Document over 50 pages, can be viewed in Minutes

Agenda Item No. 4C1

PALM BEACH COUNTY
BOARD OF COUNTY COMMISSIONERS
AGENDA ITEM SUMMARY

Meeting Date: October 24, 2006 [ ] Consent [X] Regular [ ] Workshop [ ] Public Hearing

Department Submitted By: Community Services

Submitted For: Ryan White Title I

I. EXECUTIVE BRIEF

Motion and Title: Staff recommends motion to ratify: Commissioner Warren H. Newell's signature on the 2007 HIV Emergency Relief Project Grant application.

Summary: The County has been notified that it is one of the Eligible Metropolitan Areas (EMA's) which will receive funds under the Title I HIV Emergency Relief Grant. The purpose of the funds is to deliver or enhance HIV related outpatient and ambulatory health and support services, including case management and comprehensive treatment services for individuals and families with HIV disease. The emergency process was used because the grant application for FY 2007 had to be submitted to the U.S. Department of Health and Human Services by October 2, 2006. (Ryan White) Countywide (TKF)

Background and Justification: Designated EMA's are those communities which as of March 31, 1993, reported to and had confirmed by the Center for Disease Control (CDC), a cumulative total of more than 2,000 cases of AIDS, or that had a per capita incidence of cumulative cases of AIDS equal to or exceeding 0.0025.

Title I funds provide direct financial assistance to EMA's most severely affected by the HIV epidemic. The purpose of the funds is to deliver or enhance HIV related outpatient and ambulatory health and support services, including case management and comprehensive treatment services for individuals and families with HIV disease.

The goal is to provide support to, and to augment, the urban health care systems currently bearing the overwhelming burden of providing HIV-related care, by assisting EMA's to operate programs that provide an appropriate continuum of outpatient and ambulatory health care and support services. Funding priorities must be established by the designated Title I HIV Health Services Planning Council based upon an assessment of the service of all affected populations within the EMA.

Attachments:

Application

Recommended by: _____ 10-12-2006
Department Director — Date

Approved by: _____ 10-18-06
Assistant County Administrator — Date

II. FISCAL IMPACT ANALYSIS

Five Year Summary of Fiscal Impact:

Fiscal Years	2007	2008	2009	2010
Capital Expenditures	____	____	____	____
Operating Costs	8474001	4237000	____	____
External Revenue	(8,474,001)	(4,237,000)	____	____
Program Income (County)	____	____	____	____
In-Kind Match (County)	____	____	____	____
NET FISCAL IMPACT	**00**	0	____	____
# ADDITIONAL FTE POSITIONS (Cumulative)	____	____	____	____

Is Item Included in Current Budget? Yes X No

Budget Account No.: Fund 1010 Dept 142 Unit 1479 Object

Program Code

Rev Account No. 1010/142/1479/3169

B. **Recommended Sources of Funds/Summary of Fiscal Impact:**

Funding provided through the U.S. Department of Health and Human Services. No County match is required. Federal funds will provide needed services to HIV/AIDS clients in Palm Beach County.

C. **Departmental Fiscal Review:**

III. REVIEW COMMENTS

A. **OFMB Fiscal and/or Contract Administration Comments:**

10-13-06
OFMB

10/18/06
Contract Dev. and Control

10/12/06 10/12/06 10/17/06

B. **Legal Sufficiency:**

10/18/06
Assistant County Attorney

C. **Other Department Review:**

Department Director

This summary is not to be used as a basis for payment.

Department of Community Services
810 Datura Street
West Palm Beach, FL 33401
(561) 355-4700
FAX: (561) 355-3863
www.pbcgov.com

Memo

To: Warren H. Newell, Commissioner, District 3

From: Robert Weisman, County Administrator

Date: 9/27/2006

Re: Request for Emergency Authorization

Pursuant to PPM# CW-F-003, Grant Administration Policy, I, B3 this memo is written to request your prior approval to Board review and action of a 2007 HIV Emergency Relief Project Grant. The attached form SF-424 requires signature in 4 separate places.

The grant application is being electronically transmitted, but original signatures are required to be sent via regular mail. Therefore, the grant is not attached to this request.

The County has been notified that it is one of the Eligible Metropolitan Areas (EMA's) which will receive funds under the Title I HIV Emergency Relief Grant. The purpose of the funds is to deliver or enhance HIV related outpatient and ambulatory health and support services, including case management and comprehensive treatment services for individuals and families with HIV disease. The grant application for FY 2007 must be submitted to the U.S. Department of Health and Human Services by October 2, 2006. The grant application will be completed by the Twenty-ninth of September, but still must be reviewed by the Community Services Department. To ensure that the grant application deadline is met the delegation of authority to sign the application is being requested.(Ryan White).

No County match is required.

The complete application will be placed on the next agenda item for ratification.

Attachments: 1) Grant Application signature pages

9/28/06
County Attorney Date

Stephanie Sejnoha 9/27/06
OFMB Date

Project Abstract

Project Title: West Palm Beach EMA Title I, FY2007
Applicant Name: Palm Beach County
HRSA Grant Number: 93.914
Address: 810 Datura Street
West Palm Beach, FL 33401
Contact: Edward Rich
Contact Phone Numbers (561) 355-4702
Email Address: ERICH@co.palm-beach.fl.us

Palm Beach County (EMA) covers approximately 2,200 square miles and has a population of 1,165,049 (U.S. Census 2000) with a 2005 mid-year population estimate of 1,277,645. The county's racial composition consist of 68 percent (%) White, 15% Black non-Hispanic, 14% Hispanic or Latino origin and 2% was other races/ethnicities. Approximately 27 % of the population is 60 years of age and 23% under 19. A 2006 Palm Beach County EMA Comprehensive Plan indicates there are estimated to be 65,000 seasonal farm workers in the county. Many of these workers are from the Caribbean, Central America and Mexico.

Of the 6,459 people living with AIDs in the EMA, 64% are Black non-Hispanic are African Americans, 24% are white and 10% are Hispanic. The historical patterns established by the epidemic in the EMA continue and increase with respect to those who become infected and the mode of exposure. Blacks accounted for 72% of reported AIDS cases, but only 14% of the county population. Among Black males, the AIDS case rate is 13 times higher than among White males. Among Black females, the AIDS case rate is 26-fold greater than among White females. Hispanic male rates are 5 times higher and Hispanic female rates are 5 times higher than the rates among their White counterparts.

The geographic distribution of AIDS in Palm Beach County varies widely. The PLWHA prevalence rate also varies by geography. In 2004, the rate for the eastern, urban part of the county, which includes the cities of West Palm Beach, Lake Worth, Riviera Beach, Boynton Beach, and Delray Beach, was 500 per 100,000 (i.e., 1 in 200). In contrast, the rate in the western, rural part of the county, which encompasses Belle Glade, Pahokee, South Bay, and Canal Point, was 2,347 per 100,000 (i.e., 1 in 43). Thus, the PLWHA rate in the western portion of the county is nearly 5 times greater than the rate in the eastern part of the county. This geographic distribution is consistent with present case reporting with numbers in the southern section of the EMA increasing faster than other sections. This is attributed to the growing immigrant and minority populations in the areas of Lake Worth, Boynton Beach and Delray Beach.

Services for the affected population vary and are primarily provided by community-based organizations located in population centers throughout the service area. The Continuum of Care provided in the EMA offers a variety of services Palm Beach County seeks to use Title I funds to support services that enhance access to primary care/treatments and maintain quality of life. Trends and changes in epidemiology were used in this process. The outcome was an increase in medical services in order to increase accessibility, capacity, and location of services. The planning council involved the PLWHA's in the process by conducting three public forums in the northern, southern and western areas of the EMA. Some of the concerns consumers raised were access to case management in the southern area of the county, access to acupuncture and home health care services.

Forms

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424

Version 02

* 1. Type of Submission:	* 2. Type of Application:	* If Revision, select appropriate letter(s):
☐ Preapplication	☑ New	
☑ Application	☐ Continuation	* Other (Specify)
☐ Changed/Corrected Application	☐ Revision	

* 3. Date Received:	4. Applicant Identifier:
Completed by Grants.gov upon submission.	

5a. Federal Entity Identifier:	* 5b. Federal Award Identifier:

State Use Only:

6. Date Received by State:	7. State Application Identifier:

8. APPLICANT INFORMATION:

* a. Legal Name:	Palm Beach County FL Board of County Commissioners
* b. Employer/Taxpayer Identification Number (EIN/TIN):	59-6000785
* c. Organizational DUNS:	100219570

d. Address:

* Street1:	810 Datura Street
Street2:	
* City:	West Palm Beach
County:	
* State:	FL: Florida
Province:	
* Country:	USA: UNITED STATES
* Zip / Postal Code:	33401

e. Organizational Unit:

Department Name:	Division Name:
Department Community Services	Administration

f. Name and contact information of person to be contacted on matters involving this application:

Prefix:	Mr.	* First Name:	Edward
Middle Name:	L		
* Last Name:	Rich		
Suffix:			

Title: Director

Organizational Affiliation:
Palm Beach County Community Services Department

* Telephone Number:	561-355-4702	Fax Number:	561-355-3863

Email: ERICH@co.palm-beach.fl.us

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424

Version 02

9. Type of Applicant 1: Select Applicant Type:

B: County Government

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

* Other (specify):

*** 10. Name of Federal Agency:**

Health Resources & Services Administration

11. Catalog of Federal Domestic Assistance Number:

93.914

CFDA Title:

HIV Emergency Relief Project Grants

*** 12. Funding Opportunity Number:**

HRSA-07-059

* Title:

HIV Emergency Relief Project Grants (EMRPG)

13. Competition Identification Number:

2390

Title:

14. Areas Affected by Project (Cities, Counties, States, etc.):

Palm Beach County, Florida

*** 15. Descriptive Title of Applicant's Project:**

Palm Beach County Title I, FY 2007 Ryan White CARE Act Grant Program

Attach supporting documents as specified in agency instructions.

Add Attachments | Delete Attachments | View Attachments

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424

Version 02

16. Congressional Districts Of:

* a. Applicant: Attach
* b. Program/Project: Attach

Attach an additional list of Program/Project Congressional Districts if needed.

Add Attachment

17. Proposed Project:

* a. Start Date: 03/01/2007
* b. End Date: 02/29/2008

18. Estimated Funding ($):

* a. Federal	12,711,001.00
* b. Applicant	0.00
* c. State	0.00
* d. Local	0.00
* e. Other	0.00
* f. Program Income	0.00
* g. TOTAL	12,711,001.00

*** 19. Is Application Subject to Review By State Under Executive Order 12372 Process?**

☐ a. This application was made available to the State under the Executive Order 12372 Process for review on

☐ b. Program is subject to E.O. 12372 but has not been selected by the State for review.

☑ c. Program is not covered by E.O. 12372.

*** 20. Is the Applicant Delinquent On Any Federal Debt? (If "Yes", provide explanation.)**

☐ Yes ☑ No

21. *By signing this application, I certify (1) to the statements contained in the list of certifications and (2) that the statements herein are true, complete and accurate to the best of my knowledge. I also provide the required assurances** and agree to comply with any resulting terms if I accept an award. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. (U.S. Code, Title 218, Section 1001)**

☑ ** I AGREE

** The list of certifications and assurances, or an internet site where you may obtain this list, is contained in the announcement or agency specific instructions.

Authorized Representative:

Prefix:	Mr.
* First Name:	Warren
Middle Name:	
* Last Name:	Newell
Suffix:	
* Title:	County Commissioner
* Telephone Number:	561-355-2203
Fax Number:	
* Email:	wnewell@co.palm-beach.fl.us
* Signature of Authorized Representative:	Completed by Grants.gov upon submission.
* Date Signed:	Completed by Grants.gov upon submission.

Authorized for Local Reproduction

Standard Form 424 (Revised 10/2005)
Prescribed by OMB Circular A-102

APPROVED AS TO FORM
AND LEGAL SUFFICIENCY
COUNTY ATTORNEY

OMB Approval No. 0348-0044

BUDGET INFORMATION - Non-Construction Programs

SECTION A - BUDGET SUMMARY

Grant Program Function or Activity (a)	Catalog of Federal Domestic Assistance Number (b)	Estimated Unobligated Funds		New or Revised Budget		
		Federal (c)	Non-Federal (d)	Federal (e)	Non-Federal (f)	Total (g)
1. Title I - Ryan White	93.914	$	$	$ 12,711,001.00	$	$ 12,711,001.00
2.						0.00
3.						0.00
4.						0.00
5. TOTALS		$ 0.00	$ 0.00	$ 12,711,001.00	$ 0.00	$ 12,711,001.00

SECTION B - BUDGET CATEGORIES

6. Object Class Categories	GRANT PROGRAM, FUNCTION OR ACTIVITY (1)	(2)	(3)	(4)	Total (5)
a. Personnel	$ 260,141.00	$ 149,864.00	$	$	$ 410,005.00
b. Fringe Benefits	84,730.00	50,603.00			135,333.00
c. Travel	31,650.00	7,061.00			38,711.00
d. Equipment	22,500.00	27,157.00			49,657.00
e. Supplies	3,173.00	2,213.00			5,386.00
f. Contractual	155,395.00	54,315.00			209,710.00
g. Construction					0.00
h. Other	77,962.00	28,787.00	475,000.00	11,280,450.00	11,862,199.00
i. Total Direct Charges *(sum of 6a - 6h)*	635,551.00	320,000.00	475,000.00	11,280,450.00	12,711,001.00
j. Indirect Charges					0.00
k. TOTALS *(sum of 6i and 6j)*	$ 635,551.00	$ 320,000.00	$ 475,000.00	$ 11,280,450.00	$ 12,711,001.00
7. Program Income	$	$	$	$	$ 0.00

Standard Form 424A (7-97)
Prescribed by OMB Circular A-102

Title I - Ryan White CARE Act Grant
Budget Narrative /Justification
March 1, 2007 - February 29, 2008

	Detail Cost	Total Cost
(1) ADMINISTRATION		**635,551**
a. PERSONNEL		**260,141**
Program Manager-Gayle Corso 1 F.T.E.	59,621	
The Program Manager's position requires the initiation, coordination and administration of the program		
Program Monitor - Pat Davis .75 F.T.E.	48,962	
The Program Monitor position is responsible for analyzing and monitoring the Title I services		
Program Monitor - Pedro Medina .75 F.T.E.	40,864	
The Program Monitor position is responsible for analyzing and monitoring the Title I services		
Financial Analyst I - Anna Balla 1 F.T.E.	50,794	
The Financial Analyst I position is responsible for performing detailed financial analyses, reviewing and preparing budgets, preparing revenue and expenditure forecasts, preparing financial reports for Community Services Administration, Program Staff and Planning Council.		
Fiscal Specialist III - Robert Guarascio 1 F.T.E.	59,900	
This position is responsible for auditing reimbursements.		
b. FRINGE		**84,730**
FICA - 6.20%	15,892	
FICA Medicare - 1.45%	3,717	
Retirement - 8.39%	21,506	
Health & Life Insurance	42,909	
Workers Compensation	706	
c. TRAVEL		**31,650**
Out-of-County	25,650	
Three (3) trips to HRSA conferences for (6) six staff members		
Trip Breakdown - Per Trip $8550.		
Airfare $425 x6 people = $2550		
Meals $40 a day x 5 days x6 people = $1200		
Hotel $200 per day x 4 days x 6 people = $4800.		
Local Travel-Mileage- grantee staff Approx.13484.	6,000	
at $.445 per mile for monitoring, technical assistance, and meetings. Including parking fees		
d. EQUIPMENT	22,500	**22,500**
Printers, Computers, Scanners		

Title I - Ryan White CARE Act Grant
Budget Narrative /Justification
March 1, 2007 - February 29, 2008

	Detail Cost	Total Cost
e. SUPPLIES		**3,173**
Consumable office supplies-pens, pencils, paper, calendars and desk top supplies.	3,173	
f. CONTRACTUAL		**155,395**
Grant Application Consultant - Contracts for assistance in the preparation of the grant application.	155,395	
g. CONSTRUCTION		**0**
h. OTHER		**77,962**
Attorney Fees - County Attorney $130 per hr x about 10 hrs per month x 12 months	15,600	
Advertising Advertisement for request for proposal for service providers in five newspapers.	4,259	
Casualty Self Insurance Including bonding	2,086	
Postage Mailing - Contracts, letters, grant packages including express mail and a portion of the postage machine (postage and rental).	1,760	
Equipment Maintenance Maintenance on Computer Equipment	4,400	
Registration Fees (Grantee Staff) Registration Fees for staff members for HRSA sponsored trainings/meetings.	5,000	
Communications Local and long distance calls	2,086	
Books, Publications & Subscriptions Copies of CFR, Government in the Sunshine, other relevant materials.	1,629	
Training and Development Staff attendance at training, seminars, and software training.	8,000	
Printing Printing of letter head, envelopes, reports	2,453	
Copy Cost Paper, supplies, portion of rent	1,560	
Motor Pool Rental of vehicle for staff to attend conferences	2,500	
Rental of Office Space	25,000	

Title I - Ryan White CARE Act Grant
Budget Narrative /Justification
March 1, 2007 - February 29, 2008

	Detail Cost	Total Cost
Dues and Memberships	1,629	
Membership for NMAC		
(2) QUALITY MANAGEMENT		**320,000**
a. PERSONNEL		**149,864**
Quality Assurance 1 F.T.E -Shoshana Ringer	58,588	
The program Quality Assurance position is responsible for establishing and implementing a Quality Management system and assuring compliance with all applicable Federal, State and Local standards. Ensuring providers implement Continuous Quality Improvement.		
Computer Specialist II - Sheron Hoo-Hing 1 F.T.E.	61,333	
The Computer Specialist II position provides desktop support for Departmental computer users and is responsible for the day to day administration of a server configured with a single operating system or minicomputer system.		
Program Monitor - Pedro Medina .25 F.T.E.	13,622	
The Program Monitor position is responsible for Medical chart review of the Title I services.		
Program Monitor - Pat Davis .25 F.T.E.	16,321	
The Program Monitor position is responsible for medical chart review of the Title I services.		
b. FRINGE		**50,603**
FICA - 6.20%	10,685	
FICA Medicare - 1.45%	3,801	
Retirement - 8.39%	14,370	
Health & Life Insurance	21,454	
Workers Compensation	293	
c. TRAVEL		**7,061**
Out-of-County		
Trip to HRSA conferences for staff members	4,888	
Trip Breakdown		
Airfare $425		
Meals $40 a day x 5 days = $200		
Hotel $200 per day x 4 days = $800		
Mileage		
approximate 4495 miles at .445 per mile for monitoring technical assistance and meetings. Including parking fees	2,173	

Title I - Ryan White CARE Act Grant
Budget Narrative /Justification
March 1, 2007 - February 29, 2008

	Detail Cost	Total Cost
d. DP EQUIPMENT		**27,157**
Purchase of a Server, Laptops (2) and a printer	27,157	
e. SUPPLIES		**2,213**
Consumable office supplies-pens, pencils, paper, calendars and desk top supplies.	2,213	
f. CONTRACTUAL		**54,315**
Contract with consultant for Quality Assurance.	54,315	
h. OTHER		**28,787**
Registration Fees QA	2,173	
Registration fees for QA staff member for HRSA sponsored training/meetings.		
Rental of Office Space	8,690	
Office Furniture		
Purchase of office furniture for new offices	12,493	
Training and Development		
Staff attendance at seminars and training.	5,431	
(3) PLANNING COUNCIL SUPPORT - Contractual		**275,000**
a. PERSONNEL		**147,003**
Health Planner-Sonja Swanson - 1 FTE	57,901	
Responsible for the development and implementation of all needs assessment activities, the Comprehensive Plan and provision of professional support to several committees. Assists in the priority setting and allocations process with the Care Council.		
Secretary -Anette Williams - 1 FTE	33,503	
Provides general secretarial support as assigned. Works under the supervision of the HIV CARE Council Executive Director.		
Membership Coordinator- Annette Murzike -Dunn -.6 FTE	18,250	
Coordinate all membership activities for CARE Council inclusive of interviewing and recruiting new members.		
Health Planner Tech Assistant-Barbara Feeney-.05 FTE	2,573	
Provides technical assistance and general support to the CARE Council's Health Planner in fulfillment of HRSA required planning activities.		

Title I - Ryan White CARE Act Grant
Budget Narrative /Justification
March 1, 2007 - February 29, 2008

	Detail Cost	Total Cost
Executive Director-Barbara Jacobowitz - .25 FTE	20,434	
Responsible for overall agency operations and fulfilling duties of the Care Council Director including direct supervisory responsibilities of Care Council Staff. Liaison with Grantee and others entities that impact the provision of services.		
Director of Administrative Services-Andee Hasbrook - .25	14,342	
Responsible for the office management, fiscal and human services sections of the agency. Coordinates reimbursements for Title I, payment of bills and payroll.		
b. FRINGE		**47,213**
FICA	11,245	
Fl Unemployment	1,192	
Retirement	7,351	
Health & Life Insurance	26,484	
Workers Compensation	941	
c. TRAVEL		**1,900**
Local Travel (Mileage for Planning one Council Staff and one Council member) Approx. 1124 miles @$.445 per mile	500	
Conferences/Registration-Florida all Titles Ryan White Conference for two staff members and one council member.	1,400	
d. EQUIPMENT		**0**
e. SUPPLIES		
Consumable Office Supplies - pens, pencils, paper, calendars, desk top supplies.		**2,500**
f. CONTRACTUAL		**700**
g. CONSTRUCTION		**0**
h. OTHER		**75,684**
Telephone	2,600	
Postage & Shipping	400	
Utilities	3,600	
Food Service	400	
Building Rental	28,200	
Equipment Rental	3,000	
Building Maintenance	2,200	
Audit Fees (Formulated strictly on the amount of each Contract in relation to the total agency budget)	550	
Training and Development	14,000	

Title I - Ryan White CARE Act Grant
Budget Narrative /Justification
March 1, 2007 - February 29, 2008

	Detail Cost	Total Cost
Insurance/Bonding	2,534	
Member's Fund - (Transportation, Child Care and Meeting supplies)	18,200	
(4) PROGRAM SUPPORT Contractual		**200,000**
a. PERSONNEL		**72,838**
MIS Director- Robert Bytnar - 1 FTE	64,266	
Provides design, development and database administration, user security and anti-virus, and firewall maintenance, software and computer installation as well as user training, help desk support to all agencies utilizing the database. Purchases and installs all computer equipment for all participating agencies across the EMA.		
Executive Director-Barbara Jacobowitz - .03 FTE	2,452	
Directly supervises the Program Support staff and is responsible for all budgetgary expenditures incurred by Program Support		
Director of Administrative Services-Andee Hasbrook - .03 FTE	1,721	
Office manager, coordinates reimbursements for Title I, responsible for payment of bills and payroll, completes supply orders.		
Medical Eligibility Specialist- Louis Kolber - .10 FTE	4,399	
Acts as Medical Coder agencies' client data in the Factors Database. Performs duties related to the submission of the CADR and provides technical assistance to providers in the Coordinated Services Network.		
b. FRINGE		**20,284**
FICA	5,573	
Fl Unemployment	438	
Retirement	3,642	
Health & Life Insurance	10,165	
Workers Compensation	466	
c. TRAVEL		**50**
Local Travel (Program Support Staff Mileage)	50	
Approx. 112 miles at $.445 per mile		
Conferences/Registration	0	
HRSA sponsored training and MIS system training		

Title I - Ryan White CARE Act Grant
Budget Narrative /Justification
March 1, 2007 - February 29, 2008

	Detail Cost	Total Cost
d. EQUIPMENT		**25,000**
Computer workstations, monitors, laser printers and network equipment.		
e. SUPPLIES		**2,200**
Office supplies	700	
Program supplies	1,500	
f. CONTRACTUAL(annual license renewal)		**19,300**
g. CONSTRUCTION		
h. OTHER		**60,328**
Telephone	1,060	
MIS Network Data Transmission Lines	42,000	
Postage & shipping	50	
Utilities	1,500	
Building Rental	12,000	
Equipment Rental	200	
Building Maintenance	1,000	
Training & Development	0	
Data Processing Supplies	968	
Audit Fees (Formulated based on the amount of each Contract in relation to total agency budget)	450	
Insurance Bonding	1,100	
(5) HIV SERVICES		**11,280,450**
f. CONTRACTUAL		
Medical Care		**6,980,450**
Ambulatory/Outpatient Primary Care: Access to comprehensive outpatient ambulatory medical care for eligible patients. Also, primary care services in targeted areas throughout the EMA according to documented need with regard to demographics, epidemiology and special populations. Nutritional counseling for persons living with HIV and taking medication.	750,000	

Title I - Ryan White CARE Act Grant
Budget Narrative /Justification
March 1, 2007 - February 29, 2008

	Detail Cost	Total Cost
Laboratory Diagnostic Testing HIV viral load testing, CD4/CDS, CBC with diff., blood chemistry profile and other FDA approved routing tests for the treatment of patients with HIV disease. In addition, routine tests pertinent to the prevention of opportunistic infections (VDRL, tuberculin skin tests, AFB, pap smear, toxoplasmosis, hepatitis B, and CMV serology) and all other laboratory tests as clinically indicated (e.g. HCV serology) that are generally accepted to be medically necessary for the treatment of HIV disease and its complications and have an established Florida Medicaid reimbursement rate.	1,750,000	
Local Supplemental Drug Program Program to expand the number of covered medications available to ADAP eligible patients when such medications are medically necessary to prolong life or prevent the serious deterioration of health, and to reimburse Ryan White eligible patients with private insurance for prescription co-pays. Medically necessary vaccines shall be covered. Vaccines, intra muscular injections and intravenous injections to be delivered in a primary care setting. Pharmacy pickup service to be available on a County wide basis, coordinated with ADAP distribution, with patients signing for new and refill prescriptions to track adherence and compliance.	999,950	
ADAP Supplemental Drug Program Program to expand Florida AIDS Drug Assistance Program (ADAP) locally by paying for FDA approved medications on the State of Florida ADAP formulary when the Florida ADAP is unable to pay for such medications for patients enrolled in the Florida ADAP program and patients are ineligible for other local health care programs which pay for these medications. Medications purchased under this program must be purchased at Public Health Services prices or less.	300,000	
Nutritional Supplements Provision of nutritional supplement prescribed as a treatment for diagnosed wasting syndrome. Counseling linked to Primary Medical Care, Nurse Care Management or Human Services Management	40,000	

Title I - Ryan White CARE Act Grant
Budget Narrative /Justification
March 1, 2007 - February 29, 2008

	Detail Cost	Total Cost
Pediatric AZT To provide AZT medication to infants born to HIV+ Mothers.	6,000	
Specialty Outpatient Health Care Short term treatment of specialty medical conditions and associated diagnostic procedures for HIV positive patients based upon referral from a primary care provider. Specialties may include, but are not limited to outpatient rehabilitation, dermatology, oncology, obstetrics, gynecology, urology, podiatry, pediatrics, rheumatology, physical therapy, speech therapy, occupational therapy, developmental assessment and psychiatry.	750,000	
Dental Care Routine dental care examinations and prophylaxis, X-rays, treatment of gum diseases, oral surgery and medically necessary dentures.	600,000	
Nurse Care Coordination A range of client-centered services provided by a registered nurse specialist and coordinated with the client's primary outpatient healthcare provider, providing the Ryan White patient's main link with ongoing medical services.	325,000	
Outreach Identifying people with HIV disease so that they are aware of the availability of services and treatment care	300,000	
Treatment Adherence Provision for widely disseminated, culturally appropriate information to HIV infected community members regarding HIV disease and related illnesses, clinical trials and treatment options.	300,000	
Insurance Continuation Financial assistance for eligible individuals with HIV Disease to maintain continuation of health insurance.	59,500	
Residential Substance Abuse Treatment Provision of residential substance abuse treatment counseling, including specific HIV counseling in secure drug-free state licensed residential (non-hospital) substance abuse detoxification and treatment facility, not to exceed 90 days.	250,000	

Title I - Ryan White CARE Act Grant
Budget Narrative /Justification
March 1, 2007 - February 29, 2008

	Detail Cost	Total Cost
Outpatient Substance Abuse Treatment/Counseling Provision for regular, ongoing substance abuse monitoring and counseling, including specific HIV counseling, on an individual and group basis in a State licensed outpatient setting.	75,000	
Mental Health Therapy/Counseling Psychological and psychiatric counseling services, including individual counseling, group counseling and facilitation of support groups, provided by a mental health professional licensed or authorized to practice within the State, including psychiatrists, psychologists, clinical nurse specialists, social workers and counselors.	300,000	
Home Health Care Therapeutic, nursing, supportive and/or compensatory health services provided by a licensed/certified home health agency in a home/residential setting in accordance with a written individualized plan of care ordered by a physician. Provides eligible patients with durable medical equipment (prosthetics, devices and equipment used by clients in a home/residential setting, wheelchairs, inhalation therapy equipment or hospital beds.) Also, provide skilled and unskilled nursing care to eligible patients.	175,000	
Support Services		**4,300,000**
Case Management Includes: Arranging of client-centered services that links clients with Primary Medical Care, Psychosocial and other services to insure timely, coordinated access to medically-appropriate levels of health and support services and continuity of care. Initial assessment of eligibility for Ryan White funded services.	3,500,000	
Food Bank/Home Delivered Meals Provision of actual food or meals to enhance the nutritional health of Ryan White eligible clients and their families. Availability of food vouchers for culturally diverse populations. Home delivered meals for those unable to visit sites.	150,000	

Title I - Ryan White CARE Act Grant
Budget Narrative /Justification
March 1, 2007 - February 29, 2008

	Detail Cost	Total Cost
Transportation Conveyance services provided to a client in order to access health care or psycho-social support services. May be provided routinely or on an emergency basis. Transportation services must be appropriate to the client's level of disability and priority shall be given to transportation services that link the client with health care services.	300,000	
Legal Services/Permanency Planning Legal Services Assessment of individual need, provision of legal advice and assistance by an individual authorized to render such advice and assistance in the State of Florida in obtaining medical, social, community, legal, financial or other needed services. Permanency Planning Assist parents/guardians who are HIV/AIDS infected with the planning for the temporary and/or long term legal custody of their legal dependents in the event that they become disabled or deceased. Allow parents to appoint permanent or temporary guardians.	200,000	
Emergency Financial Assistance Provision of short-term payments to agencies, or establishment of voucher programs, to assist with emergency expenses related to food, rent, utilities, insurance co-pay or other critical needs to prevent homelessness or institutionalization.	150,000	
TOTAL BUDGET		12,711,001

OMB Approval No. 4040-0007
Expiration Date 04/30/2008

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

NOTE: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant, I certify that the applicant:

1. Has the legal authority to apply for Federal assistance and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project cost) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States and, if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to nondiscrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and, (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Titles II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally-assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally-assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clean Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended (P.L. 93-523); and, (h) protection of endangered species under the Endangered Species Act of 1973, as amended (P.L. 93-205).

