Area 12

COMPREHENSIVE PLAN

2009

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Section 1A: The Public Advisory Planning Process

The organizations listed in the table below have participated in the development of this comprehensive plan through direct participation in the Volusia/Flagler planning consortium, the *Partnership for Comprehensive HIV/AIDS Planning* ("PCHAP"), community surveys and key informant interviews, and also through indirect representation on the planning body via various community partners and peers.

The Health Planning Council of Northeast Florida is the Lead Agency for PCHAP, and also participates and collaborates with other Community Health Initiatives such as Healthy Volusia, Inc. and the Volusia/Flagler Coalition for the Homeless in order to facilitate coordination of services across otherwise unrelated programs. Health Planning Council staff have also provided training and technical assistance to a variety of community organizations, including Halifax Hospital, the area's largest taxing-district hospital, regarding Ryan White services, eligibility, and referral processes.

Section 1A-Table IA: Public Advisory Comprehensive Plan Participants

Individuals and Organizations		✓	Name(s) of participating agency or organization
1	PLWH/A	✓	
2	PLWH/A former prisoners released during the last three years and/or their representative.	✓	
3	Providers:		
	➢ Health care	✓	Positive Healthcare, University of Florida Rainbow Center, CMS, Volusia County Health Dept. (VCHD)
	➢ Social service	✓	Children's Advocacy Center
	➢ Housing and Homeless	✓	HOPWA, Volusia/Flagler Coalition for the Homeless
	➢ Mental Health	✓	ACT Corporation, Responsible Choices, Stewart Marchman Ctr.
	➢ Substance Abuse	✓	Stewart Marchman Center, Salvation Army
	➢ HIV prevention providers	✓	Outreach Community Care, Diggs Miracle Care, VCHD, Stewart Marchman Center – Prevention on the Move *(Mobile Unit)*
	➢ Agencies providing services to WICY	✓	UF Rainbow Center, CMS, VCHD, Diggs Miracle Care, Outreach Inc, Children's Advocacy Center
	➢ Modernization Act	✓	Florida Department of Health, Health Planning Council of NE FL
4	Public health agency representatives	✓	Volusia County Health Dept (VCHD), Florida Dept of Health
5	CBO's serving affected population	✓	Outreach Community Care Network, Inc. Diggs Miracle Care
6	ASO's serving affected population	✓	Outreach Community Care Network, Inc. Diggs Miracle Care
7	Hospital and/or health care planning agency	✓	Health Planning Council of NE FL Halifax Medical Center
8	Non-elected community leaders		
9	State Medicaid/Medicare Agencies	✓	AHCA Area Office

Section 1: WHERE ARE WE NOW: *WHAT IS OUR CURRENT SYSTEM OF CARE?*

Section 1A-Narrative box 1A

The regular PCHAP meeting schedule includes at least seven full-membership meetings each year; based on a pre-determined annual calendar that has been approved by the membership. Sub-committee and workgroup meetings are scheduled to occur on the same day, prior to the full planning body meetings in order to simplify scheduling and transportation for all members. The meetings are announced through electronic and paper mailings at least two weeks in advance; and the full meeting schedule, agendas, minutes, and supplementary materials are posted on the PCHAP website.

Planning body meetings are held at centrally located and universally accessible public locations. Venues for planning body meetings are ultimately determined by the Lead Agency, with strong consideration for the needs of consumers such as proximity to public transportation routes, or any potential stigma they may perceive around specific service organizations or funders. All planning body members are routinely encouraged to invite additional community stakeholders, especially persons who are living with HIV/AIDS.

All planning body members are also asked to complete and submit meeting evaluation forms at every full membership meeting. A composite of all responses is presented to members at the following meeting, and are also available for viewing on the PCHAP website for member review. The Partnership's Steering Committee reviews the meeting evaluation responses to ensure that feedback from members is considered when determining the future direction and activities of the planning body.

The table below shows the total number of planning body meetings along with the average number of participants that attended each during the 2007/2008 Ryan White fiscal year (4/1/07-3/31/08). The table also indicates the approximate average number of known PLWHA's who attended each type of meeting.

It is important to note that these numbers include only PLWHA's who have self-disclosed at a planning body meeting or who have confidentially disclosed their HIV-positive status on a paper PCHAP application submitted to the HPCNEF. There may be other members who are HIV-positive but have not disclosed their status, or who are *affected* by HIV/AIDS through the infection of a family member or loved one.

Section 1A- Table IIA: Type of Meetings and number of participants

Total number of individuals who are members of the consortium: 21

Type of Meeting	Consortium Meetings	Steering Committee Meetings	Planning Committee Meetings	Ad-Hoc Meetings	Public Hearings	Other Monthly Meetings
How many meetings?	**7**	**2**	**17**	**4**	**0**	**0**
Average number of participants per meeting.	**17**	**5**	**12**	**14**	***N/A***	***N/A***
Of the average above, how many were PLWH/As?						
Average number of PLWH/A per meeting.	**6**	**2**	**5**	**4**	***N/A***	***N/A***

1B: Epidemiological Data

Accurate HIV and AIDS case reporting provides the foundation on which the service delivery system is structured. Case reports assist researchers by providing information about who is living with HIV/AIDS, their health status, what risk factors are most prevalent in a community, and what related needs those persons may be experiencing.

Except where otherwise noted in Tables IIIB and IVB, the data for the following tables and figures was provided by the State Health Office, HIV/AIDS Surveillance Data Analysis Unit. Data source is the HIV/AIDS Reporting System (HARS).

Section 1B – Table IB: AIDS Incidence, HIV (Regardless of AIDS Status) Incidence, and HIV/AIDS Case Deaths (2 year period)

Demographic Group/ Exposure Category RISKS REDISTRIBUTED	AIDS Incidence in 2006 & 2007 AIDS incidence is defined as the number of new AIDS cases diagnosed during the period specified, data as of 01/08/08.					HIV Cases (regardless of current AIDS Status) Reported in 2006 & 2007 HIV Cases (regardless of current AIDS Status) Reported: is defined as the number of new HIV cases reported during the period specified, data as of 01/08/08.					HIV/AIDS Case Deaths in 2006 & 2007 HIV or AIDS cases that died (regardless of cause) in 2007, data as of 03/31/08.				
Race/Ethnicity	2006	% of Total	2007	% of Total	% change	2006	% of Total	2007	% of Total	% change	2006	% of Total	2007	% of Total	% change
White, not Hispanic	43	44%	26	44%	-39.5%	38	48%	48	52%	26.3%	24	52%	28	57%	16.7%
Black, not Hispanic	46	47%	31	53%	-32.6%	27	34%	41	44%	51.9%	18	39%	16	33%	-11.1%
Hispanic	7	7%	2	3%	-71.4%	13	16%	4	4%	-69.2%	3	7%	4	8%	33.3%
Asian/Pacific Islander	0	0%	0	0%	0.0%	0	0%	0	0%	0.0%	0	0%	0	0%	0.0%
American Indian/Alaskan Native	0	0%	0	0%	0.0%	0	0%	0	0%	0.0%	0	0%	0	0%	0.0%
Not Specified/Other	1	1%	0	0%	-100.0%	1	1%	0	0%	-100.0%	1	2%	1	2%	0.0%
Total:	97	100%	59	100%	-39.2%	79	100%	93	100%	17.7%	46	100%	49	100%	6.5%
Gender	2006	% of Total	2007	% of Total	% change	2006	% of Total	2007	% of Total	% change	2006	% of Total	2007	% of Total	% change
Male	67	69.1%	39	66.1%	-41.8%	57	72.2%	55	59.1%	-3.5%	33	71.7%	37	75.5%	12.1%
Female	30	30.9%	20	33.9%	-33.3%	22	27.8%	38	40.9%	72.7%	13	28.3%	12	24.5%	-7.7%
Total:	97	100.0%	59	100.0%	-39.2%	79	100.0%	93	100.0%	17.7%	46	100.0%	49	100.0%	6.5%
Age at Diagnosis (Years)	2006	% of Total	2007	% of Total	% change	2006	% of Total	2007	% of Total	% change	2006	% of Total	2007	% of Total	% change
0- 2 years	0	0.0%	0	0.0%	0.0%	0	0.0%	1	1.1%	0.0%	0	0.0%	0	0.0%	0.0%
3-12 years	0	0.0%	0	0.0%	0.0%	1	1.3%	2	2.2%	100.0%	0	0.0%	0	0.0%	0.0%
13-19 years	2	2.1%	0	0.0%	-100.0%	2	2.5%	8	8.6%	300.0%	1	2.2%	0	0.0%	-100.0%
20-24 years	3	3.1%	2	3.4%	-33.3%	14	17.7%	11	11.8%	-21.4%	4	8.7%	2	4.1%	-50.0%
25-29 years	4	4.1%	5	8.5%	25.0%	9	11.4%	11	11.8%	22.2%	4	8.7%	12	24.5%	200.0%
30-39 years	30	30.9%	13	22.0%	-56.7%	23	29.1%	21	22.6%	-8.7%	11	23.9%	10	20.4%	-9.1%
40-44 years	18	18.6%	13	22.0%	-27.8%	13	16.5%	9	9.7%	-30.8%	11	23.9%	7	14.3%	-36.4%
45-49 years	18	18.6%	7	11.9%	-61.1%	9	11.4%	16	17.2%	77.8%	7	15.2%	10	20.4%	42.9%
50-59 years	16	16.5%	15	25.4%	-6.3%	6	7.6%	9	9.7%	50.0%	7	15.2%	7	14.3%	0.0%
60+ years	6	6.2%	4	6.8%	-33.3%	2	2.5%	5	5.4%	150.0%	1	2.2%	1	2.0%	0.0%
Total:	97	100.0%	59	100.0%	-39.2%	79	100.0%	93	100.0%	17.7%	46	100.0%	49	100.0%	6.5%

HIV data (for 2007) includes those cases that have converted to AIDS. These HIV cases cannot be added with AIDS cases to get combined totals since the categories are not mutually exclusive.

Section 1B – Table IB: AIDS Incidence, HIV (Regardless of AIDS Status) Incidence, and HIV/AIDS Case Deaths (2 year period), Continued.

Demographic Group/ Exposure Category RISKS REDISTRIBUTED	AIDS Incidence in 2006 & 2007					HIV Cases (regardless of current AIDS Status) Reported in 2006 & 2007					HIV/AIDS Case Deaths in 2006 & 2007				
	AIDS incidence is defined as the number of new AIDS cases diagnosed during the period specified, data as of 01/08/08.					HIV Cases (regardless of current AIDS Status) Reported: is defined as the number of new HIV cases reported during the period specified, data as of 01/08/08.					HIV or AIDS cases that died (regardless of cause) in 2007, data as of 03/31/08.				
Male Adult/Adolescent AIDS Exposure Category	2006	% of Total	2007	% of Total	% change	2006	% of Total	2007	% of Total	% change	2006	% of Total	2007	% of Total	% change
MSM	49	73.1%	18	47.0%	-62.6%	44	77.5%	41	75.9%	-7.2%	17	52.1%	21	57.7%	24.0%
IDU	7	10.4%	9	23.9%	33.3%	4	7.7%	6	11.1%	36.4%	6	17.0%	9	23.4%	54.8%
MSM/IDU	6	9.0%	4	10.3%	-33.3%	3	5.3%	0	0.0%	-100.0%	5	15.2%	3	8.1%	-40.0%
Heterosexual	5	7.5%	7	18.8%	46.7%	5	9.5%	7	13.0%	29.6%	4	12.7%	4	10.8%	-4.8%
Other	0	0.0%	0	0.0%	0.0%	0	0.0%	0	0.0%	0.0%	1	3.0%	0	0.0%	-100.0%
Total:	67	100.0%	39	100.0%	-41.8%	57	100.0%	54	100.0%	-5.3%	33	100.0%	37	100.0%	12.1%
Female Adult/Adolescent AIDS Exposure Category	2006	% of Total	2007	% of Total	% change	2006	% of Total	2007	% of Total	% change	2006	% of Total	2007	% of Total	% change
IDU	5	16.7%	8	38.3%	53.3%	2	9.5%	2	5.6%	0.0%	2	15.4%	8	66.7%	300.0%
Heterosexual	20	66.7%	12	61.7%	-38.3%	19	90.5%	34	94.4%	78.9%	1	7.7%	4	33.3%	300.0%
Other	5	16.7%	0	0.0%	-100.0%	0	0.0%	0	0.0%	0.0%	10	76.9%	0	0.0%	-100.0%
Total:	30	100.0%	20	100.0%	-33.3%	21	100.0%	36	100.0%	71.4%	13	100.0%	12	100.0%	-7.7%
Pediatric AIDS Exposure Categories (ages 0-12)	2006	% of Total	2007	% of Total	% change	2006	% of Total	2007	% of Total	% change	2006	% of Total	2007	% of Total	% change
Mother with/at risk for HIV infection	0	0%	0	0%	0.0%	1	100%	3	100%	200.0%	0	0%	0	0%	0.0%
Risk not reported/Other	0	0%	0	0%	0.0%	0	0%	0	0%	0.0%	0	0%	0	0%	0.0%
Total:	0	0%	0	0%	0.0%	1	100%	3	100%	200.0%	0	0%	0	0%	0.0%

HIV data (for 2007) includes those cases that have converted to AIDS. These HIV cases cannot be added with AIDS cases to get combined totals since the categories are not mutually exclusive.

Section 1: WHERE ARE WE NOW: *WHAT IS OUR CURRENT SYSTEM OF CARE?*

Section 1B – Table IB: AIDS Incidence, HIV (Regardless of AIDS Status) Incidence, HIV/AIDS Case Deaths (2 year period) continued.

