIP's. Proposed activities to be reviewed and monitored by the QMC are below. Additional monitoring activities and timeframes may be added as needed.

Monitoring and Evaluation Process Implementation Timeline

The Clinical Quality Management (CQM) program is committed to improving the quality of services provided to HIV+ Broward County residents by ensuring that an action-oriented CQM infrastructure is carefully aligned with HAB and Grantee's goals for quality improvement (QI).

Quality Management Mission, Goals, and Objectives

Quality Statement: The purpose of the QM Program for Ryan White Part A and MAI funded services in Broward County EMA is to monitor, evaluate, and systematically and continuously improve the quality and appropriateness of HIV care and services provided to consumers

Quality Mission: Our mission is to ensure access to and retention in high quality HIV core and support services for Part A and MAI eligible Broward County residents living with HIV

Quality Goals and Objectives:

- Develop a planning mechanism incorporating baseline data from external and internal sources and input from department leadership, staff and patients. Clinical, operational and programmatic aspects of patient care will be reviewed
- Emphasize design needs associated with new and existing services, patient care delivery, work flows and support systems which maximize results and satisfaction on the part of the patients and their families, physicians and staff
- Evolve and refine measurement systems for identifying trends in care by regularly collecting and recording data (through a valid sampling program when appropriate)
- Employ assessment procedures to determine efficacy and appropriateness and to judge how well services are delivered and whether opportunities for improvement exist
- Focus on improving quality in all of its dimensions by implementing multidisciplinary, data driven, project teams and encouraging participatory problem solving
- Promote communication, dialogue and informational exchange throughout the organizations reporting structure, with regard to findings, analyses, conclusions, recommendations, actions and evaluations pertaining to performance improvement
- Strive to establish collaborative relationships with diverse community agencies for the purpose of collectively promoting the general health and welfare of the community served
- Support EIIHA strategy and objectives by reviewing and evaluating linkage activities and processes for improved service delivery

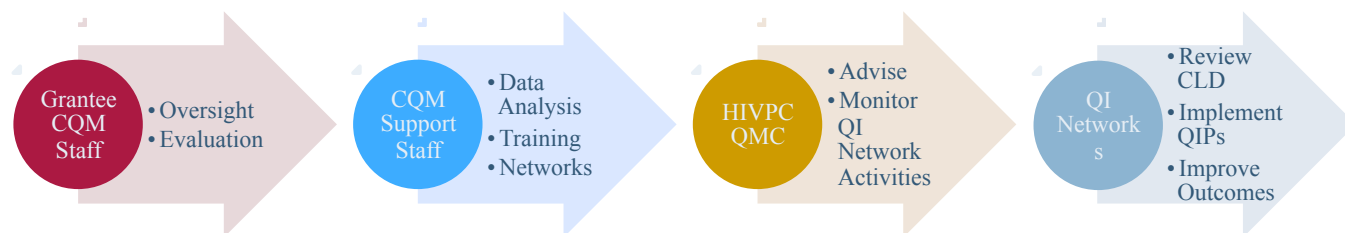
The EMA has an established CQM program in place. It is guided by a three-year QM Plan, annual QMC work plan, and QI Network work plans. The three-year QM plan, established in 1998, guides the CQM program. The plan is updated periodically to reflect evolution of HAB's QM requirements, PHS guidelines, and best practices disseminated by HAB.

The CQM program has five objectives: (1) assess the extent to which HIV clinical care is consistent with the most recent PHS guidelines for the treatment of HIV and related OIs; (2) develop strategies for improving quality through the application of HAB performance measures and best practices identified by the NQC; (3) implement continuous quality improvement (CQI) to ensure core and support services are strongly linked to promote engagement and retention in care and adherence to medical treatment; (4) apply client-level demographic, clinical, and utilization data to identify areas of improvement in clinical processes and outcomes; and (5) apply action-oriented QI processes to test and adopt new or improved care and support strategies.

Four interconnected bodies oversee the CQM program: Grantee CQM staff, subcontracted CQM support and consultant staff, QMC, and QI Networks. The Grantee has primary responsibility for developing, overseeing, and jointly evaluating progress made in completing the CQM three-year and annual work plans with HIVPC and community stakeholders. The Grantee and subcontracted CQM

staff have overall responsibility for analyzing system-wide and subgrantee client-level data to assess achievement of clinical outcomes.

CQM Partners Roles and Responsibilities



The QMC is the QM arm of the Broward County HIVPC. It is comprised of consumers and providers representing various Ryan White and non-Ryan White services and funding streams (e.g., Part A Oral Health Care, Part C, Medicaid). The QMC advises the Grantee on clinical performance issues to be addressed in the CQM three-year and annual work plans, provides feedback on quarterly, annual, and periodic in-depth quality assessments; guides design of system-wide QIPs, and coordinates the QI Networks' activities. The QMC meets monthly and provides detailed reports to the HIVPC on its activities and progress towards achieving annual work plan goals. To conduct its work, the QMC collaborates with, monitors, and makes recommendations to the QI Networks. The Networks are comprised of subgrantees representing all locally funded Ryan White Part A service categories. The Networks are charged with reviewing client-level data and designing and implementing QI Projects (QIPs) to improve system-wide and agency-specific outcomes. Currently there are five Networks: Outpatient Ambulatory Medical Care, Medical Case Management, Mental Health/Substance Abuse, Oral Health Care, and the Combined Network which includes representatives of the following: Centralized Intake and Eligibility Determination, Food Bank, Pharmacy, and Legal Services as well as representatives from Housing Opportunities for People with AIDS (HOPWA) and Part B funded Transportation services. The Networks meet on a regular basis (either monthly, every other month, or quarterly) to conduct business.

The structure of the QI Networks has been changed to promote greater collaboration among Networks and ensure Network activities reflect the Comprehensive Plan, three-year QM plan, and annual QM Plan goals. In addition, meeting agendas were modified to be outcome oriented and advance the development of QIP's.

All QM activities are guided by the theme of increased access, adherence, and retention in care. During FY 2011-2013, emphasis has been placed specifically on improving retention in care. To that end, the EMA selected to participate in the National Quality Center's (NQC) In+Care Campaign. The yearlong campaign began in October 2011 and includes regular reviews of system-wide and client

level data along with bi-monthly data submissions to NQC. The QI Networks and QMC reviews of campaign measures have been essential to developing Network specific QIP's that focus on retention.

The EMA conducts ongoing data-driven QI activities to assess how Part A and MAI-funded services improve HIV-related health outcomes of HIV+ Broward County residents. These activities include annual chart reviews, cost effectiveness and impact evaluations, special population assessments, annual on-site monitoring visits, quarterly outcome reports, client satisfaction surveys, and QIPs. Client-level, administrative, and utilization data are collected to meet HAB RSR reporting requirements, assess HAB clinical performance measures, and measure EMA-specific client-level outcomes and indicators. The EMA monitors specific indicators for each funded service category. Indicators include HAB Core Clinical Performance Measures, as well as standards of care in the service delivery model. RFPs and subgrantee contracts require that all Part A-funded subgrantees participate in the EMA's CQM initiatives. These efforts include, but are not limited to, participation in service category-specific QI Networks, chart reviews, and trainings.

QM activities and infrastructure are continuously assessed in various ways. Monthly review of the annual QM work plan goals allows the Grantee and QMC to monitor progress made towards achieving these goals. Regular meetings between Grantee and CQM support staff facilitate the development and implementation of changes to the QM infrastructure as needed. Grantee and subcontracted CQM staff lead the QI Networks in developing, implementing, and evaluating QIPs. Network meetings are the venue for identifying and resolving both service category specific and system-wide barriers. Network members are comprised of leaders of subgrantee organizations who are charged with communicating and implementing the QI activities agreed upon within their agencies. Quality priorities, both local and national, are incorporated into Network discussions and information on QI activities and priorities is shared with all Networks. For example, all NQC webinar and training announcements are shared system-wide to encourage all providers to be knowledgeable of, and participate in, the CQM process. Additionally, the EMA has begun a three-year Health Literacy initiative in response to the increased attention, both nationally and locally, to the impact of health literacy and cultural competency on health outcomes. To that end, the EMA is the first EMA to pilot, with Medical and Medical Case Management providers, AETC's Operation H.O.P.E.F.U.L (Healthy Objectives for People Enjoying Full, Uninterrupted Lives with HIV/AIDS). The project is designed to assist providers deliver education and prevention messages to their clients during the Medical or Medical Case Management encounter. It is the goal of the EMA to implement the project among all core and support services once the pilot phase is evaluated.

The CQM program is monitored by reviewing and updating the CQM annual plan to refine processes and ensure responsiveness to evolving HIV+ Broward residents' needs, Comprehensive Plan goals, and HAB guidelines.

Process for Tracking Change - Improved Use Of Ryan White Client-Level Data

CQM data plays a critical role in documenting that services delivered to clients are improving their health status. Information gathered through the CQM program as well as client-level health outcomes data should be used as part of the EMA planning process and ongoing assessment of progress toward achieving program goals and objectives. It should also be used by the grantee to examine and refine services based on outcomes.

The CQM program's mission is to ensure high quality services are provided to HIV+ Broward residents that meet or exceed HAB's clinical and other performance measures, through an inclusive structure that integrates consumer and provider input. Central components of monitoring and evaluating the Comprehensive Plan involve continued and improved use of epidemiological data including population-based measures of community viral load, utilization and cost data, Ryan White Part A client level data, and measurement of clinical outcomes. The Joint Planning and Joint Priorities Committees regularly review epidemiological data and utilization data, respectively. The CQM program conducts regular reviews of client level data and clinical outcomes.

The Grantee funds the Provide Enterprise (PE) system, a web-based, integrated data system, to collect client-level demographic and epidemiologic characteristics, intake and eligibility data, detailed procedure-level service units, clinical outcomes, and an invoice and payment system. PE features a systemwide clinical management alert and reminder system to ensure continuity of care and coordinated care management. PE's highly secure computing environment protects clients' confidentiality and maintains secure client-level records. In anticipation of the RSR, the Grantee transitioned to the PE web-based version, and offered TA and training to subgrantees to ensure a smooth transition.

All funded Part A service categories have established client-level outcomes, indicators, and service delivery models that delineate standards of care based on PHS guidelines, HAB performance measures, and best practice models. Grantee CQM staff uses PE to generate analyze each subgrantee's Part A and MAI client-level data on a monthly basis. Grantee CQM staff compare the reports with established benchmarks for each quality indicator to assess overall achievement of the EMA's client-level outcomes. Grantee CQM staff has integrated clinical measures across core services in PE's design. This approach has allowed for automation and streamlining of data entry, reporting, and analysis of compliance with PHS standards, HAB performance measures, and client-level outcomes and indicators.

Desktop reviews are conducted to capture real time data entry strengths and weaknesses and identify areas for system and subgrantee-level improvement. Grantee CQM staff provides ongoing TA and capacity building to subgrantees to assist in data collection and analysis, reporting, and operations to improve performance. Grantee staff conducts annual site visits and reviews quarterly subgrantee reports to monitor compliance with established benchmarks. Findings elicited through this comprehensive process are shared with the HIVPC QMC and the QI Networks to address collaboratively areas of weakness and improve service delivery.

The EMA monitors specific indicators for each funded service. Indicators include HAB core clinical performance measures, as well as standards of care in the SDM. The HAB measures not included in the RSR (lipid screening, gonorrhea screening, hepatitis, alcohol counseling, influenza vaccination, MAC prophylaxis, pneumococcal vaccination, tobacco cessation counseling, and toxoplasma screening) are included in the EMA's service delivery model as standards of care, are tracked by subgrantees, and are monitored by the Grantee and CQM support staff. MCM standards include HAB performance measures, and measures adapted from NASW. The Grantee monitors subgrantees' compliance with standards through PE and chart reviews. Client-level outcomes and indicators measuring improvement in a client's condition are captured in PE.

Core Clinical Performance Measures For Adults And Adolescents: Group 1

Indicator	How Measured
ART Pregnant Women	Percentage of pregnant women prescribed antiretroviral therapy (ART)
CD4 T-Cell Count	Percentage of clients who had two or more CD4 T-cell counts performed in measurement year
Antiretroviral Therapy	Percentage of clients with AIDS who were prescribed ART
Medical Visits	Percentage of clients with 2 or more medical visits in an HIV care setting in measurement year
PCP Prophylaxis	Percentage of clients with a CD4 count below 200 cells/ μ who prescribed PCP prophylaxis
Viral Load Monitoring	Percentage of patients with VL test performed at least every 6 months during measurement year
Viral Load Suppression	Percentage of patients with VL below <200 copies/mL at last test during measurement year

Core Clinical Performance Measures for Adults and Adolescents: Group 2

Indicator	How Measured
Adherence: Assessment and Counseling	Percentage of clients on ARVs assessed and counseled for adherence 2 or more times in measurement year
Cervical Cancer Screen	Percentage of women who had a Papanicolaou screening in the measurement year
Hepatitis B Vaccination	Percentage of clients who completed the vaccination series for hepatitis B
Hepatitis B Screening	Percentage of patients, regardless of age, for whom Hepatitis B screening was performed at least once since diagnosis of HIV or for whom there is documented infection or immunity
Hepatitis C Screening	Percentage of clients for whom hepatitis C screening was performed at least once since the diagnosis of HIV infection
HIV Risk Counseling	Percentage of clients who received HIV risk counseling within the measurement year
Lipid Screening	Percentage of clients on ART who had a fasting lipid panel in the measurement year
Oral Examination	Percentage of clients with an oral exam by a dentist at least once in measurement year
Syphilis Screening	Percentage of adult clients who had a test for syphilis performed in the measurement year
Tuberculosis Screening	Percentage of clients who received testing with results documented for latent TB infection since HIV diagnosis

Core Clinical Performance Measures for Adults and Adolescents: Group 3	
Indicator	How Measured
Chlamydia Screening	Percentage of clients with HIV infection at risk of sexually transmitted infections who had a test for chlamydia in the measurement year
Gonorrhea Screening	Percentage of clients at risk of STIs who had a test for gonorrhea in measurement year
Hepatitis/HIV Alcohol Counseling	Percentage of clients hepatitis B or hepatitis C infection who received alcohol counseling in the measurement year
Influenza Vaccination	Percentage of clients who have received influenza vaccination in measurement period
MAC Prophylaxis	Percentage of clients with CD4 <50 cells/μL who were prescribed Mycobacterium avium complex prophylaxis in the measurement year
Mental Health Screening	Percentage of new clients who have had a mental health screening
Pneumococcal Vaccination	Percentage of clients with HIV infection who ever received pneumococcal vaccine
Substance Use Screening	Percentage of new clients with HIV infection who have been screened for substance use (alcohol & drugs) in the measurement year
Tobacco Cessation Counseling	Percentage of clients with tobacco cessation counseling within year
Toxoplasma Screening	Percentage of clients with Toxo screening at least once since HIV diagnosis

Oral health Performance Measures for Adults and Adolescents	
Indicator	How Measured
Dental and Medical History	Percentage patients with a dental and medical health history (initial or updated) at least once in measurement year
Dental Treatment Plan	Percentage of patients who had a dental treatment plan developed or updated at least once in measurement year
Oral Health Education	Percentage of oral health patients who received oral health education at least once in measurement year
Periodontal Screening or Examination	Percentage of oral health patients who had a periodontal screen or examination at least once in measurement year
Phase 1 Treatment Plan Completion	Percentage of HIV-infected oral health patients with a Phase 1 treatment plan that is completed within 12 months

To improve client level data analysis, the QMC chose to conduct an in-depth review of the Broward County client-level outcomes and indicators. A central aspect of this review and revision process is ensuring all service categories are measured by their impact on reinforcing and improving retention in medical care. In addition, the EMA's participation in the In+Care Campaign required the programming of the campaign's four retention measures (Gap Measure, Medical Visit Frequency, Patients Newly Enrolled In Medical Care, and Viral Load Suppression) in PE. The measures allow the EMA to report aggregate, system-wide, results to NQC as well as generate client-level reports per measure. The EMA is in the process of programming the four measures per core and support service category to identify specific barriers and promote the EMA's goal of including all service categories in retention efforts.

Use of Data in Monitoring Service Utilization

Grantee and CQM staff align service utilization, clinical performance, clients' demographics, and billing data by individual subgrantees to assess the EMA's systemwide quality and performance to

identify and address areas of QI. The HIVPC uses QM data in the priority setting and resource allocation process. Service utilization, tracked through PE (the Part A/MAI billing system), is reported quarterly to the Joint Priorities Committee. In addition, the Grantee tracks the percentage of Part A funds that serve specific racial/ethnic minorities and analyzes service utilization data for possible discrepancies, which are reported to the Joint Priorities Committee for consideration during allocations and “sweeps.” Utilization per specific special population (e.g., transgender) may be generated as needed to assist in the prioritization process. QM data play a critical role in identifying service needs and gaps, as well as ensuring delivery of high quality services to clients. The Joint Priorities Committee and HIVPC request, as needed, to review PE QM data, quarterly outcome reports, annual on-site visits, and client satisfaction surveys to prioritize services and allocate resources.

Along with service utilization and client satisfaction, the EMA also considers unmet need and service gaps and the capacity to address them. The HIVPC has commissioned ongoing population assessments since 2003 to further understand and respond to the needs of special populations. The assessments identify barriers in accessing medical care, social, cultural, and economic factors influencing retention in OAMC and provide recommendations for the consideration of the Grantee and the HIVPC. The Grantee has jointly planned with the Part B and HOPWA grantees to conduct the countywide HIV+ Broward resident survey. The results were integrated into HIVPC planning and priority setting.