12 Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead-based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."

18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations, and policies governing this program.

* SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	* TITLE
Completed on submission to Grants.gov	County Commissioner
* APPLICANT ORGANIZATION	* DATE SUBMITTED
Palm Beach County FL Board of County Commissioners	Completed on submission to Grants.gov

OMB Approval No. 0920-0428

CERTIFICATIONS

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

(a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;

(b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

(c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and

(d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, In eligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with sub- grantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free workplace in accordance with 45 CFR Part 76 by:

(a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

(b) Establishing an ongoing drug-free awareness program to inform employees about--
  (1) The dangers of drug abuse in the workplace;
  (2) The grantee's policy of maintaining a drug-free workplace;
  (3) Any available drug counseling, rehabilitation, and employee assistance programs; and
  (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

(c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;

(d) Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
  (1) Abide by the terms of the statement; and
  (2) Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

(e) Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central

point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

(f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted--

(1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or

(2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

(g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget
Department of Health and Human Services
200 Independence Avenue, S.W., Room 517-D
Washington, D.C. 20201

3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

CERTIFICATION REGARDING LOBBYING

Certification for Contracts, Grants, Loans, and Cooperative Agreements

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly. This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Statement for Loan Guarantees and Loan Insurance

The undersigned states, to the best of his or her knowledge and belief, that:

If any funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this commitment providing for the United States to insure or guarantee a loan, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. Submission of this statement is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, U.S. Code. Any person who fails to file the required statement shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

* APPLICANT'S ORGANIZATION					
Palm Beach County FL Board of County Commissioners					
* PRINTED NAME AND TITLE OF AUTHORIZED REPRESENTATIVE					
Prefix: Mr.	* First Name: Warren		Middle Name:		
* Last Name: Newell	Suffix:		* Title: County Commissioner		
* SIGNATURE: Completed on submission to Grants.gov		* DATE: Completed on submission to Grants.gov			

APPROVED AS TO FORM
AND LEGAL SUFFICIENCY

COUNTY ATTORNEY

DISCLOSURE OF LOBBYING ACTIVITIES

Approved by OMB
0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C.1352

Review Public Burden Disclosure Statement

1. * Type of Federal Action:
- ☐ a. contract
- ☑ b. grant
- ☐ c. cooperative agreement
- ☐ d. loan
- ☐ e. loan guarantee
- ☐ f. loan insurance

2. * Status of Federal Action:
- ☐ a. bid/offer/application
- ☑ b. initial award
- ☐ c. post-award

3. * Report Type:
- ☑ a. initial filing
- ☐ b. material change

4. Name and Address of Reporting Entity:

☑ Prime ☐ SubAwardee

*Name

*Street 1 | Street 2

*City | State | Zip

Congressional District, if known:

6. * Federal Department/Agency:

7. * Federal Program Name/Description:

HIV Emergency Relief Project Grants

CFDA Number, *if applicable:* 93.914

8. Federal Action Number, *if known:*

9. Award Amount, *if known:*

$

10. a. Name and Address of Lobbying Registrant:

*Prefix: Ms. | *First Name: Heidi | Middle Name:

*Last Name: Hanson | Suffix:

*Street 1: 1055 North Fairfax Street | Street 2: Suite 201

*City: Alexandria | State: VA: Virginia | Zip: 22314

b. Individual Performing Services (including address if different from No. 10a)

*Prefix | *First Name | Middle Name

*Last Name | Suffix

*Street 1 | Street 2

*City | State | Zip

11.

Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when the transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

*** Signature:** Completed on submission to Grants.gov

***Name:** *Prefix:* Mr. | *First Name:* Warren | Middle Name:

*Last Name: Newell | Suffix:

Title: County Commissioner

Telephone No.: 561-355-2203

Date: Completed on submission to Grants.gov

Federal Use Only:

Authorized for Local Reproduction
Standard Form - LLL (Rev. 7-97)

APPROVED AS TO FORM
AND LEGAL SUFFICIENCY

COUNTY ATTORNEY

PHS-5161-1 (7/00)

CHECKLIST

OMB Approval No. 0920-0428

Public Burden Statement:

Public reporting burden of this collection of information is estimated to average 4 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC, Clearance Officer, 1600 Clifton Road, MS D-24, Atlanta, GA 30333, ATTN: PRA (0920-0428). Do not send the completed form to this address.

NOTE TO APPLICANT:

This form must be completed and submitted with the original of your application. Be sure to complete both sides of this form. Check the appropriate boxes and provide the information requested. This form should be attached as the last age of the signed original of the application. This page is reserved for PHS staff use only.

TypeofApplication: ☑ NEW ☐ Noncompeting Continuation ☐ Competing Continuation ☐ Supplemental

PART A: The following checklist is provided to assure that proper signatures, assurances, and certifications have been submitted.

	Included	NOT Applicable
1. Proper Signature and Date	☑	
2. Proper Signature and Date on PHS-5161-1 "Certifications" page.	☑	
3. Proper Signature and Date on appropriate "Assurances" page, i.e., SF-424B (Non-Construction Programs) or SF-424D (Construction Programs)	☑	
4. If your organization currently has on file with DHHS the following assurances, please identify which have been filed by indicating the date of such filing on the line provided. (All four have been consolidated into a single form, HHS Form 690)		
☐ Civil Rights Assurance (45 CFR 80)		
☐ Assurance Concerning the Handicapped (45 CFR 84)		
☐ Assurance Concerning Sex Discrimination (45 CFR 86)		
☐ Assurance Concerning Age Discrimination (45 CFR 90 & 45 CFR 91)		
5. Human Subjects Certification, when applicable (45 CFR 46)	☐	☐

PART B: This part is provided to assure that pertinent information has been addressed and included in the application.

	YES	NOT Applicable
1. Has a Public Health System Impact Statement for the proposed program/project been completed and distributed as required?	☐	☑
2. Has the appropriate box been checked on the SF-424 (FACE PAGE) regarding intergovernmental review under E.O. 12372 ? (45 CFR Part 100)	☑	
3. Has the entire proposed project period been identified on the SF-424?	☑	
4. Have biographical sketch(es) with job description(s) been attached, when required?	☑	☐
5. Has the "Budget Information" page, SF-424A (Non-Construction Programs) or SF-424C (Construction Programs), been completed and included?	☑	
6. Has the 12 month detailed budget been provided?	☑	☐
7. Has the budget for the entire proposed project period with sufficient detail been provided?	☑	☐
8. For a Supplemental application, does the detailed budget address only the additional funds requested?	☐	☑
9. For Competing Continuation and Supplemental applications, has a progress report been included?	☐	☑

PART C: In the spaces provided below, please provide the requested information.

Business Official to be notified if an award is to be made

Name: Prefix: * First Name: Warren Middle Name:
* Last Name: Newell Suffix:
Title: County Commissioner Organization: PBC Board of County C
Address: * Street1: 301 N. Olive Ave. Street 2:
* City: West Palm Beach * State: FL: Florida
Province: * Country: UNITED S
* Zip / Postal Code: 33401
* Telephone Number: 561-355-2203
E-mail Address:
Fax Number:

Program Director/Project Director/Principal Investigator designated to direct the proposed project

Name: Prefix: * First Name: Edward Middle Name:
* Last Name: Rich Suffix:
Title: Director Organization: PBC Community Servi
Address: * Street1: 810 Datura Street Street2:
* City: West Palm Beach * State: FL: Florida
Province: * Country: UNITED S
* Zip / Postal Code: 33401
* Telephone Number: 561-355-4702
E-mail Address:
Fax Number:

APPLICANT ORGANIZATION'S 12-DIGIT DHHS EIN (If already assigned)

__-59-6000785-__

SOCIAL SECURITY NUMBER

HIGHEST DEGREE EARNED

PART D: A private, nonprofit organization must include evidence of its nonprofit status with the application. Any of the following is acceptable evidence. Check the appropriate box or complete the "Previously Filed" section, whichever is applicable.

- ☐ (a) A reference to the organization's listing in the Internal Revenue Service's (IRS) most recent list of tax-exempt organizations described in section 501(c)(3) of the IRS Code.
- ☐ (b) A copy of a currently valid Internal Revenue Service Tax exemption certificate.
- ☐ (c) A statement from a State taxing body, State Attorney General, or other appropriate State official certifying that the applicant organization has a nonprofit status and that none of the net earnings accrue to any private shareholders or individuals.
- ☐ (d) A certified copy of the organization's certificate of incorporation or similar document if it clearly establishes the nonprofit status of the organization.
- ☐ (e) Any of the above proof for a State or national parent organization, and a statement signed by the parent organization that the applicant organization is a local nonprofit affiliate.

If an applicant has evidence of current nonprofit status on file with an agency of PHS, it will not be necessary to file similar papers again, but the place and date of filing must be indicated.

Previously Filed with: * *(Agency)* on * *(Date)*

INVENTIONS

If this is an application for continued support, include: (1) the report of inventions conceived or reduced to practice required by the terms and conditions of the grant; or (2) a list of inventions already reported, or (3) a negative certification.

EXECUTIVE ORDER 12372

Effective September 30, 1983, Executive Order 12372 (Intergovernmental Review of Federal Programs) directed OMB to abolish OMB Circular A-95 and establish a new process for consulting with State and local elected officials on proposed Federal financial assistance. The Department of Health and Human Services implemented the Executive Order through regulations at 45 CFR Part 100 (Inter-governmental Review of Department of Health and Human Services Programs and Activities). The objectives of the Executive Order are to (1) increase State flexibility to design a consultation process and select the programs it wishes to review, (2) increase the ability of State and local elected officials to influence Federal decisions and (3) compel Federal officials to be responsive to State concerns, or explain the reasons.

The regulations at 45 CFR Part 100 were published in Federal Register on June 24, 1983, along with a notice identifying the Department's programs that are subject to the provisions of Executive Order 12372. Information regarding PHS programs subject to Executive Order 12372 is also available from the appropriate awarding office.

States participating in this program establish State Single Points of Contact (SPOCs) to coordinate and manage the review and comment on proposed Federal financial assistance. Applicants should contact the Governor's office for information regarding the SPOC, programs selected for review, and the consultation (review) process designed by their State.

Applicants are to certify on the face page of the SF-424 (attached) whether the request is for a program covered under Executive Order. 12372 and, where appropriate, whether the State has been given an opportunity to comment.

Narrative

Table of Contents

1) Severe Need

This section describes the severity of the HIV/AIDS epidemic in the West Palm Beach EMA using quantitative epidemiological data; comorbidities, costs, and complexities of providing care; the service needs of special populations; and unique service delivery challenges. The purpose of this section is to explain why supplemental funding for services is needed for people living with HIV disease in Palm Beach County.

a) HIV/AIDS Epidemiology

This sub-section describes Palm Beach County's AIDS Incidence, AIDS prevalence, and HIV (not AIDS) prevalence by demographic characteristics and exposure category; trends in incidence and prevalence over time; the disproportionate impact of HIV/AIDS on certain populations; populations of PLWHA that are underrepresented in the CARE Act-funded system of HIV/AIDS primary medical care; and the estimated level of service gaps among PLWHA.

Palm Beach County Demographics

Palm Beach County is a geographically large (2,200 square miles) and demographically diverse EMA. The county is the largest of the state's 67 counties and is located on the southeast coast of the peninsula. Most of the population is concentrated in the coastal area between the Atlantic Ocean and the Florida Turnpike. The western portion of the county is predominantly rural. The county is remarkable for its extraordinary socioeconomic contrasts, ranging from one of the nation's wealthiest municipalities, Palm Beach, on the Atlantic Ocean, to one of its poorest, Belle Glade, on the shores of Lake Okeechobee in the extreme western portion of the county.

The 2005 mid-year population estimate for Palm Beach County was 1,277,645. Of these, 49% were male and 51% female. The county is racially and ethnically diverse. In 2005, 68% of the population was White non-Hispanic, 15% was Black non-Hispanic, 14% was Hispanic, and 2% was other races/ethnicities. A large proportion of the county's population is senior retirees. The 2005 age distribution in years was as follows: 0-12, 15%; 13-19, 8%; 20-24, 6%; 25-29, 5%; 30-39, 12%; 40-49, 15%; 50-59, 13%; 60+, 27%.[1] Additionally, an estimated 20% of the county's residents are foreign-born.[2] There are over 65,000 foreign-born seasonal farm workers in the county.[3] Many of these are from the Caribbean, Central America, and Mexico. In recent years, many immigrant workers have become employed in construction, landscaping, and other jobs throughout the county, especially the suburban coastal areas.[4]

Incidence and Prevalence

In 2005, a total of 6,833 people were reported to be living with HIV/AIDS (PLWHA) in Palm Beach County.[5] Using the above total population estimate yields an overall PLWHA prevalence rate per 100,000 in Palm Beach County of 535 (6,833/1,277,645 X 100,000). In other words, 1

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[1] Florida Department of Health, Bureau of HIV/AIDS Surveillance Section (2006). *Epidemiological Profile, Palm Beach County.*

[2] U.S. Census Bureau (2006). *2005 American Community Survey Data Profile Highlights, Palm Beach County.*

[3] Treasure Coast Health Council (2006). *Palm Beach County EMA Comprehensive Plan.*

[4] Ibid.

[5] Florida Department of Health, Bureau of HIV/AIDS Surveillance Section (2006). *Section 2 – Table 1b: Background Data Used for the Calculations of AIDS Prevalence, and HIV (Not AIDS) Prevalence (Excluding Department of Corrections).*

in 187 people in Palm Beach County is reported to be living with HIV/AIDS. In comparison, the analogous rate for the State of Florida is 417, or 1 in 240 people.[6]

This prevalence rate varies by race and gender.[7] In Palm Beach County, the PLWHA prevalence rate per 100,000 population in 2005 was 297 for White males (i.e., 1 in 337); 2,494 for Black males (i.e., 1 in 40); 527 for Hispanic males (i.e., 1 in 190); 298 for males of other ethnicities (i.e., 1 in 336); 86 for White females (i.e., 1 in 1163); 2,076 for Black females (i.e., 1 in 48); 237 for Hispanic females (i.e., 1 in 422); and 196 for females of other ethnicities (i.e., 1 in 510). Thus, among Black males, this rate is 8 times higher than among White males. Among Black females, this rate is 24 times higher than among White females. Hispanic male rates are 2 times higher and Hispanic female rates are 3 times higher than the rates among their White counterparts.[8]

The PLWHA prevalence rate also varies by geography. In 2004, the rate for the eastern, urban part of the county, which includes the cities of West Palm Beach, Lake Worth, Riviera Beach, Boynton Beach, and Delray Beach, was 500 per 100,000 (i.e., 1 in 200). In contrast, the rate in the western, rural part of the county, which encompasses Belle Glade, Pahokee, South Bay, and Canal Point, was 2,347 per 100,000 (i.e., 1 in 43). Thus, the PLWHA rate in the western portion of the county is nearly 5 times greater than the rate in the eastern part of the county.[9]

The following data on AIDS incidence, AIDS prevalence, and HIV (not AIDS) prevalence are shown in Attachment 1-B.[10]

AIDS Incidence

AIDS incidence is defined as the number of new AIDS cases diagnosed during 2004 and 2005, as of 01/06/06. A total of 796 AIDS cases were diagnosed during this period. In regard to race/ethnicity, about two-thirds (61%) of the total was comprised of non-Hispanic Blacks; about one-fifth (21%) were non-Hispanic Whites, and 16% were Hispanics. About two-thirds (63%) of these cases were males. Almost all of these cases (99%) occurred among adults aged 20 and over, with 62% occurring among the 20-44 year age group. The adult/adolescent population (age 13+) constituted 793 of the total 796 cases. Among this population, the most frequent exposure category was heterosexual (59%), followed by MSM (31%). IDU accounted for only 7% of the cases. Among the pediatric population (age 0-12), all 3 were in the exposure category of mother with/at risk for HIV infection.

AIDS Prevalence Estimate

The AIDS prevalence estimate is defined as the number of reported AIDS cases plus 5% for unreported cases through 2005, as of 04/05/06. These data exclude cases within the Florida Department of Corrections. As of the above date, an estimated 4,474 people were living with AIDS in Palm Beach County. The racial/ethnic, gender, and age distributions closely mirror

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[6] Ibid.

[7] Florida Department of Health, Bureau of HIV/AIDS Surveillance Section (2006). *HIV/AIDS Epidemoilogy, Palm Beach County.*

[8] Ibid.

[9] Lieb, S. (2005). *The Impact of HIV/AIDS on the Glades.* Florida Department of Health Bureau of HIV/AIDS.

[10] Florida Department of Health, Bureau of HIV/AIDS Surveillance Section (2006). *Table 1: AIDS Incidence, AIDS Prevalence, and HIV (not AIDS) Prevalence.*

those of the AIDS incidence data. Two-thirds (66%) of the cases are non-Hispanic Blacks, 23% are non-Hispanic Whites, and 10% are Hispanics. About two-thirds (64%) are males, and 99% are adults aged 20+. However, opposite to the adult age distribution of AIDS incidence, AIDS prevalence is higher among older adults aged 45+ (54%) than younger adults aged 20-44 (44%). Of the total 4,474 cases, 4,435 are among adults and adolescents (age 13+). Again, the exposure categories mirror those of AIDS incidence. 57% of the cases are heterosexual, 28% are MSM, and 10% are IDU. Among the 39 pediatric cases, almost all (97%) were exposed due to a mother with/at risk for HIV infection.

HIV (Not AIDS) Prevalence Estimate

The HIV (not AIDS) prevalence estimate is for 2005, as of 04/05/06. This estimate is defined as the total PLWAH minus AIDS prevalence. The estimate is adjusted for underreporting PLWH (not AIDS) and includes those diagnosed but not reported. As of the above date, the estimated total of people living with HIV (not AIDS) in Palm Beach County was 6,459. Their demographic characteristics again mirror those described above. 64% of these cases are non-Hispanic Blacks, 24% are non-Hispanic Whites, and 10% are Hispanics. 58% are males. Almost all (99%) are adults age 20+. Somewhat more (54%) are in the younger age group (20-44 years) than the older group (age 45+; 45%). The most frequent exposure category is heterosexual (62%), followed by MSM (27%). Among the 35 pediatric cases, 98% were due to a mother with/at risk for HIV infection.

Summary of Incidence and Prevalence

As seen from the above data, the HIV-infected population in Palm Beach County consists primarily of adults (age 20+) Blacks, males, heterosexuals, and MSM. This is further illustrated by the following findings reported by the Florida Department of Health, Bureau of HIV/AIDS Surveillance Section[11]:

- In 2005, Blacks accounted for 72% of reported AIDS cases, but only 14% of the county population.
- In 2005, Blacks are over-represented among AIDS cases, accounting for 56% of adult cases among men and 73% of adult cases among women.
- In 2005, Blacks are over-represented among HIV cases, accounting for 54% of adult cases among men and 68% of adult cases among women.
- Among Black males, the AIDS case rate is 13 times higher than among White males. Among Black females, the AIDS case rate is 26-fold greater than among White females. Hispanic male rates are 5 times higher and Hispanic female rates are 5 times higher than the rates among their White counterparts.
- Among Black males, the HIV case rate is 9 times higher than among white males. Among Black females, the HIV case rate is 17-fold greater than among White females. Hispanic male rates are 3 times higher and Hispanic female rates are 4 times higher than the rates among their white counterparts.
- HIV cases tend to be younger than AIDS cases: 19% of male HIV cases and 28% of female HIV cases in 2005 occurred among those aged 13-29, compared with only 12% of male AIDS cases and 13% of female AIDS cases in this age group. HIV cases tend to reflect more recent transmission than AIDS cases, and thus present a more current picture of the epidemic.

[11] Florida Department of Health, Bureau of HIV/AIDS Surveillance Section (2006). *HIV/AIDS Epidemoilogy, Palm Beach County.*

- Among male PLWHAs, MSM represents the highest risk for all races. White males have the smallest percentage of heterosexual contact cases.
- Among female PLWHAs, heterosexual contact is the majority risk for all races.

Incidence and Prevalence Trends Over Time

The following are notable changes in HIV/AIDS incidence and prevalence in Palm Beach County over time[12]:

Overall Trends in Palm Beach County

- The number of PLWA has steadily increased every year since 1986.
- However, the number of newly-diagnosed AIDS cases (incidence) has decreased from 759 in 1996 to 360 in 2005. Accordingly, the AIDS incidence rate per 100,000 population has decreased from 76.6 in 1996 to 28.2 in 2005. Increasingly, a diagnosis of AIDS reflects late diagnosis of HIV and limited access to treatment.
- HIV incidence has decreased from 552 (53.5 per 100,000 population) in 1998 to 397 (31.1 per 100,000 population) in 2005. Newly reported HIV cases have decreased each year.
- From 2003 to 2005, there was a decrease of 27% in HIV cases and a decrease of 19% in AIDS cases.

Gender Trends in Palm Beach County

- The relative ratio of males to females among adult AIDS cases has decreased over time. In 1996 the male to female ratio was 1.8 to 1, whereas in 2005 it was 1.5 to 1. This relative increase in female cases represents the changing face of the AIDS epidemic over time.
- The trend for HIV cases by sex is the opposite of that for AIDS cases. Recent trends in HIV transmission are best described by the HIV case data. In 1996 the male to female ratio was 1.2 to 1, whereas in 2005 it was 1.3 to 1. The relative increase in male HIV cases might be attributed to proportional increases in HIV transmission among MSM, which may influence future AIDS trends.

Racial/Ethnic Trends in Palm Beach County

- In absolute numbers, from 2000-2005, HIV cases among Blacks decreased by 30%, while increasing by 20% among Whites. The decreases among Blacks may correspond to some extent with recent targeted prevention, while the increases among whites may be associated with recent increases in HIV transmission among White MSM.
- Hispanic AIDS cases increased from 3% in 1996 to 12% in 2005.

Combined Gender and Racial/Ethnic Trends in Palm Beach County

- For most of the past 10 years, Black males accounted for more than 50% of AIDS cases among men.
- For most of the past 10 years, Black women accounted for more than 70% of AIDS cases among women.
- The percent of Black male HIV cases has decreased from 66% in 1998 to 54% in 2005. Increases have been observed among both White and Hispanic male HIV cases over this same time period.

[12] Ibid.

- Although the majority of HIV cases among women are Black, the percent of Black female HIV cases has decreased from 85% in 1998 to 67% in 2005. Increases have been observed among both White and Hispanic female HIV cases over this same time period.

Age Trends in Palm Beach County

- The percent of newly reported AIDS cases has shown increases among the 20-29 and 30-39 age groups over the past several years.
- The percent of newly reported HIV cases has shown increases among the 20-29 and 50+ age groups over the past several years.

Exposure Trends in Palm Beach County

- Among males, MSM is the predominant mode of exposure, and HIV/AIDS prevalence due to MSM increased the fastest between 1996 and 2005 among all the exposure categories.
- Among females, HIV/AIDS, the primary mode of exposure is heterosexual and it is increasing the fastest.
- From 2000-2005, MSM AIDS cases increased by 18%, while heterosexual male cases decreased by 59% and IDU male cases decreased 59%.
- From 2000-2005, MSM HIV cases increased by 61%, while heterosexual male cases decreased by 56% and IDU male cases decreased 40%.

Disproportionate Impact on Certain Populations

As indicated by the data above, incidence and prevalence rates vary significantly by race/ethnicity, gender, and mode of exposure. This is further illustrated in the following table:

Average HIV Incidence Rates per 100,000 population age 13+, 2003-2005

	Heterosexual		MSM	IDU	
	Males	Females	Males	Males	Females
White	5.4	17.2	62.9	7.0	6.5
Black	347.0	500.7	207.6	48.3	21.6
Hispanic	43.1	85.1	127.0	19.5	12.0

Source: Florida Department of Health Bureau of HIV/AIDS Surveillance Section[13]

Based on the above data, the above subgroups are ranked from largest to lowest rate as follows. The higher the rate, the larger the disproportionate impact, thus the higher the rank:

Ranking of Average HIV Incidence Rates per 100,000 population age 13+, 2003-2005

Rank	Population	Rate
1	BF-Hetero	500.7
2	BM-Hetero	347.0
3	B-MSM	207.6
4	H-MSM	127.0
5	HF-Hetero	85.1
6	W-MSM	62.9
7	BM-IDU	48.3

[13] Florida Department of Health, Bureau of HIV/AIDS Surveillance Section (2006). *Priority Setting Tool for Florida's Prevention Plannng Group.*

Rank	Population	Rate
8	HM-Hetero	43.1
9	BF-IDU	21.6
10	HM-IDU	19.5
11	WF-Hetero	17.2
12	HF-IDU	12.0
13	WM-IDU	7.0
14	WF-IDU	6.5
15	WM-Hetero	5.4

Source: Florida Department of Health Bureau of HIV/AIDS Surveillance Section[14]

Thus, the top six subpopulations that are most disproportionately affected based on HIV incidence in the last three years are Black heterosexual females, Black heterosexual males, Black MSM, Hispanic MSM, Hispanic heterosexual females, and White MSM.

Further, the following subpopulations experienced increases in HIV (regardless of current AIDS status) incidence between 2004 and 2005 (Table 1a, Appendix A):[15]

- Black MSM (37.5% increase)
- White female IDU (267% increase)
- Black female IDU (100% increase)
- Female Haitian born (9% increase)
- White male youth ages 13-24 (150% increase)
- Black male youth ages 13-24 (27% increase)
- Black female youth ages 13-24 (33% increase)
- Hispanic female youth ages 13-24 (25% increase)
- White women ages 15-44 (47% increase)
- Black pediatric cases ages 0-12 (400% increase)

The following subpopulations experienced increases in AIDS incidence between 2004 and 2005 (Table 1a, Appendix A):[16]

- Black MSM (38% increase)
- Hispanic MSM (32% increase)
- Hispanic Male IDU (100% increase)
- Black male youth ages 13-24 (125% increase)
- White women ages 15-44 (33.3% increase)
- Hispanic women ages 15-44 (40% increase)

Some of the above-identified groups are ranked in the lower half of the HIV incidence rates shown in the preceding table. Thus, they are not presently experiencing a high disproportionate impact, yet are experiencing increases in HIV and AIDS incidence. This suggests that these

[14] Ibid.
[15] Florida Department of Health, Bureau of HIV/AIDS Surveillance Section (2006). *Section 2 – Table 1a: HIV and AIDS Incidence, HIV/AIDS Deaths (Excluding Department of Corrections)*
[16] Ibid.

subgroups represent new and emerging populations with HIV disease. Specifically, these new and emerging populations are:

- Hispanic male, White female, and Black female IDU
- White women ages 15-44
- White male youth ages 13-24
- Black pediatric cases ages 0-12

Finally, as noted earlier, there is a major disproportionate impact in HIV and AIDS prevalence rates in the western, rural part of the county, compared to the eastern, urban part. The demographic and exposure factors in these two regions differ as well, as illustrated in the following table:

Persons Living with AIDS as of 12/31/03[17]

Subgroup	Eastern Region N=3,399	Western Region N=611
Male	64%	59%
Female	35%	41%
White	29%	2%
Black	61%	94%
Hispanic	10%	4%
Other	1%	<1%
MSM	31%	8%
IDU	12%	5%
MSM/IDU	3%	2%
Heterosexual	52%	82%
Other	2%	3%

As the table shows, in the western compared to the eastern region, PLWHA have a higher percentage of females, a much higher percentage of Blacks, a much higher percentage of heterosexual exposure, and a much lower percentage of MSM exposure.