Demographic Group/ Exposure Category RISKS REDISTRIBUTED	AIDS Incidence in 2006 & 2007					HIV Cases (regardless of current AIDS Status) Reported in 2006 & 2007					HIV/AIDS Case Deaths in 2006 & 2007				
	AIDS incidence is defined as the number of new AIDS cases diagnosed during the period specified, data as of 01/08/08.					HIV Cases (regardless of current AIDS Status) Reported: is defined as the number of new HIV cases reported during the period specified, data as of 01/08/08.					HIV or AIDS cases that died (regardless of cause) in 2007, data as of 03/31/08.				
Special Populations	2006	% of Total	2007	% of Total	% change	2006	% of Total	2007	% of Total	% change	2006	% of Total	2007	% of Total	% change
White MSM*	25	N/A	15	N/A	-40.0%	25	N/A	26	N/A	4.0%	15	N/A	18	N/A	20.0%
Black MSM*	19	N/A	6	N/A	-68.4%	14	N/A	12	N/A	-14.3%	4	N/A	3	N/A	-25.0%
Hispanic MSM*	2	N/A	1	N/A	-50.0%	6	N/A	1	N/A	-83.3%	2	N/A	1	N/A	-50.0%
Whte Male IDU**	5	N/A	7	N/A	40.0%	5	N/A	4	N/A	-20.0%	5	N/A	6	N/A	20.0%
Black Male IDU**	7	N/A	6	N/A	-14.3%	0	N/A	1	N/A	0.0%	3	N/A	3	N/A	0.0%
Hispanic Male IDU**	1	N/A	0	N/A	-100.0%	2	N/A	1	N/A	-50.0%	1	N/A	1	N/A	0.0%
Whte Female IDU**	2	N/A	2	N/A	0.0%	1	N/A	1	N/A	0.0%	0	N/A	2	N/A	0.0%
Black Female IDU**	2	N/A	4	N/A	100.0%	1	N/A	1	N/A	0.0%	2	N/A	4	N/A	100.0%
Hispanic Female IDU**	0	N/A	0	N/A	0.0%	0	N/A	0	N/A	0.0%	0	N/A	0	N/A	0.0%
Whte Male Homeless	1	N/A	1	N/A	0.0%	0	N/A	0	N/A	0.0%	1	N/A	2	N/A	100.0%
Black Male Homeless	1	N/A	0	N/A	-100.0%	0	N/A	0	N/A	0.0%	0	N/A	0	N/A	0.0%
Hispanic Male Homeless	0	N/A	0	N/A	0.0%	0	N/A	0	N/A	0.0%	0	N/A	0	N/A	0.0%
Whte Female Homeless	0	N/A	0	N/A	0.0%	0	N/A	1	N/A	0.0%	0	N/A	0	N/A	0.0%
Black Female Homeless	0	N/A	0	N/A	0.0%	0	N/A	0	N/A	0.0%	0	N/A	0	N/A	0.0%
Hispanic Female Homeless	0	N/A	0	N/A	0.0%	0	N/A	0	N/A	0.0%	0	N/A	0	N/A	0.0%
Male Haitian Born	1	N/A	0	N/A	-100.0%	0	N/A	0	N/A	0.0%	0	N/A	0	N/A	0.0%
Female Haitian Born	1	N/A	1	N/A	0.0%	0	N/A	0	N/A	0.0%	0	N/A	0	N/A	0.0%
Whte Male Youth (ages 13-24)	1	N/A	0	N/A	-100.0%	4	N/A	2	N/A	-50.0%	0	N/A	0	N/A	0.0%
Black Male Youth (ages 13-24)	2	N/A	0	N/A	-100.0%	7	N/A	8	N/A	14.3%	1	N/A	1	N/A	0.0%
Hispanic Male Youth (ages 13-24)	0	N/A	0	N/A	0.0%	2	N/A	0	N/A	-100.0%	1	N/A	0	N/A	-100.0%
Whte Female Youth (ages 13-24)	0	N/A	0	N/A	0.0%	1	N/A	3	N/A	200.0%	1	N/A	1	N/A	0.0%
Black Female Youth (ages 13-24)	1	N/A	2	N/A	100.0%	1	N/A	6	N/A	500.0%	0	N/A	0	N/A	0.0%
Hispanic Female Youth (ages 13-24)	1	N/A	0	N/A	-100.0%	0	N/A	0	N/A	0.0%	0	N/A	0	N/A	0.0%
White WCBA* (ages 15-44)	7	N/A	3	N/A	-57.1%	7	N/A	8	N/A	14.3%	4	N/A	2	N/A	-50.0%
Black WCBA* (ages 15-44)	5	N/A	10	N/A	100.0%	5	N/A	15	N/A	200.0%	6	N/A	4	N/A	-33.3%
Hiapanic WCBA* (ages 15-44)	3	N/A	0	N/A	-100.0%	3	N/A	0	N/A	-100.0%	0	N/A	0	N/A	0.0%
White Ped Cases (ages 0-12)	0	N/A	0	N/A	0.0%	0	N/A	0	N/A	0.0%	0	N/A	0	N/A	0.0%
Black Ped Cases (ages 0-12)	0	N/A	0	N/A	0.0%	1	N/A	3	N/A	200.0%	0	N/A	0	N/A	0.0%
Hispanic Ped Cases (ages 0-12)	0	N/A	0	N/A	0.0%	0	N/A	0	N/A	0.0%	0	N/A	0	N/A	0.0%
DOC cases	0	N/A	1	N/A	0.0%	2	N/A	2	N/A	0.0%	0	N/A	1	N/A	0.0%

*WCBA=Women of Child Bearing Age

HIV data (for 2007) includes those cases that have converted to AIDS. These HIV cases cannot be added with AIDS cases to get combined totals since the categories are not mutually exclusive.

*MSM includes MSM & MSM/IDU

**Male IDU includes IDU & MSM/IDU

Section 1B – Table IIB: AIDS Prevalence and HIV (not AIDS) Prevalence

Demographic Group/ Exposure Category RISKS REDISTRIBUTED	AIDS Case Prevalence (excl DOC) through 2007 as of 04/15/08		HIV (not AIDS) Case Prevalence (excl DOC) through 2007 as of 04/15/08		HIV/AIDS Case Prevalence PLWHA (excl DOC) through 2007 as of 04/15/08	
	AIDS Case Prevalence is defined as the number of reported AIDS Cases as of the date specified.		HIV Case Prevalence is defined as the number of reported living HIV (not AIDS) cases as of the date specified.		HIV/AIDS Case Prevalence is defined as the number of reported living HIV (not AIDS) and AIDS cases as of the date specified.	
Race/Ethnicity	# number	% of Total	# number	% of Total	# number	% of Total
White, not Hispanic	376	53.2%	238	43.1%	614	48.8%
Black, not Hispanic	261	36.9%	253	45.8%	514	40.8%
Hispanic	66	9.3%	57	10.3%	123	9.8%
Asian/Pacific Islander	0	0.0%	2	0.4%	2	0.2%
American Indian/Alaskan Native	0	0.0%	0	0.0%	0	0.0%
Not Specified/Other	4	0.6%	2	0.4%	6	0.5%
Total:	707	100.0%	552	100.0%	1,259	100.0%
Gender	# number	% of Total	# number	% of Total	# number	% of Total
Male	501	70.9%	338	61.2%	839	66.6%
Female	206	29.1%	214	38.8%	420	33.4%
Total:	707	100.0%	552	100.0%	1,259	100.0%
Current Age on 12/31/05 (Years)	# number	% of Total	# number	% of Total	# number	% of Total
0- 2 years	0	0.0%	0	0.0%	0	0.0%
3-12 years	3	0.4%	8	1.4%	11	0.9%
13-19 years	12	1.7%	11	2.0%	23	1.8%
20-24 years	9	1.3%	31	5.6%	40	3.2%
25-29 years	23	3.3%	66	12.0%	89	7.1%
30-39 years	126	17.8%	149	27.0%	275	21.8%
40-44 years	153	21.6%	90	16.3%	243	19.3%
45-49 years	140	19.8%	92	16.7%	232	18.4%
50-59 years	177	25.0%	80	14.5%	257	20.4%
60+ years	64	9.1%	25	4.5%	89	7.1%
Total:	707	100.0%	552	100.0%	1,259	100.0%

Section 1B – Table IIB: AIDS Prevalence and HIV (not AIDS) Prevalence, continued.

Demographic Group/ Exposure Category RISKS REDISTRIBUTED	AIDS Case Prevalence (excl DOC) through 2007 as of 04/15/08 AIDS Case Prevalence is defined as the number of reported AIDS Cases as of the date specified.		HIV (not AIDS) Case Prevalence (excl DOC) through 2007 as of 04/15/08 HIV Case Prevalence is defined as the number of reported living HIV (not AIDS) cases as of the date specified.		HIV/AIDS Case Prevalence PLWHA (excl DOC) through 2007 as of 04/15/08 HIV/AIDS Case Prevalence is defined as the number of reported living HIV (not AIDS) and AIDS cases as of the date specified.	
Male Adult/Adolescent AIDS Exposure Category	# number	% of Total	# number	% of Total	# number	% of Total
MSM	316	63.4%	203	60.6%	519	62.3%
IDU	85	17.1%	49	14.7%	135	16.1%
MSM/IDU	30	6.1%	17	5.1%	47	5.7%
Heterosexual	60	12.0%	63	18.9%	123	14.8%
Other	7	1.4%	2	0.6%	9	1.1%
Total:	499	100.0%	335	100.0%	834	100.0%
Female Adult/Adolescent AIDS Exposure Category	# number	% of Total	# number	% of Total	# number	% of Total
IDU	48	23.6%	25	11.9%	73	17.7%
Heterosexual	141	68.9%	183	87.6%	324	78.4%
Other	15	7.5%	1	0.5%	16	4.0%
Total:	205	100.0%	209	100.0%	414	100.0%
Pediatric AIDS Exposure Categories (current ages 0-12)	# number	% of Total	# number	% of Total	# number	% of Total
Mother with/at risk for HIV infection	3	100.0%	8	100.0%	11	100.0%
Risk not reported/Other	0	0.0%	0	0.0%	0	0.0%
Total:	3	100.0%	8	100.0%	11	100.0%

Section 1B – Table IIB: AIDS Prevalence and HIV (not AIDS) Prevalence, continued.

Demographic Group/ Exposure Category	AIDS Case Prevalence (excl DOC) through 2007 as of 04/15/08		HIV (not AIDS) Case Prevalence (excl DOC) through 2007 as of 04/15/08		HIV/AIDS Case Prevalence PLWHA (excl DOC) through 2007 as of 04/15/08	
	AIDS Case Prevalence is defined as the number of reported AIDS Cases as of the date specified.		HIV Case Prevalence is defined as the number of reported living HIV (not AIDS) cases as of the date specified.		HIV/AIDS Case Prevalence is defined as the number of reported living HIV (not AIDS) and AIDS cases as of the date specified.	
Special Populations	**# number**	**% of Total**	**# number**	**% of Total**	**# number**	**% of Total**
White MSM	227	N/A	135	N/A	362	N/A
Black MSM	67	N/A	50	N/A	117	N/A
Hispanic MSM	20	N/A	20	N/A	40	N/A
Whte Male IDU	48	N/A	26	N/A	74	N/A
Black Male IDU	34	N/A	15	N/A	49	N/A
Hispanic Male IDU	16	N/A	12	N/A	28	N/A
Whte Female IDU	19	N/A	11	N/A	30	N/A
Black Female IDU	18	N/A	7	N/A	25	N/A
Hispanic Female IDU	4	N/A	1	N/A	5	N/A
Whte Male Homeless	1	N/A	3	N/A	4	N/A
Black Male Homeless	2	N/A	0	N/A	2	N/A
Hispanic Male Homeless	0	N/A	0	N/A	0	N/A
Whte Female Homeless	0	N/A	2	N/A	2	N/A
Black Female Homeless	0	N/A	0	N/A	0	N/A
Hispanic Female Homeless	0	N/A	0	N/A	0	N/A
Male Haitian Born	2	N/A	0	N/A	2	N/A
Female Haitian Born	3	N/A	0	N/A	3	N/A
Whte Male Youth (current ages 13-24)	1	N/A	5	N/A	6	N/A
Black Male Youth (curent ages 13-24)	6	N/A	17	N/A	23	N/A
Hispanic Male Youth (current ages 13-24)	0	N/A	1	N/A	1	N/A
Whte Female Youth (current ages 13-24)	1	N/A	5	N/A	6	N/A
Black Female Youth (current ages 13-24)	9	N/A	12	N/A	21	N/A
Hispanic Female Youth (current ages 13-24)	4	N/A	1	N/A	5	N/A
White WCBA* (current ages 15-44)	41	N/A	35	N/A	76	N/A
Black WCBA* (current ages 15-44)	65	N/A	95	N/A	160	N/A
Hiapanic WCBA* (current ages 15-44)	10	N/A	11	N/A	21	N/A
White Ped Cases (current current ages 0-12)	0	N/A	1	N/A	1	N/A
Black Ped Cases (current ages 0-12)	3	N/A	7	N/A	10	N/A
Hispanic Ped Cases (current ages 0-12)	0	N/A	0	N/A	0	N/A
DOC Cases	26	N/A	22	N/A	48	N/A

*WCBA=Women of Child Bearing Age

MSM includes MSM & MSM/IDU

Male IDU includes IDU & MSM/IDU

Section 1: WHERE ARE WE NOW: *WHAT IS OUR CURRENT SYSTEM OF CARE?*

Section 1B – Table IIIB: Co-Morbidities / Other Factors / Surrogate Markers

Documented Co-morbidity cases in 2007	Prevalence of the HIV/AIDS Population in this Area	Prevalence Rate of this Indicator per 100,000 living HIV/AIDS Cases from this Area	Data Source	Date of Data	Prevalence Rate of this Co-morbidity within the general population of this Disease in this Area
	N= 1,259				
AIDS Cases diagnosed through 2007 with Tuberculosis diagnosed in 2007	-	-	HARS	Data through 2007 (as of 03/08)	3.5
Infectious Syphilis reported in 2007 among HIV/AIDS patients by the County Health Department (minimal estimate, based on STD client data only)	3	238.3	STDMIS	Data through 2007 (as of 03/08)	1.7
Gonorrhea reported in 2007 among HIV/AIDS patients by the County Health Department (minimal estimate, based on STD client data only)	5	397.1	STDMIS	Data through 2007 (as of 03/08)	105.2
Chlamydia reported in 2007 among HIV/AIDS patients by the County Health Department (minimal estimate, based on STD client data only)	5	397.1	STDMIS	Data through 2007 (as of 03/08)	202.9
Hepatitis C (defined as ***any*** HIV/AIDS case noted with a history of acute and/or chronic viral Hepatitis C and documented in HARS and/or MERLIN)	104	8,260.5	HARS (local use variable) and/or matched with reported cases in the Hepatitis database	Data through 2007 (as of 03/08)	

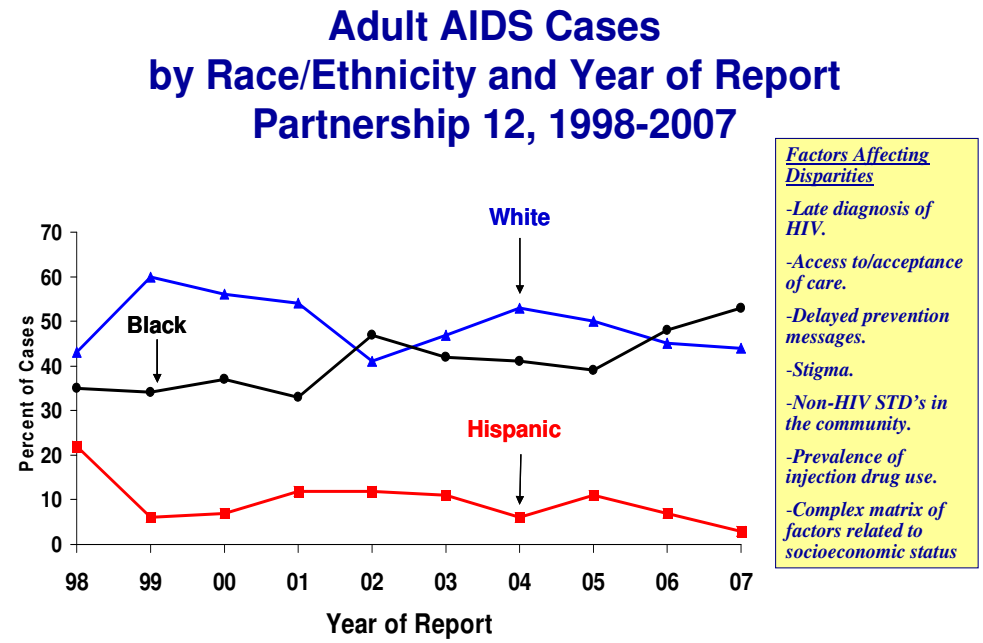
Other Factors / Surrogate Markers Documented in 2007	Prevalence of the HIV/AIDS Population in this Area	Prevalence Rate of this Indicator per 100,000 living HIV/AIDS Cases from this Area	Data Source	Date of Data
Homelessness (defined as any living HIV/AIDS case who was homeless at diagnosis of HIV or AIDS and documented in HARS)	8	635.4	HARS (address variable)	Data through 2007 (as of 03/08)
Substance Abuse (defined as any living HIV/AIDS case noted with a history of substance abuse, e.g.. alcohol, methamphetamine, cocaine, inhalants, etc, and documented in HARS)	94	7,466.2	HARS (local use variable)	Data through 2007 (as of 03/08)
Chronic Mental Illness (defined as any living HIV/AIDS case noted with a history of mental illness and documented in HARS)	6	476.6	HARS (local use variable)	Data through 2007 (as of 03/08)
MSM (estimated seroprevalance of males with HIV/AIDS who have an MSM or MSM/IDU risk)	567	45,028.7	(Determined by PLWHA data)	Data through 2007 (as of 03/08)
IDU (estimated seroprevalance of persons with HIV/AIDS who have and IDU or MSM/IDU risk)	255	20,273.8	(Determined by PLWHA data)	Data through 2007 (as of 03/08)

Release of FL Department of Corrections Cases into the Local Area	Total Offenders Released	HIV-infected Offenders Released		Data Source	Date of Data
		Number	% HIV+		
Offenders who returned to the Area in 2007	1,055	41	3.9%	Dept. of Corrections Offender-based Information System	CY 2007, data as of 02/08
Offenders who returned to the Area in 2006	1,246	47	3.8%	Dept. of Corrections Offender-based Information System	CY 2006, data as of 01/07
Offenders who returned to the Area in 2005	1,196	33	2.8%	Dept. of Corrections Offender-based Information System	CY 2005, data as of 04/06