Measurement of Clinical Outcomes

All funded Part A service categories have established client-level outcomes, indicators, and service delivery models that delineate standards of care based on PHS guidelines, HAB performance measures, and best practice models. The EMA has implemented specific activities to assess the quality of services by Part A-funded subgrantees and individual providers, including activities to ensure clinical practices adhere to PHS guidelines and adhere to the EMA’s established standards of care. The CQM program uses PE client-level data and abstracted chart review data to assess subgrantees’ clinical performance and adherence to HAB and Grantee measures, identify areas of needed performance improvement, and evaluate adherence to the Grantee’s QM contract requirements. Grantee staff prepares subgrantee and aggregate systemwide data to improve subgrantee and systems’ outcomes. Grantee staff generates quarterly subgrantee reports, and distributes summaries to QI Networks to ensure performance is improved. FL/Caribbean AETC and other consultants conduct periodic chart reviews focusing on specific areas of clinical improvement, with the results disseminated to subgrantees and QI Networks to design QIPs. Subcontracted CQM

staff disseminates aggregate reports, summaries of peer-reviewed articles and best practices, and assists in the design and implementation of QIPs. Annually, the Grantee funds an in-depth assessment of a service category to ensure high quality, cost-effective, and accessible services are delivered.

HAB core clinical performance measures, as well as locally developed outcomes and indicators, are programmed into PE. The OAMC Service Delivery Model (SDM) incorporates both the HAB measures and local outcomes and indicators. The measures are reviewed quarterly and results inform the development of QIPs. For example, the Medical QI Network has undertaken the development of a QIP to improve cervical screening rates following a review of the screening rates in PE. The QIP

stages include: 1) resolving data integrity issues, 2) identifying demographic and other trends among those clients who are not screened annually, 3) developing strategies to promote screenings and improve screening rates and overall health outcomes.

The EMA ensures continuously adapting performance measurement to changes in care and treatment guidelines. The SDMs, which include each service category's standards of care, are modified as needed to adapt to changing care and treatment guidelines as well as local priorities. For example, the medical standards for initiating HAART were changed to align with the revised HHS guidelines (HAART initiation recommended at CD4 <500 instead of CD4 <350). Additionally, in response to local and national attention to the importance of providing culturally appropriate treatment to transgender clients, the OAMC Network added specific language to the SDM addressing these needs.

The Grantee initiated PE to collect RSR and HAB clinical performance measurement data. All subgrantees submit client-level data directly to PE or export data from electronic health records into PE. All subgrantees received training prior to the initial and subsequent RSR submissions. Subgrantees have direct access to assistance from the PE vendor helpdesk. The Grantee and PE staff works with subgrantees to improve this process even further, including building interfaces between PE, CAREWare, and the FL Medicaid Program. The Medicaid interface has been particularly helpful in ensuring that the CIED and Part A-funded providers comply with HAB's payer of last resort policy, by linking automatically to Medicaid using clients' Social Security number to determine if clients are enrolled and their Medicaid numbers. PE was updated to include client-specific alerts aimed at integrating QM measures with retention and adherence efforts for front-line workers' operations. PE alerts facilitate a collaborative systemwide approach that ensures efforts are taken to assist patients meet their health outcomes. To expedite clients' PAP applications, PE was modified to include online PAP applications.

As indicated earlier, the Comprehensive Plan serves as the roadmap to guide HIV care and treatment in the Broward County EMA over the course of the next three years. The Plan acknowledges the need for adaptability to respond to changes in funding and priorities, the state of the epidemic, and barriers and challenges identified throughout the monitoring process. The Plan reflects the EMA's successes and challenges thus far, its future goals, and its commitment to continuous evaluation of its success in achieving these goals within a changing healthcare landscape.

GLOSSARY			
ACA	Affordable Care Act 2010 (Patient Protection)	FL	Florida
ADAP	AIDS Drug Assistance Program	FPL	Federal Poverty Level
AETC	AIDS Education and Training Center	FQHC	Federally Qualified Health Center
AHCA	Agency for Health Care Administration	FY	Fiscal Year
AICP	AIDS Insurance Continuation Program	HAART	Highly active retroviral therapy
AIDS	Acquired Immunodeficiency Syndrome	HAB	HIV/AIDS Bureau
APA	AIDS Pharmaceutical Assistance	HARS	HIV/AIDS Reporting System
ARV	Antiretroviral	HCBS	Home and Community Based Services
ASO	AIDS Service Organization	HCS	Healthcare Services
BARC	Broward Addiction Recovery Center	HUD	Housing and Urban Development
BCBC	Broward County Board of Commissioners	IDU	Injection Drug User
BCHD	Broward County Health Department	Incidence	The rate of occurrence
BHP	Bureau of Health Professions	JLP	Jail Linkage Program
BIGA	Broward is Greater than AIDS	KFF	Kaiser Family Foundation
BOHA	Bureau of HIV/AIDS (<i>FLDOH</i>)	LIS	Low Income Subsidy (<i>Part D</i>)
BRHPC	Broward Regional Health Planning Council	LTC	Linkage to Care
BSO	Broward Sheriff Office	MAI	Minority AIDS Initiative
CBO	Community-Based Organization	MCO	Managed Care Organization
CDC	Centers for Disease Control (<i>and Prevention</i>)	MOU	Memorandum of Understanding
CDTC	Children's Diagnostic and Treatment Center	MSA	Metropolitan Statistical Area
CEO	Chief Executive Officer	MSM	Men who have Sex with Men
CHC	Community health center	MUA	Medically Underserved Area
CIED	Centralized Intake Eligibility Determination	MUP	Medically Underserved Populations
CLAS	Culturally and Linguistically Appropriate Services	NASTAD	National Alliance State and Territorial AIDS Directors
CLD	Client level data	PPG	Prevention Planning Group
CMS	Centers for Medicare/Medicaid Services	PREP	Personal Responsibility Education Program
CQA	Clinical quality assurance	Prevalence	The condition of being widespread
CQI	Continuous quality improvement	QI	Quality Improvement
CTS	Counseling and testing site	QIP	Quality Improvement Project
DCF	Department of Children and Families	QM	Quality Management
DIS	Disease Intervention Specialist	RARE	Rapid Assessment Response Evaluation
DOH	Department of Health	RSR	Ryan White Service Report
ED	Emergency Department	SCHIP	State Children's Health Insurance Program
EHARS	Enhanced HIV/AIDS Reporting System	SCSN	Statewide Coordinated Statement of Need
EIIHA	Early Intervention of Individuals with HIV/AIDS	SOAR	SSI/SSDI Outreach, Access and Recovery
EIS	Early intervention service	SPMI	Severe and Persistent Mental Illness
ELR	Electronic lab reporting	SPNS	Special Projects of National Significance
EMA	Eligible Metropolitan Area	SSA	Social Security Administration
EPI	Epidemiology	SSI	Supplemental Security Income
Epidemic	Disease affecting many persons	STI	Sexually Transmitted Infection
FDOC	Florida Department of Corrections	TA	Technical Assistance
FDOH	Florida Department of Health	TANF	Temporary Assistance to Needy Family
FHAAN	Florida HIV/AIDS Advocacy Network	TB	Tuberculosis
FIMR	Fetal Infant Mortality Review	VA	Veterans Administration
EPT	Expedited Partner Therapy	WICY	Women Infants Children Youth

Outcomes and Indicators Revision

MENTAL HEALTH OUTCOMES AND INDICATORS (APPROVED BY QMC)

Original Outcomes	Original Indicators	Noted Limitations	QM Recommendations	MH/SA Network Discussion	Revised Outcomes	Revised Indicators
Improvement in client's symptoms associated with primary diagnosis.	60% of clients showed improvement in related clinical scale over baseline (quarterly until discharge or at the end of one year).	Reflects only clients who have had a related clinical scale done.	Indicators should be based on every client's improvement not only those who had a clinical scale done.	Approximately 5% of clients are administered clinical scales (which were previously predetermined by the Grantee). This is the reasoning for altering the indicator. Provide Enterprise (PE) will measure indicators based on achieved goals by a designated target date. Target dates will be identified by provider and client. If goal isn't due during a quarterly reporting period, it will not be captured. Treatment plans need to be sustainable, achievable and individually customized to gauge clients' progress based on services provided. Goals should be written to reflect the same.	Improvement in client's symptoms associated with primary mental health diagnosis.	85% of clients achieve Plan of Care goals by designated target date.

Outcomes and Indicators Revision

Original Outcomes	Original Indicators	Noted Limitations	QM Recommendations	MH/SA Network Discussion	Revised Outcomes	Revised Indicators
Increased retention and adherence to Outpatient/Ambulatory Medical Care for clients who have not been in care or have been out of care for a period of 6 months or more.	<u>Initial:</u> 85% of clients referred to Outpatient/Ambulatory Medical Care kept their initial appointment. <u>Long-Term:</u> 85% of clients remain enrolled in Outpatient/Ambulatory Medical Care at time of discharge.	Reflects initial appointments only.	Develop indicator that captures retention beyond the initial appointment. Develop outcome that more accurately reflects improvement in retention Outcome should read: 'Increase and/or maintain retention in Outpatient/Ambulatory Medical Care'.	The Network agreed with the recommendations and definition of retention suggested by the QM Committee.	Increase and/or maintain retention in Outpatient/Ambulatory Medical Care. <i>Retention in care reflects an OAMC visit with a provider in the first 6 months and the last 6 months of a 12 month measurement period.</i>	85% of clients remain enrolled in Outpatient/Ambulatory Medical Care.

Outcomes and Indicators Revision

SUBSTANCE ABUSE OUTCOMES AND INDICATORS (APPROVED BY QMC)

Original Outcomes	Original Indicators	Noted Limitations	Recommendations	MH/SA Network Discussion	Revised Outcomes	Revised Indicators
Improvement in client's symptoms associated with co-occurring diagnosis.	60% of clients showed improvement in related clinical scale (if applicable) over baseline.	Reflects only clients who have had a clinical scale done.	Indicators should be based on every client's improvement not only those who had a clinical scale done. Is the reference to a co-occurring diagnosis in the outcomes and indicators appropriate?	The Network decided the Substance Abuse Outcomes and Indicators should mirror the Mental Health Outcomes and Indicators. Reasoning: treatment plans for substance abuse will be based on a substance abuse diagnosis and co-occurring mental health diagnosis for the majority of clients. Action plans will be customized to clients' needs. The Network noted that Substance Abuse outcomes should reflect Substance Abuse services only.	Improvement in client's symptoms and/or behaviors associated with primary substance abuse diagnosis.	85% of clients achieve Plan of Care goals by designated target date.
Increased Access, Retention and Adherence to Outpatient/Ambulatory Medical Care.	<u>Initial:</u> 60% of clients referred to Outpatient/Ambulatory Medical Care that kept their initial appointment. <u>Intermediate:</u> 85% of	Reflects only clients' initial appointments Captures clients referred to Outpatient/	Develop indicator that captures retention beyond the initial appointment. Develop outcome that more accurately reflects improvement	The Network agreed with the recommendations and definition of retention suggested by the QM Committee.	Increase and/or maintain retention in Outpatient/Ambulatory Medical Care. <i>Retention in care reflects an OAMC visit with a provider in the</i>	85% of clients remain enrolled in Outpatient/Ambulatory Medical Care.

Outcomes and Indicators Revision

Original Outcomes	Original Indicators	Noted Limitations	Recommendations	MH/SA Network Discussion	Revised Outcomes	Revised Indicators
	clients remain enrolled in Outpatient/ Ambulatory Medical Care at time of discharge.	Ambulatory Medical Care through the Ryan White system only	in retention Outcome should read: 'Increase and/or maintain retention in Outpatient/ Ambulatory Medical Care'.		<i>first 6 months and the last 6 months of a 12 month measurement period.</i>	
Decreased substance use.	60% of all clients will achieve at least 30 days clean/sober at time of discharge (data collection only).	Depends on accurate data entry	Network should consider harm reduction and adherence to treatment plan. Network to research mechanism in PE that reflects decrease in substance use.	The indicator does not consider lapses and relapses. Length of time in treatment is an indicator of success.	Outcome Removed	Indicator Removed

Outcomes and Indicators Revision

LEGAL SERVICES OUTCOMES AND INDICATORS (APPROVED BY QMC)

Original Outcomes	Indicators	Noted Limitations	Recommendations	Network Discussion	Revised Outcomes	Revised Indicators
Increased access to benefits for which the client is eligible.	70% of clients whose cases are accepted for representation at a Social Security administrative Law Judge hearing will win approval of cash benefits and/or medical benefits thus improving their financial stability. 60% of clients whose cases are accepted for representation at the Social Security Appeals Council will win approval of benefits or will have their case remanded for a hearing before an Administrative Law Judge.	None noted	To consider at a later date an indicator that better reflects the services provided (e.g., permanency planning)	Indicator 1.1 was increased based on Legal Services' history of surpassing the original benchmark. Indicator 1.2 remained the same with the justification that if the case is lost at the hearing level (measured in indicator 1.1), it is very unlikely it will be reversed (as measured in indicator 1.2).	No changes made	80% of clients whose cases are accepted for representation at a Social Security administrative Law Judge hearing will win approval of cash benefits and/or medical benefits thus improving their financial stability. (No changes made) 60% of clients whose cases are accepted for representation at the Social Security Appeals Council will win approval of benefits or will have their case remanded for a hearing before an Administrative Law Judge.

Outcomes and Indicators Revision

AIDS PHARMACEUTICAL ASSISTANCE OUTCOMES AND INDICATORS (NETWORK RECOMMENDATION)

Original Outcomes	Indicators	Noted Limitations	Recommendation	Network Discussion	Revised Outcomes	Revised Indicators
Clients provided an opportunity to improve medication adherence.	100% of clients accepts or rejects counseling as indicated by Patient's signature.	Data not entered in PE Signature does not indicate the content of adherence needs of the client Adherence to ARV's is not measured through Part A pharmacy services since clients generally receive ARV's from other sources.	Develop outcome that more accurately reflects improvement in adherence. Must be programmed in PE.		Improve access to medication.	80% of new prescriptions filled and available within 24 hours or refills filled and available within 48 hours. Justification: Data collection purposes only.
Improve access to medication.	80% of new prescriptions filled and available within 24 hours or refills filled and available within 48 hours.	Data not entered in PE Access to ARV's is not measured through Part A pharmacy services since clients generally receive ARV's through ADAP	Develop outcome that more accurately reflects improvement in adherence and retention. Must be programmed in PE.		Clients provided an opportunity to improve medication adherence.	100% of clients who do not pick up medications within 7 days of filling the prescription will be contacted. 100% of those clients that were not successfully contacted and/or did not pick up medications will be referred to appropriate provider (i.e., medical case management, Clinical pharmacist, prescribing physicians, Treatment Adherence

Outcomes and Indicators Revision

Original Outcomes	Indicators	Noted Limitations	Recommendation	Network Discussion	Revised Outcomes	Revised Indicators
						Program) Justification: Identifying clients who have difficulty with adherence and referring to appropriate provider for intervention with a goal of improving adherence.

UPDATE:

1. The Pharmacy Network met on 5.8.12 to discuss the QMC recommendations to change the medication pick up time from 'within 14 days of filling a prescription' to 7 days. Agreement was not reached. In addition, it was agreed that further discussion is needed regarding development of a better indicator for improved medication adherence.
2. Pharmacy Network members held an informal meeting on 5.22.12 to continue the discussion. A suggestion was made to run a Roll Call report consisting of all RW clients who did not pick up their medications. The report would be given to MCMs for follow up with clients. Members to determine: 1) the capability of each pharmacy to create a report consisting only of prescriptions that were reversed due to non-pick up, and 2) whether a Return to Stock report can be programmed in PE.
3. An additional meeting has been scheduled for 6.22.12.

Outcomes and Indicators Revision

MEDICAL CASE MANAGEMENT OUTCOMES AND INDICATORS (NETWORK RECOMMENDATION / PENDING)

Original Outcomes	Indicators	Noted Limitations	Recommendation	Network Discussion	Revised Outcomes	Revised Indicators
Improved ability to independently navigate and access needed services	Initial: 100% of new clients receive information regarding available services and corresponding eligibility criteria Intermediate: 80% of clients achieve initial POC goals by designated target date	Mainly a CIED function Measures initial POC goals only	Develop an outcome that reflects MCM impact on independently navigating needed services Achievement of POC goals should be measured continuously Continue discussion about Indicator 1.1 at 1.23.12 QMC meeting	1.1 80% of clients achieve POC goals by designated target dates	MCM ad-Hoc Revisions: ~~Improved ability to independently navigate and access needed services~~	Justification for removal: Outcome more reflective of CIED function.
Increased access, retention and adherence to Outpatient/ Ambulatory Medical Care	80% of clients self-report adherence with their prescribed medication regimen (data collection only) Initial: 80% of new clients have outpatient medical visit scheduled to occur within 2 weeks of intake Intermediate: 80% of clients remain enrolled in OAMC at time of discharge or episodic status	Self-reported information Mainly a CIED function This should measure overall retention in care	Develop indicator that does not rely on self-reported information Develop CIED indicators Develop outcome that more accurately reflects improvement in retention measuring CD4 and viral load Increase and/or maintain, retention* in OAMC	2.1 85% of clients remain enrolled in Outpatient/Ambulatory Medical Care** QMC Motion: To “set Medical Case Management Indicator 2.1 at 80%” Develop MCM ad-Hoc Network	Increased access, retention and adherence to Outpatient/ Ambulatory Medical Care	2.1 80% of clients achieve <u>POC goals related to Outpatient/ Ambulatory Medical Care</u> services by designated target dates 2.2 80% of clients remain enrolled in Outpatient/ Ambulatory Medical Care

Outcomes and Indicators Revision

* Retention in care reflects an OAMC visit with a provider in the first 6 months and the last 6 months of a 12 month measurement period.