Populations Underrepresented in CARE Act-Funded Primary Medical Care

Underrepresented populations may be identified by comparing demographic characteristics of the PLWHA population in the county with the characteristics of PLWHA served by the CARE-Act funded system in the county. The following table shows these comparisons in relation to race/ethnicity, gender, and age:

Comparison of all PLWHA with PLWHA Served, Palm Beach County, 2005

	PLWHA[18]	PLWHA Served[19]
RACE/ETHNICITY		
White	24%	27%
Black	65%	58%
Hispanic	10%	9%
Asian/Pacific Islander	0%	0%
American Indian	0%	0%
Other/Unknown	1%	5%

[17] Lieb, op cit.

[18] Florida Department of Health, Bureau of HIV/AIDS Surveillance Section (2006). *Epidemiological Profile, Palm Beach County.*

[19] Palm Beach County Department of Community Services (2006). 2005 Palm Beach County CARE Act Data Report (CADR).

	PLWHA	PLWHA Served
GENDER		
Male	61%	56%
Female	39%	43%
AGE (years)		
0-12	1%	2%
13-44	51%	51%
45+	48%	47%

The demographic characteristics of the PLWHA population in the county were described earlier. The demographic characteristics of PLWHA served by the CARE-Act funded system are obtained from the county's 2005 CARE Act Data Report. The latter figures may include duplicated numbers as they are based on totals from individual agencies. Nonetheless, these figures provide a reasonable estimate of the demographics of the PLWHA served. As seen in the table above, the demographic characteristics of the PLWHA population and the PLWHA served are very similar, with the exception of Blacks and males. Blacks comprise 65% of the PLWHA population, but 58% of the PLWHA served. Males comprise 61% of the PLWHA, but 56% of the PLWHA served. These figures suggest that these populations may be underserved.

Estimated Service Gaps

The Palm Beach County CARE Council conducted an interim PLWHA survey in the summer of 2006, while developing a revised Comprehensive Needs Assessment for 2007-2010.[20] The PLWHA Survey 2006 utilized a survey instrument similar to that which was used in the 2000 & 2003 Comprehensive Needs Assessments. Service categories specified in the survey were consistent with those used by the planning council and HRSA to promote consistency of the data and subsequent analysis.

Using an on-line data collection tool, the survey instrument was posted on the CARE Council's website. PLWHA were encouraged to respond to the survey questions directly on the website, or complete the survey on a paper copy. The paper surveys were subsequently entered into the website database. Surveys were collected from June 7, 2006 through July 28, 2006.

Because the target group is known to be relatively reticent about disclosing information relevant to the topic of HIV/AIDS, respondents were recruited using variants of convenience sampling combined with purposive sampling strategies. Several HIV/AIDS service providers offered to conduct the surveys at their locations. The surveys were administered to PLWHAs by staff or the PLWHAs completed the surveys on their own with staff available to answer questions and clarify directions as needed. In addition, 30% of the surveys were conducted in high-risk neighborhoods by a trained data collector who guided the PLWHAs through the survey. Surveys were also promoted and distributed at community forums and other appropriate venues. The surveys were distributed throughout the four main geographic areas of the county to ensure a broad and representative sample. Throughout the surveying process, aggregate demographic information of the respondents was monitored by the health planner to ensure a reflective sample. A total of 176 respondents completed the survey.

Data were collected using a 73-item survey instrument constructed to collect information from PLWHAs within Palm Beach County relating to service priorities and needs.

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[20] Swanson, S. (2006). Survey of PLWHAs, August 2006. Riviera Beach, FL: Treasure Coast Health Council.

Survey respondents were asked to describe their level of utilization of the 31 service categories that the planning council prioritizes. The PLWHAs chose "need and use" if they utilize the service, "do not need" if they do not need the service, "need, can't get" to show gaps in services, and "can get, won't use" to show barriers in service utilization. In regard to primary medical care, reported levels of utilization by various demographic groups were as follows:

Primary Medical Care Utilization, Gaps, and Barriers

	Utilization (Need and Use)		Gaps (Need, Can't Get)		Barriers (Can Get, Won't Use)	
	N	%	N	%	N	%
All respondents (N=176)	124	71%	9	5%	2	1%
White Hetero (N=13)	9	69%	1	8%	0	0%
Black Hetero (N=93)	66	71%	4	4%	0	0%
Hispanic Hetero (N=10)	7	70%	1	10%	0	0%
White MSM (N=32)	28	88%	1	3%	0	0%
Black MSM (N=5)	2	40%	1	20%	0	0%
Hispanic MSM (N=7)	4	57%	5	14%	0	0%
White Women (N=8)	5	63%	1	13%	0	0%
Black Women (N=57)	36	64%	3	5%	1	2%
Hispanic Women (N=11)	6	54%	1	9%	0	0%
Black Hetero Men (N=40)	30	75%	1	3%	0	0%
White Hetero Women (N=7)	4	57%	1	14%	0	0%
Black Hetero Women (N=53)	36	68%	3	5%	0	0%
Hispanic Hetero Women (N=7)	5	71%	1	14%	0	0%
Rural Men (N=18)	124	71%	9	5%	2	1%
Rural Women (N=21)	17	81%	9	5%	2	1%

Source: Swanson, 2006.[21]

As seen in the table, only 5% of all respondents indicated that they need but can't get primary medical care, and only 1% indicated that they can get primary medical care but won't use it. The numbers for the various demographic subpopulations should be viewed with caution due to the small total in some cases. As seen in the table, the following populations exceeded the overall respondents in regard to primary medical care gaps (need, but can't get): White and Hispanic heterosexuals, Black and Hispanic MSM, White and Hispanic women, and White and Hispanic heterosexual women. In other words, these subpopulations appear to experience greater primary care gaps than the overall population, because their percentages of "need, but can't get" are higher than the whole sample's percentage of 5%.

In regard to all the service categories, the five most commonly ranked utilized services (need and use) for all respondents were:[22]

- Case Management (83%)
- Laboratory/Diagnostic Testing (80%)
- Dental Care (74%)
- Ambulatory Primary Outpatient Medical Care (71%)
- HIV Prevention (67%)

[21] Ibid.
[22] Ibid.

In regard to all service categories, the five services that were most commonly ranked by all respondents as "need, can't get", which shows gaps in services were:[23]
- Complementary Therapies (Massage) (35%)
- Complementary Therapies (Acupuncture/Reiki Therapies) (31%)
- Food (27%)
- Housing (20%)
- Direct Emergency Assistance (19%)

Overall the number of respondents that said they "can get, won't use" a service were very low. The five services most commonly ranked by respondents as 'can get, won't use', which shows barriers in services were:[24]
- Legal Services (6%)
- Day and Respite Care (5%)
- Clinical Trials (4%)
- Complementary Therapies (Massage) (4%)
- Complementary Therapies (Acupuncture and Reiki Therapy) (4%)
- Home Healthcare (4%)
- Substance Abuse Treatment-Outpatient (4%)

In summary, the 2006 Needs Assessment suggests that overall, most respondents need and use primary medical care, although certain racial/ethnic, gender, and sexual orientation subpopulations report a greater primary medical care service gap than the overall population. Additionally, the largest service gaps overall were in complementary therapies and basic necessities (food, housing, emergency assistance).

b) Impact of Co-Morbidities and Medicaid/Medicare Funding on the Cost and Complexity of Providing Care

This subsection addresses selected co-morbidities (tuberculosis; sexually transmitted diseases; hepatitis; substance abuse; and chronic mental illness) and economic characteristics (homelessness; lack of insurance; and poverty) and how they increase the cost and complexity of delivering care to persons living with HIV/AIDS in Palm Beach County. Additionally, the impact of the state Medicaid program and the Medicare program in covering PLWHA health care costs, trends in enrollment and benefits, and how Title I funds fill the gaps, are described.

Co-Morbidities and Economic Characteristics

The following narrative describes how both costs and the complexity of providing care to PLWHA in the West Palm Beach EMA are affected by co-morbidities and economic characteristics by comparing their rates in the general EMA population with their rates among PLWHA in the EMA. The quantitative data and data sources supporting this narrative are provided in Attachment 1-C.

The co-morbidity prevalence rates among the PLWHA population were computed by taking the number of PLWHA affected by the co-morbidity, dividing this by the total number of reported PLWHA in the EMA (6,833), and multiplying by 100,000. The co-morbidity prevalence rates among the general EMA population were computed by taking the number of EMA residents

[23] Ibid.
[24] Ibid.

affected by the morbidity, dividing this by the total number of residents of the EMA in the relevant year and multiplying by 100,000. The economic characteristic prevalence rates for the both PLWHA population and the total EMA population were computed as percentages rather than rates per 100,000.

Percentage changes for both groups (PLWHA and general population) between 2004 and 2005 were computed by taking the number of affected persons in 2005, subtracting the number of affected persons in 2004, and dividing by the number of affected persons in 2004.

Tuberculosis

In 2005, the tuberculosis rate among PLWHA in Palm Beach County was 44 per 100,000, compared to 7 per 100,000 for the general population. Thus the PLWHA rate is more than 6 times the general population rate. The tuberculosis rate among both populations declined between 2004 and 2005. The percentage change among PLWHA was –50%, a greater decline than that of the general population at –8%.

Tuberculosis adds to cost and complexity of care by requiring these co-infected individuals to be hyper-vigilant about medical protocols and even requiring a period of quarantine from the general population. Temporary housing is provided, yet this is expensive and it then becomes difficult to place such an individual after the patient becomes eligible for alternate placement. In fact, when TB patients are non-compliant with medical protocols they can be incarcerated and forced to adhere. In Palm Beach County the main TB clinic is housed next to the main HIV clinic. This allows for easy access for these co-infected individuals.

Sexually Transmitted Diseases

The epidemic of sexually transmitted diseases (i.e., infectious syphilis, gonorrhea, and chlamydia) in Palm Beach County is of concern. In 2005, the infectious syphilis rate among PLWHA in Palm Beach County was 132 per 100,000, compared to 2 per 100,000 for the general population. Thus the PLWHA rate is 66 times the general population rate. However, the infectious syphilis rate among PLWHA declined by 18% while it increased by 25% among the general population between 2004 and 2005.

In 2005, the gonorrhea rate among PLWHA in Palm Beach County was 263 per 100,000, compared to 67 per 100,000 for the general population. Thus the PLWHA rate is nearly 4 times general population rate. Additionally, the gonorrhea rate among PLWHA increased by 63%, compared to an increase of 38% among the general population between 2004 and 2005.

In 2005, the chlamydia rate among PLWHA in Palm Beach County was 293 per 100,000, compared to 172 per 100,000 for the general population. Thus the PLWHA rate is over 1-1/2 times the general population rate. The chlamydia rate among PLWHA declined by 5% while it increased by 29% among the general population between 2004 and 2005.

Providing medical care for these individuals can be challenging as STDs compromise an already weakened immune system and create additional opportunities for infection. STDs are leading indicators of who may be at risk for HIV due to practicing unsafe sex. In relation to complexity, STDs increase the likelihood both of transmitting and acquiring HIV and inflate the cost of treating PLWHA. Reducing STDs may prevent much of the sexually transmitted HIV infection.

There is a need for secondary prevention services in order to prevent these individuals from further transmitting HIV into the general population.

Hepatitis

In 2005, the rate of acute and/or chronic hepatitis among PLWHA in Palm Beach County was 3,644 per 100,000, compared to 115 per 100,000 for the general population. Thus the PLWHA rate is more than 30 times the general population rate. The hepatitis rate among PLWHA declined by only 4%, compared to a decline of 91% among the general population between 2004 and 2005.

Intravenous drug use increases the risk of HIV/hepatitis co-infection. Because HIV diminishes the ability of the immune system to fight off infection, it speeds the rate of liver damage caused by hepatitis. This places the co-infected patient at a greater risk of cirrhosis, liver cancer, and liver failure than persons infected with HIV alone. This co-morbidity is expensive and complicated to treat. This co-infection adds to cost and complexity of care because treating hepatitis with medications such as Interferon, Ribavirin, combination Interferon/Reibavirin, and/or Pegylated Interferon is expensive and usually requires the liver to process two regimens of medications instead of one associated with HIV. This combination of therapies creates severe side effects and often requires the co-infected individual to interrupt HIV protocols or stop treatment for hepatitis. Because HIV anti-retroviral protocols tend to compromise liver functions, having hepatitis adds the additional strain to the already compromised immune system of PLWHA. It has been necessary for the CARE Council to advocate for payment from insurance companies and public agencies including Ryan White and prisons for patients with HIV who need treatment for hepatitis.

Intravenous Drug Use (IDU)

In 2005, the rate of intravenous drug use (i.e., IDU exposure category) among PLWHA in Palm Beach County was 17,869 per 100,000, compared to an estimated 451 per 100,000 for the general population in 2003 (latest date available). Thus the PLWHA rate is nearly 40 times the general population rate. The IDU exposure rate among PLWHA increased by 2% between 2004 and 2005. Percent change for the general population is unavailable as the data were collected at only one point in time (2003).

Intravenous drug use plays a significant role in the spread of HIV, either through sharing needles or unprotected sex. Treatment of PLWHA IDUs is complex and costly because neither the HIV community nor the substance abuse community want to take ownership of this population, claiming that the co-morbidities of IDU and HIV are too difficult to treat and that the protocols of substance abuse treatment are incompatible with HIV treatment regimens.

Other Substance Abuse

In 2005, the rate of substance abuse other than IDU among PLWHA in Palm Beach County was 4,859 per 100,000, compared to an estimated 8,660 per 100,000 for the general population in 2004 (latest date available). Thus, interestingly, the PLWHA rate is approximately one-half the general population rate. However, the substance abuse rate among PLWHA increased by 60% between 2004 and 2005. Percent change for the general population is unavailable as the data were collected at only one point in time (2004).

Substance abuse interferes with an individual's ability to adhere to his/her treatment regimen and keep appointments. It may also divert financial resources needed for food, shelter and other basic human requirements to the purchase of alcohol and/or drugs. Thus, substance abuse impacts health outcomes and contributes to the cost of providing services for persons with HIV who have a substance abuse problem.

Chronic Mental Illness

In 2005, the rate of chronic mental illness among PLWHA in Palm Beach County was 512 per 100,000, compared to an estimated 9,040 per 100,000 for the general population in 2004 (latest date available). Thus, interestingly, the PLWHA rate is only approximately 5% the general population rate. However, the chronic mental illness rate among PLWHA increased by 315% between 2004 and 2005. Percent change for the general population is unavailable as the data were collected at only one point in time (2004).

The complexity of serving mental health clients is increased by HIV infection. HIV infection increases the burden of illness among individuals who are mentally ill, encumbers their quality of life, and shortens their life expectancy. Evidence increasingly suggests that treating mental illness or distress can improve survival and reduce the progression of HIV, not only in obvious ways like improving adherence and social support, but also through biochemical mechanisms that researchers are only beginning to understand. Depression has been found to be associated with worse outcome in HIV disease. There are growing indications that treatment of mental health conditions can make a big positive difference in the progression and physical outcome of disease. Additionally, the cost and complexity of service delivery to chronically mentally ill PLWHA in Palm Beach County is further complicated by poverty, no insurance, a lack of education and a lack of affordable and safe housing for this vulnerable population.

Homelessness

In 2005, the rate of homelessness among PLWHA in Palm Beach County was 1.2% compared to .01% among the general population. Thus the PLWHA rate is approximately 10 times the general population rate. The homelessness rate among PLWHA increased by 6% between 2004 and 2005, while it decreased by 5% among the general population.

In Palm Beach County, homelessness and HIV are not limited to urban populations. The prevalence of HIV appears to be more likely in our coastal metropolitan areas; however, there is evidence that both problems are widespread throughout our rural areas, yet do not get reported in the same manner. In fact, homelessness is not even defined the same way in rural areas as it is in urban areas. One of the complexities of tracking this vulnerable population is that they are transient. Many homeless PLWHA are not being treated and are not being identified for services since they are difficult to target. A higher cost for case managers, disease intervention specialists, and technicians is incurred because these are problem cases that require a great deal of time and close attention. Living with HIV spectrum disease and being homeless is a complicated situation. Maintenance of physical and emotional health is frequently ignored when food, clothing and shelter are of primary concern. Medical appointments are difficult to meet and maintaining complicated HIV drug therapies is a major challenge. Finally, homeless men and women often do not have available to them preventive measures used with other populations who are at risk for HIV. Shelters, food kitchens, and health clinics are model centers for HIV prevention; however, insufficient resources in Palm Beach County limit health education to the homeless and

other interventions that others receive. Individuals who are homeless have limited access to health care. Such individuals are vulnerable to increased morbidity and mortality since they lack the care they need. Some barriers to access HIV-related health care in Palm Beach County for the homeless are: lack of health insurance, absence of financial resources, and lack of transportation.

Lack of Insurance

The number of uninsured PLWHA in Palm Beach County is unknown. However, it can be estimated based on their poverty levels. The 2004 Florida Health Insurance Study[25] found that 50% of Palm Beach County residents living at or below 100% of the poverty level were uninsured; 82% of those living between 101-200% of the poverty level were uninsured, and 17% of those living at or below 300% of the poverty level were uninsured. Applying these figures to the estimated PLWHA population at each of these poverty levels in 2005 results in an estimated 43% of PLWHA in Palm Beach County being without insurance coverage (including Medicaid). In contrast, 19% of the general population was estimated to be uninsured in 2004 (latest date available). Thus the PLWHA rate is more than double the general population rate. Percent change for either the PLWHA population or the general population is unavailable as the data were collected at only one point in time (2004).

Lack of health insurance, high deductibles, the price of prescription drugs and co-payments are barriers to accessing health care for many PLWHA. In Palm Beach County, there are several federal, state, and local programs to assist low-income people with the financial burdens of health care, but they do not come close to meeting the full need. Health care programs for the uninsured include: primary, preventive, specialty, AIDS treatment, prenatal, family-planning, pharmaceutical, labs, radiology, vision, dental, substance abuse, and mental health services. These are provided through the county health department and a network of Title I funded private doctors and community-based HIV medical providers.

While individuals with fee-for-service Medicaid have good health coverage, in some instances they have fewer choices than those with private insurance, especially in rural areas where many providers do not accept Medicaid. Fortunately, the providers in the EMA who tend to have the largest patient loads and most experience with HIV/AIDS do currently accept Medicaid; however, this is a tenuous alliance and is threatening to change.

Statewide, the numbers of HMOs have collapsed, leaving gaps in private insurance for much of the state's population. As the HMO crisis evolves, it is expected that more PLWHA will have difficulties securing and maintaining private insurance.

The Health Council of South administers the AIDS Insurance Continuation Program (AICP) for those diagnosed with AIDS or who are HIV-positive with symptoms and who, because of their illness, are unable to maintain their private health insurance coverage. The program makes direct payments of up to $650 per month to each client's employer or insurance company for the continuation of medical, dental, mental health and optical coverage. AICP also pays any fees associated with conversion of a COBRA policy to an individual policy or policy upgrades. The

[25] Florida Agency for Health Care Administration, Office of Medicaid Research and Policy (2004). *Highlights from the Florida Health Insurance Study, Palm Beach County Augmentation.*

program also pays client co-payments and deductibles on an as needed basis. This program is funded through the Florida Department of Health.

The State of Florida also administers the AIDS Drug Assistance Program (ADAP). ADAP is intended to help HIV-positive people stay healthy by assisting with the purchase of HIV prescription medications. ADAP provides HIV drug treatments for people who do not have private health insurance, do not qualify for Medicaid or are waiting for Medicaid eligibility and cannot afford to purchase the medications themselves.

Poverty

In 2005, an estimated 82% of PLWHA in Palm Beach County lived at or below 300% of the federal poverty level, compared to 46% of the general population. Thus the PLWHA rate is almost double the general population rate. The rate among PLWHA increased by 13% between 2004 and 2005, while the general population rate was unchanged.

PLWHA living at, near, or below poverty are often marginalized and distrustful of governmental service systems and tend to be less educated or illiterate and less likely to follow treatment regimens than others who are not living at, near, or below poverty. In order to be successful in achieving health outcomes, individuals living in poverty require intensive follow-up, adherence counseling and treatment education. This presupposes they place a personal value on their own health, which in many cases, they do not; or at best, their health needs are a low priority. Higher priority is placed on financial stability, housing, food, care of children and other family members, as well as other daily requirements and non-essentials. The stress these individuals place on the system is great and complex as linkages between a variety of services along the continuum are needed in order to effectively meet their needs.

In conclusion, PLWHA frequently have co-morbidities that are further complicated by low income, lack of insurance, and/or homelessness. These patients bring a multitude of costly life issues to the primary care provider's office and rightly expect these complicated factors to be included in the provision of quality clinical care.

Medicaid/Medicare Funding

This subsection describes the impact of the State Medicaid program and the federal Medicare program in covering PLWHA health care costs in Palm Beach County, including information on trends in enrollment and benefits, and how Ryan White Title I funds fill the gaps.

Medicaid

In 2005, 1,463 PLWHA in Palm Beach County received care through Medicaid. Of these, 746 (51%) were diagnosed with AIDS and 717 (49%) with HIV (not AIDS). 700 (48%) were male and 763 (52%) female. 970 (66%) were Black, 280 (19%) White, 94 (6%) Hispanic, and 119 (9%) other races/ethnicities.[26]

This is 13% of the total PLWHA population in the county. In 2004, the number of PLWHA receiving Medicaid was 2,277[27]; thus, the number of PLWHA receiving Medicaid has decreased

[26] Florida Department of Health, Bureau of HIV/AIDS Surveillance Section (2006). *EMA ADAP Medicaid by HIV AIDS Status.*

[27] 2006 Ryan White Title I Application.

by 36% between 2004 and 2005. In 2004 the total Medicaid benefits paid to PLWHA were $5,732,904, or $2518, per enrollee.[28]

Medicaid reforms are being implemented on both the state and federal levels. Many of the reforms will severely impact those who utilize or need to utilize Medicaid. The impact will be felt particularly hard by CARE Act funded programs in that clients who fall off the Medicaid rolls will be seeking Ryan White funded services for health and medication.

New identification regulations require that nearly all applicants for Medicaid provide proof of Identification and U.S. Citizenship. Nearly every individual who indicates U. S. citizenship on an application must provide documentation of U.S. citizenship and identity to receive, or continue to receive, Medicaid. Self-declaration is no longer sufficient. All citizenship and identity documents must be original or copies certified by the issuing agency. This poses a barrier because the majority of Medicaid applicants are low income, cannot afford to pay for certified copies of their birth certificates or may not have birth records, cannot replace documents lost in hurricanes, and cannot afford to obtain state identification cards. Eligibility requirements have also been tightened by lowering the qualifying income level to the SSI level. Statewide in Florida, this will cause 77,000 to lose benefits. Immigrants who lose SSI benefits because of recent immigration reform have also reported being terminated from Medicaid even though they remain eligible for both food stamps and Medicaid.

HIV/AIDS medication seems to be largely untouched at this point, but non-HIV medications must be in the new Medicaid drug formulary. The prior authorization rule has a "fail first" feature: To be covered, some more costly mental health drugs must not only secure physician-requested prior authorization--but less expensive formulary-preferred drugs must be shown to have already failed for that patient.

Florida is currently rolling out privatization of Medicaid. It in effect creates a HMO-based Medicaid program. Though it is in its initial stages, concerns are being raised over lack of choice on behalf of patients, the need to change established health care providers because current ones may not be covered, limitations and caps on services and medications.

Medicare

An estimated 8% of the county's PLWHA received Medicare in 2005[29]. It is presumed that most of these were receiving Medicaid due to disability, not to being age 65+. In comparison, 2% of the county's general population received Medicare for disabilities in 2003 (latest date available)[30]. The estimated number of PLWHA receiving Medicare decreased by 5% between 2004 and 2005.[31]

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[28] Ibid.

[29] Treasure Coast Health Council (2006). *FACTORS Clients by Medical Payer Source through Calendar Year 2005.*

[30] Centers for Medicare and Medicaid Services (2003). *Medicare County Enrollment.*

[31] Treasure Coast Health Council (2005, 2006). *FACTORS Clients by Medical Payer Source through Calendar Years 2004, 2005.*

Further data, including data on trends in benefits, are not available, as Medicare officials have informed us that matching their database with the State's HARS would cost several thousand dollars, and neither the local nor state governments have budgeted for this expenditure.

How Title I Funds Fill the Gaps

As described above, an estimated 43% of the PLWHA population has no insurance, including Medicaid. Ryan White Title I funds fill the gaps in medical care for these PLWHA who have no private insurance and have been denied benefits from public sources such as Medicaid and the Palm Beach County Health Care District, a local taxing district. Since 82% of PLWHA in Palm Beach County live at or below 300% of the poverty level, these individuals likely would not be able to afford care if not for Title I funds.

c) Assessment of Populations with Special Needs

Palm Beach County has identified the following special populations of PLWHA who have limited access or are disenfranchised from existing HIV/AIDS care services: (1) Men Who Have Sex With Men (MSM); (2) Injection Drug Users (IDU) and MSM/IDU; (3) Heterosexual Black (non-Haitian) Men; (4) Women of Child Bearing Age (15-44); (5) Haitian-Born Men and Women; and (6) Foreign-Born Hispanic Men and Women. The CARE Council seeks to improve access to care for these special populations primarily through culturally appropriate and gender appropriate case management and clinical care services delivered in the county through our coordinated system of CARE. Outreach efforts target individuals who are not currently receiving primary medical care, especially those who know their HIV status and are not in care.

The following table summarizes the epidemiology of these special populations. The subsequent narrative addresses each special population in terms of unique challenges that it presents to the service delivery system and service gaps. Finally, the estimated costs of delivering services to each population are addressed.

Epidemiology of Special Populations in West Palm Beach EMA, 2005[32]

	Percent of Total County Population	Percent of PLWHA (N=6,833)	HIV/AIDS PREV* Rate per 100,000	Percent of AIDS INC* (N=360)	AIDS INC* Rate per 100,000	AIDS INC* Percent Change 2004-2005	Percent of HIV INC* (N=397)	HIV INC* Rate per 100,000	HIV INC* Percent Change 2004-2005
MSM Age 13+	2% (n=30,819)	27% (n=1852)	6,009	36% (n=129)	419	7%	35% (n=140)	454	-10%
IDU and MSM/IDU Age 13+	0.4% (n=5,400)	11% (n=764)	14,148	7% (n=26)	481	-40%	9% (n=36)	667	13%
Hetero Black Men Age 13+	5% (n=60,610)	22% (n=1482)	2,445	21% (n=74)	122	-34%	19% (n=77)	127	-9%
Women Age 15-44	17% (n=214,132)	24% (n=1656)	773	29% (n=103)	48	6%	28% (n=111)	52	-13%
Haitian-Born Men and Women Age 13+	2% (n=25,479)	18% (n=1218)	4,780	16% (n=59)	232	-23%	15% (n=59)	232	-6%
Foreign-Born Hispanic Men and Women Age 13+	6% (n=80,417)	7% (n=453)	563	12% (n=42)	52	0%	10% (n=38)	47	-18%

***PREV = Prevalence** ***INC = Incidence**

Challenges and Service Gaps

Men Who Have Sex with Men (MSM), Age 13+

It is estimated that 6.2% to 6.5% of men have had sex with men within the previous five years.[33] Applying the midpoint of these figures (6.35%) to the population of men aged 13+ in Palm Beach County yields an estimated 30,819 MSM in the county, or 2% of the total population. However, MSM constitute 27% of the county's PLWHA population, 36% of the 2005 AIDS incidence cases, and 35% of the 2005 HIV incidence cases. Their HIV/AIDS prevalence rate is 6,009 per 100,000.

A challenge to serving this population is that when HIV went from being a fatal disease to a chronic disease in the mid-1990s with the advent of HAART (Highly Active Anti-Retroviral Therapy), it led to some complacency among MSM.[34] This is particularly true among young MSMs who have not witnessed the devastating effect of the disease on the MSM community, but

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[32] Data Sources:
Population Data: U.S. Census Bureau (2006). *American Community Survey, 2005, Palm Beach County.*
HIV/AIDS Incidence and Prevalence Data: Florida Department of Health, Bureau of HIV/AIDS Surveillance Section (2006). *Table 1a: HIV and AIDS Incidence, HIV/AIDS Deaths (Excluding Department of Corrections); Table 1b: Background Data Used for the Calculations of AIDS Prevalence and HIV (not AIDS) prevalence.*

[33] Kinsey Institute (2006). *Prevalence of Homosexuality.*

[34] Cochran, J. (2006). *Taking it to the Street.* Miami, FL: The University of Miami Magazine, Fall 2006, p. 24-27.

instead see older men who have been living with the infection for decades and appear healthy. Thus, young MSM are less likely to practice safe sex than in the earlier years of the epidemic. Thus, a service gap for this population is in the provision of secondary prevention to stop the spread of more virulent strains.

Increased access to medical providers for MSM in the county has been achieved by offering a wider variety of service locations in all areas of the EMA. Additionally, there is one case management agency that solely serves gay and lesbian clientele. The agency conducts treatment education and outreach on the Internet, on strolls, and in bars. Outreach workers that identify new clients can link them directly to the HIV/AIDS Coordinated System of Care. However, this requires an increase in funding for this activity. Furthermore, targeted outreach for men of color who have sex with men is not sufficiently addressed in the county at present.