Section 1B – Table IVB: Socio-Economic Data

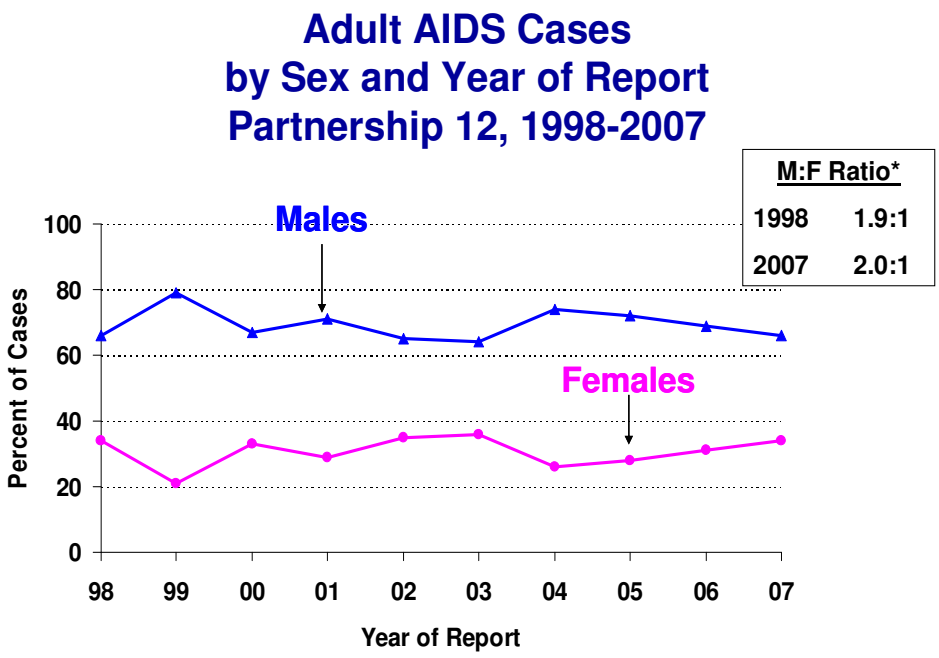
Race/ Ethnicity	Civilian Labor Force Unemployed			Population Living Below 100% Poverty			Without insurance coverage including without Medicaid.		
	Partnership		FLORIDA	Partnership		FLORIDA	Partnership		FLORIDA
	Number	Percent	Percent	Number	Percent	Percent	Number	Percent	Percent
White	10,553	71.3%	4.7%	48,251	70.0%	9.6%	486	87.4%	14.7%
Black	2,236	15.1%	9.1%	12,661	18.3%	23.4%	44	7.9%	26.0%
Hispanic	1,826	12.3%	5.4%	8,143	11.7%	16.5%	26	4.7%	33.2%
Other*	187	1.3%	6.5%	N/A	N/A	18.2%	N/A	N/A	18.0%
Total	**14,802**	**100.0%**	**6.4%**	**69,055**	**100.0%**	**16.9%**	**556**	**100.0%**	**23.0%**

Section 1B: Figure 1: 5-year data trends of AIDS Cases by Race/Ethnicity



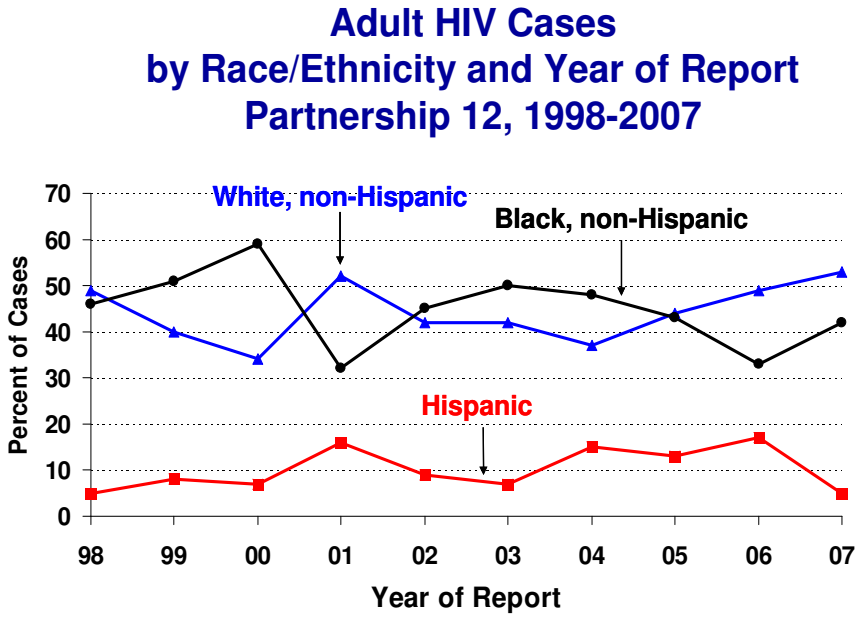
Comment: In 2007, blacks accounted for 53% of reported AIDS cases, but only 10% of the population. Hispanic cases decreased from 22% in 1998 to 3% in 2007. Disparities are even more evident among women: Annually, more than 70% of female AIDS cases have been reported among black women since 1988. *HIV case reporting,* implemented in mid-1997, has shown a very similar distribution of cases by race/ethnicity and sex.
*Other includes American Indian/Alaska Native, Asian/Pacific Islander, and Multi-racial.

Section 1B: Figure 2: 5-year data trends of AIDS Cases by Gender



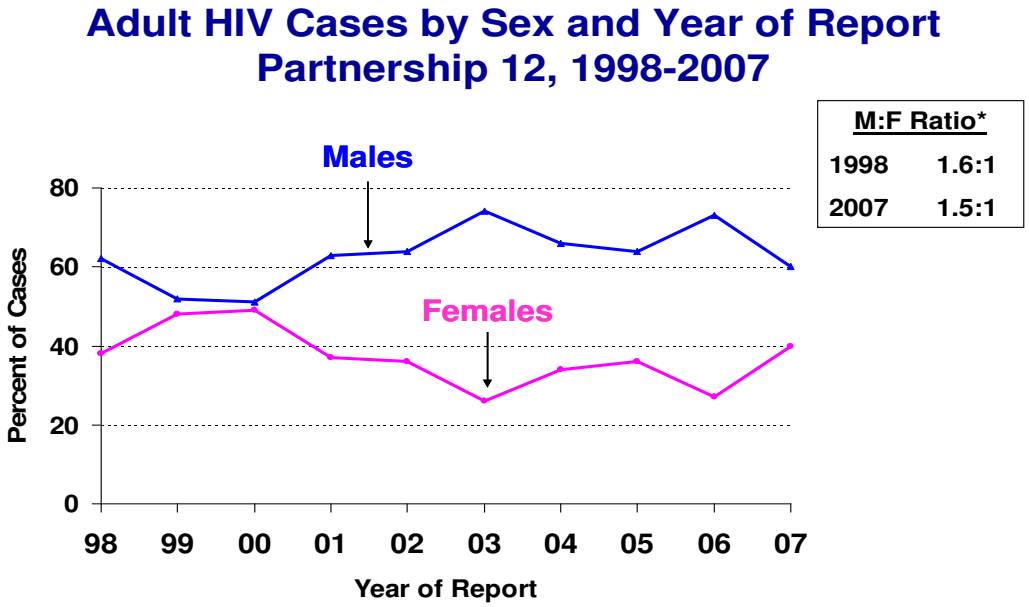
Comment: AIDS cases tend to represent HIV transmission that occurred many years ago. The relative increases in female cases reflect the changing face of the AIDS epidemic over time. *The male-to-female ratio is the number or percent of cases among males divided by the number or percent of female cases.

Section 1B: Figure 3: 5-year data trends of HIV (regardless of AIDS status) Cases by Race/Ethnicity



Comment: In absolute numbers, from 200-2007, HIV cases among blacks decreased by 7%, while cases among whites increased by 21%. HIV cases among Hispanics decreased during the same time period.

Section 1B: Figure 4: 5-year data trends of HIV (regardless of AIDS status) Cases by Gender



Comment: 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. The relative increases in male HIV cases might be attributed to proportional increases in HIV transmission among men who have sex with men (MSM), which may influence future AIDS trends.

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Data has been recorded and provided by the Florida Bureau of HIV/AIDS in a variety of formats for use in the local planning areas. This data assists planners in identifying and addressing any trends or changes within the number of reported HIV/AIDS cases over time. Both the prepared epidemiologic profile, and the corresponding Partnership Slide Set were reviewed with the planning body; and the trends described in the narrative below were identified.

Section 1B: – Narrative box 1B

The number of newly diagnosed and reported HIV and AIDS cases per year have not changed significantly in Area 12 over the past 10 years. There have been an approximate average of 76 new AIDS cases and 84 new HIV cases each year since 1998; while there have been an average of only 36 HIV/AIDS related deaths each year during the same time period (data available through 2007). For these reasons, the number of persons presumed to be living with HIV/AIDS in Area 12 has more than doubled since 1999. (HIV Prevalence estimates offered from the Florida Bureau of HIV/AIDS indicate that the true HIV prevalence may have even tripled during that time, but that many of those cases remain unreported – and may not even be aware of their own positive status.) The ratio of male to female cases has also remained consistent, at nearly 2 to 1.

There has also been little variation in the overall proportion of new HIV and AIDS cases by race/ethnicity during the same time period. White/non-Hispanics and Black/Non-Hispanics have each contributed around 45% of new cases each year, while Hispanics have accounted for around 10%. There is, however, a significant difference in the racial composition between male and female cases. This is well illustrated among living HIV and AIDS cases where just over 2/3 of male cases are white and only 30% of cases Black; but nearly 2/3 of female cases are Black while only 31% of female cases are White.

The most frequently reported risk behavior among men is MSM, accounting for nearly 3 out of 4 new HIV and AIDS cases during recent years. MSM in Area 12 are predominantly White. Heterosexual contact is consistently ranked second among men, followed by a notable rate of transmission among IDU also.

Women, on the other hand, are mostly infected through heterosexual contact, followed by IDU. IDU rates are higher among AIDS cases (presumably more long-term infection) than HIV cases – indicating either a slight decline in transmission via IDU during more recent years; or that physical health declines toward AIDS more quickly among IDU; or that the medical diagnosis of AIDS is likely to trigger entry into medical care in which IDU can be more effectively recognized and reported.

The vast majority of both new HIV or AIDS infections as well as those persons who are living with HIV or AIDS are adults between the ages of 30 and 59. Younger adults between 20 and 29 years of age are an emerging group among new cases; and there remains a notable proportion of cases who are over the age of 60. A comparison of reported age at diagnosis versus current age among Area 12 client survey respondents indicates a wave of AIDS-diagnosed adults who are passing through their 50's and who may soon begin to need higher levels of care due to common conditions associated with aging (and likely accelerated by the presence of HIV).

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The narrative below describes the disproportionate impact of HIV/AIDS on populations in terms of the ratio of HIV/AIDS cases in specific groups as compared to the general population of the area (regardless of their HIV status).

Section 1B – Narrative box 2B

As mentioned above, approximately 30% of all living male HIV and AIDS cases, and an even more alarming 60% of female cases in Area 12, are Black/non-Hispanic - despite the fact that persons of this race comprise only an estimated 10% of the total population for this Area. More than half (53%) of new AIDS cases in 2007 were Black.

The majority of Black male cases report as Heterosexual, with a smaller percentage identifying as MSM – although there is qualitative data from the community available that indicates that many Black men may be participating in but not admitting to same-sex relations, otherwise known as being on the *Down Low*. Rates of IDU appear to be relatively low in Black men, per available case reporting.

The vast majority of Black female cases are also heterosexual, also with only a very small additional number reporting injecting drug behaviors. Black females consistently account for nearly 3 out of every 4 infected women in Area 12.

The paragraph below describes geographic variations of HIV/AIDS cases within the Area.

Section 1B – Narrative box 3B

The highest concentrations of both new and living HIV/AIDS cases have consistently been within the largest central zip code in Daytona Beach, zip code 32114. Approximately 1/3 of all Area 12 cases are reported to reside within this 20 square mile urban core; and the vast majority of those cases are Black/non-Hispanic. This district also suffers from the highest rates of poverty, unemployment, and lack of education in the region; and is the most densely populated - with a lack of affordable housing.

Additional pockets of concentrated cases have also been identified in two cities of Western Volusia County; as well as 2 separate and isolated communities in Flagler County where socio-economic indicators point that there are high rates of poverty and low education levels when compared to the rest of the Area and the State as a whole.

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1C: Assessment of Service Needs, Unmet Needs and Service Gaps

AREA: 12 **COUNTIES SERVED (LIST):** Volusia / Flagler

Needs Assessment conducted by: Health Planning Council of Northeast Florida, Inc
101 S Palmetto Ave, Suite 5,
Daytona Beach, Florida, 32114
Phone: (386) 323-2046

Primary Contact(s): Joyce Case, Program Coordinator
Nikole Helvey, Program Planner

Section 1C -Table IC: Information and method used for Needs Assessment

The following items were reviewed and utilized during the Needs Assessment process:

INFORMATION / METHOD USED:	☑
Epidemiological Information	✓
Demographics	✓
Focus Groups (include number of people)	✓
Key Informant Interviews	✓
Surveys	✓
Resource Inventory	✓
Provider Capacity Development Needs	✓
Provider Capacity Profile	✓
Assessment of Service Gaps	✓
Customer Satisfaction Surveys	✓

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The table below describes the method(s) used to ensure the inclusion of the groups listed in the Area 12 Needs Assessment process. Interested parties can participate in a wide variety of ways, including through paper and/or electronic surveys, personal interviews, focus groups, written correspondence, feedback provided through case managers and advocates, as well as direct and indirect representation on the planning consortium (PCHAP).

Section 1C - Table IIC: Participants and Methods of Inclusion

PARTICIPANTS	Included (Yes/No)	DESCRIPTION OF METHOD USED TO ENSURE INCLUSION
PLWH (in care)	**Yes**	PLWHA regularly participate in the planning body and sub-committees, annual surveys, focus groups, interviews, provider feedback/advocacy
PLWH (not in care)	**Yes**	Feedback and advocacy from providers (outreach workers) and peers, as well as some contact through community surveys. VCHD conducts ARTAS and provides feedback based on learned information to PCHAP.
Women and Children	**Yes**	Annual surveys, focus groups, interviews, and provider feedback. There are representatives from specialty women's and children's providers on the Area 12 planning consortium (PCHAP).
Minority Groups	**Yes**	Annual surveys, focus groups, interviews and provider feedback. There are several minority organizations that participate on PCHAP.
Ex-offenders	**Yes**	Annual surveys, focus groups, interviews, and provider feedback. There are ex-offenders within PCHAP, and the HIV DIS worker from the county jail also regularly participates on the planning body.
IDU / Substance Abuse	**Yes**	Surveys, interviews, focus groups, provider feedback, etc. There are former substance users in the planning body. The area's largest substance abuse treatment provider regularly participates on PCHAP.
Coordination with:		
• **Ryan White Part A**	**No**	Area 12 does not qualify for Part A.
• **Ryan White Part C**	**Yes**	Area 12 does not qualify for Part C. However, a Part C provider from a neighboring Area regularly participates on the planning body.
• **Ryan White Part D**	**Yes**	Area 12 does not qualify for Part D. However, a Part D provider from a neighboring Area regularly participates on the planning body.
• **AETC**	**Yes**	AETC has been utilized to conduct quality review and education for Area 12 Ryan White medical and dental providers during each of the past 3 yrs.
• **Medicaid**	**Yes**	Regular coordination with the local Medicaid Area Office, as well as Medicaid PAC Waiver case managers for Area 12 clients.
• **Medicare Part D**	**Yes**	The Ryan White Lead Agency coordinates with the local Office on Aging to facilitate provider training and coordination relating to Medicare Part D.
• **Hepatitis C Workgroup**	**No**	There are currently no representatives from Area 12 on this State group.
Substance Abuse Prevention/Treatment	**Yes**	The Area's largest substance abuse prevention and treatment provider is a regular participant within the planning body; and provides direct HIV counseling, testing, and education on a mobile unit throughout Area 12.
Mental Health Treatment	**Yes**	The substance abuse treatment provider mentioned above recently merged with the Area's largest mental health services provider – and both have regular historical representation on the planning body in Area 12.
Coordination with agencies who serve women, infants, children and youth (WICY)	**Yes**	All of the agencies in Area 12 serve these populations. There are also several agencies represented in the planning body that specialize in providing services to women and/or children.
TOPWA	**No**	Area 12 does not qualify for TOPWA. However, a TOPWA provider from a neighboring Area is a regular participant with the Area 12 planning body.
Other Coordination: **Hospital Taxing Authority** **Area Homeless Coalition** **County Jail(s)/Corrections**	 **Yes** **Yes** **Yes**	The Lead Agency regularly coordinates with the Taxing Authority Hosp. Lead Agency staff participate with the local Homeless Coalition The County Health Dept. DIS worker for the Jail is an active on PCHAP

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Below is a more detailed description of the Ryan White Patient Care Needs Assessment process in Area 12:

Section 1C – Narrative Box 1C: Additional Comments from Table IIC.