** The justification for mirroring the 85% rate agreed upon by MH/SA for Indicator 2.1 is that a higher rate may be difficult to achieve since in addition to MH/SA issues, MCM clients may also experience additional complexities such as homelessness, cognitive issues, and incarceration.

OUTREACH OUTCOMES AND INDICATORS (NETWORK RECOMMENDATION / PENDING)

Original Outcomes	Indicators	Noted Limitations	Recommendation	Network Discussion	Revised Outcomes	Revised Indicators
Facilitate client access to outpatient/ambulatory medical care and/or medical case management.	1.1 80% of new clients will have an outpatient/ambulatory medical care and/or medical case management visit to occur within 2 weeks of establishing eligibility (Ryan White, Medicaid, Medicare or other 3rd party funder). 1.2 25% of lost to care clients that are contacted will have an outpatient/ambulatory medical care and/or medical case management visit to occur within 2 weeks of establishing eligibility (Ryan White, Medicaid, Medicare or other 3rd party funder).		The QM committee considered creating separate indicators for new clients and returning clients. The Committee will continue discussion about this service category during its next meeting.			

Outcomes and Indicators Revision

FOOD BANK OUTCOMES AND INDICATORS (PENDING)

Original Outcomes	Indicators	Noted Limitations	Recommendation	Network Discussion	Revised Outcomes	Revised Indicators
Improve and/or maintain a client's adherence to medication when food is required.	80% of clients report an improved ability to take medications when food is required.				Improve and/or maintain a client's BMI (Body Mass Index)	100% of clients will have a BMI at X interval. 100% of clients medical providers will be notified of an abnormal BMI.
Improve client's knowledge of food handling.	Initial: 100% of clients will receive food handling information as indicated by clients signature.				Increase and/or maintain retention in Outpatient/Ambulatory Medical Care.	X % of clients remain enrolled in Outpatient/Ambulatory Medical Care.

UPDATE:

1. A meeting took place between Grantee, CQM support staff, and Food Bank representative on 6.4.12 to discuss the impact of food bank on health outcomes and develop outcomes and indicators that reflect the type of service provided by Food Bank. Suggestions were made to consider linking Food Bank and Nutrition services with outcomes/indicators focused on educating new Food Bank clients on nutrition and referring those who score below a defined percentage to the appropriate provider for follow up. Additional suggestions were to consider adding medical criteria/exceptions to Food Bank eligibility and increasing the income eligibility.
2. The next meeting will be held on 6.18.12. Additional research will be conducted prior to the meeting.

Outcomes and Indicators Revision

CIED OUTCOMES AND INDICATORS (PENDING)

Original Outcomes	Original Indicators	Noted Limitations	Recommendations	Network Discussion	Revised Outcomes	Revised Indicators
Provide rapid engagement of clients into care.	95% of clients requiring Ambulatory Outpatient Medical Care or Medical Case Management services shall have an appointment scheduled within 1 business day.				Provide rapid engagement of clients into care.	95% of clients eligible for Part A OAMC who have not had a Part A OAMC appointment within the last 6 months shall have an OAMC or Medical Case Management appointment scheduled within 1 business day.
Provide access to benefits for which client is eligible.	95% of clients eligible for 3rd party benefits will receive assistance in completing applications for those benefits.				Provide access to benefits for which client is eligible.	95% of clients that meet eligibility criteria for 3rd party benefits will receive assistance in completing applications for those benefits.
Clients will have their HIV/AIDS related needs met.	95% of clients will receive referrals to both Ryan White and/or Non-Ryan White services as identified in the Intake Needs Assessment. 95% of clients receiving referrals will have a disposition follow up within 14 business days.				~~Clients will have their HIV/AIDS related needs met.~~	~~95% of clients will receive referrals to both Ryan White and/or Non-Ryan White services as identified in the Intake Needs Assessment.~~ ~~95% of clients receiving referrals will have a disposition follow up within 14 business days.~~

UPDATE:

- 95% of clients eligible for Part A OAMC who have not had a Part A OAMC appointment within the last 6 months **at the time of recertification** shall have an OAMC or Medical Case Management appointment scheduled within 1 business day.
- QM Committee members questioned how requests for assistance for third party benefits would be monitored. CIED representative will attend the next meeting to provide input.

Outcomes and Indicators Revision

ORAL HEALTH CARE OUTCOMES AND INDICATORS (PENDING)

Original Outcomes	Original Indicators	Noted Limitations	Recommendations	Network Discussion	Revised Outcomes	Revised Indicators
Reduction in number of teeth with unrestored caries (tooth decay)	1.1 90% of caries identified in the initial treatment plan will be restored upon completion of the initial treatment plan. <i>(Initial Indicator)</i> 1.2 90% of patients will be free of new recurrent caries on restorations placed in the initial treatment plan upon examination at a period of six to twelve months after completion of the initial treatment plan. <i>(Long-Term Indicator)</i>	None	None	1.1 – The Network recommended keeping the indicator but changing the language; the indicator should not be associated with initial treatment plan only 1.2 – The Network noted that the indicator as it is now seems to measure the quality of the dentist's work, not improved oral health. The Network suggested changing the indicator to show improvement in overall oral health as would be indicated by no new caries (as opposed to recurrent caries on previously restored teeth)	Pending	Pending
Improved periodontal disease status.	75% of clients will have a 50% reduction in the number of teeth that initially presented with a pocket depth of 5mm or greater, at the completion of active periodontal treatment. <i>(Intermediate Indicator)</i>			The Network recommended changing 'periodontal disease status' to 'periodontal health' 2.2 – Members agreed that a reduction in papilla bleeding, as indicated through the use of the PBI, would be an adequate measure for improved periodontal health. It was noted measurement of bleeding was included in the HAB measure definition as one of the signs of poor periodontal health		

UPDATE:

1. The Network met informally to finalize revisions to the outcomes and indicators and discuss programming in PE.
2. A conference call will be scheduled prior to the 7.11.12 Network meeting to review the revisions.

Outcomes and Indicators Revision

HICP OUTCOMES AND INDICATORS (PENDING)

Original Outcomes	Original Indicators	Noted Limitations	Recommendations	Network Discussion	Revised Outcomes	Revised Indicators

TRANSPORTATION OUTCOMES AND INDICATORS (PENDING)

Original Outcomes	Indicators	Noted Limitations	Recommendation	Network Discussion	Revised Outcomes	Revised Indicators
Provide access to primary medical care appointments via van transportation.	95% of all clients receiving medical transportation arrive on time for their medical appointment.					
Support adherence to primary medical care appointments via van transportation	100% of medical appointment 'no-shows' will be reported to their medical case manager					

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INTRODUCTION

This annotated bibliography is based upon a review of the published literature in support of the development of the Quality of HIV Care Consumer Training Workshop Curriculum, "**Making Sure Your HIV Care Is The Best It Can Be.**" The literature review was conducted as part of the needs assessment process for curriculum development.

Absent from this bibliography is any publication citation for a consumer training curriculum related to the use of quality of care data. None was found. It appears, based upon this review, that the curriculum to which this bibliography is a companion, is unique.

Lacking published literature on the development, utilization, and evaluation of similar curricula, the review of the literature was focused on publications that could be used to inform the curriculum development process. Publications were sought for their relevance to: identifying the need for consumer training in the use of quality of care performance data; describing potential target populations and guidance in tailoring the curriculum to meet the needs of those populations; describing factors found to influence consumer satisfaction with health care and consumer choices in health care decision making; identifying factors that specifically influence consumer assessment of the quality of HIV health care; self-advocacy education for people with HIV/AIDS; and, the relationship between health literacy and health care practices and health status in people with HIV/AIDS.

This annotated bibliography is limited to only those publications that were found to provide valuable insights and guidance in the curriculum development process. Not included is any reference to publications that were reviewed and found lacking specific relevance to the creation of the curriculum.

Annotations have been grouped in sections containing closely related citations. Each annotation consists of the following: Author and publication citation information (boldface type); a key quotation from the article cited (italicized type); a brief summary of the content and conclusions of the article; and, bulleted points that form the "take home message" of the article as interpreted by the reviewer and possible its application to the development of the curriculum.

QUALITY OF CARE DATA, REPORT CARDS AND PROCESSES

JENCKS S. CLINICAL PERFORMANCE MEASUREMENT: A HARD SELL.
JAMA 2000;283(15):2015-2016

A number of studies indicate that, in general, patients rank quality information far behind convenience, coverage, access, and cost in choosing health plans, and this likely holds for choice of provider organizations and practitioners.

An editorial accompanying the publication of an article by Erickson, et al., on the relationship between managed care insurance and the use of lower-mortality hospitals for CABG surgery, this article presents the arguments which are used to support the use of performance data in the health care marketplace. In each case, Jencks concludes that the actual use of performance data never measures up to the potential. His conclusion is that neither physician referral practices, managed care plan contracting practices, nor patient choices of providers are currently affected by the availability of performance data.

Nevertheless, Jencks argues that clinical performance data should continue to be collected and disseminated to the clinical and patient community. Anecdotal reports indicate that hospitals use the data internally to make improvements without market pressure. Patients have a right to know the information. And, performance data will be used to drive improvements in the market in the future as a result of both provider and consumer education efforts.

- Personal factors take precedence over institutional factors in the assessment of quality—of—care from the patient's perspective. The training workshop should recognize this and start with this approach to quality assessment and then move on to include clinical/institutional information as part of rating the quality of care.

LONGO DR, LAND G, SCHRAMM W ET AL. CONSUMER REPORTS IN
HEALTH CARE: DO THEY MAKE A DIFFERENCE IN PATIENT CARE?
JAMA 1997;278(19):1579-1584.

The results reported here confirm that consumer reports are associated with changes in the quality of hospital care...It appears that although consumer reports were initially designed to assist patients in making better decisions about personal health care, they have been carefully evaluated by health care clinicians and delivery organizations.

One year following the 1993 release of the Missouri Department of Health obstetrics consumer report, "Show Me Buyer's Guide: Obstetrical Services," a retrospective study was conducted to assess the impact of the Guide on clinician practice behavior.

The results of the study show that consumer reports can change provider behavior. Hospitals with either low or average patient satisfaction quality indicators were more likely to have changed, or be planning to change, policies relating to those indicators than hospitals with high quality scores. Changes were most often seen in hospitals in areas where competition for patients existed.

Nevertheless, the authors of this report are concerned about the use of consumer guides by patients themselves. They write, "...while there appears to be a consensus that information facilitating patient participation in health care decision-making is in the best interest of the patient, an examination of how patients themselves use consumer reports and related information is still needed."

MARSHALL M, SHEKELLE P, LEATHERMAN S, ET AL. THE PUBLIC RELEASE OF PERFORMANCE DATA: WHAT DO WE EXPECT TO GAIN? A REVIEW OF THE EVIDENCE.

JAMA 2000;283:1866-1874.

The reasons for consumers' lack of interest in and use of performance data include difficulty in understanding the information, disinterest in the nature of the information available, lack of trust of the data, problems of timely access to the information, and lack of choice. There is evidence from descriptive studies that consumers rate anecdotal evidence from family and friends more highly than empirical evidence.

The peer-reviewed published literature on the public release of performance data was collected and reviewed for evidence of the utility of the data and the extent to which expectations of public disclosure have been realized. Publications in the U.S. from January 1986 through October 1999 were reviewed.

In answer to the question, "Do consumers use public reports?", the data reviewed show that consumers want more information about health care provider performance but that the information has only a limited impact on consumer decision-making.

- Many of the factors cited in this review of the literature have been confirmed in the consumer focus groups we have conducted. In particular, age of the data and the lack of personal relevance to them of the clinical indicators evaluated, have been routinely identified as criticism of the Consumer's Guide. If the data in the Guide is to prove useful to consumers, its relevance must be explained, they must have an opportunity to use the Guide in personally relevant ways, and they should have an opportunity to have their criticism of the Guide be acknowledged.

HOCHHAUSER M. WHY PATIENTS HAVE LITTLE PATIENCE
FOR REPORT CARDS.

Managed Care 1998; MARCH: 31-34.

Policy makers believe that if consumers are given detailed information about the quality of health care plans available to them, they will choose an “above average” plan and reject a “below average” plan. That won’t happen...

The reason that consumers are not likely to use health plan performance data in the way that policy-makers expect them to is that policy-makers fail to take into account the way consumers think and behave. According to Hochhauser, people don't always make decisions rationally. In fact, most people do not rely on objective information to decide what to buy.

In support of this position, a 1996 Agency for Health Care Policy and Research survey found that most people relied on personal recommendations from doctors, family and friends to make health care decisions. While more than 80% who saw a report card thought it would be useful to someone trying to make decisions about health plans, only one third have actually used the information to make decisions.

The use of a worksheet to help consumers make use of the data in health plan report cards relies too heavily on the reading and thinking skills of the consumer. Additionally they are too data-heavy, too time-consuming, and not clearly linked to assistance in decision-making.

- Many of the issues raised in this article have been reiterated in our focus group and interview experience. Of particular similarity is the initial statement by interviewees that the Guide looks good and useful to consumers which is then taken back later when the actual data in the Guide is reviewed. On a conceptual, rational basis the Guide looks valuable but on a personal, practical basis, it loses value.

WICKS E AND MEYER J. MAKING REPORT CARDS WORK.

Health Affairs 1999;18(2):152-155

...our research suggests that present measurement and reporting initiatives have not yet had much impact on consumers or the choices they make.

Report cards can be effective at facilitating consumer decision-making only if: 1) consumers are willing to use them; 2) consumers can correctly interpret the performance comparisons; 3) performance measures measure the kinds of health plan and provider activities that purchasers want to influence; 4) quality data truly distinguishes high performance from lesser performance; 5) reported measures reflect outcomes that plans can significantly influence; and, 6) health organizations are convinced that good performance will be rewarded and poor performance penalized.

- From this it is clear that the consumer training workshop should provide consumers with the tools to critically assess the value of clinical performance data in order to benefit from the Consumer's Guide.

GUADAGNOLI E, EPSTEIN A, ZASLAVSKY A, ET AL.
PROVIDING CONSUMERS WITH INFORMATION ABOUT THE QUALITY OF
HEALTH PLANS: THE CONSUMER ASSESSMENT OF HEALTH PLANS
DEMONSTRATION IN WASHINGTON STATE.

***The Joint Commission Journal on Quality Improvement* 2000;26(7):410-420.**

...dissatisfaction is due, in part, to the fact that few available surveys were developed with the explicit goal of collecting information that would be useful to consumers and purchasers when selecting health plans.

Survey research was conducted in May-June 1997 with 1500 responses from consumers in Washington State regarding their use of the Washington State Health Care Authority health plan Report Card on health plans in the state. Nearly everyone who was mailed the report said they saw it. A large proportion said they read most or all of it and most thought it was easy to understand and was apparently useful. Those who used it said they felt confident it helped them to switch health plans. The value of the report to those not anticipating switching health plans is questionable.

- Since quality of health care report cards have many potential uses, and consumers have differing, though probably overlapping, data needs for determining the quality of health care from that of regulators and providers, the value of the report cards to consumers will depend upon the performance indicators for which data was collected and reported. Consumer training in the use of report cards (Consumer's Guide) should address the various uses of performance data and assist the consumer in making the best use of available data.

SMITH M, ATHERLY A, KANE R, ET AL. PEER REVIEW OF THE QUALITY OF CARE: RELIABILITY AND SOURCES OF VARIABILITY FOR OUTCOME AND PROCESS ASSESSMENTS. ***JAMA* 1997;278:1573-1578.**

Peer assessments can play an important role in characterizing the quality of care for complex patients with multiple interrelated chronic conditions, but reliability can be poor.

The poor reliability and significant variability of peer assessments of the quality of care provided for frail, elderly patients makes this form of quality assessment less valuable than other measures. Both systematic bias and inter-rater variability were deterrents to the use of peer assessments. Nevertheless, the potential value of the insightful and nuanced assessment of process that can be derived from peer assessments of the quality of care require that this form of quality evaluation be refined.

- Consumers may be interested in the quality of care ratings that other providers might give their doctors. The bias inherent in this form of assessment may make the information significantly less useful. It should be made clear in the workshop that alternative types of quality assessment could be done and that each has certain strengths and weaknesses.

VALENTI W. HIV, MANAGED CARE, AND OUTCOMES.

The AIDS Reader 2000;10(5):274-278.

HIV is first and foremost a medical issue, with the patient at the center of a series of steps that deliver complex health care, the standards for which change rapidly.

The transition from delivering HIV care in fee-for-service settings to managed care requires that the quality of care remain high. Focusing on outcome measures appears to be the most useful strategy for monitoring the quality of care. A variety of methods of data collection are reviewed, the most unique methods include: structured reports by standardized patients, abstraction of medical records from those same visits, and physician responses to clinical vignettes. Chart review appears to be the most often used method in HIV settings.

Patient satisfaction surveys provide valuable data as well. The Community Health Network, Rochester, NY, distributes patient questionnaires in the office and collects 100 surveys three times a year. The New York State Department of Health AIDS Institute has developed one of the surveys the office uses.

A list of types of quality-indicators for potential use in managed care settings is offered.

- There are a number of alternative quality-indicators that might provide information of value to consumers, in addition to the five clinical indicators presented in the **Consumer's Guide**. These should be provided to the facilitators for use in a possible expanded discussion of "other indicators" in Module Two.