In summary, the challenges and service gaps for the MSM population in Palm Beach County are in the areas of secondary prevention, outreach, and services to MSM of color. In the Palm Beach County 2006 PLWHA Survey (described in subsection a), 16% of MSM surveyed reported that they either need but can't get, or can get but won't use, primary medical care.

Injection Drug Users (IDUs) and MSM/IDUs, Age 13+

It is estimated that there are 5,400 IDUs (including MSM/IDUs) in Palm Beach County.[35] This constitutes 0.4% of the total county population. However, IDUs and MSM/IDUs constitute 11% of the PLWHA population, 7% of the 2005 AIDS incidence cases, and 9% of the 2005 HIV incidence cases. Their HIV/AIDS prevalence rate is an astounding 14,148 per 100,000.

Although the sharing of drug paraphernalia by IDUs has long been a known risk factor for HIV infection, the problem is worsening with the growing popularity of crystal methamphetamine. This drug is both highly addictive and increases sex drive, while users are less apt to practice safe sex when using. A recent South Florida survey revealed that crystal methamphetamine users were more likely than non-users to have in excess of ten sexual partners, to engage in the riskiest types of sexual behaviors, and to find sex partners on the Internet.[36]

Additionally, as noted earlier, a challenge is that neither the HIV community nor the substance abuse community wants to take ownership of this population, claiming that the overlapping comorbidities of IDU and HIV are too difficult to treat and that the protocols of substance abuse treatment are incompatible with the regimens designated for HIV. The largest case management agency in the county is the gatekeeper of substance abuse treatment. Therefore, it is natural to assume that one must be a case management client in order to receive substance abuse treatment. Since IDUs aren't necessarily compliant, it would be difficult to assume that they are involved in any case management services. Case Management agencies have suggested that without their referral process into substance abuse treatment, IDUs would never access substance abuse treatment and would remain compromised.

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[35] Florida Department of Health, Bureau of HIV/AIDS, Surveillance Section (2005). *HIV/AIDS among Intravenous Drug Users, Florida.*

[36] Cochran, op cit.

Finally, the mixing of IDU and MSM is complex. While our Gay and Lesbian Community and Service Center does provide services for MSM who are HIV+, there are no services directed to the special population of MSM/IDU. Currently, our Continuum of Care does little accommodate these men who are IDUs. Further, our Alcohol, Drug Abuse and Mental Health Continuum does not direct any funds to this special population.

In summary, challenges and service gaps for this special population are in the areas of secondary prevention, substance abuse treatment, and lack of services targeted specifically for IDU/MSM.

The Palm Beach County 2006 PLWHA Survey did not identify IDU and IDU/MSM. Therefore, the percentage of IDU and IDU/MSM who either need but can't get, or can get but won't use, primary medical care, must be estimated as equal to the percentage for all respondents, which is 6%.

Heterosexual Black (Non-Haitian) Men, Age 13+

As noted above, an estimated 6.35% of men have had sex with men in the past five years; consequently, the remaining 93.65% may be presumed to be heterosexual. Applying this percentage to the population of Black men age 13+ in Palm Beach County results in an estimated 60,610 heterosexual Black men, or 5% of the total county population. Most of these men are native-born African Americans (i.e., not Haitian-born). Heterosexual Black men constitute 22% of the county's PLWHA population, 21% of the 2005 AIDS incidence cases, and 19% of the 2005 HIV incidence cases. Furthermore, as noted earlier (subsection a), Blacks and men appear to be underserved by the county's Title I program.

There are several challenges to and service gaps in providing care to this population. First, a substantial proportion of the population may be "on the down low," that is, claiming to be heterosexual while practicing sex with men[37], because homosexuality is highly stigmatized in the African American community. An increase in funding would allow earmarked services to conduct outreach to this "hidden" population.

Second, it is likely that another proportion of this population acquires and/or transmits the disease while incarcerated. Nationwide, Black men are incarcerated at a rate higher than their representation in the population. Increased funds would allow for enhanced coordinated care between the prison system and the community care system. Prior to release, infected inmates in Palm Beach County are referred to available treatment and medical care, but many ex-offenders do not follow through with provided recommendations for a variety of reasons. Approximately two-thirds of state prisoners serve their full sentences and are released without supervision. If an ex-offender is released with no community supervision conditions, there are no corrections officials to assist the individual with entering a system of care. Further, ex-offenders frequently have a high distrust of government that presents an additional barrier to provision of HIV/AIDS care services. This overall situation could be improved by assigning a case manager to the inmate prior to release and having that case manager follow up after release.

Third, recent studies conducted by the Palm Beach County HIV CARE Council have revealed that Blacks felt forgotten by the HIV/AIDS CARE Act System and were refusing to access care

[37] Ibid.

in appropriate proportion to their representation in the county's epidemiology. Additionally, African Americans did not seem to want to go to the public health clinics close to home due to stigma, and they felt frustrated with the treatment they received there, especially the long waits and difficult eligibility processes.

Finally, Black men have a disproportionately lower socio economic status compared to the general population. Therefore, they are more reliant on public funding systems for all forms of support. In response to these challenges, we have started to more aggressively fund case management for Blacks. We currently require additional funding, a shift in existing resources, or both, to be able to provide Black heterosexual men a more equitable distribution of resources.

In summary, the challenges and service gaps for this special population include the "down low" phenomenon, incarceration, stigma, frustrations and disappointments with the care system, and low socio-economic status. In the Palm Beach County 2006 PLWHA Survey, 3% of Black heterosexual men surveyed reported that they either need but can't get, or can get but won't use, primary medical care.

Women of Child Bearing Age (15-44)

Women aged 15-44 constitute 17% of the county's population, but 24% of the county's PLWHA, 29% of the 2004 AIDS incidence cases, and 28% of the 2005 HIV incidence cases. Their HIV/AIDS prevalence rate is 773 per 100,000.

As noted earlier, approximately 70% of female PLWHA are Black. In 2005, the Palm Beach County HIV CARE Council completed a two-year Special Project of National Significance aimed at identifying barriers to HIV/AIDS care for Black women.[38] The identified barriers were the following:

- The care system lacks sufficient comprehensiveness and capacity to serve this special population
- Services are located at multiple sites that are difficult to get to
- Some staff treat Black PLWHA disrespectfully
- The atmosphere in the care settings is unappealing
- Black female PLWHA lead lives of economic hardship lacking in basic resources
- Black female PLWHA are powerless, lacking the agency to act on their own behalf
- Black female PLWHA place other individual and family needs before the need for HIV care
- Black female PLWHA do not use the care system because they fear HIV status exposed to members of their community.

Another important indicator of the necessity for enhanced services to this population is mother-to-child HIV transmission. Palm Beach County had 2 new pediatric AIDS cases in 2004 and 1 in 2005, all of which were born to Black female PLWHA. These are completely preventable cases if the mothers had received appropriate medical care.

Based on the barriers to care identified in the above-mentioned study, six recommendations for programmatic changes were made: expansion of HIV/AIDS education; development of a single

[38] Palm Beach County HIV CARE Council (2005). *Care System Assessment Demonstration Project, Palm Beach County.*

point of entry into care; strengthening confidentiality; increasing treatment adherence; addressing stigma; and addressing cultural beliefs, practices, and behaviors. Additional funds are needed to implement these recommendations.

Although Black women constitute the majority of female PLWHA in Palm Beach County, as noted earlier (subsection a), HIV cases among White and Hispanic females have been increasing over the last several years, presenting a need for increased funding for these populations.

In summary, the challenges and service gaps for female PLWHA of childbearing age are multiple and require increased funds to address. In the Palm Beach County 2006 PLWHA Survey, 8% of women surveyed reported that they either need but can't get, or can get but won't use, primary medical care.

Haitian-Born Men and Women, Age 13+

According to the U.S. Census, the Haitian-born population in Palm Beach County numbers 35,338.[39] Although an age breakdown is not provided, an estimate can be made using the percentage of the county's Black population that is age 13+ (72%). Applying this proportion to the Haitian population yields an estimated 25,479 Haitian-born men and women age 13+, accounting for 2% of the total county population. However, this special population accounts for 18% of the county's PLWHA, 16% of the 2005 AIDS incidence cases, and 15% of the 2005 HIV incidence cases. As in Haiti, heterosexual sex is the main mode of transmission among Haitians. MSM transmission accounts for only 9% of all reported Haitian HIV/AIDS cases in Florida.[40]

Haitians face all the same challenges and service gaps as the general Black population, as described above. However, in addition, Haitians face additional difficulties due to their foreign-born status. Studies conducted by the Palm Beach County HIV CARE Council, including the above-mentioned Special Project of National Significance, have revealed that barriers for Haitians include distrust of established health systems; language (few agencies have Creole-speaking staff); literacy; stigma and community ostracism; lack of transportation; and the inability or unwillingness to tell employers about the need to leave work to keep doctors appointments for fear of being fired. Another barrier is that the Haitians don't believe that they can access care if they are undocumented immigrants, and they are fearful of deportation if they seek services. They report rather staying away and getting sick than being returned to Haiti. Yet another challenge is the use of indigenous healing practices (voodoo) in lieu of or in addition to mainstream health care. For Haitian women there are gender and power disparities. Haitian women do not ask their men to use protection. They risk the withdrawal of financial support from the men if they ask and they cannot afford to care for their families alone.

We have augmented the amount of services we provide to this special population. We have Haitian members on the Care Council and the CEO of the largest case management organization in our county (Comprehensive AIDS Program) is of Haitian descent. This organization serves a sizable Haitian population in the southern part of the county. Additionally, we have one agency, the Haitian Center for Family Services, devoted solely to serving Haitians throughout the county.

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[39] US. Census (2006). *American Community Survey, 2005, Palm Beach County.*

[40] Richardson, A. (2003). *HIV/AIDS among Haitians: Epidemiological Profile, 2003.* Florida Department of Health, Bureau of HIV/AIDS, Surveillance Section.

Nonetheless, continued enhanced programming and funding are needed to effectively serve this special population.

In summary, there are many challenges and service gaps for the Haitian-born population in Palm Beach County. The Palm Beach County 2006 PLWHA Survey did not identify respondents by country of birth. Therefore, the percentage of Haitian-born PLWHA who either need but can't get, or can get but won't use, primary medical care, must be estimated as equal to the percentage for all Black respondents, which is 5%.

Foreign-Born Hispanic Men and Women, Age 13+

According to the U.S. Census Bureau, the foreign-born Hispanic population in Palm Beach County numbers 107,223.[41] As with the Haitian-born population, an age breakdown is not provided, but an estimate can be made using the percentage of the county's total Hispanic population that is age 13+ (75%). Applying this proportion to the foreign-born Hispanic population yields an estimated 80,417 foreign-born Hispanic men and women age 13+, accounting for 9% of the total county population.

In 2003 (latest date available), 65% of Palm Beach County's Hispanic PLWHA were foreign-born.[42] Applying this percentage to the epidemiological data for all Hispanic PLWHA in Palm Beach County in 2005 reveals the following: Foreign-born Hispanic men and women age 13+ account for 9% of the county's population, but 7% of the PLWHA, 12% of the 2005 AIDS incidence cases, and 10% of the 2005 HIV incidence cases. Thus, although the proportion of foreign-born Hispanic PLWHA in the county is lower than their representation in the population, both their AIDS and HIV incidences are higher. Furthermore, as noted earlier (subsection a), Hispanic prevalence and incidence are higher than those among Whites, and incidence among Hispanics has been increasing over the past several years.

One challenge to serving this population is the national and cultural diversity within the foreign-born Hispanic population. The following table shows the countries of birth of foreign-born Hispanic PLWHA in Palm Beach County in 2003 (latest year available):

Foreign-Born Hispanic PLWHA in Palm Beach County, 2003[43]

Country of Birth	Number	Percent
Puerto Rico*	173	31%
Mexico	95	17%
Cuba	74	13%
Guatemala	41	7%
Colombia	23	4%
Honduras	16	3%
Brazil	12	2%
Venezuela	7	1%
Nicaragua	6	1%
Other/Unknown	105	19%
TOTAL	552	100%

[41] US. Census (2006). *American Community Survey, 2005, Palm Beach County.*

[42] Florida Department of Health, Bureau of HIV/AIDS, Surveillance Section (2004). *Impact of HIV/AIDS on Minorities by Country of Birth, Florida, 2003.*

[43] Ibid.

*Although Puerto Ricans are not technically foreign-born, they experience many of the same issues as other immigrants, except for legal issues.

Additionally, Mayan Indians, primarily from Guatemala, are lumped with Hispanics in statistical data, although they are ethnically and linguistically distinct.

Another challenge is deportation fears. Both documented and undocumented immigrants fear reprisal occurring locally by arrest, detainment, and deportation, preventing many foreign-born Hispanics who are at high risk for HIV/AIDS from accessing health care. As a result, they often ignore their health and symptoms of HIV/AIDS until they are forced to seek treatment at emergency rooms. By this time the progression of their disease is end-stage.

Employment for foreign-born Hispanics is often seasonal and part-time; therefore, this population is not stable in residence and tends to move with crop times and harvesting schedules. Their healthcare across the spectrum is as sporadic as their resident status. Unstable employment and transient lifestyle make it difficult to connect with much-needed medical and social services.

There are also transportation gaps for this community. The Mexican and Guatemalan farm workers walk to everything. The middle of the county, where most of the foreign-born Hispanic farm workers reside, is about 20 miles away from the South and North Department of Health HIV clinics. Transportation without childcare and the ability to take time off during a workday is useless. Nonetheless, it could provide some incentive for keeping doctors' appointments and deter infection progression.

Further, the issues of language and literacy prevent many members of this population from receiving effective HIV/AIDS care. Although most health care provider agencies have some Spanish-speaking staff, they do not have translators and interpreters for Mayan languages.

Many foreign-born Hispanic and Mayan women are trafficked to Palm Beach County for the purpose of being sex slaves for the male fieldworkers. Obviously, these women are at high risk for HIV infection but are not in a position to protect themselves or to seek health care. Other foreign-born Hispanic and Mayan women perceive that they are not at risk and that it would be inappropriate for them to protect themselves from risk by insisting on risk reduction practices.

We have enhanced our efforts to serve the foreign-born Hispanic population. Four of the eleven enrollment centers for the Coordinated System of CARE are operated by minority community-based organizations dedicated to working with recent entrants (e.g., immigrants and refugees). Among primary medical care service providers, several are Hispanic and one Mayan Indian. Two service centers operate in the middle coastal region of the county and serve a Hispanic/ Mayan Indian/ Mexican population. Three service centers are located in the western section of the county, which serves the most diverse migrant population: Mayan, Mexican, Jamaican, West Indian, Caribbean Islander, Central and South American and Middle Eastern, and Haitian. Through the school district, migrant and recent entrant youth are being targeted for prevention. Special attention is given to the cultural and language needs of these vulnerable populations. Outreach workers are trained to locate and work with these populations and build trust for medical care services. Continued delivery and enhancement of these services is needed to more effectively serve this population.

In summary, the barriers and service gaps for the foreign-born Hispanic population include the national and ethnic diversity within the population, deportation fears, seasonal employment, transportation, language and literacy, and female disempowerment. In the Palm Beach County 2006 PLWHA Survey, 35% of Hispanic respondents surveyed reported that they either need but can't get, or can get but won't use, primary medical care.

Estimated Costs of Service Delivery

Estimated costs of service delivery to each of the identified special populations were calculated as follows. First, the number of reported PLWHA in the special population was multiplied by the proportion (or estimated proportion) who reported in the 2006 PLWHA Survey that they either need but can't get, or can get but won't use, primary medical care. This provides an estimate of the number of people within each population who experience service gaps or barriers. It must be noted, however, that this is a very rough estimate since it is based on a small, non-probability sample.

Next, an estimated cost of service delivery per person was calculated. In 2005, the total annual cost of service delivery per Ryan White Title I consumer was $2819.[44] This includes health care services, case management, and support services. Since the identified special populations present numerous and complex service delivery challenges, it is assumed that they would need all of these service categories in order to access and utilize primary medical care. The 2005 per person expenditure was multiplied by a factor of 1.04 to account for inflation,[45] resulting in an estimated per person expenditure in FY 2007 of $2932.

Finally, the estimated per person expenditure was multiplied by the estimated number of people within each population who experience service gaps or barriers to yield a total estimated cost of service delivery for each special population. The results are presented in the following table.

Estimated Costs of Service Delivery to Special Populations, West Palm Beach EMA

	(A) Number of Reported PLWHA	(B) Percentage of Reported PLWHA experiencing service gaps or barriers	(C) Number of Reported PLWHA experiencing service gaps or barriers (A X B)/100	(D) Estimated Cost of Service Delivery (C X $2932)
MSM	1,852	16%	296	$867,872
IDU and IDU/MSM	764	6%	46	$134,872
Hetero Black Men	1,482	3%	44	$129,008
Women Age 15-44	1,656	8%	132	$387,024
Haitian-Born	1,218	5%	61	$178,852
Foreign-Born Hispanic	453	35%	159	$466,188
TOTAL	7,669	11%	823	$2,163,816

[44] Palm Beach County Dept. of Community Services.(2006). *Final FY 2005 Title I Expenditure Report.*
[45] U.S. Bureau of Labor Statistics (2006). *Inflation Calculator.*

d) Unique Service Delivery Challenges

There are three factors that further contribute to the need for HIV/AIDS emergency grant funds in the West Palm Beach EMA: PLWHA migration, rural PLWHA, and incarcerated PLWHA. PLWHA migration has not been addressed in the preceding sections. Rural and incarcerated PLWHA have been addressed in brief in the context of certain special populations, but these factors are of sufficient importance to merit further discussion. The following narrative describes the unique service delivery challenges presented by each of these factors in terms of complexity of providing care. Finally, estimated service costs associated with these factors are presented.

Challenges

PLWHA Migration

The Florida Department of Health, Bureau of HIV/AIDS, Surveillance Section, recently conducted a study on HIV/AIDS patient mobility in 12 counties in Florida in 2004-2005.[46] The rationales for this study were the following:

- Florida leads the U.S. in annual net population gain due to migration. Thus it is reasonable to consider that Florida may attract substantial numbers of those seeking to relocate following a diagnosis of HIV, many of whom will enroll in publicly funded HIV/AIDS treatment programs.
- Ongoing needs assessments that plan for secondary HIV prevention and patient care should take into account the demographic and risk profiles of persons who migrate to Florida communities following a diagnosis of HIV.
- Continuity of care of those in-migrating who are already receiving treatment would prevent progression of HIV disease and minimize viral load to reduce further transmission.
- Future funding will largely depend on the number of HIV cases and may continue to be counted by residence at time of diagnosis, not current residence.

Using a brief, self-administered, random sample survey in publicly funded HIV/AIDS clinics, the study found that overall, an estimated 23% of PLWHA in Palm Beach County migrated from elsewhere following their HIV diagnosis. 9% migrated from another county in Florida, 12% from another state, and 2% from another country. Further, Whites, males, and MSM tended to migrate from other states to a greater extent than those in other demographic/risk groups. The study concluded that an estimated 6% of Palm Beach County PLWHA could have been reported with HIV outside the county: 2% from other Florida counties and 4% from other states. Applying the 6% to the total 6,833 reported PLWHA in Palm Beach County results in 410 PLWHA who may be receiving public care, yet are not included in the Title I formula funding. This would mean that the West Palm Beach EMA is underfunded by Title I; therefore the funds are spread among more people than were budgeted for, resulting in reduced service levels for the consumers.

Rural PLWHA

The western, rural portion of Palm Beach County is referred to in local vernacular as "the Glades," due to its location in the area of Lake Okeechobee, which is the source of the

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[46] Lieb, S. (2006). *HIV/AIDS Patient Mobility: A 12-County Study, Florida, 2004-2005.* Florida Department of Health, Bureau of HIV/AIDS, Surveillance Section.

Everglades ecosystem. As noted in earlier subsections, the PLWHA prevalence rate in the Glades is nearly 5 times greater than the rate in the eastern, urban portion of the County, and the demographics and exposure factors between the two regions differ substantially. A recent study on the impact of HIV/AIDS on the Glades revealed the following findings[47]:

- The PLWHA prevalence rate through 2004 was 2,374 per 100,000 in the Glades, compared to 500 per 100,000 in the eastern portion of the county.
- PLWA in the Glades have a higher percentage of females, a much higher percentage of Blacks, a much higher percentage of heterosexual exposure, and a much lower percentage of MSM exposure, compared to the eastern portion of the county (see table comparing eastern and western regions of the county in subsection a).
- Encouragingly, HIV cases in the Glades steadily decreased by 59% from 1998-2004, and AIDS cases decreased by 59% from 2002-2004. This indicates that progress has been made, yet the overall prevalence rate is still staggering.
- In the Glades, HIV and AIDS cases among Blacks have predominated at over 90% of all cases over the past decade. White and Hispanic cases have remained level below 10% of all cases over the same time period.
- The male to female ratio of adult AIDS cases in the Glades in 2004 was 1.5 to 1, while the male to female ratio of adult HIV cases (regardless of AIDS) in the Glades in 2004 was 0.5 to 1.
- Heterosexual contact HIV (regardless of AIDS) cases predominate among males in the Glades. However, from 1998-2004 there was a 92% decrease among heterosexual male HIV cases in the Glades. There are few MSM and IDUs.
- There was a decrease of 52% in female heterosexual HIV (regardless of AIDS) cases in the Glades between 1998-2004.
- The percentage of male AIDS cases steadily increases with age in the Glades, which is an unusual pattern.
- 31% of female HIV cases in the Glades occurred among those aged 13-29 in 2004, compared with only 14% of males.
- The demographic PLWHA profiles for eastern Palm Beach County and the Glades are radically different, particularly for whites and blacks, but the percentage Haitian is very similar (20% in the Glades, 17% in the eastern portion).
- Among male PLWHA in the Glades, the distribution of exposure mode among Blacks and Hispanics is similar (primarily heterosexual).
- The risk profile of Black female PLWHA in the Glades is similar to that in eastern county (95% heterosexual).

The report concluded that the following underlying factors affect the disproportionate impact of HIV/AIDS in the Glades:

- Pre-existing density of HIV in the community.
- Late diagnosis of HIV.
- Access to/acceptance of care; HIV/AIDS conspiracy beliefs.
- Delayed prevention messages to minorities (considered a gay, white male disease for some time).

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[47] Lieb, S. (2005). *The Impact of HIV/AIDS on the Glades.* Florida Department of Health, Bureau of HIV/AIDS, Surveillance Section.

- Prevalence of STDs in the community.
- Complex matrix of factors related to economic status.
- Non-disclosure (closeting) of MSM risk to female partners.
- Prevalence of injection drug use.
- Incarceration.

Two other very important factors that were uncovered by the recent study of Black women conducted by the Treasure Coast Health Council[48] were stigma and transportation. Consumers in the Glades were extremely concerned about being seen in the HIV/AIDS clinics, due to the small and insular character of the community. Additionally, the public health clinic and case management agency are located several miles from the center of Belle Glade (the major town in the area), where most of the consumers live. Most of the PLWHA population in this area does not have cars and must rely on public transportation to get to these agencies. The transportation is sporadic, is problematic for women with small children, and waiting for the bus in the heat is unhealthy for an already ill population.

Additionally, the challenges faced by the Hispanic migrant worker population in the Glades have been addressed above in the subpopulations section.

Based on the proportion of the county's reported PLWHA who lived in the Glades in 2004[49], it is estimated that there are 823 PLWHA in the Glades in 2005. The 2006 Palm Beach County PLWHA Survey (described in subsection a) found that 5% of Glades respondents reported that they "need, but can't get" primary medical care (service gap) and 1% reported that they "can get, but won't use" primary medical care (service barrier).

We have implemented and plan to implement strategies to reach the rural PLWHA population. Various of these strategies were described earlier in the special populations subsection, specifically in relation to Black heterosexual males, women of child-bearing age, and foreign-born Hispanics. The continued enhancement of services for this unique area will require additional funding.

Incarcerated PLWHA

The Florida corrections system has two types of incarceration facilities: prisons, which are funded and operated by the state Department of Corrections, and jails, which are operated and funded by local county governments.[50] The average length of stay in prisons is three to five years, and the prisons are mandated to test each inmate for HIV within 60 days of release. The average length of stay in jails is 23 to 46 days and the jails are not required to test inmates for HIV unless they have been convicted of a sex crime.

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[48] Palm Beach County HIV CARE Council (2005). *Care System Assessment Demonstration Project, Palm Beach County.*

[49] Lieb, S. (2005). *The Impact of HIV/AIDS on the Glades.* Florida Department of Health, Bureau of HIV/AIDS, Surveillance Section.

[50] Florida Department of Health, Bureau of HIV/AIDS (2006). *Florida Corrections Programs.*

On June 30, 2005 there were 84,901 inmates in Florida prisons, 3,364 of whom were known to be infected with HIV.[51] This is a PLWHA prevalence rate of 3,962 per 100,000, nearly ten times greater than the state's PLWHA prevalence rate among the non-incarcerated population, which is 417 per 100,000. Approximately 100 HIV-positive inmates leave Florida's prisons each month.[52] Clearly, HIV/AIDS is a critical issue for inmates and service providers, both during incarceration and after release.

On June 30, 2005, there were 3,449 inmates in prisons located in Palm Beach County.[53] The average daily population in Palm Beach County jails in 2005 was 2,767.[54] Adding these two figures results in an estimated average daily incarcerated population in Palm Beach County of 6,216. Applying the above incarcerated PLWHA prevalence yields an estimated 246 incarcerated PLWHA in Palm Beach County on any given day: 137 in prisons and 109 in jails.

Since the average jail stay is less than two months, all of the estimated 109 PLWHA in Palm Beach County jails will be released back into the community within a year's period. Regarding the prisons, a total of 1,062 inmates were released in Palm Beach County during fiscal year 2004/2005.[55] Again applying the above incarcerated PLWHA rate, this yields an estimated 42 PLWHA being released from Palm Beach County prisons within a year's period. Thus, there is an estimated total of 151 PLWHA inmates (109+42) being released in Palm Beach County within a year's period.

The Florida Department of Health operates a Pre-Release Planning Program in all the state prisons.[56] The program is responsible for offering pre-release services to all known HIV-positive prisoners. Four release planners cover the entire state. The release planners also work with correctional staff and either provide the service directly to the inmate or work with corrections staff in other facilities to assist in the pre-release planning process. The program is responsible for tracking all HIV-positive prisoners being released. Nonetheless, as noted earlier (in the special populations section on Black heterosexual males) many released PLWHA inmates do not follow through with pre-release medical care referrals for a variety of reasons, including no parole for two-thirds of prisoners, and high distrust of government.

Additionally, the Florida Department of Health operates a jail linkage project in eleven counties. This program includes HIV/AIDS counseling and testing, prevention education, pre-release planning, and follow up services to ensure the releasees are still in care in the county. However, Palm Beach County is not one of the counties in this project. In sum, pre- and post-release services for incarcerated PLWHA in Palm Beach County require significant attention, enhancement, and increased funding.

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[51] Florida Department of Corrections (2005). *Trends and Conditions Statement.*
[52] Florida Department of Health, Bureau of HIV/AIDS (2006). *Florida Corrections Programs.*
[53] Florida Department of Corrections (2005). *Summary of Florida State Correctional Facilities.*
[54] Florida Department of Corrections (2005). *Average Daily Populations and Incarceration Rates per 1,000 County Population.*
[55] Florida Department of Corrections (2005). *Prison Releases by County (Top 20) by Violent, Property, Drug, and Other.*
[56] Florida Department of Health, Bureau of HIV/AIDS (2006). *Florida Corrections Programs.*

Estimated Costs of Service Delivery
The rural and incarcerated PLWHA populations overlap significantly with the special populations described in the previous subsection. The rural population overlaps with the IDU and MSM/IDU, Women of Childbearing Age, Heterosexual Black Men, Haitian-Born, and Foreign-Born Hispanic special populations. The incarcerated population overlaps with the Heterosexual Black Male special population, inasmuch as 89% of prison releasees in fiscal year 2005/2006 were male and 49% were Black.[57] Therefore, the estimated costs of service delivery to the rural and incarcerated populations will be assumed to be folded in with the special populations, i.e., it is assumed that there will be no additional costs for serving the rural and incarcerated populations.

Regarding the estimated 410 PLWHA in-migrants who may not be included in Title I formula funding, multiplying by the previously-described estimate of $2,932 cost per person served results in an additional estimated cost of $1,202,120.

Summary of Severe Need
In conclusion, the West Palm Beach EMA has a demonstrated severe need. We are currently serving more clients with a diminishing amount of funding. Two years ago, we were funded for $9,526,000. That year the reported PLWHA prevalence was 6,528. Therefore, the available funding per reported PLWHA was $1459. During that year we served 2,890 consumers. Therefore, the available funding per consumer was $3,296.

Last year our funding was reduced to $8,276,000. That year the reported PLWHA prevalence was 6,374. Therefore, the available funding per reported PLWHA was $1298. During that year we served 3,004 consumers. Therefore, the available funding per consumer was $2,755.

Thus, the available funding per reported PLWHA decreased by 11% between the last two years, and the available funding per consumer decreased by 16%. These decreases had a substantial impact on service delivery, as staff and services had to be reduced.

We have identified above a need for an estimated $2,163,816 to serve the identified special populations, and $1,202,120 to serve the in-migrant population, for a total of $3,365,936. We believe we have clearly demonstrated the need for additional funding.