The Needs and Resources Committee, a standing sub-committee of PCHAP, purpose is to direct and assist in the implementation of the annual Ryan White Needs Assessment in Area 12. The committee is comprised of representatives from the Volusia County Health Department, Ryan White Medical Case Managers, PLWHA's, other service providers, and Health Planning Council staff. Each year the committee reviews and updates the survey tools that will be used to gather information from Area 12 PLWHA's. They also assist in the identification and organization of focus groups as well as coordination with individuals for key informant interviews.

Persons living with HIV or AIDS (PLWHA) who have received at least one Ryan White Part B service within the previous 12 months are contacted through the annual Ryan White Needs Assessment survey(s); as well as the separate annual Client Satisfaction survey(s). Surveys are distributed by standard post to all clients who have indicated that they are willing to receive mail; and through case managers and other providers to clients who do not receive mail. Additional focused discussions were scheduled with population groups that had relatively low return rates from the mail-out surveys. Key informant interviews were also used among providers and active clients representing specific population groups. Persons who are HIV-positive but currently not enrolled in care are invited to participate in both the focus groups and key informant interviews by enrolled peers and/or service providers who may know them through outreach or other programs. These organizational representatives also ensure that issues and concerns related to them from un-enrolled PLWHA's are heard during the assessment process through indirect representation.

It is important to note that virtually all of the known HIV/AIDS service providers and supporting organizations in Area 12 are invited to participate in the comprehensive plan development process through annual provider surveys, attendance at consortia meetings, and both formal and informal agreements with the Lead Agency and/or other service providers. Information is collected throughout each year during routine meetings and discussions, as well as during the collaborative and collective management of unique individual cases.

The Area 12 Consortium (PCHAP) has also historically been the HIV Prevention Planning Group (PPG) for Volusia/Flagler; and many of the members are directly involved in HIV Prevention activities and programs. This dual role ensures close collaboration between HIV Care and Prevention programs within Area 12; and assists in integrating needs and services associated with HIV transmission into the existing HIV Care system where infected persons can be reached most readily.

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A comparison of findings from the current and previous Needs Assessments indicates that there are some trends, emerging issues, and recurrent themes among HIV Patient Care needs in Area 12. Some of the primary issues are listed in the table below:

Section 1C – Table IIIC: Common Themes and Trends

#	Common Theme and/or Trend, as related to HIV/AIDS Patient Care Service Needs
1	HIV/AIDS Prevalence has more than doubled in Area 12 since 1999; meaning that at least twice as many individuals require access to primary health and support services - in a care system that has not proportionally doubled in capacity – creating service gaps and unmet needs.
2	Male PLWHA's continue to outnumber females by 2 to 1 in Area 12 – although females make-up a larger proportion of HIV cases *(presumably newer cases)* when compared to AIDS cases *(presumably older cases)*, indicating a possible increasing trend of new transmissions to females. An increasing trend in female PLWHA's will necessitate a corresponding increase in capacity and accessibility of specialty women's services, including OB/GYN and family planning services.
3	There is a higher proportion of Black HIV cases *(presumably newer cases)* when compared to AIDS cases *(presumably older cases)*- despite the fact that more than half of newly reported AIDS cases in 2007 were Black/non-Hispanic. This indicates an increasing trend in new infections among Black men and women. A continued rise in Black/non-Hispanic PLWHA's will lead to increased need for culturally appropriate medical and support services, including reach-out services in non-traditional settings, such as Churches and community centers.
4	At least 1 in every 4 PLWHA's in care in Volusia/Flagler reported being diagnosed with HIV and/or AIDS outside of Florida, meaning that those cases may not be counted when funding allocations are determined for the Area. Already high, and increasing rates of "*in-migration*" into Florida, and particularly Flagler County (designated by the US Census Bureau in 2004, 2005, and 2006 as the fastest increasing population in the Nation) will create an increased level of need that cannot be matched by the existing service delivery system at the current funding levels. In the absence of proportional funding increases, efforts will need to be made to sustain core primary medical services and health self-management support for all eligible PLWHA's.
5	There has been a sharp upward trend in the utilization of Health Insurance Continuation services among Area 12 clients – creating a significant cost-savings for the program.
6	There is an anticipated expansion of the eligibility criteria for Ryan White Part B statewide during 2008-2009, indicating a potential rapid increase in program enrollment and service needs. It is unknown what impact this will have on service providers in Area 12 that already operate at full capacity; as there is no planned corresponding boost in funding to augment staffing/facilities.
7	Risky sexual behavior continues to be the foremost common mode of exposure among HIV-infected persons in Area 12 – indicating a significant need for Prevention education and risk-reduction counseling to be integrated into every aspect of HIV-related care for all persons who are known to be positive. More intense risk reduction strategies should be explored for persons who demonstrate a continued inability to reduce risky behaviors despite repeated interventions.
8	There is a significant and worsening under-utilization of Substance Abuse Treatment services in Area 12, despite recurring reports from providers and the community that both recreational drug use leading to risky behaviors, as well as drug addictions, are relatively common among PLWHA.

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The information contained in the table below were provided by the State Health Office, HIV/AIDS Surveillance Data Analysis Unit. The reported data source is the statewide HIV/AIDS Reporting System (HARS). *(See Appendix I for a more detailed explanation of unmet need.)*

Section 1C - Table IVC: Unmet Need Calculation

INPUT	VALUE	DATA SOURCE
POPULATION SIZES		
(A.) Persons living with AIDS (PLWA) as of 12/06	**726**	CALCULATED BY THE STATE
(B.) Persons living with HIV (PLWH, non-AIDS) and aware of their status as of 12/06.	**476**	CALCULATED BY THE STATE
CARE PATTERNS		
(C.) PLWA who received the specified primary medical care services in the previous 12-month period.	**528**	CALCULATED BY THE STATE Data from HARS, ADAP, Medicaid **A x calculated value**
(D.) Number of PLWH (aware, non-AIDS) who received the specified primary medical care services in the same 12-month period.	**252**	CALCULATED BY THE STATE Data from HARS, ADAP, Medicaid **B x calculated value**
CALCULATED RESULTS	**RESULT**	
(E.) Number of PLWA who did not receive any specified primary medical care services.	**198**	CALCULATED BY THE STATE **A x calculated value, or** **A – C**
(F.) Number of PLWH (aware, non-AIDS) who did not receive any specified primary medical care services	**224**	CALCULATED BY THE STATE **B x calculated value, or** **B - D**
(G.) Total HIV+/aware and not receiving specified primary medical care services (quantified estimate of unmet need).	**422**	**= E + F**

Table VC on the following page lists the Historically Underserved Populations in Area 12, as identified by the regional planning body, and based on HIV/AIDS case data. Along with each population, there are reported disparities in access as observed and reported by both PLWHA and providers throughout the Area. The disparities listed were reported as unmet needs in the Ryan White Client Needs survey, or are inferred based on an under-representation of specific groups within survey findings and/or enrolled in care, when compared to the proportion of reported PLWHA within the Area. There may be additional disparities experience by specific groups within the region that have not yet been adequately identified or reported to date. The following list should be considered a minimum estimate of HIV/AIDS service disparities for the Area.

Section 1: WHERE ARE WE NOW: *WHAT IS OUR CURRENT SYSTEM OF CARE?*

Section 1C - Table VC: Disparities in Access to Care

HISTORICALLY UNDERSERVED POPULATION		DISPARITIES IN ACCESS	
1	Black/non-Hispanic Men and Women	**1**	Infection rates are 7 times higher among Blacks than Whites in Volusia County *(Silence is Death)*; and case data shows that the most significant differences are among women. More than half of new AIDS cases in 2007 were Black. This group historically does not access primary healthcare services, resulting in a high rate of late diagnosis of HIV infection – often simultaneously with an AIDS diagnosis. Black women suffer higher rates of poverty, lack of education, unemployment, and single parenthood than any other population group in the Area. There is also a high rate of stigma toward HIV among this group – leading to very low rates of disclosure to partners or seeking HIV care.
2	Men who have Sex with Men (MSM)	**2**	Nearly 2/3 of living male AIDS cases and 61% of living male HIV cases in Area 12 are MSM. When added with MSM/IDU – this group accounts for at least 2 out of every 3 HIV-positive men in Volusia/Flagler. Rates of new infections remain high within this population – indicating a need for more prevention among HIV-positives in this group. There are currently no funded support groups or "prevention for positives" programs in Area 12 that target this population.
3	Women	**3**	The healthcare system in Area 12 remains fragmented, especially in regards to women's services. Women often have to visit multiple providers and locations to get the comprehensive services they need – but are less likely to have personal transportation; and are often caring for dependent children. Cultural and gender norms also create barriers for many in this group.
4	Residents of West Volusia and Flagler	**4**	The vast majority of service providers in Area 12 are located within the central urban core of Daytona Beach. Individuals who reside in the more outlying cities of Deltona, DeLand, Pierson, and also Bunnell and Palm Coast (Flagler County) must travel long distances to access routine health services. Coupled with a lack of personal transportation and/or rapidly rising fuel costs – this creates a significant access barrier for these residents.
5	Hispanic Men and Women	**5**	While this group comprises a relatively smaller proportion of HIV-infected individuals in Area 12, they have unique needs that are not adequately addressed by the existing service system in the region. This group is very private in nature, and is less likely to seek care outside of their immediate community. They often experience language and cultural barriers with providers, including those attempting to assist them in navigating the healthcare delivery system in the area. This population is most concentrated in Western Volusia County. Lack of transportation is also a common barrier among this group.

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Table VIC below lists the reported barriers for enrolled clients as well as those reported for individuals who know their HIV status and are not in care. A barrier is anything that gets in the way, obstructs or prevents clients from accessing and/or receiving services. Clients may experience internal barriers such as fear of disclosing their HIV-positive status; or external barriers such as a lack of transportation to get to needed services or they do not know how or where to access certain services. PLWHA's may also experience systemic barriers such as the unavailability of primary medical care services during non-traditional hours or a lack of specialty providers within the accessible care network. The top 5 barriers listed below are presented in the order of frequency as reported from the 2007 Ryan White Client Needs Survey respondents in Area 12.

Section 1C - Table VIC: Barriers to Care

1	***"I do not want people to know that I have HIV"*** was the most frequently reported barrier from survey respondents in Area 12 in 2006-07. Strong social stigma toward HIV and AIDS has fueled a deep fear of disclosure for many individuals - preventing them not only from informing sex and needle sharing partners of their status; but also preventing them from accessing needed medical care and support. A focus on privacy surrounding patient information (both spoken and written) must prevail in order to combat long-standing cultural norms that isolate and devalue individuals who have HIV and AIDS.
2	***"I was told that I am not eligible for assistance and cannot afford to pay for services…"*** was the second most commonly reported barrier among survey respondents in regards to their experiences within the past year. Service guidelines and access limitations vary between programs, and individuals often must apply for multiple different programs (at different locations) to get all of the assistance that they need. Rapidly rising fuel and food costs are creating an emerging and significant need among individuals who fall just above income eligibility limitations – those who do not qualify for assistance but have the greatest need among all ineligibles.
3	***"I did not have transportation"*** and ***"service site was too far away from home"*** were nearly equally reported among survey respondents. While some public transportation does exist in central Volusia County, the bus routes are reportedly long – creating very long riding and wait times for clients. Clients who reside among the outer borders of the public transit routes report riding for more than 2 hours each way to medical appointments, coupled with multiple and confusing transfers and/or long waiting times at bus stops during extreme weather conditions. This is especially hindering for mothers with young children. Even individuals who have personal vehicles or access to rides report that service sites are too far away, and that rising fuel costs prohibit them from being able to visit providers as expected. Many clients report having to choose between purchasing a meal or driving to a doctor's appointment.
4	***"Too much paperwork,"*** coupled with a complex service delivery system have contributed to additional barriers such as ***"I did not know how/where to ask for the help I needed."*** There are multiple resources in Volusia/Flagler, but each have their own eligibility and enrollment requirements and processes. Clients often become confused and/or frustrated when they are referred to multiple sites and asked to complete multiple applications (often providing duplicate information from other applications). Lack of transportation often plays a role in this process.
5	***"Takes too long to get the help I need"*** was the fifth most commonly reported barrier among Area 12 clients. This refers to the length of time between when help or treatment is first requested and/or recommended – and when the service is actually completed. Clients also refer to time spent applying for multiple programs in separate locations and having to complete multiple but similar applications. Some clients also referred to long wait times in clinic waiting rooms.

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STATEWIDE COORDINATED STATEMENT OF NEED (SCSN): All Ryan White program planning partners within Florida have identified the following six (6) core service categories as priorities; and have determined that the various geographical areas should align their provision of services accordingly. The table below, shows each of the priority service categories, along with the rank that has been assigned to each by the Area's community planning partnership. Any associated service gaps that were identified through the local Needs Assessment process are also listed.

Section 1C - Table VIIC: Service Priorities and Gaps

AREA RANKING	SCSN STATEWIDE COORDINATED STATEMENT OF NEED	SERVICE GAPS Gaps in services - based on Needs Assessment findings. *(See Appendix I for a more detailed explanation of service gaps.)*
2	Ambulatory/Outpatient	Comprehensive primary medical services for women are fragmented and incomplete. There is a lack of specialists in the Area who will accept Medicaid rates and/or Ryan White clients. There are very few providers outside of central Volusia County (Daytona Beach) – creating a transportation/distance barrier for many clients.
1	Medical Case Management	Case Managers are located in Daytona Beach, although they can travel to clients when needed. There is also a reported high turnover in case managers, creating reported trust barriers as clients are frequently "starting over with someone new." Eligibility and enrollment processes and paperwork can be difficult and confusing to some clients. The frequency of re-eligibility determinations is an issue also for some.
3	Pharmaceutical	While all clients appear to get needed HIV/AIDS related medications, there are gaps noted in regards to medications for other illnesses. Also, more coordination is needed with other medical providers (including the Area hospital) beginning clients on HAART therapy without a comprehensive assessment to determine whether they are truly ready for ARV therapy and/or how their medications will be covered long term.
4	Oral Health	There are only 1-2 dental providers in the Area who will accept Medicaid rates for services, and or Ryan White clients. Many clients have been found to have a long history of poor oral health – and the preventative and treatment services needed to restore their teeth are complex and sometimes extensive.
6	Substance Abuse	There is an extremely limited number of treatment beds within the Area; meaning that often when a client reaches a "moment of clarity" and requests treatment – there is not an accessible bed available at that moment. There is also a general perceived lack of need for substance abuse treatment/counseling among clients, despite reports from providers that indicate this is a priority need for the Area.
5	Mental Health	There is a low rate of acceptance for this service among enrolled clients, despite feedback from providers that many clients are dealing with issues related to depression regarding their HIV-positive status. It is believed that stigma related to mental health issues is a primary barrier to accessing this service.
7	Health Insurance	Utilization of this service category has increased dramatically during recent years, as well as premium rates of the individual plans. This has created an increase in costs to the program that cannot be met by the State's existing AICP funds. Supplemental funds from Ryan White Part B are allocated each year to offset the difference between increasing need and available AICP allocations for the Area.