OERMANN M. CONSUMERS' DESCRIPTIONS OF QUALITY OF HEALTH CARE.
J Nurs Care Qual 1999;14(1):47-55.

While consumers have reported an interest in having access to this information, how they actually define quality of care is not yet clear.

Providers' perceptions of quality often differ from patients' perceptions. The expectations of consumers influence their satisfaction with care. This study involved 239 (non-HIV) consumers in a convenience sample of patients in a general medical clinic population, in interviews using open-ended questions to determine their descriptions of quality health care (and quality nursing care). Consumers described quality health care in terms of access to care, followed by having competent and skilled providers, and receiving proper treatment. They defined quality nursing care as having nurses were concerned about them and demonstrated caring behaviors, were competent and skilled, communicated effectively with them, and taught them about their care.

- Competent providers who are able to communicate well with patients are considered to be essential components of quality health care. These qualities are echoed in studies of HIV-infected patients.

HIBBARD J AND JEWETT J. WILL QUALITY REPORT CARDS HELP CONSUMERS?

Health Affairs 1997;16(3):218-228.

The findings show that poorly understood indicators are viewed as useful. Consumers often do not understand quality information because they do not understand the current health care context.

This survey study of 104 consumers assesses the relationship between the salience of quality information and how well it is understood by consumers. Though the study relates to health plans and not to providers, it finds that without an understanding of the indicators, ratings are not viewed as useful in decision-making. Some problems include: not understanding terms, not understanding whether high or low rates of an indicator show good performance, and not understanding what an indicator is supposed to tell about quality of care.

Prior research by this group showed that the indicators consumers rated as most useful did not match the ones they actually used in choosing a plan. This underscores the difference between stated preferences (salience) and actual choices. The findings also suggest that when risk is made explicit (and personal control is low), consumers will make a risk-averse choice.

- The understanding of terms that define quality indicators and the relevance of those indicators to actual concerns of consumers is essential to the usefulness of quality data to consumer choices.

LOUGHRAN S. HEALTHCAREREPORTCARDS.COM: VALUABLE CONSUMER INFORMATION. **Health Care Strategic Management** 1999 JUNE:19-20.

When it comes to information, the perfect should not be enemy of the good. Were one to keep consumers and others in the dark until "perfect" data were available, no light would ever be shed on differences in quality between U.S. hospitals.

This article critically reviews the website HealthCareReportCards.com. The site reportedly provides accurate and objective grading of the performance of every hospital in the United States. The need for this information is supported by the belief that historically, consumers have been able to get more performance information on a new car than on their own hospital.

The response to the site has been overwhelming. In its first five months, the site received more than 187,000 visitors, with slightly more than half being consumers.

- This demonstrates the health consumer desire for comparative data on health care facilities and providers. It also supports the belief that it is legitimate to bring quality performance data information to the attention of consumers, even though it may not be "perfect."

EDDY D. PERFORMANCE MEASUREMENT: PROBLEMS AND SOLUTIONS.
Health Affairs 1998;17(4):7-25.

Recent efforts to measure performance have established its feasibility and value. However, its full potential is currently limited by several problems...Solutions are to rely more on process measures...

This article reviews the problems and potential solutions associated with the measurement of health quality performance. One significant problem is related to the probability of health outcomes. Almost all health outcomes are highly probabilistic. They don't always occur when a plan or a provider does the right thing, and they can occur even when a plan or provider does the wrong thing. One solution is to measure processes rather than outcomes.

- The measurement of processes rather than outcomes is at the heart of the use of the five quality indicators used by the AIDS Institute Clinical Performance Quality Program. The curriculum should address, even if only in trainer notes, the validity and usefulness of process indicators as opposed to outcome measures (e.g., survival).

HIBBARD J, HARRIS-KOJETIN L, MULLIN P, ET AL.
INCREASING THE IMPACT OF HEALTH PLAN REPORT CARDS
BY ADDRESSING CONSUMERS' CONCERNS.
Health Affairs 2000;19(5):138-143.

Consumers understand report-card information best when it is succinct and conveys a message of risk, not benefit.

This article refers to the utilization of health plan report cards. Decision research has shown that although almost all health plan report cards present or frame decisions about plan choice as an opportunity to obtain better-quality care, framing a decision as a potential loss or risk has more impact. In addition, consumers are more likely to respond effectively if risk measures are accompanied by clear directions about how to reduce the potential risk.

- The potential application of these findings to the curriculum may be to frame the description of quality indicators in terms that make it clear that if the performance indicators are not provided, HIV care is less than adequate and can put the patient at risk of further disease progression.

ANONYMOUS. DOCTORS, NOT REPORT CARDS, SHAPE CONSUMER CHOICES. **Physician Relations Update** 1997

Despite the prevalence of ratings and report cards, physician recommendations about health plans, hospitals, or other providers continue to be patients' most valued resource...

A national telephone survey of 2,006 adults, conducted in 1996, found that consumers cited "a regular doctor" as the most influential source of recommendations on health plans, other doctors, or hospitals. The second most influential source was reported to be family and friends. The study was funded by the federal Agency for Health Care Policy and Research (AHCPR).

In choosing doctors, surveyed consumers said that they are most influenced by how well a doctor communicates with patients and shows a caring attitude. The majority of those surveyed believe that doctors have more influence over the quality of health care than do health insurance plans.

- The relationship between a consumer and physician is often a factor that confounds the usefulness of other forms of performance data. Loyalty to a physician and the value placed upon information and opinion received from a personal doctor can often override other sources of quality information. These personal and loyalty factors make the logical “exit” or “voice” choices less simple.

BATES D AND GAWANDE A. THE IMPACT OF THE INTERNET ON QUALITY MEASUREMENT. *Health Affairs* 2000;19(6):104-114.

Most people sought advice on specific medical conditions rather than to compare sources of care. However, as the volume and quality of health-related content grow and use of the Web increases, U.S. consumers inevitably will become more comfortable finding and using comparative information.

The extensive and growing diversity of health-related information in the internet is described in this review. Of great significance is the observation that “word-of-mouth” advice about providers is gaining respectability through the web.

- The power of personal recommendations in health care choice and decision-making (best exemplified by information from family, friends and doctors) can be derived through the impersonal internet.

THE KAISER FAMILY FOUNDATION/AGENCY FOR HEALTH CARE RESEARCH AND QUALITY. NATIONAL SURVEY ON AMERICANS AS HEALTH CARE CONSUMERS: AN UPDATE ON THE ROLE OF QUALITY INFORMATION.

Highlights and Chartpack. DECEMBER 2000.

The public is still more likely to choose doctors and hospitals that they are familiar with, over those that are more highly rated, although this gap has narrowed over time. And, as in 1996, people are more likely to say they rely on recommendations of friends, family, and health professionals they know than on standardized quality indicators.

This highlights data collected in a survey conducted to learn more about the role of quality information in consumers’ health care decision-making, and to assess changes over time by making comparisons with a similar survey conducted in 1996.

The majority of people say that they felt confident that they had enough information to make the right choices the last time they decided on a treatment option (81%), a new prescription drug (79%), hospital (73%), or health plan (67%).

People seeking quality information are more likely to ask for recommendations from people they know instead of contacting official groups or looking at printed information.

Few Americans have actually used quality information to make their health care choices.

It may not be surprising that so few people have used this type of information given that less than 30% have seen quality information in the last year.

At the same time, 63% of the public says the government should be involved in promoting, monitoring, or providing information about quality of health care. And, nearly 75% favors mandatory reporting and public availability of medical error information.

- The value of personal recommendations in health care choice and decision-making (best exemplified by information from family, friends and doctors) over official sources of information is significant. This must be acknowledged in the curriculum. Nevertheless, the role of the government in making quality of care information available is also supported. It is likely that consumers will appreciate the intent, if not the information, of the Consumer's Guide.

COMMUNICATION AND THE DOCTOR-PATIENT RELATIONSHIP

SULLIVAN LM, STEIN MD, SAVETSKY JB, ET AL. THE DOCTOR-PATIENT RELATIONSHIP AND HIV-INFECTED PATIENTS' SATISFACTION WITH PRIMARY CARE PHYSICIANS.

***J Gen Intern Med* 2000;15:462-469.**

Specific aspects of the doctor-patient relationship were highly significantly associated with overall or global satisfaction. In particular, patients' perception of their physician's HIV knowledge was highly related to satisfaction as was patient's ratings of their physician's empathy.

The results of a longitudinal, observational study of 146 HIV-infected patient-satisfaction at two urban medical centers in the northeastern U.S. are presented.

Previously, satisfaction has been shown to be associated with adherence with treatment, utilization of services, continuity of care and improved clinical outcomes. Satisfaction with care reflects the extent to which patients' expectations have been met. Satisfaction with medical care in general and with primary care physicians, in particular, may promote continuity of care and adherence in HIV-infected patients.

Patients studied included a spectrum of asymptomatic and symptomatic HIV-infected and AIDS-diagnosed individuals. Patients were interviewed at enrollment as a new patient and then six months later. Patient satisfaction was found to be greatest among patients who were more comfortable discussing personal issues with their physicians, who perceived their primary care physicians as more empathetic, and those who perceived their physicians as more knowledgeable about HIV. Factors found not to be associated with patient satisfaction included sociodemographic characteristics of both patients and physicians, HIV risk characteristics, alcohol and drug use, quality of life, and concordance of patient-physician gender and racial matching.

- HIV Patient satisfaction with a primary care provider is largely determined by the quality of the interaction with physicians. Both physician- and patient-centered factors influence this interaction. Patient practice in techniques that initiate and personalize the interaction may enhance its quality.

BARTLETT E, GRAYSON M, BARKER R, ET AL.
THE EFFECTS OF PHYSICIAN COMMUNICATIONS SKILLS
ON PATIENT SATISFACTION, RECALL, AND ADHERENCE.
J Chron Dis 1984;37(9,10):755-764.

Nonetheless, the accumulated evidence indicates that the physician-patient relation - ship can play a crucial role in influencing patient satisfaction, adherence to the regimen, and even act as a therapeutic modality in itself.

This study examined the effects of physician interpersonal skills and teaching on patient satisfaction, recall, and adherence to a therapeutic regimen in 63 patient visits to five medical residents at a teaching hospital in Baltimore.

Verbal, nonverbal, and affective communication skills all influenced patient variables. All effects of interpersonal skills and teaching are mediated by patient satisfaction and recall.

- One primary objective of the training should be to assist the participants in getting the most information, explanation, and advice directly from their physician. This will enhance the value and utility of that information.

WILSON I AND KAPLAN S. PHYSICIAN-PATIENT COMMUNICATION IN HIV DISEASE:
THE IMPORTANCE OF PATIENT, PHYSICIAN, AND VISIT CHARACTERISTICS.
JAIDS 2000;25:417-425.

...in our study the positive effects of female gender and gay/lesbian/ bisexual sexual preference in HIV-specific communication were present across relevant patient subgroups, including patient HIV risk factor, patient gender, and patient sexual preference.

The results of a cross-sectional survey of 69 HIV physicians and 264 of their patients are presented. In multivariable models relating patient and visit characteristics to general communication, longer reported visit length, longer duration of the physician-patient relationship, and female gender were significantly associated with better communication. The interaction of patient gender and visit length was also significant; longer visit length was more strongly associated with better general communication for male than female patients. Both female physician gender and gay/lesbian/bisexual sexual preference were significantly associated with better HIV-specific communication.

The pressure to shorten visit length may compromise physician-patient communication and this effect may be seen more with male patients. Women may be better able to “negotiate” the physician-patient relationship than men, perhaps as a result of the likelihood that they have more experience with that relationship.

- Training workshop activities should assist consumers in developing strategies which engage physicians in communication directed to solving patient-centered problems, with the possible consequence of lengthening the time of the visit, while being sensitive to physician/provider constraints.

GERBERT B, LOVE C, CASPERS N, ET AL. "MAKING ALL THE DIFFERENCE IN THE WORLD": HOW PHYSICIANS CAN HELP HIV-SEROPOSITIVE PATIENTS BECOME MORE INVOLVED IN THEIR HEALTHCARE. **AIDS Patient Care and STDs** 1999;13(1):29-39.

Persons who are more actively involved in their healthcare, who participate in making treatment decisions and plans, and who collaborate with their physicians to change their own health behaviors have improved health outcomes and greater satisfaction with their care...It really does matter when physicians take a few minutes to stroke a hand or just listen to what [patients] have to say.

The active, effective participation of HIV/AIDS patients in their health care improves both their satisfaction with the care they receive and health outcomes. This is consistent with the experience of patients with diabetes, breast cancer and heart disease. Physicians can and should help HIV patients become more involved in their health care.

This qualitative study, involving in-depth interviews with 64 HIV-infected patients in the San Francisco area, showed that involvement led to improved quality of life and health outcomes; increased involvement was most facilitated by using "opportune moments" (passages from one stage of HIV care to another) to effect change; and participants became more involved when their physicians used a "relationship-centered approach to care.

The results of the study suggest that physicians should be aware of and utilize opportune moments to enhance patient involvement in HIV care.

- A training workshop intervention which assists patients to create opportune moments by raising issues related to the interpretation of quality data may serve to enhance relationship-centered communication between physician and patient and increase patient involvement in health care.

KRAVITZ R, BELL R, AND FRANZ C. A TAXONOMY OF REQUESTS BY PATIENTS (TORP): A NEW SYSTEM FOR UNDERSTANDING CLINICAL NEGOTIATION IN OFFICE PRACTICE. **J Fam Pract** 1999;48:872-878.

Requests are the primary means of patient-initiated action in office practice. But these requests can be problematic because they consume time and resources...Patients who participate in their own care, however, often achieve better outcomes than those who do not...Patients are more than passive recipients of doctors' actions; they influence the clinical encounter through use of their own linguistic resources.

The Taxonomy of Requests by Patients (TORP) was developed to provide a standardized and valid tool for the identifying and categorizing patient "requests." In this study of the reliability and validity of TORP, in 1994, 139 patients made 772 requests of six physicians in a community-based university-affiliated general internal medicine practice.

There were 619 requests for information and 153 requests for physician action. The majority of both information and action requests were related to treatment and medications.

Physicians viewed visits with a high relative number of patient requests as both demanding and of longer duration. Patients with better health status made fewer requests. Having more chronic disease was associated with more requests for physician action. Patients with more unfulfilled requests had lower visit satisfaction.

- Training workshop activities should assist consumers in developing techniques that directly communicate the need for information or physician action.

PATIENT SATISFACTION

TSASIS P, TSOUKAS C AND DEUTSCH G. EVALUATION OF PATIENT SATISFACTION IN A SPECIALIZED HIV/AIDS CARE UNIT OF A MAJOR HOSPITAL.

AIDS Patient Care STDs 2000;14(7):347-9.

...the overall satisfaction of quality of care of HIV/AIDS patients in a dedicated HIV/AIDS unit is affected mainly by the patient's perception of his/her health status, level of professional or family support, and the patient's involvement in treatment decisions.

Quality of care was measured in terms of patient satisfaction. Overall satisfaction with the quality of care of patients in a dedicated HIV/AIDS unit was found to be correlated with the patient's perception of their health status, level of professional or family support, and the patient's level of involvement in treatment decisions.

- These factors correlated with a rating of quality of care reflect the concerns of hospitalized patients and may not be as relevant to a training in which non-hospitalized and relatively healthy people will participate. There are enough similarities to support emphasis on the personal aspects of satisfaction as indicators of quality of care.

STEIN M, FLEISHMAN J, MOR V, ET AL. FACTORS ASSOCIATED WITH PATIENT SATISFACTION AMONG SYMPTOMATIC HIV-INFECTED PERSONS. **Medical Care** 1993;31(2):182-188.

Patient satisfaction has been defined as "the ultimate validator of quality of care..."

Patient satisfaction with medical care is an important outcome in evaluating the quality of medical care. A total of 1,031 HIV/AIDS patients, recruited from community-based organizations, were surveyed between 1988 and 1989. At that time, overall level of satisfaction with care was high. Satisfaction was negatively affected by frequency of HIV-related symptoms and limited access to care. Interpersonal relationships with providers was the most important quality of care factor.

STONE V, WEISSMAN J, AND CLEARY P. SATISFACTION WITH AMBULATORY CARE OF PERSONS WITH AIDS.

J Gen Intern Med 1995;10:239-245.

...the patients who were black or who were injection drug-users rated the quality of their care significantly lower than did the other patients with AIDS.

Patient surveys (N=305) and medical records review were used to determine the perceptions of PWAs of the quality of their care. The primary outcome measure was a six-item scale of patient-rated quality of care (PRQC). Patients with a primary nurse were least likely to have low PRQC ratings. Low perceived health status, black race and injection drug use were associated with lower PRQC scores.

- This study is the only one reviewed to show a correlation between race and injection drug use and quality of care satisfaction ratings.

MARQUIS M, DAVIES A, AND WARE J. PATIENT SATISFACTION AND CHANGE IN MEDICAL CARE PROVIDER: A LONGITUDINAL STUDY. **Medical Care** 1983;21(8):821-829.

Consumer satisfaction with medical care does predict subsequent changes in the medical care provider.

Using longitudinal data from the Rand Corporation's Health Insurance Experiment, the hypothesis that provider continuity is a behavioral consequence of patient satisfaction was tested. The study sample included 279 adults who used physician services in Dayton, Ohio. Patients were interviewed twice, one year apart to determine satisfaction and provider continuity. Consumer satisfaction was found to be a predictor of subsequent changes in medical care provider. The data suggests that the probability of provider change increases evenly as satisfaction decreases.

- The relevance of this study is that it demonstrates that under some circumstances patients will "exit" and find a new provider if they are sufficiently dissatisfied with the quality of care they are receiving.