2. Implementation Plan

a) Table: FY 2007 Implementation Plan – Attachment 1-D
b) The WPB EMA FY 2007 Implementation Plan was developed to ensure access to care for all persons in the current delivery system; ensure that persons are remaining in care; and to increase access for those persons not in care.

In accordance with HRSA, the ***West Palm Beach EMA Comprehensive Plan 2006*** **and the** ***Palm Beach County HIV Care Council Needs Assessment 2003 – 2006*****, service priorities, severe need data, and the unmet need data** are connected and serve as the road map for the service delivery system in the WPB EMA. The needs assessment and the comprehensive plan demonstrated service gaps in food, housing, direct emergency services, and complimentary therapies. It also identified barriers in the following services legal services, day and respite care,

[57] Florida Department of Corrections (2006). *FY 2005-2006 Release Report, Offender Characteristics.*

complementary therapies, home health care, and outpatient substance abuse treatment. Services that were identified in these documents as the *most needed and used* services were case management, laboratory/diagnostic testing, ambulatory primary medical care, and HIV prevention. Using this information in the Priorities and Allocations process, the Care Council funded all of these identified gaps, barriers, and most needed service categories with the exception of complimentary therapies, which was not funded. The majority of the available funding has been allocated to the top six core services as (Primary medical care, HIV-related medications, mental health treatment, substance abuse treatment, oral health, and case management).

The FY 2007 Implementation Plan will provide increased access to the HIV continuum of care in the WPB EMA for communities where HIV prevalence is increasing and in minority communities that are disproportionately impacted by HIV disease and to people who know their HIV status but are not in care. The Implementation Plan will continue to be enhanced through support services including case management, food bank/home delivered meals and transportation. Medical care services and Case management are targeted to areas throughout the EMA according to "documented need with regard to demographics and epidemiology." The case management agencies keep clients records of medical appointments, lab results and encourage clients to keep appointments, adhere to medications and as a goal prevent new infections. One of the case management agencies conducts monthly client educational sessions. Agencies who serve the Haitian, Hispanic and other minority communities all have staff that reflects the demographics of the populations that they serve. This is to ensure that services are culturally and linguistically appropriate.

Outreach services will be targeted **to communities where HIV prevalence is increasing in minority communities that are disproportionately impacted by HIV disease and people who know their status but are not in care.** Outreach services will identify people living with HIV and enroll them in care at an earlier state of illness. Outreach will also help bring persons back into care that may have dropped out of care for various reasons.

The **WPB Special Populations** consists of six (6) special populations, MSMs age 13+; Injection Drug Users (IDU) and MSM/IDU; Heterosexual Black (non-Haitian men); Women of Child Bearing Age (15-44); Haitian-Born Men and Women; and Hispanic Men and Women. These are the populations that are being addressed in outreach and treatment adherence. The needs of special populations are unique and varied so outreach and treatment adherence will be culturally sensitive and comprehensive to maintain them in medical care. Outreach services will link these special populations to case managers who are reflective of these special populations or have been successful in maintaining these special populations in care.

The FY 2007 Implementation Plan encourages PLWHA to remain engaged in HIV primary medical and adhere to HIV treatment by providing services at four local county health departments, providing case management, providing treatment adherence programs, assistance with funding for medications, and nurse care coordination. Quality medical care is provided in accordance to the PHPS Guidelines at four County Health departments and several private physicians located throughout the county. Case Management continues to be the #2 priority of the Planning Council and is the key access point to HIV primary care and other support services. It is reported by outcome data that 98% of case managed clients are currently in primary medical

care. Access to case management services is most often synonymous with access to primary medical care. Case management services are provided in Spanish for the Latino population and French Creole for the Haitian population. A response to the changing epidemic is increased funding for medication adherence. Title I funding that supports medication adherence services through the Local Supplemental Drug Program was increased. Specialty Outpatient Medical care was also increased, due to the growing need.

Geographical parity with the EMA is ensured through service providers that have multiple site locations throughout this EMA. This EMA has three health departments in four separate locations providing primary medical care, oral health care, laboratory and diagnostic testing, nurse care coordination, and treatment adherence. The case management agencies also have case managers on site at these locations to ensure access to care and other social services. Those locations comprise of the Coastal, Western and Southern communities of Palm Beach County. In addition 6 private physicians have contracts to provide medical services throughout the county so clients have a choice and there are 200 specialty doctors in the network that will accept referrals for Specialty Medical. Case management and the remaining support services are provided throughout the Coastal, Western and Southern areas of Palm Beach County. Culturally appropriate services are provided at all locations. Satisfaction surveys and the recent needs assessment surveys indicate that culturally sensitive services keep patients in Medical Care. The largest case management agency has five service centers located throughout the county (Belle Glade, Delray Beach, Riviera Beach, Lake Worth/Palm Springs, and Pahokee). Compass, Inc. has one service center located in West Palm Beach.

Cultural appropriateness is ensured through several objectives in the 2006 Comprehensive Plan. The competitive process to award service contracts requires potential vendors to demonstrate the ability to provide services in a culturally appropriate manner. The Planning Council has also completed and approved Standards of Care to ensure cultural and linguistic competency in all Ryan White Title I services.

The FY 2007 Implementation Plan is closely tied to Healthy People 2010, the Nations plan for healthy improvement. Healthy People 2010 has two major goals: (1) To increase the quality and years of a healthy life; and (2) Eliminate our country's health disparities. The Program consists of 28 focus areas and 467 objectives; one of the focus areas is HIV. The WPB EMA Title I FY 2007 is working towards the goals and objectives of *Healthy People 2010* through reducing barriers to care and maintaining individuals in care through such services as case management, mental health counseling, substance abuse treatment and legal assistance. Another main objective in *Healthy People 2010* is to reduce the disproportionate impact of HIV/AIDS among certain racial and ethnic groups, the WPB EMA has identified special populations, increased funding for medical services which includes treatment adherence and is funding outreach so more people will be aware and seek treatment at culturally sensitive providers. Currently, The Planning Council is also working toward ensuring that the goals of the EMA represent those in Health People 2010.

Women, Infants, Children and Youth (WICY): In accordance with the service priorities established by the Ryan White Title I Planning Council, all services directed to women, infants, children and youth (WICY) were funded. All services that are funded include primary medical care; case management and support services are all being utilized by WICY. In FY 2005, this

EMA exceeded the Center for Disease Control and Prevention (CDC) percentage of 32.77% for WICY providing WICY with 40.76% with services.

MAI funds solely fund Case Management. The dollars are used to reduce disparities and to improve access to care and primary medical services for populations that are disproportionately impacted communities of color and underserved communities through an expansion of Case Management capacity. There is a specific focus on Haitian, African American populations and, within those populations, there is a focus on Women, Youth and Children.

3. Grantee Administration

a) Program Organization

The Palm Beach County Board of County Commissioners is the local governmental agency that is responsible for the administration of the Title I funds. The Board of County Commissioners designates the authority of the Title I funds to the County Administrator. An organizational chart illustrating the location of the County Administration and the Department of Community Services who is the Grantee of the Title I Funds is located in **Attachment 1-A.**

The Ryan White Title I Program Manager is responsible for the day-to-day operations of the grant, which includes distribution of grant funds based on the Request for Proposal (RFP) open competitive process. The Program Manger also supervises two Program Monitors that conduct on-site visits to service providers as well as writing contracts and preparing reports. The Financial Analyst conducts fiscal monitoring of all providers and produces all fiscal related reports for the Program Manager and Planning Council. The Fiscal Specialist is responsible for all program reimbursements. The Computer Specialist provides MIS support to the providers, technical assistance and training of any new MIS programs. The Quality Manager is responsible for the quality management program, quality plan, quality assurance committee and ensuring providers provide performance outcome measurements. At this time there are no vacancies in the Title I Program. Planning Council Support is subcontracted to the Treasure Coast Health Council.

b)Grantee Accountability

Fiscal and Program Monitoring

This EMA has conducted one site visit, **both programmatic and fiscal monitoring** for 100% (10) of the Ryan White Title I service providers. These ten (10) service providers have multiple services in their contracts with the exception of two. The second annual fiscal **and** programmatic monitoring are scheduled to be completed by the end of FY2006/07.

In both fiscal **and** programmatic monitoring for FY2006/07, 100% of the Ryan White Title I funded service providers were in compliance with all contract requirements with the exception of two providers that are currently in the process of addressing eligibility documentation.

As defined in the service contract, the **WPB EMA process for corrective action** once a fiscal-related or programmatic concern is identified is as follows:

- Findings are documented in a formal letter and presented to the Executive Director of the service provider agency.
- The agency is given 30 days to correct the concern.

- The Grantee offers technical assistance, if needed to the service provider during the 30-day time period.
- After the corrections have been made (whether fiscal or programmatic) another site visit is arranged to verify the corrections.
- If corrective action has not been satisfied further steps will be taken, including freezing reimbursements or termination of contract.

All reporting and quality assurance activities are requirements defined in the service contract between the ten (10) providers and the Grantee of Ryan White Title I services. The contract requires that monthly the services providers submit invoices for services, monthly general ledger by service category, and WICY reports. Each agency is also required to submit an annual audit conducted by an Independent Certified Public Accountant within 180 days after the after the end of the agencies fiscal year in accordance with Federal requirements.

The **redistribution of funds** is done quarterly. If a service is under spending, the Grantee redistributes these unused funds to services, usually in the medical category, with a higher priority set by the Priorities & Allocations committee. Contract amendments are completed in a timely manner to redistribute funds after an agenda item is submitted to the Board of County Commissioners.

c) Third Party Reimbursement

The WPB EMA makes every effort to ensure that the CARE Act is the payer of last resort. This process includes a common eligibility process where all clients are thoroughly screened for any other payer source for medical services. The screening consists of a financial assessment, which includes a Medicaid or in this EMA' s case Health Care District (Palm Beach County Taxing District) denial letter that is attached to the client's records. In addition, on all Primary Medical enrollment forms and Specialty Medical referral forms, a case manager must certify with a signature from their supervisor that the screening was conducted and that Ryan White CARE Act funds are being used as "Payer of Last Resort". Services will not be approved unless this certification is made and appropriate documentation on eligibility is available

Ensuring that Care Act funds are used as the payer of last resort is a contract requirement between the Grantee and the subcontractors. The contract requires that the subcontractor maintain client records, containing evidence of financial benefit and entitlement eligibility, including documentation of **NO** other payer source, indicating their qualification for Ryan White Title I services. During the program and fiscal monitoring this documentation is verified for compliance and is documented in the subcontractors file with the Grantee, as per contractual agreement. If it found that a client is eligible for another source of funding and the funding will be reimbursed to the Grantee.

The **State Medicaid** program has a positive impact covering PLWH health care costs in this EMA. The screening process and financial assessment of each client insures that these clients are eligible for Medicaid, which in turn reduces cost for the Ryan White Title I program. In some instances, Ryan White Title I covers cost and services that are not part of the State Medicaid program benefits. These services would be Dental Assistance, Nurse Care Coordination and other ancillary services that Ryan White Title I provides and State Medicaid does not.

State Medicaid implemented a program call Disease Management Organization (DMO), which has increased enrollment through identification of Medicaid recipients that have received services that might suggest eligibility for Project AIDS Care Waiver Program (PAC), which also reduces costs to the Ryan White Title I program.

d) Administrative Assessment

The purpose of this assessment is to evaluate the performance of the grantee, Palm Beach County Board of County Commissioners, in administering the Ryan White Title I grant for the West Palm Beach EMA. The Assessment of the Administrative Mechanism is conducted annually with a survey tool, designed by the Planning Council. The Planning Council Staff redesigned the assessment survey this year in order to address the deficiencies in the 2006 application. The Assessment was conducted in August 2006.

There were thirteen (13) members in attendance and each completed an assessment. Of these 13 attendees, 7 (53%) were black 47% were white, 7 (53%) were female, 6 (46%) were providers of Ryan White services, 5(38%) identified as being a consumer of Ryan White services, 2 (15%) identified themselves as "other" who were non-elected community leaders. The results of the assessment can be seen below.

As identified in the results of the Grantee Assessment, the largest portion of the respondents indicated that the Grantee **always** communicates the financial reports well, that the RFP process is effective, contracts with services in accordance with the priorities and allocations that were adopted by the Planning Council, insures that there is provider choice and regional availability of services, works to make the contracting and payment process flow in a timely manner, reallocates funds in a timely manner in accordance with the priorities and allocations, resolution of corrective action taken by the Grantee to improve service delivery, reallocates funds in a timely manner in accordance with the priorities and allocations established by the CARE Council, informs the CARE Council if there will be unspent dollars that may be reallocated for service provision in a timely manner, works well with provider agencies in maintaining the comprehensive continuum of care in the EMA, and that the relationship with the CARE Council is cooperative and professional. There were no deficiencies identified in the assessment however, there were some comments of "don't know" that the Grantee will address through better communicating these identified items at the Care Council meetings in the upcoming year.

RESULTS – 13 SURVEYS COMPLETED

Statement of Performance	always	most of the time	occas*	rarely	never	do not know
1) The Grantee provides clear and comprehensive financial reports to the CARE Council at the scheduled Council meetings.	71% (10)	15% (2)				8% (1)
2) The Grantee provides timely information on service cost data and service utilization data upon which the CARE Council can use to make reasonable decisions during its planning process.	38% (5)	54% (7)	8% (1)			

Statement of Performance	always	most of the time	occas*	rarely	never	do not know
3) The Request for Proposal (RFP) process was fair and effective.	54% (7)	23% (3)				23% (3)
4) The Grantee provides adequate information on quality assurance and service effectiveness for planning purposes.	31% (4)	23% (3)	23% (3)	8% (1)		15% (2)
5) The CARE Council is given an opportunity to review service category definition and give input for the Request for Proposal (RFP) language in the application packet.	38% (5)	23% (3)				38% (5)
6) The Grantee contracts for services in accordance with the priorities and allocations adopted by the CARE council.	46% (6)	31% (4)	8% (1)			15% (2)
7) A written plan for allocating the Minority AIDS Initiative dollars is utilized in awarding dollars to service providers to lessen barriers into getting services for minority clients in the EMA.	31% (4)		8% (1)			70% (9)
8) The Grantee works to insure that there is provider choice and regional availability of services.	54% (7)	23% (3)				23% (3)
9) The Grantee works to make the contracting and payment process flow in a timely manner.	46% (6)	23% (3)	8% (1)			23% (3)
10) The Grantee keeps the CARE Council informed about the contract monitoring process.	31% (4)	38% (5)	8% (1)	8% (1)		15% (2)
11) The Grantee informs the CARE Council regarding overall results of patient satisfaction surveys including barriers to care, general communications, follow-up, and other service satisfaction issues.	23% (3)	31% (4)	31% (4)			15% (2)
12) The Grantee informs the CARE Council with regard to the resolution of corrective action taken by the Grantee to improve service delivery.	38% (5)	15% (2)	8% (1)	8% (1)		31% (4)
13) The Grantee reallocates funds in a timely manner in accordance with the priorities and allocations established by the CARE Council.	46% (6)	23% (3)	15% (2)			15% (2)
14) The Grantee informs the CARE Council if there will be unspent dollars that may be reallocated for service provision in a timely manner.	85% (11)	8% (1)	8% (1)			
15) The Grantee works well with provider agencies in maintaining the comprehensive continuum of care in the EMA.	62% (8)	8% (1)	8% (1)			23% (3)
16) The Grantee's relationship with the CARE Council is cooperative and professional.	69% (9)	31% (4)				

*occas = Occasionally

Suggestions or comments from the assessment included the following:

1) In the area of quality assurance, the CARE Council will be receiving minutes from the upcoming meetings and the new QA Coordinator should make presentations during the year (even under the Educational Moments section of the agenda) so that they are informed about what QA is and how it will be conducted here.

2) Another presentation could be given on what the Minority AIDS Initiative dollars are for and how we are utilizing them and monitoring the agencies to show how the dollars assist in greater access to service for minority clients in Palm Beach County.

e) Use of Cost in Evaluating Services
Provision of cost effective Ryan White funded services, which maximize benefits at a reasonable cost, is a primary goal of the West Palm Beach EMA. The Grantee's request for proposal (RFP) review committee evaluates applicants on the cost per services based on market rates (if available), number of agency applicants, scope of proposed service, applicant operating costs and Ryan White Title I funding available per service category.

The Grantee negotiates rates for units of service with each sub-contractor. Sub-contractors bill the Grantee for the number of units of service provided, and report the number of clients served. Sub-contractors must provide a detailed work plan indicating the specific minimum number of service units that will be provided per month as per their contract. Limitations are placed on some services to reign in cost, e.g. Emergency Financial Assistance. This service can only be used twice in a contract period per client need. The Grantee evaluates unit cost performance data during fiscal site visits by reviewing service utilization.

During the priorities and allocation process Planning Council staff prepares a Fiscal Year Allocation Worksheet which defines estimated number of clients to be serviced, service unit definitions, average cost per unit and total estimated cost per service category. This report is based on the Grantee's Implementation Plan, the Planning Council's needs assessment and local Health Department epidemiological statistics and trends.

This EMA's Management Information System (FACTORS) is installed at the Grantee site (Palm Beach County Department of Community Services) and is being utilized to conduct both program and fiscal audits for sub-contractors. The Grantee also generates service utilization reports through FACTORS. These reports are distributed monthly to the Planning Council for service category prioritizing and allocation purposes.

4. Impact of Title I Funding: Access to Care Services and Funding Mechanisms

a) The EMA's Established Continuum of HIV/AIDS Care and Access to Care –
The West Palm Beach EMA, which as previously discussed, is divided in two regions; the eastern, urban part of the county, which includes the cities of West Palm Beach, Lake Worth, Riviera Beach, Boynton Beach, and Delray Beach, and the western, rural part of the county, which encompasses Belle Glade, Pahokee, and Canal Point. The current continuum of care through out the EMA consists of counseling and testing, prevention, early intervention, outreach and linkage, patient care, social and supportive services that address the needs of newly infected and underserved populations.

To effectively provide a comprehensive continuum of care The West Palm Beach EMA **continuum of care** consists of a network of service providers that represent both the public and private sectors of healthcare. The continuum is called the **Coordinated Services Network (CSN).** The network's members are: The Palm Beach County HIV CARE Council (planning council), the Palm Beach County Department of Community Services (grantee), the Treasure Coast Health Council (Title II), the City of West Palm Beach (HOPWA), the State of Florida Department of Health, the Palm Beach County Health Department, Comprehensive AIDS Program of Palm Beach County, COMPASS, Florida Housing Corporation, Gratitude House, Legal Aid Society of Palm Beach County, Palm Beach County Healthcare District, Western Palm Beach County Mental Health, The Western County Oakwood Center, and several private physicians. The services provided by members of the network range from primary medical care to other support services.

Through the CSN and the Planning Council the Grantee assures that HIV/AIDS care is consistent with the Department of Health and Human Services, Health Resources Administration (HRSA) goals of increasing access and reducing disparities. Throughout the spectrum of medical and support services the providers work toward maintaining a system that is **accessible** to all PLWHA within the EMA and one that maintains PLWHA in care for the purpose or reducing health disparities.

The **HIV testing and counseling** sites are located throughout the EMA at over thirty-three sites. In 2005, the Florida Department of Health, reports that there were 24,100 (15,812 female, 8,172 Male, 116 Missing Data) HIV tests conducted within the EMA of which 581 (2.4%) were found to be positive. Importantly, although fewer males were tested 4.0% were positive compared to females (1.6%). Regarding race, Blacks accounted for 9,590 (39%) of the HIV tests in the county with 4.1% that were positive; whites accounted for 5,289 HIV tests 1.9% were positive, Hispanics accounted for 848 tests, .9% were positive, 490 reported tests had missing data regarding race, 35 refused to provide the information and other races accounted for the remaining HIV tests. The two Title I funded Case Management organizations are testing sites therefore immediately linking persons with an HIV positive result into Case Management on site. There are **Case Managers on site at the Department of Health clinics** whereby those seeking medical care can be connected with services at this single point of entry

Rapid HIV testing is also occurring in the County through support of the Florida Department of Health. The EMA has become very creative in ways to reach hard-to-reach individuals and disproportionately impacted communities of color. An example of this is the Linkage Program through which ex-offenders known to be infected with HIV are met upon release and immediately connected to Medical Care and the Continuum of Care. Also, there is a bus that ventures into the most heavily impacted communities in the middle of the night, and grills chicken for those on the street; also offering HIV testing and linkage into care for those who are HIV positive. There are a wide variety of prevention, early intervention testing and counseling services available throughout the northern, central, southern and western areas of the EMA. Many of the organization providing those services, though not funded by Ryan White, are members of the network that make up the continuum of care and have relationships that provide easy access to care. These providers work in concert to ensure that those who are identified as HIV positive are linked to case management which is the entry point in to medical care and other social services.

Early Intervention Services follow guidelines presented through the Florida State Department of Health. The manual states that providers shall make every effort to provide test results to at least ninety percent (90%) of clients that confirm as positive. In addition the provider shall make every effort to refer at least ninety percent (90%) of positive clients to the local STD program for partner counseling and referral services, as well as, to medical and/or psychosocial services. Documentation of the above should be made in the clients' records. A follow-up to confirm that the client was successful in accessing the services should also be documented in the clients' records. The list of possible referrals includes, but is not limited to the following: Complete Medical Evaluation- including TB/STD/Hepatitis tests, prenatal care, Case Management, Substance Abuse Treatment, Mental Health Treatment, Prevention Case Management and Domestic Violence.

As a result of the reduction in FY 2006 funding cycle outreach was not funded by the EMA. However, **in response to the severe need and unmet need estimates identified in the corresponding sections of this application the planning council has increased their commitment and dedication to funding Outreach.** This will enable the EMA in getting PLWHAs that are aware of their status into primary medical care. It will also assist in identifying those who currently do not know their HIV status and bringing them into care. The Continuum of Care attains this in a variety of ways, which are discussed below.

The principle purpose of the Title I funded **Outreach Program** is to identify people infected with the HIV disease, particularly those who know their HIV status so that they shall become aware of and be linked in ongoing HIV primary care and treatment. It is also working toward identifying and bringing into care those who currently do not know their HIV status. Outreach activities must be planned and delivered in coordination with federal, State and local HIV-prevention outreach activities to avoid duplication of effort and to address a specific service need category identified through State and local needs assessment processes. Activities are conducted in such a manner as to reach those known to have delayed seeking care or are newly diagnosed and will be new to care. Outreach services are continually reviewed and evaluated in order to maximize the probability of reaching individuals who know their HIV status but are not actively in treatment. In addition, Outreach assures that all people living with HIV/AIDS have access to the continuum of care and are supported in their effort to advocate on their behalf. The program provides the HIV community with information regarding HIV disease, related illnesses, treatment options, the complexity of the treatment regimens, and the necessity for adherence to these regimens. This program is widely disseminated and culturally appropriate. Also, the planning council participates in many outreach activities throughout the year, promoting HIV/AIDS services in the EMA.

Currently there are two **case management** organizations funded by Ryan White Title I: Comprehensive AIDS Program, and COMPASS. The case management agencies have multiple offices in both the eastern and western parts of the counties in order to meet the needs of all populations of PLWHAs in the EMA. The **primary access** to the continuum of care in the EMA is through case management agencies. Clients **do not have** to be case managed to have access to care, however, case managers determine a client's initial eligibility. Once eligibility is determined, a client may be assisted in navigating the continuum of care by a case manager or chose to access services independently.

The case managers conduct an initial intake, which is a preliminary assessment of the client's medical and psychosocial needs, financial situation, and eligibility. Case managers are knowledgeable of all services in the community and refer clients to the appropriate provider to have their needs met which optimizes a comprehensive coordinated continuum of care for the clients. Case managers also offer assistance to clients in preparing applications for other benefit programs, monitor client's progress, and update the client's care plans. The case management agencies use the EMA common data collection system, FACTORS, which ensures that clients do not receive duplicative services. The case management agencies have placed employees at the primary point of entry for medical services, which is the Palm Beach County Health Department. This presence gives clients access to all other support services that may be necessary to ensure medical compliance. As a result, the case management agencies occasionally experience a backlog of clients waiting to be served. This is the result of the EMA's efforts, in cooperation with its early intervention, testing and counseling partners, to get people into care. **Therefore the Planning Council has found it necessary to allocate all of the MAI funds to the case management service category.** The **Title I Minority AIDS Initiative (MAI)** dollars were reduced in FY 2006 to $673,964 from $766,268 in FY 2005. These dollars solely fund Case Management. The dollars are used to reduce disparities and to improve access to care and primary medical services for population's disproportionately impacted, communities of color, and underserved communities through an expansion of Case Management capacity. There is a specific focus on Haitian, African American populations and within the special populations which includes a focus on Women, Youth, and Children. In FY 2005, 727 persons mainly of Haitian and African American descent were served including 388 (53%) Women, 28 (3%) Youth, and 10 (1.3%) Children.

As case management services continue to be expanded in the Haitian and African American community, the case management agencies employ individuals that provide culturally appropriate services. This effective communication works to improve the health of HIV infected individuals. The case management agencies have staff that reflect the cultural and linguistic diversities of the service area, have office locations in all regions of the county or are co-located throughout the various service provider sites including the Health Department, and work closely on a daily basis with the umbrella specialty medical care provider to expand the number and types of specialists able to assist the clients. The case management agencies seek to locate other funding sources, such as the Health Care District's managed care programs, to cover the cost of care- allowing the Ryan White dollars to serve those who are truly eligible for no other medical programs. The case management system in Palm Beach County provides the linkage to all services for infected individuals and their families.

Primary Ambulatory Outpatient Medical Care and oral health services are provided by the Palm Beach County Health Department at four of its six health centers: the C. L. Brumback Health Center in Belle Glade, the Delray Beach Health Center in Delray Beach, the West Palm Beach Health Center (pediatrics) in West Palm Beach and the Riviera Beach Health Center in Riviera Beach. To provide and promote private, public and community-based care services to eligible persons living with HIV disease throughout the county, the health department:

- Oversees public health HIV counseling, testing and partner referral services;
- Promotes implementation of treatment protocols for HIV-infected pregnant women;

- Provides and promotes community-based patient care services to persons infected with HIV and
- Collects and maintains surveillance data to analyze trends and support special investigations and prevention initiatives at the local level.

The service needs and demands of the persons living with HIV/AIDS in the EMA provided by the PBCHD encompass a full range of medical services including: primary medical care, dermatology, ophthalmology, outside specialty services by referral, nutrition counseling, psychological counseling, radiology, diagnostic laboratory testing, access to on-site case management services, pediatric and adult clinical pharmacy, medical/nursing case management, nurse care coordination, drug assistance program eligibility and enrollment (ADAP), specialized gynecological care and follow-up, health education and adherence counseling/treatment education. The dually infected TB/HIV patients are provided specialized care through the clinics in Delray and Belle Glade. All medical services are provided in accordance to PHPS Guidelines.

Nutrition and Mental Health services are available at each of the PBCHD HIV/AIDS clinic sites. A licensed registered dietitian, outside of a primary care visit, provides nutritional counseling services. A mental health professional licensed or authorized within Florida to render such service provides psychological and counseling services. This typically includes psychiatrists, psychologists and licensed clinical social workers. Dental services have also been made more accessible at all sites. Oral health includes diagnostic; prophylactic and therapeutic services provided by general dental practitioners, dental hygienists and other trained primary care providers.

The Grantee has contracted with other medical providers for specialty care for persons living with HIV or AIDS in the EMA. The **network continues to address the needs of newly affected and underserved populations,** including those who know their HIV status but are not presently in care; by altering hours of operations; by establishing new care locations in communities where underserved populations reside (town of Lake Park and town of Pahokee); by increasing outreach efforts in those communities and by adding new medical providers that addresses the needs of underserved populations. For example, Title I offers medical care through infectious disease doctors who reflect the population they serve, including physicians that are of Mexican and Haitian decent and speak the national languages. This aids in the ease of communication and trust between the client and physician relationship.

The case management agencies also work with some of the newer primary care clinics that do not receive Ryan White funding, such as Samaritan Gardens Clinic and the Caridad Clinic for referrals of clients. These clinics are funded mostly through local foundations and serve some of the hardest to reach populations. One initiative supported by the Quantum Foundation is the development of a new Federally Qualified Health Care Center that will be located at the main office of our largest case management agency- providing even greater access to medical services than is currently available sometime next year.

Mechanisms in the EMA that enable the newly infected, the special and underserved populations to remain in care and enhance the continuum of care are transportation services, Nurse Care Coordination, and treatment adherence as well as the above mentioned outreach. Nurse Care Coordination provides a range of client-centered services provided by a registered nurse specialist and coordinated with the client's primary outpatient

healthcare provider. Nurse Care Coordination acts as the Ryan White patient's main link with ongoing medical services.

One of the main goals of the **Treatment Adherence Education** is to provide counseling or a targeted intervention to specifically address barriers to treatment adherence to ensure readiness for and adherence to complex HIV/AIDS treatments for those in ambulatory outpatient medical care. In addition to the Title I funded program there are many providers of treatment adherence education throughout the county funded by the local health department, pharmaceutical companies and local HIV/AIDS organizations. This service is provided through a variety of protocols including educational sessions within support groups, therapy sessions to process possible barriers to adherence. Treatment adherence is discussed at every point of service throughout the continuum during appointments with case managers, nurses, physicians, mental health therapist, and substance abuse counselors.