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There are additional services that were identified in the Area 12 Needs Assessment that are funded, but as lower priorities for the region, based on documented client need and historical utilization. The total funding for these services comprises less than 7% of the total Ryan White Part B direct service allocations for the Area. *(93% of all Ryan White Part B funding in Area 12 is allocated to the SCSN services listed previously.)*

Section 1C - Table VIIIC: Justification/Narrative

#	SERVICE CATEGORY	NARRATIVE /SERVICE GAPS
8	Transportation	**Transport to and from HIV-related medical and support service appointments/meetings is a continual challenge for many enrolled clients. The public transportation system in Volusia County is limited to lengthy and sometimes confusing bus routes; and does not extend to all communities in the 2-county region. Additional door-to-door medical transportation is needed for clients with unique circumstances or who live outside of the public transit service area.**
9	Housing Services	**Although separate HOPWA funding is carefully utilized and closely monitored in order to ensure adequate support for those who need it - it is anticipated that there may be housing and utility assistance needs that are not covered by the existing program guidelines. This service category was "opened" only to make it available in the event that such needs should arise, and is utilized only on a case-by-case basis.**
10	Food Support	**High rates of inflation relating to food and transportation costs have left many individuals who were otherwise "barely" surviving in dire need of nutritional support. Many clients report having to often choose between purchasing a nutritious meal or spending the money on fuel to attend doctor's and other HIV-related appointments. This category is used to provide a minimal "voucher" (grocery store gift card or actual voucher from an area food bank) to clients to help with grocery/food costs.**
11	Non-medical Case Management Outreach (and Referral) Early Intervention Services Psychosocial Support	**These 4 separate categories were prioritized as a group by the local planning partnership, due to a high degree of overlap in their corresponding services/activities. Funds allocated to these items are shared among multiple providers for activities related to identifying persons who are HIV-positive but are not accessing primary medical care and/or are not successfully maintaining appropriate care.**
12	Treatment Adherence	**Compliance with complex medication regimens and periodic routine medical appointments is a significant challenge for some clients. Medical providers are often too overloaded to spend adequate time addressing these issues with patients. A licensed and adequately trained nurse is the best resource to deliver comprehensive treatment adherence counseling that addresses medication scheduling, side effects, alternatives, etc.**
15	Rehabilitation	**There is an occasional need for physical or occupational therapy in which there is no other available resource to provide the service(s). (Utilized on a case by case basis.)**
19	Home Health Care	**There is an occasional need for Home Health Care in which the client does not qualify for other available resources in the Area. There is, however, currently no Home Health Care provider in Area 12 that will provide services for the Ryan White Part B program.**

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Appendix I

The Health Resources and Services Administration and HIV/AIDS Bureau (HRSA/HAB) have developed the following definitions related to unmet need. The definitions are summarized in the box below. Use these definitions to assist you in filling in Table IVC "Unmet Need Calculation" on page 4.

Definitions Related to Unmet Need

- **Unmet Need for Health Services** (also referred to as unmet need) is the need for HIV-related health services by individuals with HIV who are aware of their HIV status, but are not receiving regular primary health care.
- **Primary medical care** is medical evaluation and clinical care that is consistent with U.S. Public Health Service guidelines for the treatment of HIV/AIDS. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies.
- **Other primary health care** includes HIV-related health services other than primary medical care – oral health care, outpatient mental health care, outpatient substance abuse treatment, nutritional services and specialty medical care referrals.
- **Non-medical supportive services** are other services that contribute to PLWH accessing and remaining in primary medical care.
- **In care:** A person is considered to be **in care** when s/he is receiving regular primary HIV-related medical care (clinical evaluations and clinical care). This medical care should meet U.S. Public Health Service guidelines for the treatment of HIV/AIDS.
- **Service gaps** are *all* service needs for *all* PLWH except primary health services for those who know their status. The term unmet need is used only to describe the unmet need for HIV-related primary health care.

The Unmet Need Framework has operational definitions for **unmet and met** need for HIV primary medical care. These definitions are ***used in estimating* met *and* unmet *need in your jurisdiction***.

An individual with HIV or AIDS is considered to have an unmet need for care (or to be **out of care**) when there is **no evidence** that s/he received any of the following three components of HIV **primary medical care** during a defined 12-month time frame: (1) viral load (VL) testing, (2) CD4 count, or (3) provision of anti-retroviral therapy (ART).

A person is considered to have **met need** (or to be in care) when there **is evidence** of any one or more of the above three measures during the specified 12-month time frame.

Appendix II

SERVICE CATEGORIES

Please refer to your Part A, Part B or the Administrative Guidelines manual for a description of the services.

Core Medical Services

a. Outpatient /Ambulatory health services
b. AIDS Drug Assistance Program (ADAP) treatments
c. AIDS Pharmaceutical Assistance (local)
d. Oral health care
e. Early Intervention Services
f. Health Insurance Premium & Cost Sharing Assistance
g. Home health care
h. Home and Community-based Health Services
i. Hospice Services
j. Mental health services
k. Medical Nutrition Therapy
l. Medical Case Management (including Treatment Adherence)
m. Substance abuse services–outpatient

Support Services

n. Case Management (non-Medical)
o. Child care services
p. Pediatric development/Early Intervention (GR Network only)
q. Emergency financial assistance
r. Food bank/home-delivered meals
s. Health education/risk reduction
t. Housing services
u. Legal services
v. Linguistics Services
w. Medical Transportation Services
x. Outreach services
y. Permanency planning (GR Network only)
z. Psychosocial support services
aa. Referral for health care/supportive services
ab. Rehabilitation services
ac. Respite care
ad. Treatment adherence counseling
ae. Substance Abuse Services Residential
af. Hospital Services (GR Network only)
ag. Residential Care (GR Network only)
ah. Nursing Home Care (GR Network only)

Section 1: WHERE ARE WE NOW: *WHAT IS OUR CURRENT SYSTEM OF CARE?*

1 D: Prevention for Positives

Table 1D: Prevention for Positives

Prevention Program Provider/Message	Program provider contact information
Real AIDS Prevention Project (RAPP) **Outreach Community Care Network**	**Loretta Jennings, Executive Director (386) 255-5569**
Prevention on the Move **Stewart Marchman Center (Mobile Unit)**	**Dena Whipper, Project Director (386) 947-2461**
ARTAS, Community Education, Community Events **Volusia County Health Department**	**Patrick Forand, Interim HAPC (386) 274-0585**

The Narrative below provides a description/explanation of all Prevention for Positive programs, or activities, in Ares 12.

Area 12 has only one Prevention Program targeted specifically for Persons who are Living With HIV/AIDS (PLWHA) – the Volusia County Health Department has 1 FTE designated to conduct the intervention; although the position is vacant at this time. There had been one previously funded Prevention for Positives program in the Area that was implemented in 2004, but met multiple challenges in recruiting and retaining participants. The program was unable to complete its three year funding cycle successfully; the host agency simultaneously closed, and the program was discontinued.

There are currently two separate HIV Prevention programs for persons who are at *high-risk* of HIV infection that operate throughout Area 12. The first was funded under the Florida Bureau of HIV/AIDS Advancing HIV Prevention initiative for 2006-2008; but that funding cycle will expire on December 31st of 2008. It is unknown at this time whether this or another program will be funded by the State in Area 12 during 2009-2011. The second primary prevention program in Area 12 is operated by a large, local Substance Abuse Treatment Services provider under funding from the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA). The program includes a mobile outreach and testing unit that offers a wide variety of health screenings and is an access point for multiple social services through a network of collaborative partners. The project targets minority communities in the most disparate regions of the Area including the urban core of Daytona Beach, the Spring Hill neighborhood of DeLand, and the Flagler County town of Bunnell, among others. The funding for this program will be subject to renewal in 2008-09.

Additionally, the Volusia County Health Department provides HIV/AIDS community education, counseling/testing, and coordination of community events; as well as conducts limited ARTAS intervention. A single FTE is allocated through the CHD and provided to the Volusia County Branch Jail to provide HIV education, risk-reduction counseling, Counseling/Testing, and a variety of other services for incarcerated individuals; including coordinated linkage to case management and other support services for persons who are diagnosed with HIV. The Volusia County Health Department is also the contracted provider for Ryan White Part B Eligibility and Enrollment services for persons who are determined to be HIV-positive and in need of HIV/AIDS primary healthcare services and support.

1 E: Resource Inventory

DIRECTIONS:

Listed in Table 1E: Resource Inventory, are the six (6) Statewide Coordinated Statement of Need (SCSN) service categories (Ambulatory Outpatient, Medical Case Management, Dental Care, Pharmaceutical, Mental Health Treatment, and Substance Abuse Treatment) and the mandatory inclusion of Health Insurance. Read each column heading for further instructions.

NOTE: Table IE has a separate page included for each of the six core (SCSN) services and Health Insurance. If you do not need an entire page to list the service providers for a service you may put more than one service group on a page. Please separate and label by service

If your area funds other service categories than those that are listed, add additional rows as needed to include all the services that are being funded in your area. A blank table has been added on page 9 for your convenience.

Be sure to include all Early Intervention Services (EIS) that are funded by Part B. In addition, identify service providers that assist Women, Infants, Children and Youth (WICY) by checking the WICY column check box.

Complete columns in Table IE: Resource Inventory. The information you provide should be based upon unduplicated services to HIV/AIDS clients *only*.

EIS-HRSA definition: Activities designed to identify individuals who are HIV-positive and get them into care as quickly as possible. As funded through Parts A and B of the Ryan White Modernization Act of 2006, includes outreach, counseling and testing, information and referral services. Under Part C of the Ryan White Modernization Act of 2006, also includes comprehensive primary medical care for individuals living with HIV/AIDS.

Section 1E - Table I: Resource Inventory

(1) **Contact Information** List the name of the agency, address, contact person, telephone, fax and e-mail information in this column. In the blank table section, added for "other service categories", be sure to include all HIV/AIDS provider agencies that do testing, counseling, prevention, education and medical care referrals across all Ryan White Modernization Act funding streams.	(2) **Service Area** List the geographic area in which services are provided. List the areas based on county and further arrange by zip code, if available.	(3) **Funding Source** Describe funding received to provide patient care related services in all categories (e.g. Ryan White Modernization Act, State, local, private, Medicaid, Medicare, other Federal funding).	**W I C Y**	(4) **Target Population** List the population targeted for services by the service provider (e.g., African Americans, IDU's).	(5) **Caseload Capacity** List the number of clients that the provider is able, or willing to serve. If necessary, in a narrative, explain any capacity variations to the caseload number.	(6) **PLWH Caseload** List the anticipated number of clients that will be served by the provider for current grant period 2008-2009.	(7) **Service Utilization** For as many funding sources possible (i.e. Parts A, B, C, D, etc.), list the number of unduplicated clients serviced for grant period 2008-2009.	(8) **Tracking** Circle **Yes** or **No** for each provider listed to indicate whether there is a mechanism in place to assure referrals are being tracked?	(9) **Feedback Mechanism** (The way the referring agency ensures that PLWH's were able to obtain needed services)
Ambulatory Outpatient									
Bert Fish Hospital 401 Palmetto St. New Smyrna Bch, FL 32168 (386) 424-5100	South Volusia County	Private Insurance Medicare Medicaid Ryan White Self Pay	**Y**	All	(Unkn)	(Unkn)	(Unkn)	(Unkn)	
Central Florida Medical Associates, Syed Ahmed, MD 36 S. Hwy. 17-92, Suite 100 Debary, FL 32713 (386) 668-6888	Western Volusia County, and Eastern Orange and Seminole Counties	Private Insurance Medicare Medicaid Ryan White	**Y**	All populations	100/wk	20	12	**NO**	*Primary medical visits do not require referral or authorization*
Florida Hospital - Deland 701 W Plymouth Av. Deland, FL 32720 (386) 943-4522	Western Volusia County	Taxing District Private Insurance Medicare Medicaid Ryan White Self Pay	**Y**	All	(Unkn)	(Unkn)	(Unkn)	(Unkn)	

(1) **Contact Information** List the name of the agency, address, contact person, telephone, fax and e-mail information in this column. In the blank table section, added for "other service categories", be sure to include all HIV/AIDS provider agencies that do testing, counseling, prevention, education and medical care referrals across all Ryan White Modernization Act funding streams.	(2) **Service Area** List the geographic area in which services are provided. List the areas based on county and further arrange by zip code, if available.	(3) **Funding Source** Describe funding received to provide patient care related services in all categories (e.g. Ryan White Modernization Act, State, local, private, Medicaid, Medicare, other Federal funding).	**W I C Y**	(4) **Target Population** List the population targeted for services by the service provider (e.g., African Americans, IDU's).	(5) **Caseload Capacity** List the number of clients that the provider is able, or willing to serve. If necessary, in a narrative, explain any capacity variations to the caseload number.	(6) **PLWH Caseload** List the anticipated number of clients that will be served by the provider for current grant period 2008-2009.	(7) **Service Utilization** For as many funding sources possible (i.e. Parts A, B, C, D, etc.), list the number of unduplicated clients serviced for grant period 2008-2009.	(8) **Tracking** Circle **Yes** or **No** for each provider listed to indicate whether there is a mechanism in place to assure referrals are being tracked?	(9) **Feedback Mechanism** (The way the referring agency ensures that PLWH's were able to obtain needed services)
Florida Hospital – Flagler 60 Memorial Medical Parkway Palm Coast, FL 32164 (386) 586-2000		Private Insurance Medicare Medicaid Ryan White Self Pay	**Y**	All	(Unkn)	(Unkn)	(Unkn)	(Unkn)	
Halifax Hospital 303 N. Clyde Morris Daytona Beach, FL 32114 (386) 254-4011	Volusia County	Taxing District Private Insurance Medicare Medicaid Ryan White Self Pay	**Y**	All	(Unkn)	(Unkn)	(Unkn)	(Unkn)	
Florida Hospital – Ormond Memorial 875 Sterthaus Av. Ormond Beach, FL 32174 (386) 676-6000	Northern and Central Volusia County	Private Insurance Medicare Medicaid Ryan White Self Pay Other	**Y**	All	(Unkn)	(Unkn)	(Unkn)	(Unkn)	
Kemshol Medical Center-Dr Thomas MD 984 Orange Ave., Daytona Beach, FL 32114 (386) 226-3008	Volusia	Private Insurance Medicare Medicaid Ryan White		All (Primary Medical)	(Unkn)	(Unkn)	(Unkn)		*Primary medical visits do not require referral or authorization*
Radiology Associates 130 N. Frederick Ave., Daytona Beach, FL 32114 (386) 255-5496	Central Volusia County	Private Insurance Medicare Medicaid Ryan White	**Y**		(Unkn)	(Unkn)	(Unkn)	(Unkn)	Case Manager Follow-up