HECKMAN T, SOMLAI A, KALICHMAN S, ET AL. PSYCHOSOCIAL DIFFERENCES BETWEEN URBAN AND RURAL PEOPLE LIVING WITH HIV/AIDS.

J Rural Health 1998;14(2):138-145.

Compared with their urban counterparts, rural people with HIV reported significantly lower satisfaction with life...reduced access to medical and mental health care...and more maladaptive coping strategies.

Anonymous, self-administered surveys were completed by 276 people with HIV/AIDS in a mid-western state. Compared with their urban counterparts, rural people with HIV reported a significantly lower satisfaction with life, lower perceptions of social support from family members and friends, reduced access to medical and mental health care, elevated levels of loneliness, more community stigma, heightened personal fear that their HIV status would be learned by others, and more maladaptive coping strategies.

- Flexibility must be built into the training curriculum to allow for a range of behavioral options in response to varying levels of satisfaction with care and estimates of both the quality of care and the health care choices available to the consumer. This will account for the significant differences in both perceptions of self-efficacy and access to services in rural and urban areas of the state.

SELF-ADVOCACY TRAINING PROGRAMS

DAVIDS J, MASKOVSKY J, HARLEY A, ET AL. ADAPTING TREATMENT EDUCATION TRAININGS FOR THREE POPULATIONS OF PEOPLE WITH HIV/AIDS. 12TH WORLD AIDS CONFERENCE, GENEVA, JUNE 28-JULY 3, 1998. ABSTRACT 60292.

Treatment education programs are successful in reaching HIV positive low-income people with HIV, including women, the working poor, and injection drug-users, if they are tailored to meet the needs of the target population.

Project TEACH (Treatment Education Activists Combating HIV) is a training program that trains primarily low income people of color living with HIV/AIDS on subjects including secondary prevention, “good medical care” for HIV, peer education and communication skills, and AIDS activism. The training involve 48 hours of instruction, homework, field trips, and a graduation ceremony. Trainees reported a high level of satisfaction with the program. Pre- and post-program tests indicated a significant increase in trainee knowledge. No description of training methods are provided. Peer educators were trained to deliver the trainings.

- The use of peer educators/facilitators in the delivery of the training workshops would be consistent with Project TEACH and should be considered.

PLEASANT K, DAVIDS J, GOLD R, ET AL. PROJECT TEACH (TREATMENT EDUCATION ACTIVISTS COMBATting HIV). 11TH WORLD AIDS CONFERENCE, VANCOUVER, JULY 6-12, 1996. ABSTRACT WE.D.3784.

Low-income people of color living with HIV have demanded and begun to serve in positions peer education and treatment advocacy. However, a lack of prior experience, education, and support can impair their capabilities to be accurate, effective educators and advocates.

Project TEACH (Treatment Education Activists Combating HIV) is an interactive training program for people living with HIV who demonstrate an interest in peer education and advocacy. The five-week long training program includes ten three-hour sessions covering a broad range of topics from basic science to research and teaching methods and treatment activism.

- While no educational methods are presented, the use of interactive methods are likely to be effective for the purposes of the Quality of Care training curriculum. Interactive methods are favored because they can be effective with participants who may have lower reading levels and less understanding of clinical terms. These methods, however, work best when used by more experienced facilitators, since much of the benefit of the activities comes as a result of participant interaction which is enhanced by the trainer’s ability to give up a measure of “control” (a skill that comes with experience).

SHOUTEN J, HUBERT J, AND COPPEDGE B. (STEP) EVALUATING TREATMENT OPTION AND HEALTH CARE PROVIDERS: STRATEGIES FOR SELF-ADVOCACY. **STEP Perspective** 1996;8(3)-WINTER.

The bottom line in insuring the best treatment possible is the combination of an educated client and a knowledgeable and experienced health care provider.

According to STEP, the Seattle Treatment Education Project, the most important factor in choosing a health care provider is the level of clinical experience of the provider. All HIV/AIDS care providers are equally experienced. Consumers must be prepared to take action to insist that their health care provider and health plan provide them with the opportunity to receive the best possible care. Consumers must advocate on their own behalf to obtain quality care. Their first option is to discuss their care with their health care providers and, if necessary provide them with information to help raise their understanding of treatment options. If the health care provider has not been responsive, a second option is to request to talk with the patient care representative. Lastly, consumers can form an advocacy group and lobby for change.

- The stepwise approach to advocacy provides a starting point for our consideration of a simple, effective set of steps to self-advocacy.

JAMES J. TREATMENT ADVOCACY PROGRAM TRAINS 200: INTERVIEW WITH MATT SHARP. **AIDS Treatment News**. 1999; ISSUE 326.

We start with a discussion of health care and people's experiences with the medical system.

The curriculum for a three-day treatment advocacy training program which had trained 200 people when this article was published, was developed by Judy Leahy of Project Inform. It is designed for case managers, treatment advocates, peer advocates and counselors. The program is called Treatment Education Certification Program (TECP). One of the goals of the program is to help patients understand the complexities of HIV treatment and help guide them in working with their doctor.

- The program has a post-program certification test. While certification is a possible incentive for participation, basing it on an exam may not be consistent with the timeframe and tone of the anticipated training.

HIV AND HEALTH LITERACY

KALICHMAN S, RAMACHANDRAN B, CATZ S. ADHERENCE TO COMBINATION ANTIRETROVIRAL THERAPIES IN HIV PATIENTS OF LOW HEALTH LITERACY. *J Gen Intern Med* 1999;14:267-273.

Health literacy is frequently below functional levels in medical populations, and people with lower health literacy often experience poor health and negative treatment outcomes.

HIV-infected men and women (N=318) were recruited for this study from community based health care and social services agencies. Questionnaires and interview instruments were used to assess health literacy, HIV treatment status, health status, perceived barriers to treatment and reasons for non-adherence.

Both univariate and multivariate analyses showed that the only significant predictors of treatment adherence were years of education and health literacy. People with lower health literacy and lower education level were 4 and 3 times, respectively, more likely to have missed a dose of antiretroviral medication in the last two days. Income level, ethnic background, and HIV disease progression did not account for these associations. People of lower literacy were more likely to have missed a dose of their medications because they were confused about their treatment regimen, were depressed, or desired to cleanse their body of treatments.

- The relationship between low education and low literacy and the ability to understand and adhere with treatment information, suggests the importance of including concrete practice exercises with lots of repetition in interventions designed to improve health behaviors.

KALICHMAN S AND ROMPA D. FUNCTIONAL HEALTH LITERACY IS ASSOCIATED WITH HEALTH STATUS AND HEALTH-RELATED KNOWLEDGE IN PEOPLE LIVING WITH HIV-AIDS. *JAIDS* 2000;25:337-344.

We found that lower literacy participants were less likely to be taking antiretroviral medications despite their poorer health status, and this difference was not accounted for by years of living with HIV infection or income level. Lower health literacy participants were also more likely to doubt the potential benefits of medical treatment and were more likely to distrust their health care providers.

HIV-infected men and women (N=339) were recruited for this study from community-based health care and social services agencies. Surveys and interview instruments were used to assess health literacy, HIV treatment status, health status, HIV-AIDS treatment knowledge, health care perceptions, and experiences.

Twenty-five percent of patients sampled demonstrated difficulty comprehending simple medical instructions (lower health literacy). Lower health literacy in this sample was associated with lower health status and lower treatment adherence, as well as, lower HIV-AIDS treatment knowledge, and more negative health care perceptions and experiences.

- The relationship between low education and low literacy and the ability to understand and adhere with treatment information, suggests the importance of including nonverbal forms of communications and pictographs in delivering medical information. These should be considered for inclusion in workshop activities.

THEORIES OF DECISION MAKING

KLEIN R. MODELS OF MAN AND MODELS OF POLICY: REFLECTIONS ON EXIT, VOICE, AND LOYALTY TEN YEARS LATER.

Milbank Memorial Fund Quarterly/Health and Society 1980;58(3):416-429.

...the question of how to assess the quality of medical care is notoriously contentious. There is little agreement even among the experts, so that equipping the consumer with adequate information is no easy task. More centrally still, it is not self-evident that exit is necessarily an effective corrective mechanism...A consumer might well be satisfied with the technical treatment provided, but highly incensed about the quality of the environment in which it has been provided.

A review of the then-current thinking about consumer options in the marketplace with emphasis on the health care consumer in 1980. The contrasting (or, better, complementary) views of humans as consumers: homo economicus and homo politicus exemplify the options of exit (in a competitive marketplace) and voice (advocacy) are tempered by the recognition of the role of loyalty. Klein states that, "decisions by individuals as to whether to employ the exit or the voice option will depend on the degree of loyalty that they feel to the firm or organization [clinic or provider] in question: a high degree of loyalty is likely to inhibit exit and may encourage voice." Both options, however, carry with them costs.

In addition, the health care market is characterized by a high degree of uncertainty about the product ("about which diagnostic and treatment procedures are most apt to prove efficacious.")

The problem of finding an appropriate balance between exit and voice in health care spring from the fact that consumers are not purchasing a product but a complex and heterogeneous package of services.

- The complexity of the "options" facing HIV/AIDS patients is great. The workshop curriculum should address the options of exit and voice in the context of the strength of the physician-patient relationship and its inherent loyalty.

TVERSKY A. AND KAHNEMAN D. THE FRAMING OF DECISIONS AND THE PSYCHOLOGY OF CHOICE. **Science** 1981;211:453-458.

...people exhibit patterns of preference which appear incompatible with expected utility theory.

When faced with a choice, a rational decision-maker will prefer the prospect that offers the highest expected utility. However, people systematically violate the elementary requirements of consistency and coherence of rational choices. This is because the framing of the choice and the value placed upon the outcomes alters the perception of the probability and desirability of the outcomes. In general, the response to losses is more extreme than the response to gains; most people are risk-averse; people evaluate acts in terms of a minimal account generally accounting for a loss or gain in a situation at hand rather than as a sum of all previous acts

Framing problems in terms of risks or gains, losses, probability, etc. all effect the decision outcome.

- The performance data provided in the **Consumer's Guide** can be described in a number of ways. Framing the data and presenting a positive value to it can influence the perception of its utility to the consumer. The curriculum should provide a frame for the quality-of-care data that enhances rather than detracts from its perceived utility.

KAHNEMAN D AND TVERSKY A. CHOICES, VALUES AND FRAMES.
American Psychologist 1984;39(4):341-350.

An objective improvement can be experienced as a loss, for example, when an employee receives a smaller raise than everyone else in the office.

The cognitive and psychophysical determinants of choice are described. The psychophysics of value induce risk-aversion in the domain of gains and risk-seeking in the domain of losses. The psychophysics of chance induce overweighting of sure things and of improbable events, relative to events of moderate probability. The process of mental accounting, in which people organize the outcomes of choices, explains some anomalies in consumer behavior. In particular, the acceptability of an option can depend upon whether a negative outcome is evaluated as a cost or as an uncompensated loss.

- People do not evaluate prospects by the expectation of an objective outcome but rather by the expectation of the subjective value of these outcomes. In describing the "objective" data in quality of care reports, they can be made more valuable to the consumer by providing an opportunity to workshop participants to add a subjective assessment of the data, adding value to the usefulness of the data beyond its numerical characterization.

SHAFIR E, SIMONSON I, AND TVERSKY A. REASON-BASED CHOICE.
Cognition 1993;49:11-36.

It is proposed that, when faced with the need to choose, decision-makers often seek and construct reasons in order to resolve the conflict and justify their choice, to themselves and to others.

An alternative theory of decision-making, in comparison with the "prospect theory" of Kahneman and Tversky, is reason-based analysis. This approach identifies various reasons and arguments that are offered as explanations of the factors ("reasons for and against") that influence decisions. Although the reasons identified by researchers may not always correspond to those that actually motivated a decision, it is believed that the process of reasoning out a decision may help to explain the decision, especially where value-based models are difficult to apply. A focus on reasons seems closer to the way we normally think and talk about choices.

People's choices may stem from affective judgments that preclude a thorough evaluation of the options. However, in most cases, people claim to carefully evaluate options, discarding the less attractive ones and, faced with a choice of remaining options that is hard to resolve, they often search for a compelling rationale for choosing one alternative over another. It seems that people, contrary to classical decision theory, often do not have well-established values, and they construct preferences while in the process of rationalizing a decision.

- Since values are sometimes revealed during the process of decision-making (rather than having been identified before a decision and then applied to the decision), the process of acting out a decision may help participants come to understand and then explain what is important to them. The use of role play can help participants to gain self awareness and use that in becoming a self-advocate.

ANNAS G. PATIENTS' RIGHTS IN MANAGED CARE – EXIT, VOICE, AND CHOICE. *NEJM* 1997;337(3):210-215.

Supplementing the ability to exit with the ability to have an effective voice can foster and enhance patients' rights.

Providing patients, who depend upon physicians for expert advice, with an effective voice is a long-standing problem that has been highlighted, but not caused, by managed care. The backlash against managed care may provide an opportunity to develop options for patients to find a voice in the health care marketplace. The role of physicians as patient advocates, one of their historical roles, is being altered by the demands and constraints of managed care. If physicians cannot or will not act as their patients' advocates, some other party will have to assume that role. At best, an independent organization should fill that role. Alternatively, patients may need to become their own advocates, and may need to be supported by the legal system in conflicts.

Relying solely on the ability of patients to leave one health plan and move to another is not sufficient to ensure either the rights of patients in managed care plans or improvement in the quality of care.

- Patients will need to be supported in the development of effective strategies and tactics to ensure the quality of their care. These tactics cannot only depend upon the options of exit and voice. Self- and group- advocacy skills–development may be necessary to move a system in which their exit is of no consequence and their voice will not be heard.

*“This workshop gives you a way to
assess your own individual care.”*

-Workshop Participant

Making Sure Your HIV Care Is The Best
It Can Be *is a workshop you should attend if
you want to:*

- Learn how to evaluate the quality of
HIV health care you are getting
- Talk with others about how they rate
the quality of HIV care they get from
their providers
- Practice ways of effectively advocating
for your own health care need

The HIV Quality of Care Program

AIDS Institute

New York State Department of Health

The New York State Department of
Health AIDS Institute is committed to
promoting the quality of HIV clinical
services delivered to people with HIV in
New York State.

The curriculum used in the Making Sure
Your HIV Care Is The Best It Can Be
workshop was developed by the Quality
of Care Program. It is believed that
through participation in the workshop
HIV consumers will develop understand-
ings and skills that will assist them in
better evaluating the quality of HIV care
they receive and to better participate in
the management of that care.

Making Sure Your HIV Care *Is The* Best It Can Be!

***A Consumer Training Workshop in
HIV Quality of Care Self-Advocacy***

A Skills-Building Workshop

New York State Department of Health

AIDS Institute

The HIV Quality of Care Program

Making Sure Your HIV Care Is The Best It Can Be!

A Quality of Care Workshop for Consumers of HIV Health Care Services

What you will learn in the workshop:

- How to judge the quality of your HIV health care. What do you value most in your health care? What do you like about the HIV health care you are receiving? What would you most like to change?
- What are some of the important standards of HIV care that all HIV clinics need to provide for all HIV patients? What do terms like HAART, CD4 cell counts and viral load tests mean, and how do you use this information to judge the quality of your HIV health care?

- How to find important information about the quality of HIV health care provided by the clinic you go to. How to find that information in the “Consumer’s Guide to HIV Care in New York State.”
- How to develop an action plan to improve the quality of the HIV care you receive.
- Ways to act as an advocate for yourself in getting the best HIV care you can.

This workshop is for any consumer of HIV health care services.

Are you having trouble getting all the information you need about your HIV health care?

This workshop may help you find ways get all your information needs met.

Would you like to find out how the quality of HIV care at your clinic compared with other clinics in your area? This workshop will show you how your clinic did.

Are you interested in how other HIV health care consumers rate the quality of HIV care they are getting? This workshop will let you share experiences with other people like yourself.