Another support service that increases access to health care and decreases health disparities is the **Transportation** program. The availability of this service is contingent on the client's level of disability. Transportation services are offered in various ways through funding that includes bus passes for clients who live in the urban area and taxi cabs for clients who are outside of bus lines or in rural areas. Case managers provide assist PLWHAs in applying for the County Palm Tran and the Paratransit Services (publicly funded transportation services).

The Continuum of Care offers a comprehensive, seamless spectrum of services. **Mental Health Therapy and Substance Abuse Treatment Services** increase client's access to primary medical care by increasing the likelihood of drug therapy adherence and receipt of medical care leading to improved health and quality of life.

There are also many opportunities for client education provided throughout the county by organizations such as Comprehensive AIDS Program, COMPASS and the Department of Health where doctors and other medical professionals speak on topics such as adherence, how to understand lab work reports, medical options. **Medical Standards of Care** and **Social Standards of Care** were adopted by the Planning Council and are implemented by the Grantee, ensuring that providers follow protocols; leading to a high quality of care. These standards of care are still in place, however with the absence of a Quality Assurance Program Coordinator and the effects of Hurricane Wilma last year these standards and monitoring tools will be reviewed and updated to ensure that they reflect the recent best needs of the community and the best practices for medical care.

Legal issues that impede upon clients' ability to receive services are referred to Legal Aid Society for assistance and many of these impediments have been removed to enable them to receive care, given the large numbers of immigrants within our service area. The case management agencies maintain the monies for food vouchers, transportation and direct emergency services thereby eliminating any additional cost or time in accessing these services. They work closely with the City of West Palm Beach to access HOPWA funds for housing and provide the linkage between mental health and substance abuse services. All of the case managers utilize the FACTORS MIS database that tracks the referrals made to the services and the medical outcomes resulting from the services provided as part of the Quality Assurance program.

To **ensure responsible program management**, all service providers are required to re-evaluate the client's medical and financial eligibility at specific intervals indicated in the Standards of Care. This ensures only the neediest clients receive services, while working to move clients toward self-sufficiency as their health status improves. The results are that adequate funds remain available to provide the most crucial services to all in need. Social Standards of Care have been adopted by the Planning Council and are implemented by the Grantee, ensuring that providers follow the protocols; leading to a high quality of care.

b) Report on the Availability of Other Public Funding - Attachment 1-E shows the most recent information available on public funding for HIV-related care services within the EMA from Federal, State and local sources. These funds are anticipated for support of HIV-related services during the Title I FY 2007 budget period. This table shows a coordinated, cost effective system where Title I funds are the payer of last resort.

c) Coordination of Services and Funding Streams - Previously, in describing the continuum of care, the Coordinated Service Network was indicated as a partnership of funding organizations, planning organizations and service providers. The coordination of services and funding streams is the primary reason the Coordinated Service Network was formed. The funding members of the network: the Palm Beach County Board of County Commissioners is the grantee for Ryan White Title I; the Treasure Coast Health Council is the Lead Agency for Ryan White Title II, the Palm Beach County Health Department (Florida Department of Health) provides funds for medical and dental care through Patient Care and Network funds; the West Palm Beach City Commission is the Grantee for Housing Opportunities for People with AIDS (HOPWA); and the Palm Beach County Heath Care District (a local taxing district) administers ADAP funds through the operation of the County's pharmacy and also administers the State Children's Health Insurance Program.

These funding agencies convene annually, during the Priorities and Allocation process, to determine what services each will fund, based on their mission and amount of funding anticipated. The goal of this collaborative effort is to ensure that needs are met and services are not duplicated. After the funding agencies convene, a 'Funding Distribution' table is produced that shows the source of funds, the fiscal year for each agency (all agencies have different fiscal years), the anticipated amount of funding and the proposed services to be funded. This allows the Priorities and Allocations Committee to have a general picture of all services, the possible source of funds, the date funds will be available and the probable amount of funds. For example, Title I, due to funding constraints, is no longer going to fund Housing Services, the 'Funding Distribution' table displays the amount by housing service category that HOPWA is providing for PLWHAs. The Planning Council for the West Palm Beach EMA, plans for services and prioritizes and allocates funds for Title I, Title II, Palm Beach County Health Department (Florida Department of Health) which funds medical and dental care through Patient Care and Network funds, and Housing Opportunities for People Living with AIDS (HOPWA). All of the entities have agreed to this coordinated effort which helps to maximize the number of service units provided, avoid duplicating service, and expand accessibility to services that are available. The grantees for Title I and II issue a common Request for Proposals during the contracting for services process.

The **Health Care District of Palm Beach County (HCD) administers the AIDS Drug Assistance Program in the EMA**, which is a local taxing district. The participation of the HCD in the ADAP State Program, the HCD is able to obtain the pharmaceuticals for free, for those Ryan White clients who qualify. Only a handling fee is charged to the Title I program. The HCD purchases the majority of its pharmaceuticals at the Public Health Services pricing schedule. That pricing schedule reflects the best price possible, unless it is free. The HCD uses the best cost containment strategies wherever possible.

There is **tremendous coordination with other State and Federal Resources** in the planning for the continuum of HIV care during the priority setting and allocation processes. The EMA has established several strategies in order to reduce duplication of services. Also the planning council has a Support Service Committee and a Medical Services Committee. The committees' membership includes local experts and consumers. The committees work to coordinate and communicate efforts within the system as well as countywide. Also, as discussed above the major funding members of our network participate in a coordinated effort to discuss services that each one funds, as well as, amount of funding anticipated. These activities help to maximize the number of service units provided, avoid duplicating service, and accessibility of services that are available.

Bringing people into care that know their status but are not presently in the system of HIV/AIDS primary medical care is achieved in several ways. The **Treatment Adherence Education and Outreach** works to assure that all people living with HIV/AIDS have access to the continuum of care and are supported in their effort to advocate on their behalf; in addition, the program provides the HIV communities with information regarding HIV disease, related illnesses, treatment options, the complexity of the treatment regimens, and the necessity for adherence to these regimens. This program is widely disseminated and culturally appropriate. Also, the planning council participates in many community health fairs throughout the year, promoting HIV/AIDS services in the EMA.

The EMA ensures that CARE Act funds are the payer of last resort by having the case managers assist clients in applying for Healthcare District, Medicaid, Medicare, Social Security and Disability, and/or Veteran's Administration. Also **the Legal Aid Society of Palm Beach County assists clients in preserving their private health insurance as well as assisting clients in attaining governmental assistance, i.e. Medicaid, Medicare, Social Security and Disability**. Also, each Ryan White Title I client must sign a statement stating that they have applied for all other funding for HIV/AIDS services, but are not eligible. The services funded by the State and Federal resources are taken into consideration in planning for the continuum of HIV care and during the priority setting and allocation processes through an effort to coordinate services and funding streams.

In the area of prevention and early intervention, the EMA enjoys a good relationship with the local Community Planning Partnership (CPP-CDC Prevention Program). However, Prevention Planning funds were cut this year. This has resulted in the Palm Beach County Health Department taking over community planning activities these meetings are convened when necessary. Support staffs for the Planning Council and Title II are all employed by the same agency, the Treasure Coast Health Council.

The planning council has members that represent the entire spectrum of HIV/AIDS which includes the following: United Deliverance represents the jail linkage program, HIV testing site, early intervention, and CDC prevention programs; the Program Administrator of the Agency for Health Care Administration represents the State Medicaid program; State Children's Health Insurance Program (SCHIP) is represented by the Medical Officer and the Health Planner from the Health Care District of Palm Beach County; The Veteran's Affairs Program is in contact with the Council but is not currently directly involved; The City of West Palm Beach administers the HOPWA funding, they participate in the planning council meetings; Treasure the Children, as well as, Children Medical Services represent services for women and children; other state and local social service programs are represented including Legal Aid Society of Palm Beach County, Inc., COMPASS, and Comprehensive AIDS Program; several substance abuse and mental health treatment services agencies are involved with the planning council including Comprehensive Alcoholism Rehabilitation Program, Comprehensive Addiction and Education, Inc., Gratitude Guild, Inc., Oakwood Center and Drug Abuse Foundation.

The services funded by the State and Federal resources are taken into consideration by the Priorities and Allocations committee, as the committee is charged with considering all services for citizens within the EMA; prevention, early intervention, medical and support services prior to voting on the priorities and allocations.

The Palm Beach County Health Department, through contacts with local agencies funds several programs in the EMA these include: PBCHD currently has contracts with two local AIDS Service Organizations for Ryan White Title II Minority AIDS Initiative/Antiretroviral Treatment Access Study (ARTAS) activities. The ARTAS intervention addresses strategy three of the Advancing HIV Prevention (AHP) initiative: prevent new infections by working with HIV-infected persons and their partners.

- The ARTAS intervention is a brief, intense, research-based intervention designed to improve the follow-through of program participants with on-going medical and social services. Clients eligible for the program are recently diagnosed HIV-positive individuals and HIV-positive individuals who have been out of care for six months or longer

In addition to the ARTAS providers, two other AIDS Service Organizations, identify HIV-positive clients not in care, inform them about available treatment and services and assist them in the use of those services. These organizations work with targeted groups. One agency assists Men who have sex with Men through their Counseling, Testing and Linkage contract. The other agency serves women through their Targeted Outreach to Pregnant Women Act (TOPWA) contract.

The PBCHD has also entered into a partnership and collaboration with the University of Miami to promote health care and awareness in Palm Beach County. A memorandum of agreement reflects the desire to foster collaborative programs and initiatives in training, health care delivery and research. In addition, a contract with the University of Miami-School of Medicine (Dr. Clyde McCoy) to match Federal funding received by the school from the National Institute of Drug Abuse has been executed. The 'Administrative Supplement for the Study of Drug Abuse and HIV/AIDS' will initiate drug abuse and HIV/AIDS research infrastructure with the capacity

to design, test, adapt and evaluate culturally appropriate, evidence-based HIV prevention strategies and interventions among sexually active chronic substance abuse users in Belle Glade.

5. Planning Council Mandated Roles and Responsibilities

a) Letter of Assurance from Planning Council Chair -- The Letter of Assurance from the Planning Council Chair is located in **Attachment 2-B**.

b) Description of Priority Setting and Resource Allocation Processes

The priority setting and allocation (P&A) process began in late February and concluded in late August. **A description of the items used and activities that took place to assist the planning council in determining the priorities and allocations for the FY 2007 and 2008 follow, Attachment 1-F.**

The planning council involved PLWHAs in the planning process to gather qualitative data through the following: Community forums, a PLWHA Survey, and a permanent representation of PLWHAs as members on the planning council and it's committees including the P&A Process as defined by the bylaws.

Three public forums were held in three areas of the EMA that have been identified as being disproportionately impacted by HIV/ADS, the Belle Glade, Riviera Beach, and Delray Beach area where Thirty percent (30%) of the participants identified themselves as being HIV positive the others in attendance did not report their HIV status. Black and Hispanics persons accounted for 48% of the participants. Recommendations from the forums and the committees included the following:

- Allocate the unrestricted funds from the outside contributors to Case Management and Direct Emergency Assistance
- Provider additional funding for:
  - Residential and outpatient substance abuse
  - Transportation
- Food Pantry
- Mental Health
- Direct Emergency Assistance
- More incentives in order the help get people into care
- Advertise services on billboards and bus benches
- Money for a Lunch & Learn or a support group for black women/black men and a Hispanic women and men group
- Funding for children's medication particularly those being dropped from Medicaid
- Support Groups with incentives of transportation and food and in locations within the community
- Serve the neediest first;
- Focus on life-saving and life-extending services;
- Increase prevention efforts;
- Increase accountability; and
- Increase flexibility.

As thoroughly discussed in the "Severe Need" section of this application a client survey was conducted in June and July of 2006. The surveys were administered to PLWHAs by staff or the PLWHAs completed the surveys on their own with staff available to answer questions and clarify directions as needed. Surveys were conducted in all geographic regions of the EMA. In addition, 30% of the surveys were conducted in high-risk neighborhoods by a trained data collector who guided the PLWHAs through the survey. The survey report was also made available on the Care Council website, www.carecouncil.org In summary, the 2006 Client Survey suggests that overall most respondents need and use primary medical care and case management. The largest reported service gaps overall were in complementary therapies and basic necessities (food, housing, emergency assistance). Further demographic breakdown and the results of this survey that was completed by 176 PLWHAs who are the consumers of the HIV services in the EMA can be reviewed in the corresponding section in this application beginning on page 35.

The final method by which the PLWHAs participated in the P&A process is by serving a Planning Council through committee, including the P & A Committee or as an appointed member of the Planning Council.

The Health Planner developed a detailed work plan for the FY 2007 and 2008 P&A Process. During the final phase of the process, the Planner also included having a consultant from the Academy of Educational Development (AED) visit to conduct a workshop -- *CARE Act Planning in a Changing Environment.* This all day work shop addressed changes in the HIV/AIDS environment, using information for decision making, roles as decision makers, and putting it all together for making recommendations for the Priorities and Allocations of Ryan White Funds in the EMA. Based on this workshop, the Planning Council chose to plan based on the Justice Paradigm of Utilitarianism (greatest good for the greatest number) and secondly with the Justice Paradigm of Compassion (assisting the neediest first). Furthermore, as a result of this workshop, the Planning Council also developed three main values that decision making is based on. These values include 1) Access to services for all who need services; 2) Compassion & Respect – treating all clients with respect and care; and 3) Accountability.

The following documents were also received and reviewed by Priorities &Allocations Committee members during the P&A Process for FY 07-08:

- P&A Committee Work Plan
- Allocation FY 2006-2007 across all five funding streams
- P&A Considerations and Recommendations for FY 07-08
- Priorities FY 07-08
- Flroida Department of Health, HIV and AIDS Reporting System Data 2005
- CADR Comparison Tables 2002-2005
- PLWHAs Survey Report
- PLWHAs Survey
- PLWHAs Survey Aggregated Results Report
- Unit Costs for FY05-06 & FY06-07
- Public Forum Demographic Breakout
- FACTORS data utilization report
- Funding Grids

- Title I HRSA's:
  Section V Technical Assistance Papers, Priority Setting
  Section VII Priority Setting and Resource Allocation
- Local Service Category Definitions
- HRSA's Service Category Definitions
- Reauthorization of the Ryan White CARE Act 2005 Update

Trends and changes in HIV/AIDS epidemiology data and the Unmet Need Framework were used in the P&A Process to identify and demonstrate how costs may increase in the upcoming year as more persons are targeted to have access to care. This quantitative data identified that were an estimated 4,474 persons living with AIDS. Of these, an estimated 2,966 (66%) received the specified HIV primary medical care services, and an estimated 1,507 (34%) did not. There were an estimated 4,274 persons living with HIV (not AIDS) who were aware of their HIV-positive status. Of these, an estimated 2,041 (48%) received the specified HIV primary medical care services, and an estimated 2,233 (52%) did not. In total, there were an estimated 8,748 persons living with HIV (not AIDS) and AIDS who were aware of their status. Of these, 5,008 (57%) received the specified HIV primary medical care services, and estimated 3,740 (43%) did not.

In response to the reporting of this data the planning council allocated significantly more money to all medical services, particularly outreach, treatment adherence, nurse care coordination, and transportation. Palm Beach County anticipates an increase in persons utilizing all medical service over the next fiscal year through efforts that are made in increasing access to underserved and special populations in the EMA.

Cost data were reviewed, across all five funding streams (Title I, Title II, HOPWA, State Revenue-Patient Care and Network). The planning council was presented with a funding worksheet that attempts to estimate costs for services over the next fiscal year by displaying the following information for each service category: actual number of clients served each year FY 2004 and 2005, estimated number of clients to be served FY 2007, mid point average of PLWH/A living in the EMA who need and use the service, FY 2006 defined, average cost per unit and average units per person FY 2005.

The planning council has addressed potential funding increases and decreases by preparing budgets for three circumstances including an increase, level or decrease in Title I funding. Part of the work plan that was distributed by the Health Planner includes reconvening after awards are made to respond to the award.

c) Compatibility with Statewide Coordinated Statement of Need (SCSN)
This EMA and the State of Florida benefit from a coordinated, statewide HIV services planning process. With a combined Title I planning council and Title II consortia incorporated into the Palm Beach County HIV CARE Council, the "CARE Council" provides a collaborated response to various state and federal requirements for community based planning related to HIV/AIDS services in Palm Beach County. This unique model of coordination has served the communities impacted by HIV well and has resulted in less service duplication, eased administrative burdens on providers and enabled the CARE Council to more thoroughly plan for the full continuum of HIV care. Benefits of this collaboration would include, but are not

limited to the following: Information-sharing procedures to ensure effective communication, coordinated needs assessment activities, coordinated comprehensive plans, combined priority setting, collaborative contracts with providers that are funded by both Titles I and II, coordination of capacity development, outreach, and early intervention services (EIS), consideration of uniform data collection and reporting systems and collaborative approaches to evaluation and quality measurement. Through the Statewide Coordinated Statement of Need process, key HIV/AIDS care issues and enhanced coordination across CARE Act programs are achieved. This mechanism is used to identify cross-cutting issues across jurisdictions such as trends in the epidemic, need for both client-and provider-focused education on new therapies and adherence strategies, need to understand and respond to the impact of managed care on CARE Act programs, and the challenge of identifying people who know their status but are not in care and getting them into care. Thus, based on the above collaboration, this EMA is 100% compatible with the SCSN and have set priorities that align with the SCSN. (Ambulatory Outpatient Medical, Pharmaceuticals, Dental Care, Case Management, Substance Abuse and Mental Health Treatment.)

The **Assessment of the Administrative Mechanism** is conducted annually with a survey tool, designed by the Planning Council. The assessment survey was redesigned this year by the Planning Council Staff in order to address the deficiencies in the 2006 application. The Assessment was conducted in August 2006. The largest portion of the respondents indicated that the Grantee **always** communicates the financial reports well, that the RFP process is effective, contracts with services in accordance with the priorities and allocations that were adopted by the Planning Council, insures that there is provider choice and regional availability of services, works to make the contracting and payment process flow in a timely manner, reallocates funds in a timely manner in accordance with the priorities and allocations, resolution of corrective action taken by the Grantee to improve service delivery, reallocates funds in a timely manner in accordance with the priorities and allocations established by the CARE Council, informs the CARE Council if there will be unspent dollars that may be reallocated for service provision in a timely manner, works well with provider agencies in maintaining the comprehensive continuum of care in the EMA, and that the relationship with the CARE Council is cooperative and professional. There were no deficiencies identified in the assessment however, there were some comments of "don't know" that the Grantee will address through better communicating these identified items at the Care Council meetings in the upcoming year. A copy of the assessment tool can be found in Section 3, Part d of this application.

6) Budget and Maintenance of Effort (MOE)

Budget Summary
The Budget Information (Form SF 424A) is located in the Mandatory Forms Document Section of the Grants Application Package.

Budget Totals based on program categories:

a. Personnel: $410,005.00
b. Fringe Benefits: $ 135,333.00
c. Travel: $38,711.00
d. Equipment $49,657.00
e. Supplies: $5,386.00
f. Contractual: $11,965,160.00
g. Construction: $0
h. Other: $106,749.00
i. Total Direct charges: $12,711,001.00
j. Indirect charges: $0
k. Totals: $12,711,001.00

The Budget Justification is located in the Mandatory Forms Document Section of Grants Application Package.

Maintenance of Effort
This EMA did not experience any changes in the data set where HIV-related expenditures have been reduced or where the purpose of HIV-related expenditures have changed. Please see the Maintenance of Effort Summary Report below.

MAINTENANCE OF EFFORT WORKSHEET PAGE 1 OF 1
EMA West Palm Beach, Florida Report for Local FY's 2004 & 2005

1 Agency/Department **Palm Beach County Health Department**
Activity **3 Primary Care Clinics, Ambulatory Care & Viral Load Testing, HIV/AIDS Surveillance, TB/HIV Surveillance Control & Prevention Programs**
Most recent year amount **$9,407,965** Next most recent year amount **$ 9,453,933**
Basis of amount **x** Actual expense _____ Estimate (define below)
Basis for estimate **N/A**

2 Agency/Department **Palm Beach County Health Care District**
Activity **Case Management/Prevention**
Most recent year amount **$ 950,000 (est)** Next most recent year amount **$ 955,000**
Basis of amount **x** Actual expense _____ Estimate (define below)
Basis for estimate **N/A**

3 Agency/Department **Palm Beach County Department of Community Services**
Activity **Prevention/Education**
Most recent year amount **$ 316,200** Next most recent year amount **$252,000**
Basis of amount **x** Actual expense _____ Estimate(define below)
Basis for estimate **N/A**

4 Agency/Department **Ryan White Title II**
Activity **Case Management , Residential Substance Abuse**
Most recent year amount **$ 661,576** Next most recent year amount **$ 696,395**
Basis of amount **x** Actual expense _____ Estimate (define below)
Basis for estimate _____

5 Agency/Department **City of West Palm Beach, HOPWA**
Activity **Housing Opportunities for People with AIDS**
Most recent year amount **$ 3,426,000** Next most recent year amount **$ 3,836,000**
Basis of amount **x** Actual expense _____ Estimate (define below)
Basis for estimate _____

6 Agency/Department ***Inmates of Local Jails who are known to have HIV or AIDS***
Activity ***Health Care***
Most recent year amount **$ Unknown** Next most recent year amount **$ Unknown**
Basis of amount ___ Actual expense _____ Estimate (define below)
Basis for estimate _____

7 Agency/Department ***Public Assistance Beneficiaries who are known to Have HIV or AIDS***
Activity ***Estimate of HIV Related Expenditures for Public Assistance***
Most recent year amount **$ Unknown** Next most recent year amount **$ Unknown**
Basis of amount ___ Actual expense _____ Estimate (define below)
Basis for estimate _____

7) Quality Management/Unmet Need

i) Description of Quality Management Program

The purpose of the WPB EMA Quality Management program is to set forth a coordinated approach to addressing quality assessment and process improvement at the Palm Beach County Department of Community Services Ryan White CARE Act Program. The program has established a vision of a world class system of care to HIV related patients, that is safe, educational and research based. The Programs mission is to improve the health status of the community by: providing comprehensive health care services, continuously improving the quality of health care services, encouraging clinical research, supporting training and educational programs for health care personnel, and offering community service programs. **The EMAs QM program has not been fully active in the last year due to a staff vacancy of the QM Coordinator. This vacancy was recently filled and will now work towards implementing the QM program.**

The Quality Assurance and Evaluation Committee (QAEC) of the Planning Council is responsible for ensuring that HIV funded agencies participating in the Palm Beach County Department of Community Services Ryan White Program comply with standards of care established by the Palm Beach County HIV CARE Council in the delivery of services to their clients with HIV/AIDS. Quality Assurance and Evaluation Committee responsibilities are to oversee the Palm Beach County HIV CARE Council's Quality Assurance Program. Develop written Quality Assurance and Evaluation Plans; establish quality assurance and evaluation activities, assist Ryan White Title's I and II, HOPWA, State of Florida AIDS Network and HIV/AIDS General Revenue Grantees in ensuring funded service providers implement their own Continuous Quality Improvement Programs, report agency specific outcome results (both compliance and non-compliance) to the funded agency's grantee; report cumulative service outcome results to the Council, Executive Committee and service committee (Medical, Support or Housing).)

Although there was a vacancy in the QM program the sub-contractors are required by contract to adhere to standards of care established by the Council as a contract requirement by the Grantee. Sub-contractors (service providers) must maintain client and administrative records that clearly document services in order for client level outcomes and program level processes to be evaluated effectively. The Grantee contracts require these funded agencies to establish and maintain quality management programs that will enable them to identify problems in service delivery that impact health status outcomes at the client and system levels.

The Grantee's Quality Management (QM) Program oversees and supports the EMA's quality management infrastructure at the client and system levels. The QM Program develops, maintains and monitors the quality management infrastructure by establishing activities at the provider and system levels. The QM Program collects and compiles data from EMA projects and reports the results to the Grantee, Council, Council Committees and providers.

Data has been and will be used to improve or change service delivery The Quality Assurance Program will integrate the performance improvement activities of the funded agencies, CARE Act grantee and Council Program Support staff for reporting to the Council, the QAE, Medical, and Support Committee's. The Program consists of the Ryan White CARE Act Title I Council Program staff and additional independent consulting groups, when needed. The Council will

utilize feedback of PLWH at **three primary quality assurance and evaluation levels; 1)** During participation as members of the Quality Assurance and Evaluation Committee, service committees and workgroups in the development of work plans and evaluation implementation processes; **2)** During specific evaluation activities which may include: Serving as interviewers or focus group facilitators, Helping to develop client questionnaires and interview guides, Providing a "client perspective", Providing information about the appropriateness and impact of particular interventions and the quality of services, Helping to identify competent consultants, Assuring that special circumstances or care needs of people living with HIV disease are considered in determining cost effectiveness, Serve as the "eyes and ears" of the planning body with regard to community opinions and perceptions; **3)** During evaluations as a data source. Service effectiveness measure are in the process of being defined with expectations of benchmarks beyond the usual CD4 and viral load measurements.

The Quality Assurance Program participants (funded agencies, grantees, Council and committees) can document service quality improvement utilizing data collection tools, data reporting forms (trending profiles) and computerized databases.

Quality Improvement programs will be conducted as necessary based on assessment results through-out the contract year. QM staff will continue to review and revise all processes and procedures of the previously established Quality Management program.

ii. Unmet Need Estimate and Assessment

This section describes changes to Palm Beach County's Unmet Need estimate, including updates to the Unmet Need framework and how we have used the framework to assess and address Unmet Need.

a) Unmet Need Estimate

A copy of the Unmet Need Framework is provided in Attachment 1-G. The Unmet Need Framework Table shows that in Palm Beach County in 2005:

- There were an estimated 4,474 persons living with AIDS. Of these, an estimated 2,966 (66%) received the specified HIV primary medical care services, and an estimated 1,507 (34%) did not.
- There were an estimated 4,274 persons living with HIV (not AIDS) who were aware of their HIV-positive status. Of these, an estimated 2,041 (48%) received the specified HIV primary medical care services, and an estimated 12,233 (52%) did not.
- In total, there were an estimated 8,748 persons living with HIV (not AIDS) and AIDS who were aware of their status. Of these, 5,008 (57%) received the specified HIV primary medical care services, and estimated 3,740 (43%) did not.

b) Narrative

This subsection provides a narrative description of the methods used to develop the unmet need estimates, including revisions and updates based on feedback on the FY 2006 estimate; limitations and future plans to address them; reasons for choosing this method; and cross-title collaboration.

Methods Used to Develop Unmet Need Estimates

The following protocol describes the steps taken to identify the care patterns in the West Palm Beach EMA. The following information is also depicted in the table entitled "Assessment of in Care vs. Not in Care through the End of 2005" in Appendix A. This table shows the detailed calculations that were used to produce the Unmet Need Framework Table for Palm Beach County.

- AIDS *Case* Prevalence is defined as the number of reported AIDS cases alive and reported through 12/31/05 as of 04/05/06.
- HIV *Case* Prevalence is defined as the number of reported HIV (not AIDS) cases alive and reported through 12/31/05 as of 04/05/06.
- HIV/AIDS *Case* Prevalence is defined as the number of reported AIDS cases and HIV (not AIDS) alive and reported through 12/31/05 as of 04/05/06.
- The HIV Prevalence Estimate includes reported PLWHA, ***plus*** an estimate of PLWHA diagnosed but **not** reported. Based on CDC's recent increase in the national HIV prevalence estimate, Florida increased their previous estimates of 100,000 for 2004 up to 125,000 for 2005, including the Department of Corrections (DOC). Therefore, the statewide HIV prevalence estimate (excluding DOC) for 2005 is 119,000. As of 04/05/06, there were approximately 75,000 PLWHA (excluding DOC) thus the formula to get to that estimate of 119,000 is to multiply the reported case count by a factor of 1.6).
- The number of persons living with AIDS (PLWA) and ***aware: (letter A below)*** is defined as the number of reported AIDS Cases alive and reported through 12/31/05, as of 04/05/06, plus 5%, to account for unreported AIDS cases. (AIDS Cases / 0.95). Florida has a very timely and complete reporting system. It is assumed that all AIDS cases are aware of their diagnosis.
- The number of persons living with HIV (not AIDS) (PLWH) and ***aware: (letter B below)*** is defined as the number of PLWHA (see below) minus the number of PLWA (above).
- PLWHA and ***Aware (letter C below).*** Florida assumes 80% of all PLWHA are Aware (HIV Estimate times 0.80). CDC estimates that 25% of all HIV-infected persons do ***not*** know their status. Florida has an aggressive HIV counseling and testing program, with a strong goal to get persons to know their HIV status. Therefore, it is believed that a smaller percentage of the PLWHAs in Florida do NOT know their HIV status compared with national estimates.
- PLWA and PLWH that are estimated to be ***Aware and IN care.*** These data were calculated by a combination of several steps:
    1. HARS case data of HIV/AIDS cases living and reported through 2005 were matched with the ADAP and Medicaid data. One single database was created that contains any HIV/AIDS case from HARS with at least one CD4 or Viral Load recorded in 2005 as well as the matched HARS/ADAP and HARS/Medicaid cases with either an Office Visit, RX or CD4 or Viral Load recorded in 2005, indicating that they received the specified HIV primary medical care service within a 12-month period as defined by HRSA. Geographic, demographic and risk data were also incorporated into the database.