(1) **Contact Information** List the name of the agency, address, contact person, telephone, fax and e-mail information in this column. In the blank table section, added for "other service categories", be sure to include all HIV/AIDS provider agencies that do testing, counseling, prevention, education and medical care referrals across all Ryan White Modernization Act funding streams.	(2) **Service Area** List the geographic area in which services are provided. List the areas based on county and further arrange by zip code, if available.	(3) **Funding Source** Describe funding received to provide patient care related services in all categories (e.g. Ryan White Modernization Act, State, local, private, Medicaid, Medicare, other Federal funding).	**W I C Y**	(4) **Target Population** List the population targeted for services by the service provider (e.g., African Americans, IDU's).	(5) **Caseload Capacity** List the number of clients that the provider is able, or willing to serve. If necessary, in a narrative, explain any capacity variations to the caseload number.	(6) **PLWH Caseload** List the anticipated number of clients that will be served by the provider for current grant period 2008-2009.	(7) **Service Utilization** For as many funding sources possible (i.e. Parts A, B, C, D, etc.), list the number of unduplicated clients serviced for grant period 2008-2009.	(8) **Tracking** Circle **Yes** or **No** for each provider listed to indicate whether there is a mechanism in place to assure referrals are being tracked?	(9) **Feedback Mechanism** (The way the referring agency ensures that PLWH's were able to obtain needed services)
Midland Florida Infectious Diseases Specialists (Dr. Calderon) 955 Town Center Drive, Suite 100 Orange City, FL 32763 (386) 228-0661	Western Volusia County	Private Insurance Ryan White (Other Unkn)	**Y**	Hispanic/ Latino All populations	(Unkn)	(Unkn)	(Unkn)	(Unkn)	*Primary medical visits do not require referral or authorization*
Spradley, Mark A., P.A. 1529 S. Ridgewood Ave. South Daytona, FL 32119 (386) 304-6611	South Volusia County	Private Insurance Medicare Medicaid Ryan White Self Pay	**Y**	All (Specialty Medical)	(Unkn)	(Unkn)	(Unkn)	(Unkn)	
Tomoka Medical Lab, Inc. 738 S. Nova Road Ormond Beach, FL 32174 (386) 677-8014	Volusia / Flagler	Private Insurance Medicare Medicaid Ryan White Self Pay	**Y**	All	Unlimited	(Unkn)	(Unkn)	No	Physician Follow-up
University of Florida Rainbow Center for Women, Adolescents, and Children 653-1 W. 8th Street, 3rd Floor Jacksonville, FL 32209 (904) 244-3051	Volusia / Flagler (All)	Private Insurance Medicare Medicaid Ryan White CMS Clinical Trials Other	**Y**	Women, infants, children and families	50/wk	25 *(Est)*	(Unkn)	Yes	*Primary medical visits do not require referral or authorization*

(1) **Contact Information** List the name of the agency, address, contact person, telephone, fax and e-mail information in this column. In the blank table section, added for "other service categories", be sure to include all HIV/AIDS provider agencies that do testing, counseling, prevention, education and medical care referrals across all Ryan White Modernization Act funding streams.	(2) **Service Area** List the geographic area in which services are provided. List the areas based on county and further arrange by zip code, if available.	(3) **Funding Source** Describe funding received to provide patient care related services in all categories (e.g. Ryan White Modernization Act, State, local, private, Medicaid, Medicare, other Federal funding).	**W I C Y**	(4) **Target Population** List the population targeted for services by the service provider (e.g., African Americans, IDU's).	(5) **Caseload Capacity** List the number of clients that the provider is able, or willing to serve. If necessary, in a narrative, explain any capacity variations to the caseload number.	(6) **PLWH Caseload** List the anticipated number of clients that will be served by the provider for current grant period 2008-2009.	(7) **Service Utilization** For as many funding sources possible (i.e. Parts A, B, C, D, etc.), list the number of unduplicated clients serviced for grant period 2008-2009.	(8) **Tracking** Circle **Yes** or **No** for each provider listed to indicate whether there is a mechanism in place to assure referrals are being tracked?	(9) **Feedback Mechanism** (The way the referring agency ensures that PLWH's were able to obtain needed services)
Consultive Medicine, Daniel A. Warner, MD, PA 1630 Mason Ave., Ste. C Daytona Beach, FL 32117 (386) 274-7651	Volusia / Flagler (All)	Private Insurance Medicare Medicaid Ryan White Self Pay	**Y**	All (Primary Medical)	250/wk	350	327	No	*Primary medical visits do not require referral or authorization*
Volusia County Health Department (Daytona Beach) 1845 Holsonback Drive Daytona Beach, FL 32117 (386) 274-0537	Volusia County (All)	Florida DOH Medicaid Medicare Ryan White Self Pay	**Y**	All populations, (Incl. uninsured)	100/wk *(varies)*	100	75	Yes	*Primary medical visits do not require referral or authorization*
Volusia County Health Department (DeLand) 1330 S. Woodland Blvd. DeLand, FL 32720-7731 (386) 822-6215	Volusia County. (Located in Western Volusia County)	Florida DOH Medicaid Medicare Ryan White Self Pay	**Y**	All populations, (Incl. uninsured)	70/wk	50	35 *(Estimated)*	Yes	*Primary medical visits do not require referral or authorization*
Dermatology Associates of North-East Florida, PA 33 Old Kings Road, N. Palm Coast, FL 32137 (386) 446-4466	Flagler County	Private Insurance Medicare Ryan White Self Pay	**Y**	All (Specialty Medical)	75/wk	(Unkn)	(Unkn)	(Unkn)	
Daytona Eye Center / **Eye Savers** 701 S. Ridgewood Ave. Daytona Beach, FL 32114 (386) 253-5999	Volusia County *(Locations in: Daytona Beach, Ormond Beach, Port Orange, Orange City)*	Private Insurance Medicare Medicaid Ryan White Self Pay	**Y**	All (Specialty Medical)	100/wk	(Unkn)	(Unkn)	(Unkn)	

(1) **Contact Information** List the name of the agency, address, contact person, telephone, fax and e-mail information in this column. In the blank table section, added for "other service categories", be sure to include all HIV/AIDS provider agencies that do testing, counseling, prevention, education and medical care referrals across all Ryan White Modernization Act funding streams.	(2) **Service Area** List the geographic area in which services are provided. List the areas based on county and further arrange by zip code, if available.	(3) **Funding Source** Describe funding received to provide patient care related services in all categories (e.g. Ryan White Modernization Act, State, local, private, Medicaid, Medicare, other Federal funding).	W I C Y	(4) **Target Population** List the population targeted for services by the service provider (e.g., African Americans, IDU's).	(5) **Caseload Capacity** List the number of clients that the provider is able, or willing to serve. If necessary, in a narrative, explain any capacity variations to the caseload number.	(6) **PLWH Caseload** List the anticipated number of clients that will be served by the provider for current grant period 2008-2009.	(7) **Service Utilization** For as many funding sources possible (i.e. Parts A, B, C, D, etc.), list the number of unduplicated clients serviced for grant period 2008-2009.	(8) **Tracking** Circle **Yes** or **No** for each provider listed to indicate whether there is a mechanism in place to assure referrals are being tracked?	(9) **Feedback Mechanism** (The way the referring agency ensures that PLWH's were able to obtain needed services)
Flagler Eye Center, P.A. 61 Memorial Medical Parkway Palm Coast, FL 32164 (386) 586-3711	Volusia/ Flagler	Private Insurance Medicare Medicaid Ryan White Self Pay	**Y**	All (Specialty Medical)	(Unkn)	(Unkn)	(Unkn)	(Unkn)	
Medical Case Management									
Outreach Community Care Network 240 N. Frederick Ave. Daytona Beach, FL 32114 (386) 255-5569	Volusia/ Flagler	Ryan White Medicaid Private Insurance United Way	**Y**	All HIV+	400	400	400	YES	

(1) **Contact Information** List the name of the agency, address, contact person, telephone, fax and e-mail information in this column. In the blank table section, added for "other service categories", be sure to include all HIV/AIDS provider agencies that do testing, counseling, prevention, education and medical care referrals across all Ryan White Modernization Act funding streams.	(2) **Service Area** List the geographic area in which services are provided. List the areas based on county and further arrange by zip code, if available.	(3) **Funding Source** Describe funding received to provide patient care related services in all categories (e.g. Ryan White Modernization Act, State, local, private, Medicaid, Medicare, other Federal funding).	**W I C Y**	(4) **Target Population** List the population targeted for services by the service provider (e.g., African Americans, IDU's).	(5) **Caseload Capacity** List the number of clients that the provider is able, or willing to serve. If necessary, in a narrative, explain any capacity variations to the caseload number.	(6) **PLWH Caseload** List the anticipated number of clients that will be served by the provider for current grant period 2008-2009.	(7) **Service Utilization** For as many funding sources possible (i.e. Parts A, B, C, D, etc.), list the number of unduplicated clients serviced for grant period 2008-2009.	(8) **Tracking** Circle **Yes** or **No** for each provider listed to indicate whether there is a mechanism in place to assure referrals are being tracked?	(9) **Feedback Mechanism** (The way the referring agency ensures that PLWH's were able to obtain needed services)
Dental Care									
James E. Montgomery, DDS 3777 South Ridgewood Port Orange, FL 32119 (386) 760-1200	Volusia/ Flagler	Ryan White	**Y**	All	50/wk *(Estimated)*	(Unkn)	(Unkn)	NO	Case Manager Follow-Up
Smile Family Dentistry 3231 S. Ridgewood Av. Daytona Beach, FL 32119 (386) 788-9599	Volusia/ Flagler	Ryan White Self Pay	**Y**	All	(Unkn)	(Unkn)	(Unkn)	(Unkn)	Case Manager Follow-Up
Pharmaceutical									
Volusia County Health Department (Daytona Beach) 1845 Holsonback Dr. Daytona Beach, FL 32117 (386) 274-0580	Volusia/ Flagler	Medicaid Ryan White *(Title 2 and ADAP)* Self Pay	**Y**	All *This is the contracted pharmacy for all RWT2 clients and ADAP*	As needed			YES	Consistent communication between pharmacy staff and case managers.
Volusia County Health Department (DeLand) 1330 S. Woodland Blvd. Deland, FL 33270 (386) 822-6224	West Volusia County	Medicaid Ryan White *(Title 2 and ADAP)* Self Pay	**Y**	All *This is the contracted pharmacy for all RWT2 clients and ADAP*	As needed			YES	Consistent communication between pharmacy staff and case managers.
CVS Pharmacies 595 W. Granada Av., Ste K Ormond Beach, FL 32174 *(District Office)* (386) 677-7189	Volusia/ Flagler (*Multiple Locations)*	Private Insurance Medicare Medicaid Ryan White Self Pay Others	**Y**	All	Unlimited	*Only clients for whom RW is reimbursing insurance copayments*		NO	RW Case Managers follow-up with clients and pharmacies as needed

(1) **Contact Information** List the name of the agency, address, contact person, telephone, fax and e-mail information in this column. In the blank table section, added for "other service categories", be sure to include all HIV/AIDS provider agencies that do testing, counseling, prevention, education and medical care referrals across all Ryan White Modernization Act funding streams.	(2) **Service Area** List the geographic area in which services are provided. List the areas based on county and further arrange by zip code, if available.	(3) **Funding Source** Describe funding received to provide patient care related services in all categories (e.g. Ryan White Modernization Act, State, local, private, Medicaid, Medicare, other Federal funding).	**W I C Y**	(4) **Target Population** List the population targeted for services by the service provider (e.g., African Americans, IDU's).	(5) **Caseload Capacity** List the number of clients that the provider is able, or willing to serve. If necessary, in a narrative, explain any capacity variations to the caseload number.	(6) **PLWH Caseload** List the anticipated number of clients that will be served by the provider for current grant period 2008-2009.	(7) **Service Utilization** For as many funding sources possible (i.e. Parts A, B, C, D, etc.), list the number of unduplicated clients serviced for grant period 2008-2009.	(8) **Tracking** Circle **Yes** or **No** for each provider listed to indicate whether there is a mechanism in place to assure referrals are being tracked?	(9) **Feedback Mechanism** (The way the referring agency ensures that PLWH's were able to obtain needed services)
Florida Health Care Plans 1340 Ridgewood Avenue Holly Hill, FL 32117 (386) 676-7173	Volusia/ Flagler	Private Insurance Ryan White (Others Unkn)	**Y**	All	(Unkn)	*Only clients for whom RW is reimbursing insurance copayments*		NO	RW Case Managers follow-up with clients and pharmacies as needed
Holly Hill Pharmacy 1702 Ridgewood Ave. Holly Hill, FL 32117 (386) 677-7377	Volusia/ Flagler	Private Insurance Medicare Medicaid Ryan White Self Pay	**Y**	All	(Unkn)	*Only clients for whom RW is reimbursing insurance copayments*		NO	RW Case Managers follow-up with clients and pharmacies as needed
Orange Belt Pharmacies 112 E. New York Av. Deland, FL 32724 (386) 764-1685	West Volusia County	Private Insurance Medicare Medicaid Ryan White Self Pay	**Y**	All	(Unkn)	*Only clients for whom RW is reimbursing insurance copayments*		NO	RW Case Managers follow-up with clients and pharmacies as needed
Steve's Pharmacy 636 Mason Av. Daytona Beach, FL 32114 (386) 255-0907	Volusia County	Private Insurance Medicare Medicaid Ryan White Self Pay	**Y**	All	(Unkn)	*Only clients for whom RW is reimbursing insurance copayments*		NO	RW Case Managers follow-up with clients and pharmacies as needed
Deltona Pharmacy 776 Deltona Blvd Deltona, FL 32725 (386) 574-7690	Volusia County	Private Insurance Medicare Medicaid Ryan White Self Pay	**Y**	All	(Unkn)	*Only clients for whom RW is reimbursing insurance copayments*		NO	RW Case Managers follow-up with clients and pharmacies as needed

(1) **Contact Information** List the name of the agency, address, contact person, telephone, fax and e-mail information in this column. In the blank table section, added for "other service categories", be sure to include all HIV/AIDS provider agencies that do testing, counseling, prevention, education and medical care referrals across all Ryan White Modernization Act funding streams.	(2) **Service Area** List the geographic area in which services are provided. List the areas based on county and further arrange by zip code, if available.	(3) **Funding Source** Describe funding received to provide patient care related services in all categories (e.g. Ryan White Modernization Act, State, local, private, Medicaid, Medicare, other Federal funding).	**W I C Y**	(4) **Target Population** List the population targeted for services by the service provider (e.g., African Americans, IDU's).	(5) **Caseload Capacity** List the number of clients that the provider is able, or willing to serve. If necessary, in a narrative, explain any capacity variations to the caseload number.	(6) **PLWH Caseload** List the anticipated number of clients that will be served by the provider for current grant period 2008-2009.	(7) **Service Utilization** For as many funding sources possible (i.e. Parts A, B, C, D, etc.), list the number of unduplicated clients serviced for grant period 2008-2009.	(8) **Tracking** Circle **Yes** or **No** for each provider listed to indicate whether there is a mechanism in place to assure referrals are being tracked?	(9) **Feedback Mechanism** (The way the referring agency ensures that PLWH's were able to obtain needed services)
Mental Health Treatment									
ACT Corporation 1220 Willis Ave. Daytona Beach, FL 32114 800-539-4228	Volusia/ Flagler (Multiple locations)	Private Insurance Medicare Medicaid Ryan White FL DOC SAMHSA	**Y**	All	500+			YES	Agency has case managers, and RW clients are followed by their RW case manager
Cucchiaro, Cathryn C., MA, LMFT 2001 S. Ridgewood Ave. Daytona Beach, FL 32114 (386) 299-6555	Central Volusia County	Private Insurance Medicare Medicaid (PAC Waiver) Ryan White Self Pay	**Y**	All	20/wk			(Unkn)	RW clients are followed by their case manager
East Coast Center for Psychiatry 595 W. Granada Blvd, 2E Ormond Beach, FL 32174 386-672-4222	Volusia/ Flagler	Private Insurance Ryan White (Others Unkn)	**Y**	All	(Unkn)			(Unkn)	RW clients are followed by their case manager
Responsible Choices 1834 Mason Ave Daytona Beach, FL 32120 (386) 248-2272	Volusia County, with locations in Western Volusia County	Private Insurance Medicaid Ryan White Self Pay	**Y**	Primarily targets minorities, including Hispanics, will see all populations	(Unkn)				RW clients are followed by their case manager