About the Consumer workshops

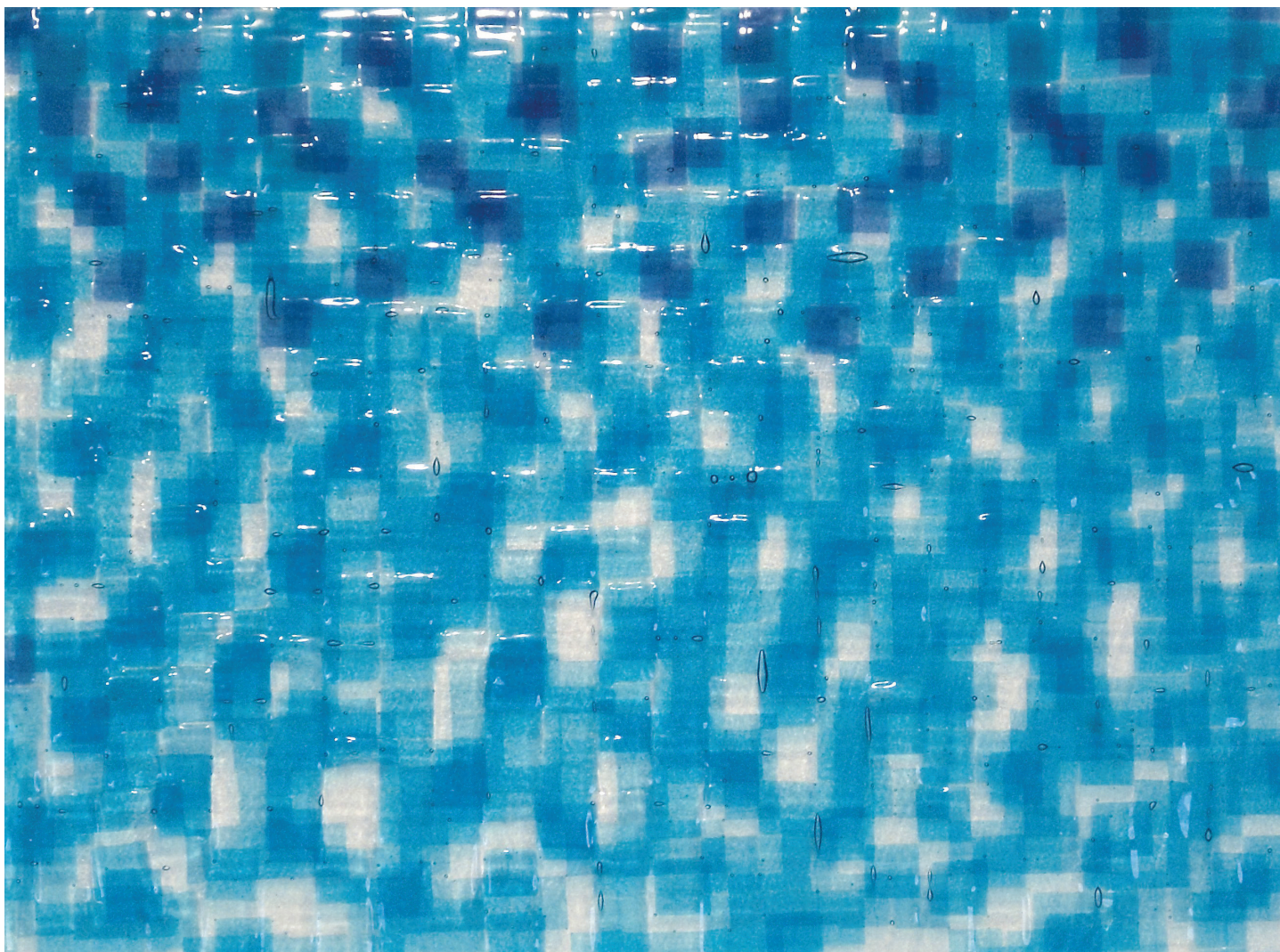
Each workshop is scheduled to take two and one-half hours to complete.

Workshops are lead by trained facilitators.

Activities in the workshops give you a chance to practice self-advocacy skills.

Group activities let you participate as much as you are comfortable with and let you learn from others like yourself.

For information about the schedule of consumer workshops in your area call (212) 268-6108.



Making Sure Your HIV Care is the Best It Can Be

A Consumer Quality of Care Training Workshop

New York State Department of Health AIDS Institute
Health Resources and Services Administration HIV/AIDS Bureau



NATIONAL QUALITY CENTER

Making Sure Your HIV Care is the Best It Can Be

A Consumer Quality of Care Training Workshop Curriculum Guide for Workshop Facilitators

Developed by the
New York Department of Health
AIDS Institute
National Quality Center

Prepared by Joseph Rukeyser, Ph. D.

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Introduction

"Making Sure Your HIV Care is the Best It Can Be" was developed to assist patient educators in the delivery of consumer training workshops. Its intent is to affirm and support the HIV health care consumer's role in treatment decision-making; to acknowledge both the rational/logical components and the personal/affective components of health care decisions; to introduce the consumer to the concepts of quality of care assessment and quality improvement.

This curriculum is designed to empower and encourage consumers to use their self-advocacy skills to gather disease-specific and quality of care information for themselves from their providers and other available resources.

Curriculum Development

The development of the Making Sure Your HIV Care is the Best It Can Be was prompted by a needs assessment process which included consumer focus groups conducted throughout the state and interviews with health care providers, key informants, and consumer advocates. In addition, a review of the relevant literature on the use of health care quality "report cards," patient-satisfaction assessment, physician/patient communication, health care decision-making, HIV advocacy training methods, functional health literacy, and the relationship between these factors and health status in people with HIV infection was conducted for the purpose of establishing a set of "best practices" in the design of HIV health care consumer-learning strategies.

The curriculum was pilot-tested twice with a diverse population of HIV health care consumers before it was made available in 2002. Since then hundreds of consumers have participated in this training across the nation to learn more about empowerment and self-advocacy. In addition to the training materials, background information, including the literature search that was conducted as part of this project can be downloaded from our website at www.hivguidelines.org.

Design of the Curriculum

The modular curriculum is highly interactive and requires little or no reading on the part of participants. Module One establishes the expectations of the workshop and introduces the participants to the group processes used throughout the workshop. Module Two introduces participants to the concept of quality of care, the use of both personal and clinical indicators of quality, and the quality improvement process. Module Three provides several opportunities for participants to combine their learning with skills development in the practice of self-advocacy techniques.

Each module is divided into a series of short, interactive “Activities” through which understandings and skills are developed. Facilitator notes and support materials, instructions for the preparation of participant training materials, templates for all written training materials, and all take-home materials are provided in each modular activity section.

The curriculum has been designed for delivery in a two and one-half hour workshop. Depending upon the training experience of the facilitator and the availability of materials, preparation for each training may require about one hour.

Workshop Facilitation

The curriculum is scripted so that facilitators, regardless of their HIV-related knowledge and their experience in consumer education and training, can deliver trainings of consistent content and quality. Of course, both HIV knowledge and training experience would be an asset. Experienced peer educators may be able to provide a level of insight that would enhance the quality of the training they deliver, though this is not considered to be a necessary qualification for facilitators. HIV case managers, treatment educators, patient educators, and patient advocates are likely to have both the skills and the experience necessary to provide high quality training workshop facilitation.

Expected Outcomes

It is expected that as a result of the consumer training workshop, participants will be able to:

- Identify what is most important to them in their HIV health care.
- Judge the quality of the HIV health care they are receiving.
- Appreciate what other people, including HIV specialists consider the most important qualities of HIV care.
- Develop an action plan that will help them improve the quality of the HIV care they receive.

Use of the Facilitators' Curriculum Guide

Modular Curriculum

The curriculum is divided into three Modules. It is intended that training workshops be conducted following the sequence of modules as they appear in the Guide. Given time constraints or preference in working with some consumer groups, it may be appropriate to conduct the training workshop as a sequential series of sessions rather than as a single training workshop covering all of the Modules.

Goals and Objectives have been developed for each of the Modules, and each Module consists of a number of Activities. The Strategies and Methods used in the Module are described, as well as Materials Needed, Preparation Needed, and Time Needed for completion of the Module curriculum.

In preparation for conducting a training workshop, facilitators may follow the directions found at the beginning of the Modules. At the beginning of each Activity there is a Rationale for that Activity followed by a listing of the Materials Needed for that Activity. It is recommended that all materials, including pre-labeled newsprint sheets and copies of all training handouts, be prepared in advance of the workshop since preparation time is lengthy and there is no time during the workshop to do preparation for the Activities. Preparation for conducting a training workshop may take 45-60 minutes.

The time estimate (Time Needed) found at the beginning of each Activity is based upon the average time required for completion of the Activity in the pilot tests of the curriculum. The time may vary with the experience of the facilitator and from one workshop to another. The estimated time for the delivery of the full curriculum is two and one half hours.

Scripted Procedure

The procedure to be followed in each Activity is described in detail in the curriculum. The Guide is intended for use by facilitators with varying degrees of training experience. The level of detail provided is included to assist facilitators with less experience in conducting consumer training workshops. The numbered directions to the facilitator were derived from the pilot test experience. The scripted text found in each Activity is what is intended to be spoken by the Facilitator. While some variation in language for clarity of presentation or to enhance the comfort level of the facilitator is encouraged, experience in pilot testing of the curriculum has shown that significant deviations from the scripted text are potentially time-consuming and often lead the discussion away from the objectives of the workshop. A common example is volunteering information about either the course of HIV infection or treatments. The facilitator might quickly find him or herself in the middle of a discussion beyond the limits of his or her competency or knowledge, being asked to make judgments about treatments, side effects of therapy, or providers, or led into areas very much unrelated to quality of care. More to the point, however, is that one of

the most important goals of the training is to help participants find ways to ask such questions of their providers. When asked questions about treatments, for example, that is a perfect opportunity for the facilitator to say, “That’s a very good question, and one you should ask your doctor about. I guarantee that by the end of this workshop you will have a plan to do that.”

Another potential problem in the workshop is the volunteering of personal experience information by either facilitator or participant. Participants often will use the discussion in an Activity as an opportunity to “tell their story.” Facilitators must judge the relevance of that information to the whole group and to the objectives of the workshop and, when necessary, sensitively but clearly bring the discussion back to the task of the Activity. Similarly, facilitators should refrain from using the workshop to share their own personal experiences. The curriculum is designed to focus the attention of the Activities on the needs, understandings, strengths, problems, and skills-acquisition of the participants. It is the facilitator’s responsibility to maintain that focus.

Notes to Facilitators

Notes to facilitators can be found in Activity sections. These notes are provided to explain procedures in more detail than can be found in the Procedures section and to relate either background information or suggestions based upon pilot test experience. These notes are not intended to be read to the participants.

The literacy level of the *Curriculum Guide* was selected to make it understandable by the majority of participants. Facilitators with knowledge and experience in working with the participants in a training workshop should adjust the language level to that which best suits the participants.

Workshop Evaluation

A workshop evaluation tool is provided for use in post-program assessment of participant satisfaction. It is recommended that participants be asked to fill out an evaluation as the last part of the closing activity of Module Three. In addition to their potential value to workshop facilitators, results of the evaluation may assist in the modification of the curriculum as well as in the creation of additional curricula to meet the changing needs of consumers.

Ordering Information

For additional free copies of this Curriculum Guide and other consumer materials, please contact the New York State Department of Health AIDS Institute Quality of Care Program by telephone at (212) 417 4730.

Electronic copies of the Making Sure Your HIV Care is the Best It Can Be guide and the literature review of key articles related to this important topic are also available online at www.hivguidelines.org.

Module One:

What To Expect From The Workshop

Goals

The Goals of this module are to:

- Introduce group members to one another, establish guidelines, and build group cohesion, comfort, and trust.
- Introduce participants to the goals of the workshop and to create a sense of personal ownership of the workshop processes.
- Permit each participant to speak and to express their thoughts in a supportive, potentially low-anxiety environment before engaging in broader group activities.

Objectives

After completing this module, participants will be able to:

- Identify the value of participating in the workshop.
- Describe the purpose of the workshop.
- Identify the value of interactive group activities in the learning process.
- Describe a range of expectations that participants have for the workshop experience.

Strategies and Methods

- Discussion Circle
- Sharing in Pairs

Materials Needed

- Clock
- Pre-labeled newsprint
- Markers
- Masking tape
- Name tags

Preparation Needed

1. Arrange chairs in a circle.
2. Hang newsprint with workshop title, facilitator's name, and time of the workshop.
3. Label newsprint with "Expectations."
4. Fill out a name tag with the name of each participant as they come in and ask them to put it on.

Time needed:

20 minutes

ACTIVITY	TIME
A. Workshop Welcome And Overview	5 minutes
B. Sharing Expectations	15 minutes

Activity A:

Workshop Welcome and Overview

Rationale:

Welcoming the participants and providing them with a general overview of the workshop can serve to foster ownership of the workshop process and outcomes. This activity tells the participants that this workshop is about them and is designed to meet their needs.

Materials Needed:

One pre-labeled newsprint:

“Making Sure Your HIV Care is the Best it Can Be”

Facilitator’s Name: _____

Workshop Time: _____

Time Needed:

5 minutes

Procedure

1. Arrange the participants’ chairs into a circle.
2. Hang the newsprint with workshop title, facilitator’s name, and workshop time in a visible location in the room.
3. Welcome the group and provide an overview of the workshop by saying:

Hello, my name is _____ and I am the facilitator for today’s workshop entitled: “Making Sure Your HIV Care is the Best it Can Be.”

I know that it may have been challenging for some of you to make the necessary arrangements to be here, but I believe that you will find today a good investment in your health.

This workshop is scheduled to run for two and one-half hours, from: _____ to _____ .

Today we will talk about your HIV health care. We will learn ways to evaluate the quality of the care you are getting and we will discover ways to improve the quality of your care to meet your needs.

This workshop was designed because we believe that you have a right to the highest quality care. And it was designed to help you make decisions about what to do if you think that you are not getting the highest quality care.

A lot of what we will do in the workshop will be in large and small group activities rather than in lectures with me doing all of the talking. As many of you will probably agree, people often learn best by “doing” instead of listening.

Are there any questions about the workshop before we begin with our first activity?

4. Answer any questions about time, bathrooms, telephone, etc., but explain that all other questions about the workshop will be answered in the later activities.
5. Establish the “ground rules” for workshop participation. You should use the following as a guide. Add or delete ground rules based upon your preference and experience.

6. Say the following:

There are just a few ground rules that I will ask that we all agree to before we begin.

There are no right or wrong answers to most questions about health care. We all may have different views on what we will be talking about today. It is important to respect and, hopefully, learn from our differences. Only one person will speak at a time, and everyone will have an opportunity to be heard.

Much of what we will do today involves group participation. If, at any time, you don’t feel like participating, that decision is up to you and no one will require you to do so.

We have a lot to cover in the workshop. I will try to keep us on time. So, please don’t be offended if I interrupt you and ask the group to move on. We can talk more after the workshop is over if you’d like.

There will be a 10–minute break about half-way through the workshop.

Do you have any other suggestions for ground rules?
Let’s have a good time today.

Facilitator's Note

Be aware of participants with special needs. Participants in wheelchairs or who may have difficulty walking, or who are blind or deaf, may require alternative arrangements for finding and working in pairs. In addition, some participants may need help in pairing off to form the partner groups.

Activity B:

Sharing Expectations

Rationale:

This activity serves two purposes: first, it will help to “break the ice” and to provide a structure in which people can get to meet one another and feel more comfortable within the group. Secondly, it will help participants to set realistic personal goals and expectations for the workshop.

Materials Needed:

Two or more pre-labeled newsprint sheets: “Expectations”
One pre-labeled newsprint:

“Workshop Objectives”

- Identify what is most important to you in your HIV health care.
- Judge the quality of the HIV health care you are receiving now.
- Hear what other people think are the most important qualities of HIV care.
- Describe some good measures to assess of quality HIV ambulatory care.
- Make a list of action steps that will help improve the quality of HIV care you receive.

Procedure:

1. Explain the procedure to the group:

In our first group activity we will work together to identify your personal expectations for the workshop.

In a moment I will ask you to partner with the person sitting next to you.

When you do, introduce yourselves to one another and then ask each other, “What is the one thing that you want to get out of this workshop?”

I will give you a couple of minutes to do that.

When the time is up I will ask you to introduce your partner to the group and tell what his/her expectation is. Please begin now.

2. After about five minutes, tell the participants:

Time is up. Let’s all come back as a group. Let’s talk about what you have learned about your partner.

Time Needed:

15 Minutes

Facilitator's Note

It is important to be clear about those expectations that you know will not be covered in the workshop, suggesting, if possible, other ways those expectations might be met. For example, there may be an expectation that treatment or medication information will be discussed. Let the participants know that while this will not be covered, they will learn how to talk to their doctors about whatever questions they have or information they need.

This activity is a good opportunity for you to assess the literacy level of the group you are working with (if it is not a group you are already familiar with). As you list the expectations of the group you can ask individuals for further explanation and generally how well-understood selected terms are. It is important to adjust the level of language used to enable all participants to benefit from the workshop.

3. When the group has settled and you have their attention, pick one person to start and ask:

Please introduce your partner and tell us what his/her expectations are for the workshop.

4. When participants tell the group what expectations they heard, write these on the newsprint. (For example: “To learn about other places I might go for HIV care.” Or, “How to be sure my doctor is doing all the right lab tests.”)
5. Go around the room and ask for a response from each participant. When finished, review the list with the group, saying:

Thank you all for paying such close attention to what your partners said. Let’s go over the list of expectations together.

6. Go over each expectation, asking for clarification where necessary, and help participants understand how the workshop may meet them. Put a check mark next to each expectation that you believe will be covered in the workshop

7. When finished with the list of expectations, put up the newsprint list of workshop objectives and say:

Thank you for your thoughtful participation in this important activity. With your help today, by the end of the workshop each of you will be able to:

- Identify what is most important to you in your HIV health care.
- Judge the quality of the HIV health care you are receiving now.
- Hear what other people think are the most important qualities of HIV care.
- Make a list of action steps that will help improve the quality of HIV care you receive.

8. When finished with the list of objectives, say:

Are there any questions about the goals we have set?

In our next activity we will start the work of looking at how you feel about the quality of your HIV care.

Module Two:

Assessing Quality of Care

Goals

The goals of this module are to:

- Encourage participants to evaluate the degree of their satisfaction with their HIV care.
- Explore their attitudes about factors that contribute to quality of care.
- Discuss how the quality of the HIV medical care can be evaluated.

Objectives

After completing this module, participants will be able to:

- Rank the factors that contribute to the quality of their HIV care.
- Identify the factors important in selecting health care providers.
- Discuss their attitudes about quality of care factors.
- Identify four clinical indicators of HIV care quality.

Strategies/Methods

Individual Work

Consensus Group Work

Mini-lecture

Clinical Indicators Personal Assessment Activity

Materials Needed

Tape

Markers

Pens/Pencils

Continuum of Satisfaction Signs (1-5)

Quality of Care Consensus Activity Worksheet

Your Personal Quality of Care Worksheet

Pre-labeled newsprint (for details see below in Preparation Needed)

Preparation Needed:

1. Pre-label newsprint: Continuum of Satisfaction.
2. Hang Health Care Continuum of Satisfaction Signs.
3. Arrange chairs in a semi-circle and place newsprint in a visible location.
4. Label newsprint with: "Self-Advocacy Steps."
 - Identify what your health care needs are.
 - Identify obstacles to getting your needs met.
 - Develop strategies to use your resources and overcome barriers.
 - Put your plan into place.
5. Make copies of Personal Assessment Worksheet for each participant.