2. Analyses were performed on those cases who received the specified HIV primary medical care service in the 12 month period, to obtain the demographic and geographic data needed for the report to HRSA.
3. Utilizing local resources, the West Palm Beach EMA estimated the percent of persons living with HIV (not AIDS) accessing care other than through Medicaid or ADAP (private care, Medicare, VA, Ryan White, etc.). It was assumed that the majority of persons living with AIDS are most likely in care via Medicaid or ADAP, therefore no further local estimates were made for this population. Since names from payer sources other than Medicaid and ADAP are not available for matching, the percent of the PLWH in care via these sources was added to the percent of those in care found via matches with Medicaid and ADAP. Two years ago, the West Palm Beach EMA estimated the percentage of PLWH in care via sources other than Medicaid and ADAP to be 32% of the PLWH aware population. Unfortunately, the key personnel who produced this estimate two years ago have since vacated their positions. Consequently, the institutional memory is somewhat impaired and we cannot describe in exact detail how this estimate was calculated. However, we can state that it was based on random chart reviews from local infectious disease physicians, the known number of Ryan White clients, and numbers provided by the VA and the Palm Beach County Health Care District, a local taxing district. Unfortunately, this estimate has not been updated in the past two years due to the personnel change; thus it is the best estimate we have at this time. In the coming year, we intend to revise and improve this local estimate using one or more of the methods described below under "Future Plans for Improving Unmet Need Estimates: Local Estimates."

Using the above input data and estimates, we are able to generate EMA level data to estimate individual local care patterns using the HRSA formula.

A. **PLWA, AIDS Prevalence (Living) and Aware for a recent time period:** (Data Source is HARS). As defined above.
B. **PLWH, HIV (not AIDS) Prevalence (Living) and Aware for a recent time period:** (Data Source is HARS). As defined above.
PLWHA Prevalence (Living) and Aware for a recent time period: (Data Source is HARS). As defined above.
C. **Number of PLWA who received the specified HIV primary medical care services in a 12-month period.** &
D. **Number of PLWH who received the specified HIV primary medical care services in a 12-month period.** (Data Source is HARS, ADAP, Medicaid, and local primary care resources).

To calculate the numbers for both **D&E**:
These estimates are based on the findings of a documented RX, CD4 or viral load as defined by HRSA and found by matching the HARS, ADAP and Medicaid databases. Assuming that the in-care patterns for the reported cases are similar to the care patterns of the unreported cases final numbers will be inflated to reflect the diagnosed but unreported cases.

E. **Number of PLWHA who received the specified HIV primary medical care services in a 12-month period.**
F. **Number of PLWA who DID NOT receive the specified HIV primary medical care services in a 12-month period.** These numbers were calculated by subtracting the PLWA aware and in care (C above) from the total PLWA aware (A above).
G. **Number of PLWH who DID NOT receive the specified HIV primary medical care services in a 12-month period.** These numbers were calculated by subtracting the PLWH aware and in care (D above) from the total PLWH aware (B above).
H. **Total of PLWHA who DID NOT receive the specified HIV primary medical care services in a 12-month period.** This total was calculated by adding the PLWA aware and NOT in care (E above) to the total of PLWH aware and NOT in care (F above).

Limitations

Although the HIV/AIDS Reporting System (HARS) data was utilized as one of the primary tools for estimating unmet need, it must be noted that there are limitations to the data in HARS. HIV cases were not reportable in Florida until July 1, 1997. HIV reporting is not retroactive; the report is limited to HIV confirmatory tests performed in a confidential setting since that time and only via diagnostic HIV tests (i.e., Western Blot or IFA). Therefore, HIV (not AIDS) cases with diagnostic dates prior to 07/1997 are not reportable. Viral loads and CD4 counts became reportable July 1, 2005; at the same time that retroactive HIV infection reporting became law. However, implementation has taken time, and is not expected to take place until the fall of 2006 at the earliest. Thus both the HIV data and all laboratory data (Viral Loads and CD4s) for 2005 are incomplete. Once these new reporting laws are implemented, HIV and laboratory reporting will become more complete within a few years.

Staffing is a limitation to having all of the CD4 and viral loads entered into HARS. Limited funds for data entry staff force the prioritizing of data entry of new cases or updates from HIV to AIDS into HARS (and an in-house laboratory database) over updating viral loads or CD4s that have no impact on the HIV or AIDS diagnosis. A new laboratory database is currently under construction and the process of electronic lab reporting is expected to be implemented within the next few years. This will improve data reporting of CD4 and viral load results, as it will eliminate much of the manual data entry currently required to update cases in HARS and/or the laboratory database with these data.

Even though the HIV reporting database is not complete at the present time, Florida has adjusted its methodology this year to perform a match with ADAP and HARS to assess which of the living and reported HIV/AIDS cases had at least one ADAP service (RX and/or lab as defined by the Framework) in 2005. Additionally, Florida's Department of Health collaborated with the Agency for Health Care Administration to finalize a legal agreement, which allowed access to a database with names and other key variables of Medicaid cases who received the specified HIV primary medical care services in the most recent 12-month period as defined by the Framework. These data were used to match against those living cases from the HARS database.

Thus the in-care data are a combination of some labs (Viral Loads/CD4s) entered in HARS (~12% of living cases), matched data with HARS, ADAP and Medicaid, and adjustments based on local estimates of people in care through other funding sources (e.g. private, VA, Medicare). Although this methodology differs from what would be ideal according to Mosaica (the technical

assistance contractor for unmet need for the Federal Ryan White Program), it is closer to approaching that "gold standard" of estimating in care patterns of persons living and aware with HIV (not AIDS) (PLWH) and AIDS (PLWA). Furthermore, as requested by HRSA and Mosaica, Florida's methodology identifies different in-care patterns by demographic and risk groups for those data "known to be in care". In the future, as more complete client-specific in-care data becomes available, data for those PLWA (aware) but not-in care will be generated. Finally, as noted earlier, due to staff departures in the West Palm Beach EMA, the local estimate of people in care through sources other than Medicaid and ADAP was produced two years ago and its exact computation methods are unknown.

Future Plans for Improving Unmet Need Estimates

Estimates Produced for the EMA by the State

The estimates produced by the Florida Department of Health, Bureau of HIV/AIDS for all EMAs in the state are based on HARS data matched with Medicaid and ADAP data. The plans to improve these estimates are:

- Continue to re-evaluate the entire step-by-step process of calculating the unmet need in order to provide the most accurate area-specific data.
- Continue to incorporate matched data between HARS and ADAP and HARS and Medicaid in the methodology to ensure complete in-care data.
- Evaluate the completion of HARS data for use in more steps of this process of calculating unmet need.
- Evaluate the use of the out of state database (currently under construction) in this process. This database tracks cases who have moved to Florida for care, but are reported in another state, thus not in our HARS database.
- Incorporate the laboratory reporting database into the methodology next year. Electronic lab reporting is currently being established and should be in place within the next few years.

<u>EMA Local Estimates</u>

Estimates produced at the local level by the West Palm Beach EMA supplement those produced by the State. These are estimates of the number of persons living with AIDS and persons living with HIV (not AIDS) who are in care paid for by sources other than Medicaid or ADAP, that is, private insurance, Medicare, VA, Ryan White, etc. In the coming year, Palm Beach County will improve these local estimates by employing one or more of the following methods:

- Use State or local hospital discharge data to get an estimate of the percentage of people with HIV/AIDS who were discharged from the hospital during a specified 12-month period and have private insurance.
- Work with major insurance companies to get data on the number of clients with HIV and AIDS (preferably separately) who received anti-retrovirals or CD4 or viral load tests paid for through their insurance.
- Obtain data on the percentages of people with HIV/non-AIDS and with AIDS who are in care and have private insurance from providers that serve a mix of people with private and public funding. Use chart reviews to determine the payer mix, if the provider is Ryan White funded.

- Obtain data from labs that conduct viral load/CD4 testing regarding the percent of all lab tests paid for by private sources, using payer codes.

Reasons for Using the Methodology to Estimate Unmet Need
We acknowledge the limitations of the data on which these estimates are based. At present, the biggest assumption we are making is that those reported cases in HARS, ADAP and/or Medicaid for which there is a documented medical visit, RX, CD4 or viral load (as defined by HRSA) plus the local estimates of those in care via other sources are representative of those HIV/AIDS cases that are not yet reported in HARS. Nonetheless, we feel the balance of the data and assumptions are fairly robust to error and bias. Each year, Florida and Palm Beach County will strive to improve this methodology for calculating unmet need until more accurate in-care data is available via HARS and other matched databases.

Florida provides timely and comprehensive breakdowns of the HIV and AIDS cases by current age group for all of the prevalence data. Historically, Florida's estimates of prevalent AIDS and HIV (not AIDS) cases and their geographic and demographic breakdowns have been similar to those provided by the CDC, thus justifying Florida's estimates.

Cross-Title Collaboration
Data used to generate the unmet need estimates (HARS, ADAP, & Medicaid) are usually generated by the state and disseminated to the 6 EMAs and the 13 Title II consortia areas. These data are area (EMA or Consortium) specific and tailored to the needs of the grantees. The incidence, prevalence and death data also include special population data, which further characterizes the local epidemic. Data generated by this date provides ample time for the local areas to write their local plans.

c) Assessment of Unmet Need
This subsection describes the activities that Palm Beach County has carried out and is planning to carry out involving the assessment of unmet need. For completed activities, the findings are summarized, including determination of the demographics and location of people who know their HIV status and are not in care; assessment of service needs, gaps, and barriers to people not in care; efforts to find people not in care and get them into primary care; and use of the results of the Unmet Need Framework in planning and decision making about priorities, resource allocations, and the system of care.

Demographics of People Who Know Their HIV Status and Are Not in Care
The usual way to determine the demographics of people out of care is to subtract data on people in care from the entire PLWHA population demographics from HARS. However, because of incomplete HARS reporting in Florida, the State is not able to provide comprehensive data with demographics in people in care, to be subtracted from the total profile to get people out of care. The State's data, which matches ADAP and Medicaid data with HARS where possible, contains only partial information on the met need population. If that partial information were subtracted from HARS to get data on the unmet need population, what would be left would *not* be people out of care, but a mixture of people in care and people out of care. Therefore, Mosaica has recommended that we provide a side by side comparison of the demographics of people *in* care via ADAP or Medicaid, versus *all* PLWHA, to infer what population groups seem most likely to be out of care. If the total PLWHA population has a greater percentage of a demographic group

compared to the in care population, this suggests that that demographic group is *under-represented* in the *in-care* population and therefore *over-represented* in the *out-of-care* population. The following table shows this side-by-side comparison.

Demographic Comparison of PLWHA In Care vs. Total PLWHA

Race/Ethnicity	PLWHA Known To Be Receiving Primary Medical Services via ADAP or Medicaid Total=3,640		Total PLWHA Total=8,746	
	Number	Percent	Number	Percent
White, Not Hispanic	784	22%	2,084	24%
Black, Not Hispanic	2,386	66%	5,686	65%
Hispanic	422	12%	892	10%
Asian/Pacific Islander	6	0%	24	0%
American Indian	2	0%	1	0%
Not Specified/Other	40	1%	59	1%
Gender	Total=3,640		Total=8,746	
Male	2,072	57%	5,294	61%
Female	1,568	43%	3,452	39%
Current Age (Years)	Total=3,640		Total=8,746	
0-2	2	0%	0	0%
3-12	58	2%	58	1%
13-19	64	2%	102	1%
20-24	70	2%	189	2%
25-29	149	4%	430	5%
30-39	776	21%	2,036	23%
40-44	715	20%	1,696	19%
45-49	666	18%	1,563	18%
50-59	821	23%	1,832	21%
60+	320	9%	840	10%
Male Adult Exposure	Total=2,043		Total=7,104	
MSM	962	47%	2,371	33%
IDU	147	7%	584	8%
MSM/IDU	93	5%	188	3%
Heterosexual	808	40%	3,882	55%
Other	32	2%	80	1%
Female Adult Exposure	Total=1,538		Total=3,419	
IDU	181	12%	394	12%
Heterosexual	1,311	85%	2,953	86%
Other	45	3%	72	2%
Pediatric AIDS Exposure (Current ages 0-12)	Total=59		Total=59	
Mother with/at risk for HIV Infection	59	100%	58	98%
Risk Not Reported/Other	0	0%	1	2%

Source: Florida Department of Health, Bureau of HIV/AIDS, Surveillance Section (2006). Unmet Need Estimates.

As can be seen, the in-care and total PLWHA populations are very closely matched in regard to race/ethnicity, age, adult female exposure, and pediatric exposure. This suggests that there is no particular racial/ethnic group, age group, adult female exposure group, or pediatric exposure group that is *over-represented* in the *out-of-care* population.

The demographic characteristics in which there appear to be differences between the in-care population and the total PLWHA population are gender and male exposure.

In regard to gender, the percentages of in-care and total PLWHA are fairly close, although males may be slightly *over-represented* in the *out-of-care* population, since they represent 57% of the in-care population but 61% of the total PLWHA population.

In regard to male exposure categories, MSM appear to be *over-represented* in the *in-care* population: they comprise 47% of males in care, but 33% of all PLWHA males. In contrast, heterosexual males appear to be *over-represented* in the *out-of-care* population: they comprise 40% of males in care but 55% of all PLWHA males.

Location of People Who Know Their HIV Status and Are Not in Care

The location of people who know their HIV status and are not in care may be inferred in the same manner as the inference of demographics as described above. The following table shows a side-by-side comparison of the locations of PLWHA in care via ADAP or Medicaid, compared with the total PLWHA population. These data were obtained from available zip codes in HARS for the two respective populations (in care PLWHA and total PLWHA). Some zip codes were missing and others were outside Palm Beach County, creating reduced totals. Nonetheless, we believe these data accurately reflect the locations of the two populations.

Geographic Comparison of PLWHA In Care vs. Total PLWHA

	PLWHA Known To Be Receiving Primary Medical Services via ADAP or Medicaid Total=2,403		Total PLWHA Total=6,742	
City	Number	Percent	Number	Percent
Belle Glade	215	9%	639	9%
Boca Raton	96	4%	396	6%
Boynton Beach	223	9%	639	9%
Canal Point	8	0%	10	0%
Delray Beach	**282**	**12%**	**963**	**14%**
Jupiter	45	2%	88	1%
Lake Worth	375	16%	959	14%
Loxahatchee	**16**	**1%**	**134**	**2%**
Pahokee	66	3%	39	1%
Palm Beach	8	0%	25	0%
South Bay	33	1%	53	1%
West Palm Beach	1,036	43%	2,797	41%

Source: Florida Department of Health, Bureau of HIV/AIDS, Surveillance Section (2006). Living HIV/AIDS Cases, Palm Beach, by Zip Code; ADAP 2005 by Zip Code, Palm Beach; Medicaid 2005 by Zip Code, Palm Beach.

As can be seen, the percentages of the PLWHA in care and the total PLWHA are very similar in all the cities. This suggests that *there are no* particular areas of the county where out-of-care PLWHA are *over-represented.* That is, PLWHA out of care appear to be proportionately dispersed across the county in relation to the dispersal of all PLWHA.

Assessment of Service Needs, Gaps, and Barriers to Care for People Not In Care
The service needs, gaps, and barriers to care for people not in care have been previously described in the Special Populations portion of the Severe Need section. They include:

- Stigma.
- Complacency about HIV disease among young MSM.
- Need for more provision of secondary prevention among young MSM and IDU.
- Need for more outreach to MSM, particularly men of color.
- Need for more coordination between HIV service providers and substance abuse treatment providers to serve IDU and other substance abusers.
- Need for a programmatic component to specifically target MSM/IDU.
- The "down low" phenomenon, i.e., high stigmatization of homosexuality in the African American community.
- Need for more coordination between corrections and community HIV/AIDS care programs.
- Distrust of the care system among African Americans.
- Long waits at clinics.
- Difficult eligibility processes.
- Perceived poor or discriminatory treatment by clinic staff.
- Poverty.
- Insufficient comprehensiveness and capacity of the care system.
- Location of services at multiple sites that are difficult to get to.
- Unappealing atmosphere in care settings.
- Feelings of powerlessness.
- Placing other individual and family needs before the need for HIV/AIDS care.
- Language barriers for Haitians and Mayans.
- Literacy problems.
- Lack of transportation.
- Inability to leave work for medical appointments.
- Fear of arrest, detention, and deportation among documented and undocumented immigrants.
- Use of indigenous healing practices.
- Gender power disparities.
- National and cultural diversity among the Hispanic population.
- Seasonal, part-time, transient employment among foreign-born Hispanics.
- Large distances to clinics in the rural portion of the county.
- Lack of childcare.
- HIV/AIDS conspiracy beliefs.
- Lack of insurance.

Additional reasons for being out of care were found in the county's recently completed Special Project of National Significance, which was a study of Black women out of care, (described earlier in the Severe Need section).[58] Many of these reasons seem likely to apply to other

[58] Palm Beach County HIV CARE Council (2005). *Care System Assessment Demonstration Project, Palm Beach County.*

demographic groups as well. When asked why they were out of care, the respondents in the study reported that:

- Financial services are more important to them than medical services.
- They are not certain of what case management is.
- They do not want to have to abstain from drugs or speak to case managers to qualify for medical care.
- They can't get referrals.
- They can't figure out what to do, where to go, or how to get there.
- They are reluctant to take medicine because it makes them sick (side effects).
- They need to have other services in place (such as food, shelter, safety) before they even think about getting medical care.
- Some believe that they are "carriers" of HIV, but don't really have it.
- They don't think they need to go to care because they do not feel sick.
- Some believe that HIV is not a disease, but a curse or punishment, and they pray for healing.
- They prefer to use home remedies and faith healing.

Finally, the 2006 PLWHA Survey[59], also described in the Severe Need section, also examined the reasons for PLWHA being out of care. The survey included 17 respondents who were out of care. When asked why they had not received medical care in the past 12 months, the respondents stated, as recorded the interviewer's notes:

- "Stigma that surrounds the illness" (Black female, eastern county)
- "She can't read that good. She had two children and needs help but doesn't want anyone to know that she is positive. She has a few friends that don't want to have anything to do with her. She don't want that and asked me not to tell anyone she is HIV positive." (Black female, eastern county)
- He just don't want to go. He said that he rather die than go to any clinic where HIV/AIDS people go. He said he's been positive since 2002. He said he don't want to have anything to do with HIV." (Black male, eastern county)
- "It's nobody's business but his." (Black MSM, eastern county)
- "Worry about people talking about me and feeling alone." (Black female, eastern county)
- "Too many people know me at the clinic. I don't want no one to know I have HIV." (Black male, eastern county)
- "She just moved back into town. She has to go back through the process. She says they made her go here and there to be denied for other programs in order to get her meds." (Hispanic female, eastern county)
- "I don't have medical insurance." (White female, western county)
- "I am in need of dental repair and care. However I am uninsured dentally. I need special eye care, but am uninsured for special eye care and treatment." (White MSM, eastern county)
- "I had an appointment with Medicaid on the 5th of the month, but I ended up being put into the hospital. When I called my caseworker back, I was told that I had to come into the office and wait, and maybe I would see the lady." (White, MSM, eastern county)

[59] Swanson, S. (2006). *Survey of PLWHAs, August 2006.* Riviera Beach, FL: Treasure Coast Health Council.

- "Child."(Black male, western county)
- "She only took the test and never went back for care. She said she don't feel sick at all. There's no need to go back for help right now." (Black female, eastern county)

Efforts to Find People Not in Care and Get Them Into Primary Care

Within the past five years, Palm Beach County has conducted two large Projects of National Significance addressing people out of care.[60] In both of these studies, we were successful in finding people out of care through the employment of PLWHA in care as research team members. These PLWHA in care were indigenous members of particular communities (e.g., Black rural community, Haitian eastern county community) who were very familiar with their communities. They found people out of care by going to locales where they knew such people were likely to be, as well as using their personal social networks. Although these were research studies and as such were not intended to get people into care, the same strategy could readily be used to achieve this purpose. Consequently, Palm Beach County's Comprehensive Plan for 2006-2009 has as its first objective to "Build an active network of PLWHA Peer Navigators." These PLWHA navigators will be indigenous members of the communities who will find the people out of care and follow through with getting them into care by helping them navigate the system of care.

Additionally, as indicated above in regard to the reasons why people are out of care, it is clear that the problem lies not only within those people but within the care system as well. Consequently, the County's Comprehensive Plan for 2006-2009 also includes the following objectives that are pertinent to these issues:

- Raise the level of public awareness regarding the needs of the HIV/AIDS community in a manner and language that the targeted populations find acceptable and appropriate.
- Create a system of care that consumers and providers can navigate with ease in order to eliminate the duplication of services and eligibility processes as well as enhance efficiency, communication, and coordination.
- Strengthen system-wide confidentiality to increase community trust of the system. Require adherence to minimum standards regarding confidentiality for all providers. Promote consumer empowerment and education programs regarding rights and responsibilities, highlighting issues of confidentiality.
- Develop strategies to link treatment adherence protocols with substance abuse and mental health services and primary medical care.
- Develop a plan to assure that clients have the opportunity to choose their treatment adherence protocols and support the client's choices regardless of their decisions.
- Address the issue of stigma in a manner that is varied and appropriate for targeted populations. Develop social marketing techniques to be utilized at faith-based and community events that are culturally appropriate and palatable to the communities.
- Identify and work with people in their neighborhoods to devise outreach models and care maintenance interventions that are congruent with that community's beliefs, practices, and behaviors.

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[60] [60] Palm Beach County HIV CARE Council (2005). *Care System Assessment Demonstration Project, Palm Beach County;* Palm Beach County HIV CARE Council (2001). *Rapid Assessment, Response, and Evaluation, Palm Beach County.*

Since these strategies have recently been implemented, their results are not yet known. In the future, we will continue to find people out of care and bring them into care by focusing on four categories of people not in care:

- Newly diagnosed, reached through collaboration with prevention and testing sites.
- Receiving other HIV/AIDS services but not primary care, identified through support service providers.
- Formerly in care, known to primary care providers and payers.
- Never in care, who likely have co-occurring conditions such as substance use, mental health issues, and homelessness, or other barriers such as linguistic barriers and lack of transportation.

We will also continue to find people out of care in various venues such as:

- HIV counseling and testing sites
- Emergency rooms
- Substance abuse treatment programs
- Detoxification programs
- Adult correctional facilities and juvenile detention facilities
- STD clinics
- Mental health programs
- Homeless shelters
- Food banks
- Ministries

Use of the Results of the Unmet Need Framework in Planning and Decision Making about Priorities, Resource Allocations, and the System of Care

The Palm Beach County HIV CARE Council directly uses the unmet need estimates in its planning activities. As described above, many of the objectives in the current comprehensive plan relate directly to finding people out of care and bringing them into care. These objectives then lead directly to the development of priorities. Finally, the priorities, together with the number of people in care and the unmet need estimate, dictate the allocation of resources.

Attachments

Attachment 1-A — Organizational Chart

Attachment 1-B — AIDS Incidence, AIDS Prevalence and HIV (not AIDS) Data

Attachment 1-C — Selected Co-Morbidities and Economic Characteristics

Attachment 1-D — FY 2007 Implementation Plan

Attachment 1-E — Other Public Funding

Attachment 1-F — Priority Setting and Resource Allocation Tables

Attachment 1-G — Unmet Need Framework

Attachment 2 — Agreements and Certifications Assurance

Attachment 3-A — Planning Council Membership

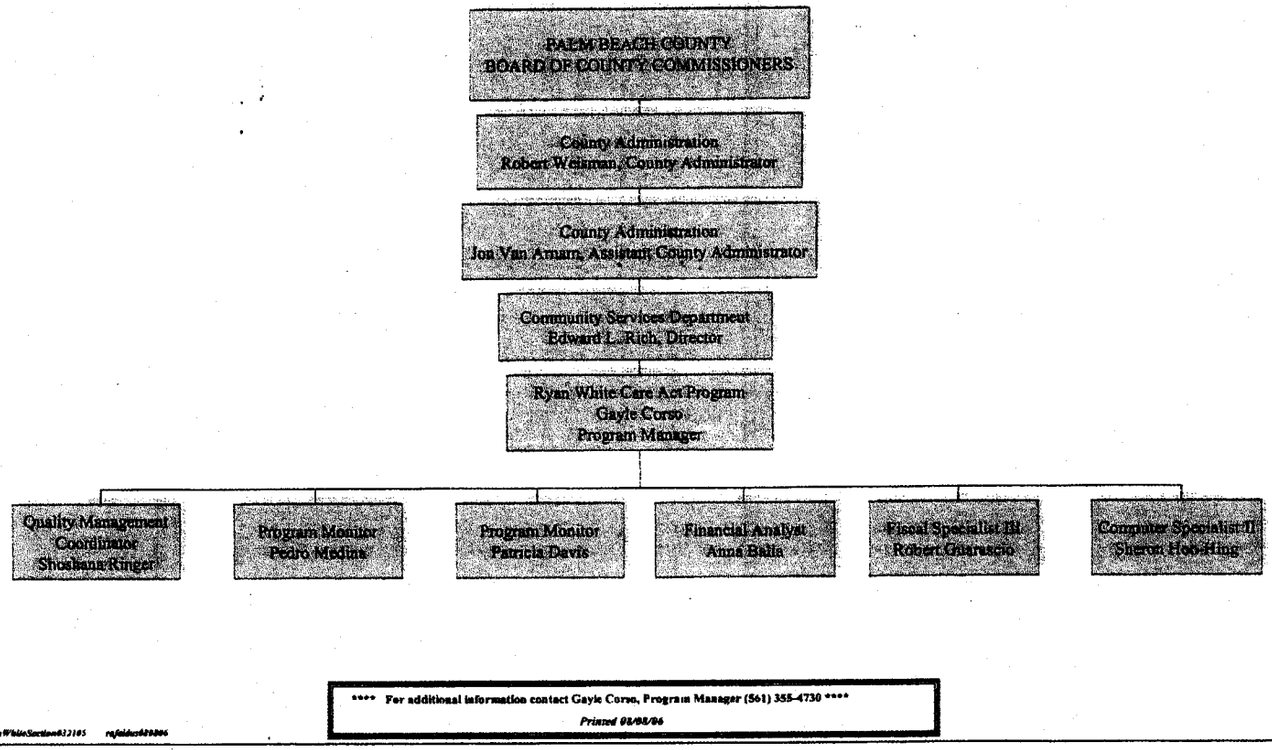
PALM BEACH COUNTY, FLORIDA

Department of Community Services

Administration

Ryan White Care Act Program Section

ORGANIZATIONAL CHART



**** For additional information contact Gayle Corso, Program Manager (561) 355-4730 ****

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Attachment 1-A

"Section 2617 (B)(2) states that the application for Title II funds shall contain a determination of the size and demographics of the population of people living with HIV in the State." [CARE Act]

Table 1: AIDS INCIDENCE, AIDS PREVALENCE AND HIV (NOT AIDS) PREVALENCE

	AIDS Incidence in 2004-2005		AIDS Prevalence Estimates (excl DOC) through 2005 as of 04/05/06		HIV (not AIDS) Prevalence Estimate, 2005, as of 04/05/06	
Demographic Group/ Exposure Category RISKS REDISTRIBUTED	AIDS incidence is defined as the number of new AIDS cases diagnosed during the period specified, data as of 01/06/06.		AIDS Prevalence is defined as the number of reported AIDS Cases plus 5% for unreported AIDS cases.		Adjusted for underreporting PLWH (not AIDS) and includes those diagnosed but not reported. (Total PLWAH minus AIDS Prevalence).	
Race/Ethnicity	#	% of Total	#	% of Total	#	% of Total
White, not Hispanic	170	21%	1,037	23%	1,568	24%
Black, not Hispanic	488	61%	2,943	66%	4,164	64%
Hispanic	128	16%	458	10%	657	10%
Asian/Pacific Islander	2	0%	3	0%	27	0%
American Indian/Alaskan Native	0	0%	1	0%	1	0%
Not Specified/Other	8	1%	32	1%	42	1%
Total:	**796**	**100%**	**4,474**	**100%**	**6,459**	**100%**
Gender	#	% of Total	#	% of Total	#	% of Total
Male	498	63%	2,871	64%	3,747	58%
Female	298	37%	1,603	36%	2,712	42%
Total:	**796**	**100%**	**4,474**	**100%**	**6,459**	**100%**
Age at Diagnosis (Incidence) / Current Age (Prevalence)	#	% of Total	#	% of Total	#	% of Total
0-12 years	3	0%	38	1%	34	1%
13-19 years	8	1%	60	1%	68	1%
20-44 years	491	62%	1,961	44%	3,479	54%
45+ years	294	37%	2,415	54%	2,878	45%
Total:	**796**	**100%**	**4,474**	**100%**	**6,459**	**100%**

Attachment 1-B

Table 1: AIDS INCIDENCE, AIDS PREVALENCE AND HIV (NOT AIDS) PREVALENCE (CONT'D)