(1) **Contact Information** List the name of the agency, address, contact person, telephone, fax and e-mail information in this column. In the blank table section, added for "other service categories", be sure to include all HIV/AIDS provider agencies that do testing, counseling, prevention, education and medical care referrals across all Ryan White Modernization Act funding streams.	(2) **Service Area** List the geographic area in which services are provided. List the areas based on county and further arrange by zip code, if available.	(3) **Funding Source** Describe funding received to provide patient care related services in all categories (e.g. Ryan White Modernization Act, State, local, private, Medicaid, Medicare, other Federal funding).	**W I C Y**	(4) **Target Population** List the population targeted for services by the service provider (e.g., African Americans, IDU's).	(5) **Caseload Capacity** List the number of clients that the provider is able, or willing to serve. If necessary, in a narrative, explain any capacity variations to the caseload number.	(6) **PLWH Caseload** List the anticipated number of clients that will be served by the provider for current grant period 2008-2009.	(7) **Service Utilization** For as many funding sources possible (i.e. Parts A, B, C, D, etc.), list the number of unduplicated clients serviced for grant period 2008-2009.	(8) **Tracking** Circle **Yes** or **No** for each provider listed to indicate whether there is a mechanism in place to assure referrals are being tracked?	(9) **Feedback Mechanism** (The way the referring agency ensures that PLWH's were able to obtain needed services)
Bonilla, Allison, LCSW 3425 S. Volusia Ave Suite B-4 Orange City, FL 32763 (386) 947-1300	Volusia/ Flagler	Private Insurance Medicare Medicaid Self Pay (Others Unkn)	**Y**	All, Varies by location	(Unkn)	(Unkn)	(Unkn)	(Unkn)	RW clients are followed by their case manager
Substance Abuse Treatment									
Cucchiaro, Cathryn, MA LMFT 2001 S. Ridgewood Ave. Daytona Beach, FL 32114 (386) 299-6555	Central Volusia County	Private Insurance Medicare Medicaid (PAC Waiver) Ryan White Self Pay	**Y**	All	20/wk			(Unkn)	RW clients are followed by their case manager
Responsible Choices 1834 Mason Ave Daytona Beach, FL 32120 (386) 248-2272	Volusia County, with locations in Western Volusia County	Private Insurance Medicaid Ryan White Self Pay	**Y**	Primarily targets minorities, incl. Hispanics, Will serve all populations.	(Unkn)			YES	RW clients are followed by their case manager
The Salvation Army 1555 LPGA Boulevard Holly Hill, FL 32117 386-236-2020	Volusia/ Flagler	Private Insurance Medicare Medicaid Ryan White	**Y**	All	(Unkn)	(Unkn)	(Unkn)	(Unkn)	Agency has case managers, and RW clients are followed by their case manager

(1) **Contact Information** List the name of the agency, address, contact person, telephone, fax and e-mail information in this column. In the blank table section, added for "other service categories", be sure to include all HIV/AIDS provider agencies that do testing, counseling, prevention, education and medical care referrals across all Ryan White Modernization Act funding streams.	(2) **Service Area** List the geographic area in which services are provided. List the areas based on county and further arrange by zip code, if available.	(3) **Funding Source** Describe funding received to provide patient care related services in all categories (e.g. Ryan White Modernization Act, State, local, private, Medicaid, Medicare, other Federal funding).	**W I C Y**	(4) **Target Population** List the population targeted for services by the service provider (e.g., African Americans, IDU's).	(5) **Caseload Capacity** List the number of clients that the provider is able, or willing to serve. If necessary, in a narrative, explain any capacity variations to the caseload number.	(6) **PLWH Caseload** List the anticipated number of clients that will be served by the provider for current grant period 2008-2009.	(7) **Service Utilization** For as many funding sources possible (i.e. Parts A, B, C, D, etc.), list the number of unduplicated clients serviced for grant period 2008-2009.	(8) **Tracking** Circle **Yes** or **No** for each provider listed to indicate whether there is a mechanism in place to assure referrals are being tracked?	(9) **Feedback Mechanism** (The way the referring agency ensures that PLWH's were able to obtain needed services)
Health Insurance ***Health Insurance premiums and co-pays are supported as needed by the Ryan White AICP program for eligible clients, with supplemental funding from Title IIfor clients who are placed on a waiting list for AICP; or in special circumstances if the client cannot be enrolled in AICP but has an eligible insurance policy.Providers are determined by the clients' existing insurance policies.)***									
Transportation									
Diggs Miracle Care 875 Mary McLeod-Bethune Blvd Daytona Beach, FL 32114 (386) 323-9067	Volusia/ Flagler	Ryan White	**Y**	All	20/wk			YES	Consistent communication with RW case managers
Treatment Adherence									
University of Florida Rainbow Center for Women, Adolescents, and Children 421 S. Keech Street Daytona Beach, FL 32114 (386) 238-4980 ext 134	Volusia/ Flagler	Private Insurance Medicare Medicaid Ryan White CMS Clinical Trials Other	**Y**	All HIV+ clients newly initiated on HAART medications, clients with Hx. of non-compliance, will serve all HIV+	20	100 *(Est)*	(Unkn)	YES	*Primary medical visits do not require referral or authorization*
Food Bank / Food Vouchers (Eligible RW clients may receive one food voucher (store certificate/card) every 30 days as needed, within local guidelines.)									
Halifax Urban Ministries (three locations) 215 Bay St Daytona Beach, FL 32114	Volusia/ Flagler	Self Pay Ryan White	**Y**	All	Unlimited				RW case managers track distribution of vouchers

KEY ACCESS POINTS

Key access points refer to accessible points of entry for clients into the HIV/AIDS care system. The table below indicates the type(s) of formal relationships that exist between key entities within the existing HIV/AIDS care and services network in Area 12 and the entry points listed in the first column.

Definitions and Acronyms:

Points of Entry: Health care access points frequently used by traditionally underserved HIV-positive individuals to help meet their medical and social service needs. They are therefore key access points for referring such individuals into the HIV care system.

Formal Agreement = Signed contract **Informal Agreement** = Verbal agreement **MOU** = Memorandum of Understanding
LOA = Letter of Agreement **Same Agency** = The service is provided on site
Consortium/Linkage = Agency is involved with the consortium to receive referrals

Section 1E – Table IIE: Key Access Points

Key Access Points	Formal Contract	Informal Agreement	LOA/ MOU	Same Agency	Consortium /Linkage	Other	None
Emergency Rooms		X					
Substance Abuse Treatment		X	X		X		
Detoxification Center/Program			X				
Detention Facility					X		
STD Clinic	X			X	X		
Counsel & Testing	X	X	X	X	X		
Mental Health		X	X		X		
Homeless Shelters			X				
Homeless Health Services							X
Federally Qualified Health Center (FQHC)						X	X
Migrant Health							X
County Health Departments	X		X	X	X		
Family Planning Services							X
Hemophilia Centers							X
Other(s): • County Jail • Healthy Start					X	X	

Section 2: WHERE DO WE NEED TO GO: *WHAT SYSTEM OF CARE DO WE WANT?*

The narrative below describes current activities in Area 12 that are intended to facilitate early intervention for those individuals who are newly diagnosed with HIV, as well as those who already know their HIV-positive status but are not currently in care.

Section 1E – Narrative Box 1E

The Volusia County Health Department has a full time intervention specialist conducting ARTAS interventions for persons newly diagnosed with HIV as well as persons previously reported to be HIV-positive but who have become absent from care.

The Volusia County Health Department has allocated one full-time disease intervention specialist to conduct HIV education, counseling, and testing in the county's branch jail; and to directly link individuals who are diagnosed with HIV into appropriate medical care and case management services upon discharge from the facility.

Health Department staff are also working closely with a primary medical care provider specializing in women's services as well as the Area's primary birthing hospital and the local Healthy Start Coalition service providers in order to identify HIV-positive pregnant women as early as possible during their pregnancy and linking them to appropriate treatment and medical therapies during their pregnancies in order to prevent the transmission of HIV to their unborn children.

One minority AIDS Service Organization (ASO) in Daytona Beach receives notification from the Area's largest hospital when persons are newly diagnosed with HIV in the hospital's emergency department – for the purpose of establishing a supportive relationship with the individual and assisting them in accessing appropriate medical care and support services. The agency also receives notification from the Area's main primary medical provider when enrolled clients "no show" for appointments or are otherwise determined as falling out of care.

Both of the Area's primary providers of HIV Prevention services are closely integrated into the existing HIV Patient Care services network. One of the Prevention agencies is also the sole contracted Ryan White Medical Case Management provider for the Area; and the other is the largest provider of Substance Abuse Treatment and Mental Health Services in the region. Both of these organizations maintain close working relationships with the Health Department, the Ryan White lead agency, and area medical and support service providers in order to ensure effective linkage of newly diagnosed clients into needed services.

Each fall, a Priorities and Allocations Ad-Hoc committee is formed from within PCHAP. The committee members are charged to thoroughly review all available data/information from the Area's needs assessment in order to form a recommendation for service priorities. Once the suggested priorities have been reviewed and approved by the full planning body, the committee re-convenes to review additional cost/utilization data and to form a recommendation for the proportional allocation of Part B direct care funds into the prioritized service categories. That recommendation is than also forwarded to the full planning partnership for consensus. The table below lists the various types of information used in the development of the Area's service prioritization and resource allocation process.

Section 2 – Table I: Data used for Priority Setting and Allocation of funds.

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Section 2: WHERE DO WE NEED TO GO: *WHAT SYSTEM OF CARE DO WE WANT?*

✓	Data/Information Used for Priority Setting and Allocation of Funds	Current as of (Mo./Yr.)
Epidemiological Data		
✓	**Trends/changes in HIV incidence and/or prevalence**	**04/08**
✓	**Trends/changes in AIDS incidence and/or prevalence**	**04/08**
✓	**Changes in the demographics of the HIV/AIDS cases in relation to the total population, as a measure of disproportionate impact on specific populations**	**04/08**
✓	**Other: Co-morbidity, poverty, insurance status data**	**03/08**
Outcomes Evaluation Data		
✓	**Client-level health status outcomes – primary medical care**	**07/08**
✓	**Other health status outcomes**	**07/08**
✓	**System-level health status outcomes**	**07/08**
Service Utilization Data		
✓	**Numbers of unduplicated clients; numbers of units of service provided**	**06/08**
✓	**Demographic information regarding who is accessing care**	**06/08**
Service Cost Data		
✓	**Unit costs for each service, known or estimated**	**07/08**
✓	**Cost-effectiveness data, if available**	**07/08**
✓	**Percentage of Ryan White funds spent on women, infants, children and youth (WICY)**	**06/08**
✓	**History of expenditure data by category**	**07/08**
✓	**History of encumbrance data by category**	**07/08**

Section 2: WHERE DO WE NEED TO GO: *WHAT SYSTEM OF CARE DO WE WANT?*

Qualitative and Quantitative Needs Assessment Data		
✓	**Quantitative data regarding persons living in the TGA who know they have HIV but are not receiving HIV/AIDS primary medical care**	**7/08**
✓	**Focus group findings**	**7/08**
✓	Client Survey results	**7/07**
✓	**Provider Survey results**	**7/07**
✓	**Key informant interview findings**	**7/08**
✓	**Estimates of unmet need among clients in the service area's continuum of HIV/AIDS care**	**7/08**
✓	**Estimates of unmet need among clients not in the service area's continuum of HIV/AIDS care**	**7/08**
✓	**Information regarding populations with special needs, including barriers to care and other access issues**	**7/08**
Other Relevant Data		
✓	**List of service categories, including definitions**	**7/08**
✓	**Information on other Ryan White Modernization Act of 2006 and prevention funding streams**	**7/07**
✓	**Information on Medicaid data**	**7/07**
✓	**Information on Substance Abuse treatment programs**	**7/07**
✓	**Other governmental and non-governmental programs**	**7/07**
✓	**Information on private funding**	**7/07**
✓	**Comprehensive Plan – goals and strategies**	**8/06**
✓	**Capacity development needs**	**7/07**
✓	**Current local data on women, infants, children and youth (WICY)**	**6/08**
✓	**Funding stream**	**7/07**
✓	**Gap analysis**	**7/07**

Section 2: WHERE DO WE NEED TO GO: *WHAT SYSTEM OF CARE DO WE WANT?*

This section briefly describes the process and resources utilized during the annual Priority Setting and Allocations recommendation process in Area 12.

Section 2 - Table II: Legislative and programmatic resources utilized

Guidance and Programmatic Resources		☑
1	Ryan White Modernization Act 2006	✓
2	HAB/DSS Policies	✓
3	DOH/Bureau of HIV/AIDS Policies	✓
4	Application Guidance	✓
5	Healthy People 2010 (www.healthypeople.gov/)	✓
6	Locally developed service guidelines	✓

Section 2 – Narrative Box

PCHAP members are invited to volunteer for the Priorities and Allocations Ad-Hoc Committee each July. The members first meet for an orientation and informational session where they receive detailed reports and discuss the committee's objectives, purpose and work plan, as well as the region's current HIV/AIDS epidemiology (case data), client enrollment data, needs assessment findings (including both client and provider survey data), service category definitions, reported access barriers and service gaps, existing and anticipated legislative factors, the Statewide Coordinated Statement of Need (SCSN), and other appropriate data as background information to establish the Area's service priorities. The group then re-convenes at a later date (approximately 1-2 weeks) to develop a recommendation for (i.e. to "rank") the service priorities. The committee's service ranking recommendation is then taken to the full planning body during their next regularly scheduled meeting (in October) for review and approval.

Once the service categories have been approved by the planning body, the committee re-convenes for a third meeting to review and discuss specific information relating to service utilization, costs, effectiveness, and availability. Members are provided with actual spending reports, unit-cost data, utilization reports, outcomes data, and other coverage information to help guide decision making. The committee convenes for a fourth and final 3-4 hour work session each fall to develop a recommendation for the proportional allocation of the Area's Ryan White Part B funds into the prioritized service categories. That recommendation is then carried forward to the full planning partnership (usually in November) for consensus.

For each submission to the full planning partnership, the members of the Priorities and Allocations committee present a summary of the data that was reviewed and the highlights of discussions leading to the given recommendation. PHCAP bylaws require that Recommendations from the Priorities and Allocations Committee can be only either approved or declined by the full planning body. Any needed revisions require that the committee re-convene and form a new recommendation that must then be taken back to the full membership.

Section 2: WHERE DO WE NEED TO GO: *WHAT SYSTEM OF CARE DO WE WANT?*

The principles employed for decision making during the Priorities and Allocations process in Area 12 are presented in the table below. Each Priorities and Allocations Committee member receives an orientation packet that includes the principles as well as additional decision guiding criteria as presented on the following page. Members are reminded of these principles and criteria regularly throughout the committee process.

Section 2 – Table III: Decision-making principles

PRINCIPLES		✓
1	Decisions must be based on documented needs.	✓
2	Services must be responsive to the epidemiology of HIV in your service area.	✓
3	Priorities should contribute to strengthening the agreed-upon continuum of care, providing primary health care and limiting duplication of services.	✓
4	Decisions are expected to address overall needs within the service area, not narrow advocacy concerns.	✓
5	Services must be culturally appropriate.	✓
6	Funded services should fill identified service gaps for underserved populations.	✓
7	Equitable access to services should be provided across geographic areas and subpopulations.	✓
8	Services should meet Public Health Service treatment guidelines and other standards of care; and be of demonstrated quality and effectiveness.	✓
9	Funded services should not duplicate other available resources in the Area.	✓
10	There should be at least one identified provider within the region that is able and willing to provide the prioritized service.	✓

Section 2: WHERE DO WE NEED TO GO: *WHAT SYSTEM OF CARE DO WE WANT?*

The criteria listed below are utilized by the members of the PCHAP Priorities and Allocations Committee each year when developing recommendations for Area 12.

Section 2 – Table IV: Priority setting criteria

CRITERIA		☑
1	Cost effectiveness	✓
2	Quality control measures	✓
3	Outcome effectiveness of services	✓
4	Client surveys	✓
5	Outcomes evaluation	✓
6	Consumer preferences or priorities.	✓
7	Quality management programs	✓
8	Services and interventions for particular populations	✓
9	Services for particular populations with severe needs, historically underserved communities, and individuals who know their status but are not in care.	✓
10	Consistency with the continuum of care: An approach that helps communities plan for and provide a full range of emergency and long-term service resources to address the various needs of PLWH	✓
11	Balance between ongoing emerging needs.	✓
12	Providers who serve women, infants, children and youth (WICY)	✓
13	Needs of other special populations	✓
14	Other evaluation methods.	✓
15	Available funding	✓
16	Anticipated legislative changes	✓
17	Anticipated funding stream changes	✓
18	Availability and capacity of providers	✓

Section 2: WHERE DO WE NEED TO GO: *WHAT SYSTEM OF CARE DO WE WANT?*

Section 2 - Table V: Funding Allocation by service category.