Time Needed:

50 minutes

ACTIVITY	TIME
A. Quality of Care Information	5 minutes
B. The HIV Satisfaction Continuum	15 minutes
C. Consensus Activity: Force Ranking of Care Factors	15 minutes
D. Roadmap to the Consumer's Guide	15 minutes
E. Your Personal Quality of Care Factors	5 minutes

Activity A:

Quality of Care Information

Rationale:

Providing an explanation of "Quality of Care" and a framework for this session increases comfort among the participants and focuses their attention on the quality of their HIV care.

Materials Needed:

Hang newsprint: Self-Advocacy Steps

Time Needed:

5 minutes

Procedure:

1. Explain the following to the group:

As consumers of HIV health care, you may not always be happy with the care you receive. Sometimes you may be happy with your health care and your provider. At other times you may be unhappy with your health care or provider. It is important that you learn how to become your own HIV health care advocate so that you can become happy with your care more of the time. Some of you already know how to do this. Everyone can learn how.

Self-Advocacy involves four stages. *[Read these from the newsprint.]* The first stage is identifying the health problem that concern you and what factors are important to you in your health care. The second stage is identifying obstacles that you face in getting health care that meets your needs. The third stage is developing strategies to overcome the barriers and the fourth stage is implementing a plan that helps you to reach your goal.

You will learn how to move through all four of these stages during this program. For the next hour, we will focus specifically on how you rate your care and how quality of HIV ambulatory care can be measured. You will also learn how to design your own quality of care checklist.

2. Ask the participants if they have any questions so far.
3. Add the following:

You can be your own advocate. As a consumer you deserve to be satisfied with your health care. Let's spend the next hour concentrating on how to rate your care and how to become an advocate for yourself.

Facilitator's Note

Some of the participants may find the term “satisfaction” vague and they may ask for clarification. They may want you to tell them what aspect of care you want them to rate. Tell them to use whatever definition they want. While each individual may have a different idea about what satisfies them about their care, the group will work collaboratively to develop a broad understanding of the quality care.

Activity B:

The HIV Care Satisfaction Continuum

Rationale:

Providing a visual rating continuum will allow participants to see that others are satisfied with their care and help them to explore their own attitudes about their HIV health care.

Materials Needed:

HIV Satisfaction Numbered Continuum Signs (1-5)

Tape

Newsprint pre-labeled: "Continuum of Satisfaction"

Markers

Time Needed:

15 minutes

Procedure:

1. Hang HIV Care Satisfaction Continuum signs (1, 2, 3, 4, and 5) along the wall in a straight line. Space the numbers far enough apart so that each of the participants can find a place to stand near one of the numbers. Pre-label newsprint "The Continuum of Satisfaction" and hang on an easel stand or a wall that is not being used for the continuum.
2. Say the following:

This activity is a moving activity called "The Continuum of Satisfaction," so be ready to move around. In this activity, you will have the chance to decide if you are unhappy (point to card number 1), in between (point to cards 2-4) or very satisfied (point to card number 5) with your HIV care. "1" is the lowest possible rating and equals being unhappy with your care; "5" is the highest rating and equals being totally satisfied with your care. I want you to think for a minute about the quality of your HIV care and then stand near the number that best describes your satisfaction with your care. Remember that this activity is about how you perceive your care. You can stand anywhere between 1 and 5.

3. Allow the participants a few moments to find a place to stand near a sign.

Facilitator's Note

When reporting back from the Satisfaction Continuum start at the #1 end and move along the continuum, It is not necessary, particularly in the interest of saving time, to ask each participant to explain why they chose to stand where they did, but be sure to ask representatives from each area along the continuum.

4. Say the following to the group:

Let's pause for a minute to see where people are standing. As you can see, people are standing near different numbers. There is diversity in how people rate their HIV care. This means that people have different feelings or attitudes about their health care. Some people are satisfied, others are not.

[NOTE: Pause for a moment so that the group can take notice of the difference within the group.]

Look around and see if there are other people near your number or standing next to you at the next number. Talk to one another about why you have decided to stand where you did.

5. Allow the participants a few minutes to discuss with each other the reasons that they are standing under the number.
6. Ask the participants the following discussion questions:

What made you stand where you are standing?

7. Have the participants take their seats. Say the following:

There were several important factors that influenced how you rated your quality of care. Let's summarize what they were.

8. Summarize the most important reasons people gave for being satisfied or dissatisfied with their HIV care.

Write these on the newsprint pre-labeled "The Continuum of Satisfaction."

9. Then ask the following question:

Can you think of any other factors that might influence how you rate your quality of care?

10. Elicit responses from several participants in the group and add them to the list.

11. Summarize by saying:

As you can see, there are many factors that determine how you rate your HIV care. Whether you have a long list of factors or a short list, the important thing is to have a list.

This will help you to focus on what is important to you in your health care. In the next activity we will see if we can be more specific about the factors that help you to determine your quality of care.

Facilitator's Note

The “Quality of Health Care Checklist Consensus Activity” and the personal checklist used later in this module, “Your Personal Quality of Health Care Checklist,” can be modified and updated as necessary to meet changing perceptions of important factors related to the assessment of quality of HIV health care.

The value of this activity is in the experience of reaching consensus and not necessarily in the actual ranking of factors. This is self-advocacy practice. Taking a position, defending it and then listening to the positions of others are essential advocacy skills. In discussing this activity, take the opportunity to talk about each of these skills and how they were used in the group activity.

Activity C:

Consensus Activity: Support Ranking of Quality of Care Factors

Rationale:

Encouraging group interaction and consensus allows the participants to verbalize their attitudes about ranking quality of care characteristics.

Materials Needed

Pens/Pencils

Quality of Care Consensus Activity Worksheet (See p. 17)

Time:

15 minutes

Procedure

1. Explain the activity by saying the following:

We have spent some time talking about what makes you satisfied with your quality of care. It is important that you think about the factors that cause you to be satisfied.

For this activity, you will be given a list of quality of health care factors and you are going to rank them from most important to the least important. To help you do this, you will work in small groups and everyone in the small group will work to agree on the ranking. First get into groups of 3 or 4 for this activity.

2. Help the group get into small groups of 3 or 4 participants. Make sure there are at least two groups so that there can be a comparison of top ranked factors between the groups.
3. Hand out the “Quality of Care Checklist Consensus Activity” Worksheet to each person in the group and read the directions aloud to the group. Ask them to read the list individually first and think about their own ranking before starting the group work.

This is the “Quality of Care Checklist Consensus Activity” Worksheet. The directions are as follows: Below is a list of important Quality of Care Factors. Talk about these factors within your group and then rank the factors from 1 (most important) to 12 (least important). Consensus means that each member of the group agrees to the ranking of each factor on the checklist. A factor can have only one ranking and each ranking can only be used once. I will give you about 10 minutes to complete this activity. When all of the groups are done, one person from each group will read their group’s top 3 rankings.

4. When the 10 minutes are up, have 1 person from each group report their top 3 rankings. You can have them check off the top 3 on a newsprint sheet with the rankings list on it.
5. When the groups have read their top 3 rankings ask the following questions:

- What did you learn from doing this activity?
- In what ways was this activity easy to do?
- In what ways was this activity hard to do?

6. Summarize by saying,

Thank you. You did really well with this activity. This activity may have been hard, but it gave you the chance to talk about your health care and the factors that are important to you. It also gave you practice negotiating with other people. That is an essential part of advocating for yourself and others. Remember these factors and the way that your group ranked them. Also remember what it is like to take a position about something and defend it, while listening to what others have to say. In our next activity we will talk about some other ways to rate your care.

Quality of Health Care Checklist

Consensus Activity

Below is a list of important Quality of Care Factors. Talk about these factors within your group and rank the factors from 1 (most important) to 12 (least important). Have one person write the rankings on one list for the group. Consensus means that each member of the group agrees to the checklist. A factor can only have one ranking and each ranking can only be used once.

How important is it to me that:

- _____ I have a good relationship with my doctor.
- _____ The clinic staff makes me feel welcome.
- _____ I have confidence in the knowledge and skills of my doctor.
- _____ There is a short waiting time to be seen by my doctor.
- _____ Many different services are provided at one clinic location.
- _____ The facility is convenient to get to.
- _____ My doctor communicates well with me and answers my questions.
- _____ Other patients rate a high quality of care.
- _____ I get regular CD4 counts, viral load tests, and drug resistance testing.
- _____ HIV - related medications are available to me and their side effects have been explained to me.
- _____ Regular pelvic exams are available for women.
- _____ The staff helps me to be involved making decisions about my health care.

Activity D:

Clinical Indicators of HIV Quality Care

Rationale:

This activity introduces the concepts of quality improvement and clinical care indicators. These concepts may be new to many of the participants, even some of those who are more well - informed. The use of small group brainstorming and discussion will model the collaborative approach to information gathering.

Materials Needed:

Newsprint Sheets

Markers for newsprint

Masking tape for hanging newsprint

Time Needed:

15 minutes

Procedure:

1. Hang five sheets of newsprint on the walls. Space them enough apart to allow small groups of participants to stand around each sheet while they brainstorm and write ideas on the sheets. You will be writing a heading on each sheet after a brief discussion.
2. Introduce this activity by saying:

We have seen that each of us views the quality of our HIV care in very personal terms and each of us has different ways of deciding how satisfied we are with our care.

There are other ways of rating the quality of HIV care delivered in a clinic or doctor's office. When an external funder, regulatory agency or directors of a clinic want to evaluate the quality of care provided to patients, they are more likely to look at the medical aspects of care. These may include the types of tests used in diagnosing illness or in monitoring how treatments are working, how regularly these tests are used, or what types of medications are prescribed by doctors to treat various diseases. These medical aspects of care are called "clinical indicators" of the quality care.

What are some specific clinical indicators that you think can or should be used to evaluate the quality of HIV medical care people receive? Let's list some of them.

3. On one of the newsprint sheets write down the ideas that participants suggest.
4. These should include some or all of the following:

- HIV Viral Load Tests
- CD4 + Cell Tests
- TB or PPD Tests
- Antiretroviral Drug Resistance Testing
- Offer of antiretroviral medications
- Treatment Adherence Education and Support
- Hepatitis C Tests
- Pelvic Exams

5. Select 4 or 5 of these clinical indicators and write one each on the top of the hanging newsprint sheets.

6. Tell the group:

Most of these terms are probably familiar to you. To be sure that we all understand what each of these important terms means, let's form small groups to brainstorm as much as we know about them.

We will form groups of 3 - 5 people. Each group will start at one of the sheets and take 2 or 3 minutes to write down everything that they know about the term at the top of the sheet. One person can do the writing but each person in the group should contribute ideas to write down. You should also write down any questions that you have about the term or things that are not yet known about it. Also write down why you think it is an important measure of quality of care you receive.

After 2 - 3 minutes I will tell you to move as a group to the next sheet. You will then have the chance to add to what was written by the group before you or to answer questions they might have asked. Every few minutes you will move to each of the next sheets until your group has had the chance to write on each of them.

We will then come back as a group to discuss all of the information that you have gathered. Are there any questions? Okay, let's begin.

7. Direct the participants in forming small groups, identifying one person to write for each group, and moving to a sheet to start. Tell them that they have 2 -3 minutes to begin writing what they know.
8. After 2 - 3 minutes ask the groups to move to the next sheet. Repeat the process until each group has had the opportunity to contribute to each of the sheets.
9. When finished, ask the groups to come back to their seats.
10. You may now read what is on each sheet (one at a time) and ask if there are any points that are not clear or that you might feel are incorrect. Ask the group for help in clarifying and correcting information. Resolve any clearly inaccurate information but encourage the group to discuss how they can get the most correct and up to date information.
11. When finished with review of the sheets, say:

Good quality HIV care should include each of these clinical indicators. If they are not part of your HIV care, it may mean that less than the best quality HIV care is being provided.

Next we will take a more personal look at these indicators.

Thank you for working together on gathering the information we need on these clinical indicators. What we did here is a good model of positive self - advocacy skills by sharing information and helping to educate one another.

Activity E:

Clinical Indicators Personal Assessment Activity

Rationale:

The participants will apply their understandings about the quality of clinical care indicators to an assessment of their own care. For some participants, this activity will help them to focus their attention on an aspect of their care that they may not think much about or pay attention to in the course of their interaction with their doctors. For others, they will know very well whether or not their doctor has provided these tests or treatments. Their contribution to this activity may help to empower the less-informed participants to become more involved in the clinical aspects of their HIV care.

Materials Needed:

Newsprint sheet: list of clinical indicators discussed in Modules Activity D.
Personal Assessment Worksheet

Time Needed:

10 minutes

Procedure

1. Hand out the Personal Assessment Worksheet to each participant. Hang the newsprint sheet with the clinical indicators list. Explain:

We are now going to look at each of the clinical quality indicators we talked about in the last activity.

When we look at each indicator in turn, I want you to think about the question as I read it to you. Then answer the question, to the best of your knowledge, by checking off the answer on your worksheet.

2. Read each question on the worksheet and ask the participants to answer each question to themselves. The Personal Assessment Worksheet can be used to allow the participants to record their answers. Some participants may not be sure of their answers. Tell them to check the “not sure” box.
3. After all of the questions have been read, ask:

Are you satisfied that you were able to answer each of these questions?

What have you learned about your HIV care from this activity?

Has your personal view of the HIV care you receive changed in any way?

4. Encourage a few participants to share what they have learned about their HIV care as a result of this activity.
5. For those participants who were “not sure” about whether or not their doctor provided one or more of the indicators, ask:

Some of you were not sure about whether or not some of these tests or treatments were done. What can you do to find out more about them?

6. If no one suggests it on their own, suggest that they might consider asking their doctors about the test or the treatment they are unsure about. Ask:

What do you think might happen if you ask your doctor or nurse about a test or treatment that you are unsure about? Have you ever done that in the past?

7. If a participant says, “yes”, ask:

Please explain what happened?

8. When that person finishes describing what happened, suggest that:

Some doctors and nurses react to questions in different ways. Many appreciate it since it may help them to figure out how much you understand your care and how much you may want to participate in making decisions about your care. Others may react differently.

How can you get the information you need if you don't get your question answered by the doctor?

Ask for one or two participants to suggest some ideas. These may include: asking the doctor to explain it in another way so that you can better understand; asking the doctor where you could find out more information; asking the nurse, treatment educator or your case manager; see if you can find information in brochure or on the internet.

9. Next, ask the group to think about other indicators that might be used to evaluate the quality of care an HIV clinic provides to its patients, saying:

Based upon your personal experience, are there any other indicators that could be used to better measure the quality of HIV care a clinic provides to its patients?

10. Thank the group for participation in the activity, closing the activity with:

Thank you for participating in this activity. I hope you have a better understanding of the clinical indicators used to rate the quality of care.

This is a good time to take a brief break.

[Suggested time: 10 minutes]

Note: It is important to be clear about how long the break will be and your expectations about starting on time.

11. Close the activity with:

I also want to thank you for sharing your personal experiences in communicating with your health care providers about important issues. This serves as a model of self-advocacy for all of us. Good quality of care depends upon clear and effective communication with our health care providers. As self-advocates we need to do what we can to make that happen.

Personal Assessment Worksheet

Next to each of the statements below check off either “Yes,” “No,” or “Not Sure,” to the best of your ability.
Each of the statements relates to a measure of Clinical Indicators that maybe used to rate the quality of HIV care.

1) HAVE I HAD A VIRAL LOAD TEST IN THE LAST 4 MONTHS?

☐ Yes ☐ No ☐ Not Sure

2) HAVE I HAD A PPD TEST IN THE LAST YEAR?

☐ Yes ☐ No ☐ Not Sure

3) FOR WOMEN ONLY: HAVE I HAD A PELVIC EXAM, INCLUDING A PAP SMEAR, IN THE LAST YEAR?

☐ Yes ☐ No ☐ Not Sure

4) IF PREGNANT, HAVE I BEEN OFFERED MEDICATIONS TO PREVENT HIV INFECTION IN MY NEWBORN CHILD?

☐ Yes ☐ No ☐ Not Sure

5) I HAVE HAD A CD4 CELL TEST IN THE LAST 4 MONTHS

☐ Yes ☐ No ☐ Not Sure

6) I HAVE BEEN SCREENED FOR HEPATITIS C

☐ Yes ☐ No ☐ Not Sure

7) I HAVE BEEN OFFERED HELP IN SOLVING PROBLEMS I HAVE HAD WITH ADHERENCE WITH HIV-RELATED MEDICATIONS

☐ Yes ☐ No ☐ Not Sure

8) I HAVE DISCUSSED THE USE OF ANTIRETROVIRAL MEDICATIONS FOR HIV INFECTION WITH MY MEDICAL PROVIDER

☐ Yes ☐ No ☐ Not Sure

Activity F:

Your Personal Quality of Care Factors

Rationale:

Deciding which quality of care factors are important and ranking their importance helps participants to examine their attitudes and explore whether or not they are receiving quality care.

Materials Needed

Pens/Pencils

Your Personal Quality of Health Care Checklist

Time Needed:

4 minutes

Procedure

1. Explain the activity by saying the following:

Earlier, you worked together in small groups to rank quality of care factors. For this activity, I will give you the same worksheet and you will work by yourselves to rank the factors of quality of your own health care. I will give you about 2 minutes to complete this list.