	AIDS Incidence in	2004-2005	AIDS Prevalence Estimates (excl DOC) through 2005 as of 04/05/06		HIV (not AIDS) Prevalence Estimate. 2005, as of 04/05/06	
Demographic Group/ Exposure Category RISKS REDISTRIBUTED	AIDS incidence is defined as the number of new AIDS cases diagnosed during the period specified. data as of 01/06/06.		AIDS Prevalence is defined as the number of reported AIDS Cases plus 5% for unreported AIDS cases.		Adjusted for underreporting PLWH (not AIDS) and includes those diagnosed but not reported. (Total PLWAH minus AIDS Prevalence).	
Adult/Adolescent AIDS Exposure Category	#	% of Total	#	% of Total	#	% of Total
MSM	249	31%	1,258	28%	1,706	27%
IDU	59	7%	438	10%	549	9%
MSM/IDU	11	1%	118	3%	117	2%
Heterosexual	468	59%	2,534	57%	3,980	62%
Other	6	1%	87	2%	73	1%
Total:	**793**	**100%**	**4,435**	**100%**	**6,424**	**100%**
Pediatric AIDS Exposure Categories (ages 0-12)	#	% of Total	#	% of Total	#	% of Total
Mother with/at risk for HIV infection	3	100%	38	97%	34	98%
Risk not reported/Other	0	0%	1	3%	1	2%
Total:	**3**	**100%**	**39**	**100%**	**35**	**100%**

Attachment 1-C

Selected Co-Morbidities and Economic Characteristics
West Palm Beach EMA, 2005

	Prevalence among PLWHA in EMA[1]			Prevalence among EMA General Population[2]		
	Number	Rate per 100,000	Percent Change 2004-2005[3]	Number	Rate per 100,000	Percent Change 2004-2005[4]
Tuberculosis	3	27	-50%	92	7	-8%
Infectious Syphilis	9	82	-18%	31	2	25%
Gonorrhea	18	165	63%	851	67	38%
Chlamydia	20	183	-5%	2,196	172	29%
Hepatitis	249	2,278	-4%	1,472	115	-91%
Intravenous Drug Use	1,221	11,168	2%	5,400	451	Unavailable
Other Substance Abuse	332	3,037	60%	81,000	6,772	Unavailable
Chronic Mental Illness	35	320	315%	Unavailable	Unavailable	Unavailable
Homelessness				5,167	432	Unavailable
Lack of Insurance				236,174	18,900	Unavailable
At or Below 300% of Poverty Level				567,301	46,000	0

[1] Definitions, Data Sources, and Dates of Data:
Tuberculosis: AIDS cases diagnosed through 2005 with Tuberculosis diagnosed in 2005; Infectious Syphilis, Gonorrhea, Chlamydia: Reported in 2005 among HIV/AIDS patients by the County Health Department (minimal estimate, based on STD client data only); STDMIS; Data through 2005, as of 03/06.
Hepatitis: Any HIV/AIDS case noted with a history of acute and/or chronic Hepatitis and documented in HARS; HARS (local use variable); Data through 2005, as of 04/06.
Intravenous Drug Use: Florida Department of Health, Bureau of HIV/AIDS Surveillance Section (2006). *Table 1b: Background Data Used for the Calculations of AIDS Prevalence and HIV (not AIDS) prevalence (excluding Department of Corrections).* Data through 2005.
Other Substance Abuse: Any HIV/AIDS case noted with a history of substance abuse, e.g., alcohol, methamphetamine, cocaine, inhalants, etc., and documented in HARS; HARS (local use variable); Data through 2005, as of 04/06.
Chronic Mental Illness: Any HIV/AIDS case noted with a history of mental illness and documented in HARS; HARS (local use variable); Data through 2005, as of 04/06.
Homelessness, Lack of Insurance, At or Below 300% of Poverty Level:
[2] Data Sources and Dates of Data:
Tuberculosis, Infectious Syphilis, Gonorrhea, Chlamydia, Hepatitis: Florida Department of Health, Bureau of HIV/AIDS Surveillance Section (2006). *Epidemiological Profile, Palm Beach County.*
Intravenous Drug Use: Lieb (2003)
Other Substance Abuse: National Institute of Drug Abuse (2003). *National Household Survey, 2003 Supplement: Regional Trends.*
Homelessness: Homeless Coalition of Palm Beach County (2003). *Homeless Survey.*
Lack of Insurance: Florida Agency for Health Care Administration, Office of Medicaid Research and Policy (2004). *Florida Health Insurance Study.*
At or Below 300% of Poverty Level: U.S. Census Bureau (2006). *2005 American Community Survey.*
[3] Data Sources: 2005: Data sources as noted in Footnote 1 above. 2004: FY 2006 Ryan White Title 1 Grant Application.
[4] Data Sources:
Tuberculosis, Infectious Syphilis, Gonorrhea, Chlamydia, Hepatitis: Florida Department of Health, Office of Planning, Evaluation, and Data Analysis (2006). *Selected Sexually Transmitted Diseases (STD), Tuberculosis, (TB), Hepatitis A, B, and C, HIV and AIDS Morbidity, Same Period Comparison, Florida.*
At or Below 300% of Poverty Level: U.S. Census Bureau. *2004 and 2005 American Community Surveys.*

La Implementation Plan
EMA: Palm Beach County Prepared by: Gayle Corso
Service Priority # 1A Service Priority Name: Ambulatory/Outpatient Primary Care (MEDICAL)

Service Goal: To provide increased access to comprehensive outpatient ambulatory medical care for eligible patients.

Objective/s	Service Unit Definition	Quantity		Time Frame	FY 2007 Funds
		# of People to be Served	Total # of Service Units to be Provided		
1. 100% of all Primary care services will be targeted throughout the EMA according to documented need with regard to demographics epidemiology, and special populations. Nutritional Counseling will be provided by a licensed nutritionist as part of primary care to eligible clients.	**1.1** 1 visit = 1 unit of service. County Wide: All Targeted Populations with special emphasis on Special Populations	**1.1** – 1,200	4,624units of primary medical care will be provided to 1,200 patients @ $162.20 per unit	3/1/07 – 2/29/08	**Title I** - $750,000

Service Priority #: 1B Service Priority Name: Laboratory/Diagnostic (MEDICAL)

Service Goal: To provide viral load/CD4 testing and other laboratory tests consistent with PHS Guidelines for the treatment of HIV disease.

Objective/s.	Service Unit Definition	Quantity		Time Frame	FY 2007 Funds
		# of People to be Served	Total # of Service Units to be Provided		
1. 100% of HIV/AIDS infected persons accessing medical care will receive a CD4/VL test in accordance to PHS Guidelines.	**1.2** – 1 TEST = 1 unit County-Wide: All Targeted Populations with special emphasis on Special Populations	**1.1** – 1,900	32,234 units of laboratory diagnostic testing will be provided to 1,900eligible patients. Average cost is $54.29. This service is direct cost because of varied cost of testing service.	3/1/07 – 2 /29/08	Title I - $ 1,750,000

Service Priority #: 1C Service Priority Name: Drug Reimbursement Program (MEDICAL)

Service Goal: To increase access to HIV related medications to PLWHA's residing in the WPB EMA that have not other funding source.

Objective/s	Service Unit Definition	Quantity: # of People to be Served	Quantity: Total # of Service Units to be Provided	Time Frame	FY 2007 Funds
1. Expand ADAP locally by paying for FDA approved medications on the State of Florida AIDS Drug Assistance Program (FDAP) when FDAP is unable to pay for such medications to 950 eligible clients.	**1.1** 1 month Script = 1 unit of service County Wide: All Targeted Populations with special emphasis on Special Populations	**1.1** – 1,298	15,789 units of service will be provided to 1,298 eligible clients $19.00 average per unit	3/1/07 – 2/29/08	$300,000
2. Expand the formulary by providing access to non-FDAP prescriptions and non-prescription medications necessary in the treatment of HIV/AIDS related illnesses to 950 clients.	**2.1** 1 script = 1 unit County Wide: All Targeted Populations with special emphasis on Special Populations	**2.1**- 1,372	27,776 units will be provided to 1,372 clients @ $36 per unit average	3/1/07 – 2/29/08	$999,950
3. Provide access to physician prescribed nutritional supplements through countywide pharmacies t o 200 clients.	**3.1** 1 month supply = unit. County Wide: All Targeted Populations with special emphasis on Special Populations	**3.1- 320**	1,667 units will be provided to 320 clients @ $24.00 per unit.	3/1/07 – 2/29/08	$40,000

Service Priority #: 1D Service Priority Name: Specialty Outpatient (MEDICAL)

Service Goal: To increase access to specialty outpatient medical care for the treatment of medical and psychiatric AIDS related illness.

Objective/s	Service Unit Definition	Quantity: # of People to be Served	Quantity: Total # of Service Units to be Provided	Time Frame	FY 2007 Funds
1. Of the HIV/AIDS infected persons who need specialty treatment for their HIV/AIDS care 45% will receive the specialty treatment.	**1.1** – 1 visit = 1 unit. County Wide: All Targeted Populations with special emphasis on Special Populations	**1.1** – 608	1619 units will be provided to 608 clients @ $463.17 per unit. Average cost due to various specialty treatment.	3/1/07 – 2/29/08	$750,000

Service Priority #: 1E | Service Priority Name: Oral/Dental Care (MEDICAL)

Service Goal: To provide dental hygiene and basic oral health care and prophylaxis, including extractions and dentures countywide to eligible patients

Objective/s	Service Unit Definition	Quantity: # of People to be Served	Quantity: Total # of Service Units to be Provided	Time Frame	FY 2007 Funds
1.Of the HIV/AIDS infected persons needing oral health care 65% will receive dental services in the WPB EMA..	**1.1** 1 visit = 1 unit of service. County-wide All Targeted and Special Populations	**1.1** – 1,094	3,296 units of service will be provided to 1,094 patients @ $182 per unit.	3/1/07 – 2/29/08	Title I $600,000

Service Priority #: 1G | Service Priority Name: Nurse Care Coordination (MEDICAL)

Service Goal: To reduce health disparities by offering a full continuum of care and client centered services through nurse care coordination to the highest need PLWHAs in the WPB EMA.

Objective/s	Service Unit Definition	Quantity: # of People to be Served	Quantity: Total # of Service Units to be Provided	Time Frame	FY 2007 Funds
1. To continue to provide nursing services to enhance clinical care coordination of eligible clients that are Level III and the most in need. 90% most need will this service.	**1.1** 15 minute = 1 unit of service. County-wide: All Targeted and Special Populations	**1.1** – 928level III patients	9293 units of service will be provided to 928 clients @ $34.97per unit.	3/1/07– 2/29/08	Title I - $325,000

Service Priority #: 1H | Service Priority Name: Treatment Adherence (MEDICAL)

Service Goal: To reduce health disparities provide culturally appropriate information to HIV infected community members regarding HIV disease and related illnesses, treatment options and clinical trials.

Objective/s	Service Unit Definition	Quantity: # of People to be Served	Quantity: Total # of Service Units to be Provided	Time Frame	FY 2007 Funds
1. To provide treatment adherence to HIV/AIDS infected persons that is culturally and linguistically appropriate.	**1.1** – 15 minute = units of service. County-wide All Targeted and Special Populations	**1.1** – 1200	23,828 units of service will be provided @ $12.59 per unit average	3/1/07 – 2/29/08	$300,000

Service Priority #: 1M Service Priority Name: Substance Abuse Treatment/Counseling (MEDICAL)

Service Goal: Increase access to substance abuse treatment and counseling for HIV /AIDS infected persons to address substance abuse problems.

Objective/s	Service Unit Definition	Quantity: # of People to be Served	Quantity: Total # of Service Units to be Provided	Time Frame	FY 2007 Funds
1. To provide regular, on-going substance abuse monitoring, treatment and counseling on an individual and group basis in an outpatient setting to 100% of HIV/AIDS infected persons who seek it.	1.1 – 30 minute session = unit of service.	1.1 – 86 County Wide: All Targeted Populations with special emphasis on Special Populations	2917 units will be provided to 86 people @ $25.71 unit.	3/1/07 – 2/29/08	$75,000
2. To provide residential substance abuse treatment, including specific HIV counseling in a secure, residential substance abuse treatment facility setting to 100% of HIV/AIDS infected persons who seek it.	2.1 – 1 day = 1 unit of service.	2.1 –46 County-wide All Targeted and Special Populations	2100 units will be provided to 46 @ $119average	3/1/07 –2/29/08	$250,000

Service Priority #: 1N Service Priority Name: Mental Health Therapy/Counseling (MEDICAL)

Service Goal: To increase access to psychological and psychiatric treatment and counseling services for those HIV/AIDS infected persons.

Objective/s	Service Unit Definition	Quantity: # of People to be Served	Quantity: Total # of Service Units to be Provided	Time Frame	FY 2007 Funds
1. To provide outpatient individual and group mental health therapy/counseling to eligible to 100% of those HIV/AIDS infected persons who seek these mental health services.	1.1 15 minute = 1 unit of service. County-wide All Targeted and Special Populations	1.1 – 332	16,602 units will be provided to 332 clients @ $18.07 average	3/1/07 – 2/29/08	Title I - $300,000

Service Priority #: 2A | Service Priority Name: Case Management

Service Goal 1: To provide a range of client-centered services that links clients with primary medical care, psychosocial and other services to insure timely and coordinated access to medically-appropriate levels of health and support services, ensure continuity and develop and periodically update individualized treatment plans

Objective/s	Service Unit Definition	Quantity: # of People to be Served	Quantity: Total # of Service Units to be Provided	Time Frame	FY 2007 Funds
1. Of the HIV/AIDS infected persons 95% will receive case management services.	**1.1** –15 minute encounter = unit of service.. County Wide County-wide All Targeted and Special Populations	**1.1** – 2368	25,454 units of service will be provided to2368 clients @ $13.75 per unit	3/1/07 – 2/29/08	Title I - $3,500,000
Service Goal 2: To provide a range of client-centered services that links minority clients with primary medical care, psychosocial and other services to insure timely, coordinated access to medically-appropriate levels of health and support service, ensure continuity, and to develop and periodically update individualized treatment plans that is culturally and linguistically appropriate					
1. 95% of minority populations including special populations will receive case management that are culturally and linguistically appropriate.	County Wide targeted for Minority and Minority Special Populations	**1.1 750**	53,846 units will be provided to 750 clients @ $13.00 per unit	3/1/07-2/29/08	**FY 2007 MAI Funds Numbers are an estimate depends on award amount**

Other Public Funding

Service	RW Title I	HOPWA	Health Care District	RW Title II	Medicaid	Other Federal,State, Local
Ambulatory/Outpatient Medical Care	$4,068,490		$1,464,391		$5,732,904est.	$11,927,965
State AIDS Drug Assistance Program (ADAP)	$216,888					$7,374,491
Home & Community Based Support Services	$3,713,727	$3,595,000	$402,836..	$586,936		
Rapid Testing						$150,000
Prevention				Minority AIDS Initiative $267,497		$697,000
Inpatient Medical Care			$1,496,432			
Pharmacy			$3,611,725			

Title II, HOPWA and State of Florida Revenue (Patient Care /Network) are all taken into consideration during the Priorities and Allocation process for Title I. Before the Priorities and Allocations committee meets, all Funders meet, review needs assessment information, spending patterns, and service categories. The funders make a recommendation to the P & A before priorities and percentage amounts are set.

Attachment 1-F

Priorities and Allocations Chart

Priority	FY 2006	Allocation	Priority	FY 2007	Allocation
1	Medical		1	Medical	
1a	Ambulatory/Primary Outpatient Medical Care	$ 454,033	1a	Ambulatory/Primary Outpatient Medical Care	$750,000
1b	Laboratory Diagnostic Testing	$ 1,115,190	1b	Laboratory Diagnostic Testing	$1,750,000
1c	Drug Reimbursement Program Local Supplemental Drug Program ADAP Supplemental Drug Program Nutritional Supplements	 $ 645,617 $ 210,393 $ 25,000	1c	Drug Reimbursement Program Local Supplemental Drug Program ADAP Supplemental Drug Program Nutritional Supplements	 $999,950 $300,000 $ 40,000
1d	Specialty Outpatient Medical Care	$ 552,335	1d	Specialty Outpatient Medical Care	$750,000
1e	Clinical Trials Outreach	$0	1e	Clinical Trials Outreach	$0
1f	Dental Care Services	$ 356,000	1f	Dental Care Services	$600,000
1g	Nurse Care Coordination	$ 172,172	1g	Nurse Care Coordination	$325,000
1h 1i	Treatment Adherence Education Outreach	$ 155,000	1h	Treatment Adherence Education and Outreach	$300,000
1j	Inpatient Hospital Coordination	$0	1i	Inpatient Hospital Coordination	$0
1k	Health Insurance Continuation	$ 50,000	1j	Health Insurance Continuation	$59.500
1l	Hospice (Home Based, Residential)	$0	1k	Hospice (Home Based, Residential)	$0
1m	Complementary Therapies (other)	$0	1l	Complementary Therapies (other)	$0
1n	Substance Abuse Treatment Residential Outpatient	 $ 200,000 $ 43,500	1m	Substance Abuse Treatment Residential Outpatient	 $250,000 $75,000
1o	Mental Health Therapy/Counseling	$ 247,950	1n	Mental Health Therapy/Counseling	$300,000
1p	Home Health Care Services	$ 150,000	1o	Home Health Care Services	$175,000
2a	Case Management	$ 2,580,027	2a	Case Management	$3,500,000
2b	Peer Advocacy	$0	2b	Peer Advocacy	$0
3	Housing Assistance	$0	3	Housing Assistance	$0
4	Food Bank/Home Delivered Meals	$ 75,000	4	Food Bank/Home Delivered Meals	$150,000
5	Transportation Assistance	$ 50,000	5	Transportation Assistance	$300,000
6	Legal Services/Permanency Planning	$ 200,000	6a	Legal Services	$200,000
			6b		$0
7	Direct Emergency Assistance	$ 75,000	7	Direct Emergency Assistance	$150,000
8	Vocational Rehabilitation	$0	8	Vocational Rehabilitation	$0
9	HIV Prevention	$0	9	HIV Prevention	$0
10	Complementary Therapies Massage	$0	10	Complementary Therapies Massage	$0
11	Counseling (Other)	$0	11	Counseling (Other)	$0
12	Buddy/Companion Services	$0	12	Buddy/Companion Services	$0
13	Day and Respite Care	$0	13	Day and Respite Care	$0
14	Translation/Interpretation Services	$0	14	Translation/Interpretation Services	$0
15	CARE Council Support	$ 250,000	15	CARE Council Support	$275,000
16a	Program Support	$ 175,000	16a	Program Support	$200,000
16b	Quality Assurance	$ 80,000	16b	Quality Assurance	$320,0000
17	Capacity Development	$0	17	Capacity Development	$0
	Grantee Administration	$ 413,801		Grantee Administration	$635,551
	TOTAL	$8,276,018		TOTAL	$12,711,001

WEST PALM BEACH EMA
Unmet Need Framework Table

Column 1	Column 2	Column 3	Column 4	Column 5
	Population Sizes	Value		Data Source(s)
Row A.	Number of persons living with AIDS (PLWA), for the period of 01/01/2005 - 12/31/05	4,474		HARS + estimates
Row B.	Number of persons living with HIV (PLWH)/non-AIDS/aware, for the period of 01/01/2005 - 12/31/05	4,274		HARS + estimates
Row C.	Total number of HIV+aware, for the period of 01/01/2005 - 12/31/05	8,748		
	Care Patterns	Value		Data Source(s)
Row D.	Number of PLWA who received the specified HIV primary medical care services in 12-month period	2,966		HARS plus matches with ADAP and Medicaid
Row E.	Number of PLWH/non-AIDS/aware who received the specified HIV primary medical care services in 12-month period	2,041		HARS plus matches with ADAP and Medicaid
Row F.	Total number of HIV+/aware who received the specified HIV primary medical care services in 12-month period	5,008		
	Calculated Results	Value	Percent	Calculation
Row G.	Number of PLWA who did not receive primary medical services	1,507	34%	Value: Value A - Value D. Percent: Value G/Value A.
Row H.	Number of PLWH/non-AIDS/aware who did not receive primary medical services	2,233	52%	Value: Value B - Value E. Percent: Value H/Value B.
Row I.	Total HIV+/aware not receiving specified primary medical care services (quantified estimate of unmet need)	3,740	43%	Value: Value G + Value H. Percent: Value I/Value C

Attachment 1-G

FY 2007 Agreements and Compliance Assurances

The Chief Elected Official (CEO) of the Eligible Metropolitan Area (EMA), or her/his designee, must include a signed copy of the attached form with the Title I grant application. This form lists the program assurances, which must be satisfied in order to qualify for a Title I Grant as required under the CARE Act.

RYAN WHITE COMPREHENSIVE AIDS RESOURCES EMERGENCY ACT AMENDMENTS OF 2000 TITLE I HIV EMERGENCY RELIEF GRANT PROGRAM
FY 2007 Agreements and Compliance Assurances

I, the Chief Elected Official of the Eligible Metropolitan Area (hereinafter referred to as the EMA) - West Palm Beach, Florida, designated pursuant to the provision of Title I of the Ryan White Comprehensive AIDS Resources Emergency Act of 1990 as amended, hereby certify that:

A. as required in Section 2604 (a)(1) and (2):

the allocation of funds and services within the EMA will be made in accordance with the priorities established, pursuant to **Section 2602 (b)(4)(C),** by the HIV Health Services Planning Council that serves the EMA; and
funds provided under **Section 2601** will be expended only for the purposes described in **Sections 2604 (b) and (c)**

B. as required in **Section 2605 (a):**

1. funds received under this Title will be used to supplement, not supplant, State funds made available in the year for which the grant is awarded to provide HIV-related services to individuals with HIV disease;
2. During the grant period, political subdivisions within the EMA will maintain at least their prior fiscal year's level of expenditures for HIV-related services for individuals with HIV disease ;
3. political subdivisions within the EMA will not use funds received under this Title in maintaining the level of expenditures for HIV-related services as required in the above paragraph (2); and,
4. documentation of this Maintenance of Effort is required.

C. the EMA:

1. pursuant to Section 2602(b) has an HIV Health Services Planning Council that:

   a. is reflective of the demographics of the epidemic, with particular consideration given to disproportionately affected and historically underserved groups and

subpopulations, and is inclusive of representatives from all categories cited in the legislation;

b. is not chaired solely by an employee of the grantee **(Section 2602(b)(7)(A));**

c. maintains an open process for member nominations, with candidates selected based on locally delineated and publicized criteria, including a conflict-of-interest standard **(Section 2602(b)(1));**

d. is not directly involved in the administration of grants and does not designate (or is not otherwise involved in the selection of) particular entities as recipients of this grant, in accordance with HRSA/HAB guidance on Planning Council Roles and Responsibilities, and that individuals on the Council will not participate in the process of selecting entities to receive funds if that person has a financial interest in the entity, is an employee of that entity, or is a member of such entity (Section 2602(b)(5)(A));

e. has procedures for addressing grievances with respect to priority setting and allocation of resources, including procedures for submitting grievances that cannot be resolved to binding arbitration, and are consistent with models developed by HRSA **(Section 2602(b)(6));**

f. has documented the duties of the Council consistent with Section 2602(b)(4);

g. has incorporated or referenced all of the above provisions in the Planning Council by-laws or operating procedures;

h. has ensured that meetings of the Planning Council are open to all members of the general public, and that there is a system to ensure public announcement of all meetings (Section 2602 (b)(7)(B));

i. has ensured that Planning Council minutes must be certified by the Planning Council Chair and made available to the public no later than two weeks after they have been approved by the Planning Council or the Executive Committee. (The entire process should take no more than six weeks);

j. has ensured that the Planning Council has a location, accessible by the public, where minutes and related information can be inspected and copied if requested (Section2602 (b)(7)(B));

k. has taken steps to guard against disclosure of personal information that would constitute an invasion of privacy, including medical or other personnel matters that should not be discussed (Section 2602 (b)(7)(B));

l. has taken steps to ensure that when Planning Council committees or subgroups make recommendations or take actions subject to Planning Council review or ratification, records of the proposed recommendations and actions should be made available for public inspection;

m. has noted that in situations where the State, County or local statute, ordinance or regulation is more stringent than the legislative language cited above, those statutes or ordinances take precedence — otherwise, the new provisions contained in the Reauthorized CARE Act take precedence;

n. has noted that as a condition of award, the grantee is required to notify HRSA of any changes in Planning Council Composition and associated Reflectiveness within 30 days of the change.

2. has entered into intergovernmental agreements pursuant to Section 2602(a), with the CEOs of the political subdivisions in the EMA that provide HIV-related health services and for which the number of AIDS cases in the last five years constitutes not less than 10 percent of the cases reported for the EMA; and

3. has developed a comprehensive plan for the organization and delivery of health services to individuals with HIV disease, in accordance with **Section 2602 (b)(4)(D).**

4. has ensured that CARE Act funded entities within the EMA maintain appropriate relationships with entities considered key points of access to the healthcare system for the purpose of facilitating early-intervention services for individuals diagnosed as being HIV positive **(Section 2605 (a)(3))**;

D. As required in Section 2605 (a)(5): entities within the EMA that receive Title I funds shall participate in an established HIV community-based continuum of care, if such continuum exists within the EMA.

E. pursuant to **Section 2605(a)(6)**, Title I funds will not be used to pay for any item or service that can reasonably be expected to be paid:

1. under any State compensation program, insurance policy, or any Federal or State health benefits program or
2. by an entity that provides health services on a prepaid basis.

F. pursuant to Section 2605(a)(7) to the maximum extent practicable, that:

1. HIV primary medical care and support services provided with assistance made available under this Title will be provided without regard to:

   a. the ability of the individual to pay for such services or

   b. the current or past health conditions of the individuals to be served;

2. Such services will be provided in a setting that is accessible to low-income individuals with HIV disease; and

3. A program of outreach services will be provided to low-income individuals with HIV disease to inform them of such services.

G. in the provision of services with assistance provided under Title I, any charges for services will be made in accordance with the provisions specified in Section 2605(e).

H. pursuant to Section 2604(f)(1) and in accordance with the legislative definition of administrative activities (Sections **2604(f)(2) and (3),** will maintain administrative costs of the grantee at no more than 5 percent of the grant; and, of the funds allocated to entities, will not exceed an aggregate amount of 10 percent of such funds for administrative purposes.

I. pursuant to **Sections 2602(b)(6), (c)(1) and (2),** has developed grievance procedures with respect to funding that are determined by HRSA to be consistent with its model procedures, including a process for submitting grievances to binding arbitration.

J. pursuant to **Section 2604(b)(4)(A),** unless waived by the Secretary, grant funds of not less than the percentage of Women, Infants, Children and Youth with AIDS to the total population of persons with AIDS in the EMA shall be used to provide health and support services to each population with HIV disease, including treatment measures to prevent the perinatal transmission of HIV.

K. pursuant to **Section 2605(a)(8),** agrees to participate in the Statewide Coordinated Statement of Need process initiated by the State, and ensure that the services provided under the EMA's comprehensive plan are consistent with the SCSN.

L. pursuant to the Minority AIDS Initiative, agrees that MAI funds will be expended in a manner consistent with legislative intent.

M. pursuant to **Section 2602(e)**, assures that Planning Council member training, based on the plan submitted in the application will take place.

N. pursuant to Section **2604(c)(1)**, assures that Quality Management Programs that meet HRSA requirements are in place.

O. pursuant to Section **2604(d)**, assures that personnel needs meet expenditure limitations.

P. pursuant to Section **2604(e)**, assures compliance with Medicaid provider requirements.

SIGNED: _____ **Title:** Commissioner
Chief Elected Official

Eligible Metropolitan Area: West Palm Beach

Date: 9-28-06

Palm Beach County HIV CARE Council
4152 West Blue Heron Boulevard, Ste. 228
Riviera Beach, Florida 33404

David Begley
Chair
Telephone- (561) 844-4430 ext. 33
Fax- (561) 844-3310

September 12, 2006

Ms. Dorothy Kelley, Grants Management Officer
Room 11-30 Parklawn Building.
5600 Fishers Lane
Rockville, MD 20857

Re: Letter of Assurance

Dear Ms. Kelley:

This letter is being written to assure the following:

- That FY 2006 Formula and Supplemental funds awarded to the Palm Beach County EMA are being expended according to the priorities established by the Planning Council and all FY 2006 Conditions of Award for the Formula and Supplemental grants to Palm Beach County EMA that relate to the Planning Council have been addressed;

- That the FY 2007 priorities were determined by the Planning Council on August 21, 2006, and that the approved process for establishing those priorities, was used by the Planning Council;

- That Planning Council membership training took place according to the Membership Development Work Plan;

- That the Planning Council is representative and reflective of the epidemic in the EMA, except for the Hispanic/Latino population. The process for adding members to the Planning Council is as follows: candidates are interviewed; the Membership Committee forwards successful candidates to the Grantee; and then the Grantee places the candidates in front of the Palm Beach County Commissioners for approval. The Hispanic/Latino members have been interviewed by the Membership Committee, and their names will go before the Planning Council and the Board of County Commissioners for final approval in November 2006. There are not any vacancies or deficiencies on the Council. The demographics of the non-aligned consumers reflect the HIV disease prevalence within the EMA except for the Hispanic category. As stated above this shall be rectified by November 2006.

Sincerely,

David Begley
Chair