Ranking	Service Category	Allocation Amount Parts A & B funds - Available for 2008		Percent of Funds The percent of funds allocated for each - allocation for 2008.		Explanation If funded differently than the ranking order of the Area's Needs Assessment.	Justification If funded as a higher priority than the core services identified in the SCSN.
		PART A	PART B	PART A	PART B		
1	**Medical Case Management**	**N/A**	**$345,355**	**N/A**	22.00%	Includes enrollment and eligibility services as required for all clients.	**Included in SCSN**
2	**Ambulatory Medical Care**	**N/A**	**$384,600**	**N/A**	24.50%	Based on projected costs	**Included in SCSN**
3	**Pharmacy Services**	**N/A**	**$361,053**	**N/A**	23.00%	Based on projected costs	**Included in SCSN**
4	**Oral Health Care**	**N/A**	**$211,922**	**N/A**	13.50%	Based on projected costs	**Included in SCSN**
5	**Mental Health Services**	**N/A**	**$31,396**	**N/A**	2.00%	Based on projected costs	**Included in SCSN**
6	**Substance Abuse Treatment**	**N/A**	**$15,698**	**N/A**	1.00%	Based on projected costs	**Included in SCSN**
7	**Health Insurance Premium and Cost Sharing Assistance**	**N/A**	**$109,886**	**N/A**	7.00%	Based on trends and projected costs	**Included in SCSN**
8	**Transportation**	**N/A**	**$15,698**	**N/A**	1.00%	Based on projected costs and utilization	Commonly reported barrier in Area 12
9	**Food Bank/Vouchers**	**N/A**	**$18,838**	**N/A**	1.20%	Based on projected costs and utilization	Commonly reported need in Area 12
10	**Early Intervention Services*** ***Client Advocacy*** ***Outreach and Referral*** ***Psychosocial Support***	**N/A**	**$16,012**	**N/A**	1.02%	These 4 categories were prioritized as a group due to overlap of activities. Funds to be distributed between categories as needed.	Services to identify/locate PLWHA who are not in care – for the purpose of linking them into medical services
11	**Treatment Adherence Counseling and Support *(and Health Education)***	**N/A**	**$58,867**	**N/A**	3.75%	These 2 categories were prioritized together due to their closely related nature. Funds to be split between categories as needed.	Based on reported needs from clients and providers

Section 3 HOW WILL WE GET THERE:

HOW DOES OUR SYSTEM NEED TO CHANGE TO ASSURE AVAILABILITY AND ACCESSIBILITY TO CORE SERVICES?

In 2005, the members of PCHAP assembled to form a new shared vision for the consortium in preparation for the 2006-2009 Comprehensive Plan. The members first identified the key values and guiding principles of the organization, and also reviewed the PCHAP Mission Statement, as adopted at the planning group's inception in April of 2000. Based on these founding principles, the members of PCHAP aspire to the following Vision:

Section 3 - Narrative Box 1: Shared Vision

Public and private individuals and agencies working cooperatively in an atmosphere of mutual trust, dignity and respect, to plan a seamless continuum of accessible, high quality services to all people of Area 12 affected by HIV/AIDS across the lifespan.

The following values and guiding principles were prioritized by the planning body in 2005, and will continue to guide the organization through the next three years.

Section 3 – Narrative Box 2: Shared Values/Guiding Principles

1	**Accessibility (of both services and the planning process)**
2	**Collaboration and Partnership**
3	**Inclusiveness**
4	**Cultural Diversity**
5	**Client Empowerment**
6	**Client Centered**
7	**Dignity and Respect for all persons**
8	**Ethics**
9	**Compassion**
10	**Information and Education**
11	**Rules and Guidelines**
12	**Quality and Cost-Effectiveness**

Section 3 HOW WILL WE GET THERE:

HOW DOES OUR SYSTEM NEED TO CHANGE TO ASSURE AVAILABILITY AND ACCESSIBILITY TO CORE SERVICES?

The narrative below describes the system of care for HIV-infected pregnant women and HIV-exposed newborns in Area 12, including coordination and linkages between Ryan White Part B, Children's Medical Services and the county health department.

Section 3 – Narrative Box 3

A formal and collaborative "*Mama Bear Collaboration Protocol*" has been developed among Area 12 HIV/AIDS Service providers, the Volusia County Health Department, and Children's Medical Services (CMS). The protocol has been widely distributed among stakeholders in Area 12 who may encounter an HIV-positive pregnant woman or mother (*Mama Bear*) and/or an HIV-exposed infant (*Baby Bear*); including area hospitals, the region's Healthy Start Coalition (and related providers), and the local HIV/AIDS Planning Partnership (including multiple HIV/AIDS services providers). Provider education sessions and group presentations were also conducted in to raise awareness and compliance to the recommended protocol.

Within the protocol, the County Health Department (CHD) surveillance staff notifies both a designated CMS nurse and a designated Disease Intervention Specialist whenever a new HIV-positive pregnant woman or exposed baby is identified. The potential clients are assigned a unique identifier to indicate that they are a "mama bear" or "baby bear," with special attention being attributed to clients who present with an urgent need (such as late/no entry into prenatal care, homeless, mental illness, etc.). Pregnant women receive education, counseling and support throughout their pregnancy, including the provision of prophylactic AZT, as well as follow-up to ensure that they are attending prenatal medical visits as directed. The CMS nurse visits each new mother and newborn prior to discharge from the Hospital to ensure that adequate ZDV and instructions are provided to the mother prior to taking her newborn home. Both CHD and CMS staff meet regularly with each new mother and baby during the first 18 months of the baby's life to ensure adequate education, support, and provision of appropriate medications as determined by a comprehensive assessment and client-centered plan.

CMS follows each exposed infant for a minimum of 18 months prior to program discharge. An existing gap has been identified in the need for a full time staff case manager to follow the increasing caseload of HIV-positive pregnant mothers in Area 12.

The primary funding source for ZDV supplied to HIV-exposed newborns is typically Florida Medicaid; except in events where there is no insurance, in which case CMS pays for the child's medications. Ryan White Part B funds have been allocated to help support the provision of education, instructions, support, and follow-up. Pregnant mothers who are eligible and enrolled in the Area 12 Ryan White Part B program are provided prophylactic AZT during their pregnancy (per established recommendations/guidelines) under the program.

Section 3 How will we get there: How does our system need to change to assure availability and accessibility to core services?

This section addresses Goals, Objectives and Tasks.

Attached are tables designed to capture local goals and objectives for the 2010-2013 planning period. Priority goals were adopted directly from the Florida Department of Health's stated goals, as presented below. Goals were selected based on local data and documented priorities of the planning consortia. Objectives were formulated by the executive committee of the planning body; and were approved by the full Partnership for inclusion in the area's Patient Care Services Comprehensive Plan.

For each goal listed, objective(s) are provided along with a list of the task(s) required to complete each objective.

The objectives are intended to be very "*specific and measurable"*. The target date is meant to be "*specific*".

Florida Department of Health, Bureau of HIV/AIDS Goals

Goal 1 Identify individuals who know their HIV status and are not receiving services, for informing the individuals of and enabling the individuals to utilize the services.

Goal 2 Eliminate disparities in accessing services among affected subpopulations *(i.e.: youth, MSM, sex workers, etc.)*.

Goal 3 Coordinate the provision of services with programs for HIV prevention *(including outreach and early intervention)*.

Goal 4 Coordinate the provisions of services with programs for the prevention and treatment of substance abuse.

Goal 5 Address adherence initiatives.

Goal 6 Minority AIDS Initiative *(issues of minority access and disparity in the area)*

Goal 7 Program coordination and linkages between Parts A, B, C, D and AETC.

Goal 8 Build capacity in your area.

Section 3 How will we get there: How does our system need to change to assure availability and accessibility to core services?

Table 1

Goal #1:	**Identify individuals who know their HIV-positive status and are not receiving services; to inform and enable those individuals to access and utilize available HIV/AIDS patient care, prevention, and support services.**	
Objective#:	**Reduce the proportion of reported PLWHA who are 'not in care' by 18% (from 35% to 17%) within 3 years (by March 31, 2012).**	
Estimated impact:	**Clients: 200 additional clients would be linked to care.**	**Services: Coupled with expanded eligibility guidelines during the same time period, impacts (increased utilization/costs) will be shared among medical case management services, medical care, pharmacy, health insurance continuation, as well as other core services.**

	TASK REQUIRED TO ACCOMPLISH THE ABOVE OBJECTIVE	TARGET DATE
Task: 1	**Survey all registered HIV Counseling and Testing sites in Area 12 for referral and linkage protocols for persons newly diagnosed with HIV.**	**4/1/09 – 6/30/09**
Task: 2	**Identify and rank causes (internal and external barriers) for persons not entering care, or not staying in care.**	**7/1/09 – 9/30/09**
Task: 3	**Develop strategies to address the primary barriers that prevent PLWHA from entering and/or remaining in care.**	**10/1/09 – 1/31/10**
Task: 4	**Present strategies and recommendations to providers and provide a forum for collaborative implementation of recommended strategies.**	**2/1/10 – 3/31/10**
Task: 5	**Develop and initiate a coordinated multi-agency implementation plan employing the recommended strategies formulated by the consortia during year 1.**	**4/1/10 – 3/31/11**
Task: 6	**Sustain adopted strategies, re-assess for effectiveness (evaluate), and refine policies and procedures as needed to reach target rate.**	**4/1/11 – 3/31/12**

Section 3 How will we get there: How does our system need to change to assure availability and accessibility to core services?

Table 2

Goal #2:	**Eliminate disparities in accessing services among the affected subpopulations *(including: minorities, women substance users, MSM, sex workers, and persons in geographically isolated areas)*.**	
Objective#:	**Reduce or eliminate at least 2 access disparities among HIV-infected populations in Area 12 within 3-years (by 3/31/12).**	
Estimated impact:	**Clients: An estimated 750 black/non-Hispanic and Hispanic persons who are living with HIV/AIDS in Area 12; also an estimated 500+ women and children who are HIV infected.**	**Services: Access will be prioritized for the Core Medical Services of Medical Case Management, Ambulatory Medical Care, Pharmacy, Oral Health, Mental Health and Substance Abuse Treatment and Counseling.**

	TASK REQUIRED TO ACCOMPLISH THE ABOVE OBJECTIVE	TARGET DATE
Task: 1	**Obtain data (demographic, barriers, etc.) regarding persons who are HIV-positive but not in care.**	4/1/09 - 6/30/09
Task: 2	**Develop a methodology to quantify, measure, and rank disparities for specific populations/groups. *(Obtain technical assistance from Bureau of HIV/AIDS Epidemiology staff as needed.)***	7/1/09 – 10/31/09
Task: 3	**Prioritize access disparities among HIV-positive persons in Area 12.**	11/1/09 – 1/31/10
Task: 4	**Develop strategies to address and reduce at least 2 significant disparities within the Area, including the reduction of at least 1 system barrier within the Ryan White Part B service network.**	2/1/10 – 3/31/10
Task: 5	**Develop and initiate an implementation plan to reduce the disparities identified in tasks 3 and 4.**	4/1/10 – 6/30/10
Task: 6	**Implement strategies, educate providers and raise community awareness about new activities *(Including at least one cultural competency training opportunity for providers).***	7/1/10 – 3/31/11
Task 7	**Review results, evaluate, and implement changes as needed to assure effectiveness of strategies.**	4/1/11 – 3/31/12

Section 3 How will we get there: How does our system need to change to assure availability and accessibility to core services?

Table 3

Goal #3:	**Coordinate the provision of Patient Care services with programs for HIV Prevention, Substance Abuse Treatment, Mental Health Counseling, and Treatment Adherence services.**	
Objective A:	**Consolidate all existing/available HIV/AIDS Patient Care and Prevention services directories into a single comprehensive directory of services for all persons who are HIV-infected or at high risk of HIV transmission.**	
Estimated impact:	**Clients: Directories will be available for all 1,500 PLWHA's in Area 12 as well as an unknown number of persons at *high-risk*.**	**Services: All available HIV/AIDS Patient Care, Prevention, and Support services will be included in the comprehensive directory.**

	TASK REQUIRED TO ACCOMPLISH THE ABOVE OBJECTIVE	TARGET DATE
Task: 1	**Review and update existing directory entries/information from all available sources.**	**4/1/09 – 9/30/09**
Task: 2	**Compile updated information and organize into a user-friendly directory format.**	**10/1/09 – 12/31/09**
Task: 3	**Produce and distribute comprehensive directory to all HIV/AIDS service providers and partners.**	**1/1/10 – 3/31/10**
Task: 4	**Review and update directory information as needed.**	**4/1/10 – 3/31/12**

Table 4

Goal #3:	**Coordinate the provision of Patient Care services with programs for HIV Prevention, Substance Abuse Treatment, Mental Health Counseling, and Treatment Adherence services.**	
Objective B:	**Increase the proportion of PLWHA who access and utilize Mental Health Counseling and/or Substance Abuse Treatment services along with Primary Medical Care in Area 12.**	
Estimated impact:	**Clients: National estimates indicate approximately 40% of PLWHA (n=600 in Area 12) use substances that lead to risky behavior; statewide survey results show 34% of enrolled clients (n= 244 in Area 12) reporting substance use, including 13% who report trading sex for drugs.**	**Services: Increased utilization of Mental Health Counseling and Substance Abuse Treatment**
	TASK REQUIRED TO ACCOMPLISH THE ABOVE OBJECTIVE	**TARGET DATE**
Task: 1	**Obtain and review local and baseline data regarding substance abuse rates among PLWHA.**	**4/1/10 – 6/30/10**
Task: 2	**Survey enrolled PLWHA who access Wellness Assessment services regarding their substance use and mental health needs, their likelihood to utilize available counseling services, and potential barriers to entering counseling/treatment.**	**7/1/10 – 12/31/10**
Task: 3	**Assess and prioritize local needs and barriers surrounding mental health and substance abuse (MH/SA) treatment services for Area PLWHA.**	**1/1/11 – 3/31/11**
Task: 4	**Develop and implement collaborative strategies to address barriers to accessing MH/SA.**	**4/1/11 – 9/30/11**
Task: 5	**Evaluate success and develop/implement strategy revisions as needed.**	**10/1/11 – 3/31/12**

Section 3 HOW WILL WE GET THERE:

HOW DOES OUR SYSTEM NEED TO CHANGE TO ASSURE AVAILABILITY AND ACCESSIBILITY TO CORE SERVICES?

The remaining goals (a.k.a. strategies) presented by both the U.S. Health Resources and Services Administration (HRSA) and the Florida Department of Health, Bureau of HIV/AIDS will be addressed by the Area 12 consortia as they relate to the region's primary local goals (identified in the preceding tables). A brief description is given below for each of the remaining strategies indicating how they may be integrated into the existing goals, objectives, and tasks for 2009-2012.

Goal 4 Coordinate the provisions of services with programs for the prevention and treatment of substance abuse.

Goal 3, Objective B is intended to increase utilization of Substance Abuse treatment services.

Goal 5 Address adherence initiatives.

A guideline has been established in Area 12 requiring that all newly diagnosed PLWHA as well as any client initiating/changing to a new antiretroviral regimen be referred to the contracted Treatment Adherence Services provider for assessment and follow-up as needed.

Goal 6 Minority AIDS Initiative (issues of minority access and disparity in the area).

Goal 2 addresses access disparities among minority populations in Area 12.

Goal 7 Program coordination and linkages between Parts A, B, C, D and AETC.

Area 12 does not qualify for Ryan White Parts A, C, or D based on current epidemiologic data/findings. At least 1 service provider in Area 12 is a Part C and Part D contracted provider in a neighboring EMA Area, and participates on the planning consortia. Additionally, AETC regularly provides education, monitoring assistance, and support to Area 12 providers.

Goal 8 Build capacity in your area.

Capacity building and technical assistance are provided by the Ryan White Lead Agency and the Florida Bureau of HIV/AIDS as needed. Goal 1 will likely incorporate strategies to increase capacity for the entire service network (among priority services as identified through assessment); and Goal 2 includes a provision to provide at least one cultural competency educational opportunity for providers.