2. Hand out the Your Personal Quality of Care Checklist to the entire group.

3. Read the directions to the group and review each factor.

This is Your Personal Quality of Care Checklist. The directions are as follows: Below are 12 Quality of Care Factors. How important is each one to you? Read the following 12 factors and rank them from 1 (most important) to 12 (least important). A factor can only have one ranking and each ranking can only be used once. I will give you 2 minutes to complete this activity.

4. When 2 minutes is up, ask the group to finish their checklists.
5. Ask the following questions:

- How is this personal ranking different from your group consensus ranking?
- How have your feelings about these factors changed?

6. Summarize by saying,

Congratulations, you now have all of the information that you will need to be an effective self-advocate. It may be hard work, but you are worth it. Hold on to this worksheet; you can use it as another way to rate your quality of health care.

This is the end of Module Two.

Your Personal Quality of Health Care Checklist

This is Your Personal Quality of Care Checklist. The direction are as follows: Below are 12 Quality of Care Factors. How important is each one to you? Read the following 12 factors and rank them from 1 (most important) to 12 (least important). A factor can only have one ranking and each ranking can only be used once.

How important is it to me that:

- _____ I have a good relationship with my doctor.
- _____ The clinic staff makes me feel welcome.
- _____ I have confidence in the knowledge and skills of my doctor.
- _____ There is a short waiting time to be seen by my doctor.
- _____ Many different services are provided at one clinic location.
- _____ The facility is convenient to get to.
- _____ My doctor communicates well with me and answers my questions.
- _____ Other patients rate a high quality of care.
- _____ I get regular CD4 counts, viral load tests, and drug resistance testing.
- _____ HIV - related medications are available to me and their side effects have been explained to me.
- _____ Regular pelvic exams are available for women.
- _____ The staff helps me to be involved in making decisions about my health care.

Module Three:

Self - Advocacy for Improved Health

Goals

The goals of this module are to:

- Practice the skills necessary to be a successful self advocates for improved quality of care.
- Assist participants in developing strategies for addressing some of the more difficult health care decisions to be faced.
- Increase participants' confidence in advocating for themselves.
- Increase the participants' communication skills and enhance their ability to problem-solve situations that may occur with their HIV health care.

Objectives

After completing this module, participants will be able to:

- Identify strategies for overcoming the barriers confronted in trying to advocate for quality health care.
- Describe strategies for promoting self-advocacy skills

Strategies/Methods

Group Discussion

Role Plays

Materials Needed

Pens/Pencils

Markers

Tape

Options Scenario

Role Play Scenarios

Helpful Hints Handout

Preparation Needed:

Pre-label newsprint: "What are my Options?"

Time Needed:

50 minutes

ACTIVITY	TIME
A. What are my Options?	20 minutes
B. Role Plays	30 minutes

Facilitator's Note

1. As you read the list of options, write them on the newsprint and keep them in view for the remainder of the Module.
2. In discussing this “Options Scenario” the possibility of asking your doctor to switch your medications may be suggested. This is a good opportunity to reinforce the suggestion that the self-advocacy role of the participant may include asking for more of an explanation for the doctor’s not making the change in medications when this first came up. There are, of course, many pros and cons to switching medications and many reasons that a

physician may have for not wanting to make a switch, including the possibility that HIV drug resistance test information may indicate that a change would not be beneficial, or that the side effects of other drugs might not be well-tolerated, given the patient’s history, etc.

The opportunity here, though, is to encourage more complete communication between the patient and the physician, particularly around the problem of adherence with the recommended dosage of the prescribed medications.

Activity A:

What Are My Options?

Rationale:

Providing options for the participants provides them with additional information so that they are able to make critical decisions about their HIV care.

Materials Needed

3 Pre-labeled newsprint: Problems, Barriers, Actions
Options Scenario

Time Needed:

20 minutes

Procedure:

1. Hang three sheets, Problems, Barriers, Actions.
2. Introduce the activity by saying:

In this activity, we are going to discuss ways of handling challenging situations. We will look at a situation that has a few different solutions. In this situation I want you to first make a list of all the problems you see. Second, list the barriers to solving the problems. And third, list some actions you could take to try to solve the problems.

1. What are some of the problems in this situation?
2. What are the barriers?
3. What are some things you could do to solve the problem?

3. Say the following:

I am going to hand out and read a short scenario to you. When I am done we will talk about what you might do in this situation to make it better.

4. Hand out the Options Scenario to each participant and read the scenario.
5. After reading the Options Scenario, say:

What are some of the problems that you found in this situation?

6. List these on the sheet labeled "Problems" then ask for the barriers and list them.
7. After listening to the participants describe the problems, ask:

What are some of the options that might help make this situation better? Which of them would you try first?

8. List the options on the "Actions" sheet and discuss.
9. Summarize by saying:

From this activity we can see that problems often have many layers to them and also several possible ways of solving them. Speaking with others about problems often helps us to get a new perspective on them. Thinking about different options helps us to feel more in control of a situation and to consider our actions carefully.

Options Scenario

You are attending a job-training program, but you have been arriving late because you can't wake up on time. The director of the program has told you that if you can't show up on time, you will be kicked out. You have told your doctor that your medication is making you sleepy, but your doctor has not changed your medication. What you haven't told your doctor is that because of oversleeping you have been missing some of the doses of your HIV medication.

What do you think you can do to advocate for yourself and improve the situation?

Activity B:

Options Role Play Practice

Rationale:

Providing participants with an opportunity to practice advocating for quality health care gives them the confidence in themselves to be self-advocates.

Materials Needed

Role Play Scenarios #1 and #2

Time Needed:

30 minutes

Procedure

1. Explain the activity by saying the following:

You have done a lot of work today. We are almost finished. When you leave here today, you will be able to use all of the information and skills you have learned to make sure your HIV care is the best it can be. Remember that you deserve the best of care at all times.

We have spent a lot of time discussing which quality of care factors are important to you. We have discussed how you feel about the health care that you are receiving. Now you are going to have the chance to use all of the information that we went over today in a practice session.

2. Continue by saying:

Now we are going to do some role-plays. Role-playing is a technique that can help you practice what to do in a new or hard situation. You can use all of the information that was reviewed here today, including the information that each of the group members shared, and use it in your role-play.

For the role-plays, you will need to be in pairs, so find a partner. It would be a good idea to choose someone that you have not worked with today. I am going to hand out a role-play scenario for everyone.

Facilitator's Note

1. Some groups of participants may have no experience with the use of role play as a learning tool. If this is the case with the group in your workshop, it may be very helpful for you to model the first role play with one of the participants. For example, you might play the advocate and the participant volunteer would play the client. You could then have the participants repeat the role play in their pairs. If time does not permit this, the group could do the second role play in their pairs.

It might be helpful to instruct the advocates that their role is not to be the “problem solver.” The best way for them to help the client is to help them think through the problem, looking at each of the possible options and helping them to pick one they feel most comfort-

able with. The least helpful thing they can do is give the client “the answer,” since it may only be the “answer” that the advocate likes best and not the one that fits the client’s needs the most.

2. Time may not permit each of the pairs to answer each of the questions; try to get some of the answers from different pairs. For example, have the advocate of one pair answer the first question, and then have the client of another pair answer the second, etc.
3. An alternate role play option is to have 3 participants (triad) work together. The third participant acts as the observer and can provide a different perspective during the discussion.

Read the role-play. One of you will play the client and the other will play the advocate. Both of you are trying to solve the problem with the advocate helping the client use their problem-solving skills. You will have about 5 minutes to do this role-play. It is important for you to do your best to stay in your role until the role-play is over. Your goal in each role play is to decide on an action plan to solve the problem.

3. Hand out the Role-Play Scenarios.
4. Read the Advocate Role first; then, the Client Role.
5. Give them 5-7 minutes to practice the role-play.
6. When they are finished with the role-play ask the following questions of each of the pairs:

- How did you break down the problem?
- What possible options did you think of?
What were the risks and benefits of these options?
- Which option did you choose? Why?
- What do you think you might do if the option you chose does not work?

7. Introduce Client Role #2 by saying the following:

For the second role-play, switch roles. Whoever played the advocate will now play the client and whoever played the client will now play the advocate. The Advocate Role stays the same; the client role is different. I will give you about 5 minutes to complete this role-play.

8. Give them 5-7 minutes to practice the role-play.
9. When they are finished with the role-play ask the following questions, as you did with the first role-play:

- How did you break down the problem?
- What possible options did you think of?
- Which option did you choose? Why?
- What do you think you might do if the option you chose does not work?

10. What are some important things you learned from doing these role plays?
11. Summarize by saying:

Great job. In doing these role-plays you had a chance to practice being a self-advocate in a safe place. Now that you have practiced, you are ready to be your own self-advocate and make sure that you get quality HIV health care.

Role Play Scenarios

Client Role 1

You have been going to the same health care provider for three months and have noticed that you leave the office without really understanding what you need to know about your HIV treatment. You have tried to speak with other medical staff but the waiting room is noisy and they rush you along. There are other medical concerns that you would like to ask someone, but there doesn't seem to be anyone available. You decide to talk to a friend who goes to the same clinic you do about your problem.

Client Role 2

You have a great relationship with your doctor and you trust his/her recommendations. When you talk to some of your friends who go to another HIV clinic you find that they seem to be getting tests and treatments that you are not getting. You are concerned about this and decide to talk to a friend.

Advocate Role (Both Scenarios)

Your friend has come to talk to you about the quality of care s/he is receiving at the HIV clinic you both go to. You can help him/her break down the problem, identify possible options, and select a few actions that your friend is comfortable with.

Activity C:

Closing Activity: What Have We Learned?

Rationale:

Providing participants with strategies necessary for negotiating for quality health care gives them confidence in themselves to be self-advocates.

Materials Needed

Helpful Hints for the Self-Advocate

Consumer Workshop Take-Home Summary

Self-Assessment Worksheet

Workshop Evaluation

Time Needed:

10 minutes

Procedure

1. Say the following,

As you can see, making decisions about your HIV health care can be hard work. Although the work may be hard, you have proven that you can do it. Today, you discussed the positives and negatives about your health care. You have learned that there are resources available that will help you to get the best quality HIV health care. You can be a self-advocate.

2. Explain the following:

For our last activity, I would like for you to take a few minutes and think about what you have learned today and how has this workshop helped you. To help you do that, please fill out the Self-Assessment Worksheet. Circle the terms that best describe how prepared you now feel to do each of the things on the list. Each of these is something that we agreed we would work on in this workshop.

3. Give the participants a few minutes to fill out the worksheet and then collect them. (You can use these to evaluate how effective the workshop has been in meeting the objectives discussed in the opening module.)
4. Now ask:

Now that you have thought about the work that we have done today, would someone like to tell the group something about what you have learned in the workshop today?

5. Go around the room until each person who wants to has had a chance to speak. Thank them for their contribution.
6. Hand out the Helpful Hints for the Self-Advocate. Briefly review the handout.
7. Hand out the Consumer Workshop Take-Home Summary. Briefly review this handout.
8. Thank the participants for attending and participating in the workshop.
9. As the last activity, please can ask the participants to take a few moments to fill out the workshop evaluation form. Collect these forms as the participants finish them and leave.

Helpful Hints for the Self-Advocate

You can be an effective *self-advocate*, but you need to develop a plan for handling the obstacles that may arise. Learning how to handle obstacles makes advocating easier.

Believe In Yourself And Ask Others For Help

Believe that you are someone worthy of advocating for. The more you reach out and get the services you deserve, the better you will feel about yourself. Advocacy means taking responsibility for getting what you want and deserve. It can be tiring, so don't think you have to be an advocate alone. You can ask for help.

Be Assertive

Assertiveness shapes the way we deal with other people. Being a self-advocate means you must be persistent and knowledgeable. Remember, "The squeaky wheel gets the oil."

Manage Your Anger

Do not insult, yell at, or disrespect others while you are advocating for yourself. People will be less inclined to help you or answer questions if you make them angry, uncomfortable, or cause them trouble. Don't let people have the chance to use your anger as an excuse for not helping you. Teach yourself how to control your anger.

Educate Yourself

Take every opportunity to educate yourself. That means asking questions, getting answers, and asking more questions. That also means taking advantage of every educational opportunity. Read about services that you may be eligible for and become aware of new and different treatment options.

Consumer Workshop Take–Home Summary

Making Sure Your HIV Care is the Best It Can Be

What We Believe:

- You have a right to the highest quality HIV care possible.
- You play an important part in improving the quality of HIV care at your clinic. What you need and what you think about your care matters. If you speak, people will listen.

Factors That Contribute To The Quality Of Your Care:

- The relationships you have with your doctor and the other clinic staff.
- The location and the facilities and services provided at your clinic.
- How well your personal needs are met.
- How well your medical care is handled (Are the right tests and treatments provided when they should be?).
- When you are not satisfied with your care, someone is there to help you make improvements.
- How well you can communicate with your doctor and other health care providers.

Some Important Indicators Of The Quality Of Medical Care You Receive:

1. HIV viral load tests are done at least every 4 months and the results are discussed with you.
2. You have a TB test (PPD) every year.
3. If you are a woman, you have a pelvic exam every year.
4. If you are pregnant, you are offered antiretroviral medication to help prevent HIV infection in your newborn child.

Making Sure Your HIV Care Is The Best It Can Be

Workshop Evaluation

Please take a few moments to let us know how you felt about this workshop. Your thoughts are important to us as we prepare for future workshops. Please circle your response. The following statements are about the workshop.

	POOR	FAIR	GOOD	EXCELLENT
1) WHAT IS YOUR OVERALL RATING OF THIS WORKSHOP?	1	2	3	4
2) WHAT IS YOUR OVERALL RATING OF THE TRAINER?	1	2	3	4
3) INFORMATION WAS DELIVERED IN A WAY YOU COULD UNDERSTAND.	1	2	3	4
4) PEOPLE WERE ENCOURAGED TO EXPRESS DIFFERENT OPINIONS.	1	2	3	4
5) WAS THE TRAINING PROGRAM MEANINGFUL TO YOUR PERSONAL LIFE?	1	2	3	4
6) DID THE TRAINER APPEAR KNOWLEDGEABLE ABOUT THE INFORMATION?	1	2	3	4
7) DID THE TRAINER DELIVER THE INFORMATION CLEARLY?	1	2	3	4
8) DID THE TRAINER PROVIDE OPPORTUNITIES FOR DISCUSSION?	1	2	3	4

Other Information

HOW MUCH DID THE WORKSHOP PROVIDE USEFUL INFORMATION TO YOU?

☐ A great deal ☐ A lot ☐ Not much ☐ Not at all

WOULD YOU RECOMMEND THIS WORKSHOP TO OTHERS?

☐ Yes, definitely ☐ No ☐ I'm not sure

Please provide an explanation for your response to the following 3 questions:

What were the most important things you learned in this workshop?

What did you like the most about this workshop?

What would you like to change about this workshop?

Additional suggestions or comments:

Thank You!!!

Self - Assessment Worksheet

How well prepared do you now feel to do each of the following? Please check the term that most closely describes how prepared you feel to do each of the following.

1) TO IDENTIFY WHAT IS MOST IMPORTANT TO YOU IN YOUR HIV HEALTH CARE.

☐ Very well prepared ☐ Well prepared ☐ A little unprepared ☐ Not prepared

HOW IS IT DIFFERENT FROM HOW YOU FELT BEFORE THE TRAINING?

☐ Better prepared ☐ About the same ☐ Less well prepared

2) TO JUDGE THE QUALITY OF HIV CARE THAT YOU RECEIVE?

☐ Very well prepared ☐ Well prepared ☐ A little unprepared ☐ Not prepared

HOW IS IT DIFFERENT FROM HOW YOU FELT BEFORE THE TRAINING?

☐ Better prepared ☐ About the same ☐ Less well prepared

3) TO USE QUALITY OF CARE INFORMATION AND WHAT OTHERS MAY THINK TO HELP YOU JUDGE THE QUALITY OF HIV CARE YOU RECEIVE.

☐ Very well prepared ☐ Well prepared ☐ A little unprepared ☐ Not prepared

HOW IS IT DIFFERENT FROM HOW YOU FELT BEFORE THE TRAINING?

☐ Better prepared ☐ About the same ☐ Less well prepared

4) TO DESCRIBE THE INDICATORS USED BY THE STATE TO RATE THE QUALITY OF HIV CARE PROVIDED BY HEALTH CLINICS AND HOSPITALS

☐ Very well prepared ☐ Well prepared ☐ A little unprepared ☐ Not prepared

HOW IS IT DIFFERENT FROM HOW YOU FELT BEFORE THE TRAINING?

☐ Better prepared ☐ About the same ☐ Less well prepared

Self - Assessment Worksheet...*Continued*

5) TO COMMUNICATE EFFECTIVELY WITH HEALTH CARE PROVIDERS AND STAFF ABOUT YOUR HEALTH CARE.

☐ Very well prepared ☐ Well prepared ☐ A little unprepared ☐ Not prepared

HOW IS IT DIFFERENT FROM HOW YOU FELT BEFORE THE TRAINING?

☐ Better prepared ☐ About the same ☐ Less well prepared

6) TO USE AN ACTION PLAN TO HELP IMPROVE THE QUALITY OF CARE YOU RECEIVE.

☐ Very well prepared ☐ Well prepared ☐ A little unprepared ☐ Not prepared

HOW IS IT DIFFERENT FROM HOW YOU FELT BEFORE THE TRAINING?

☐ Better prepared ☐ About the same ☐ Less well prepared



Notes



Notes

