



# MIAMI-DADE HIV/AIDS PARTNERSHIP

## Comprehensive Plan for HIV/AIDS 2009-2011



*This Comprehensive Plan has been paid for with federal funds received under Part A of the Ryan White HIV/AIDS Treatment Modernization Act of 2006 from the United States Health Resources and Services Administration and with assistance from the Miami-Dade County Office of Grants Coordination.*



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# **Miami-Dade HIV/AIDS Partnership 2009-2011 Comprehensive Plan for HIV/AIDS Executive Summary**

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## **Introduction**

The Miami-Dade HIV/AIDS Partnership (Partnership) is responsible for preparing a comprehensive plan for the delivery of HIV/AIDS related care, treatment and support services in Miami-Dade County. The cooperation and collaboration of People Living With HIV/AIDS (PLWHA), service providers, health care planners and other key stakeholders is integral to these planning activities.

The mission statement of the Partnership is to eliminate disparities and improve health outcomes for all people living with or at risk for HIV/AIDS. People living with HIV/AIDS face medical, psychosocial and other challenges that require optimal health service delivery. Today, HIV/AIDS affects approximately 46 out of every 100,000 people living and working in the county.

Through the Miami-Dade County 2009-2011 Comprehensive Plan for HIV/AIDS (Plan), the Partnership seeks to address and monitor key areas of concern for PLWHA, including eliminating barriers to service, raising the quality of care and treatment services, increasing access to resources and tracking legislative and regulatory changes that impact clients and the service system. The 2009-2011 Plan is modeled after the 2006-2008 Plan which successfully guided the Partnership through its designated goals and objectives.

The Plan reflects the Partnership's commitment to evidence-based planning and service delivery. This document is a compilation of information and data gathered over the period of 2007 and 2008, including analysis of annual needs assessment and consumer survey data, and focus group, community forum and Partnership committee input. The Plan also updates HIV/AIDS trend data and service system information published in the 2006-2008 Comprehensive Plan. Finally, the Plan describes the goals, objectives, activities and measures of success for the next three years.

## **Comprehensive Plan Goals, Objectives and Activities**

### **Goal 1: Eliminate barriers to care and treatment to ensure all PLWHA are in care**

Objective 1.1: Improve collaboration among HIV/AIDS providers across the continuum of care

- Identify gaps and needs for collaboration in the HIV/AIDS provider community
- Create and implement strategies for sustained provider collaboration
- Plan and deliver seminars on referrals and eligibility screening
- Develop and administer a survey to identify each Part A provider's referral process

- Facilitate linkages and enhance collaboration between outreach providers and non-outreach providers to assure client retention in care

Objective 1.2: Improve collaboration among funding sources across the continuum of care

- Create and implement strategies for enhanced collaboration among all funding sources
- Streamline and simplify screens in SDIS
- Create and implement strategies for data sharing agreement with ADAP

Objective 1.3: Improve linkages between key points of entry and the continuum of care

- Key Points of Entry Survey is developed and administered to identify gaps in linkages, especially between the key points of entry, medical case management, and the HIV/AIDS service system
- Support the design of improved linkages, including the development of protocols, as needed, for areas identified in the key points of entry analysis

Objective 1.4: Improve effectiveness of outreach programs

- Conduct a systematic survey of outreach programs in Miami-Dade County and other EMAs to develop an enhancement and training program for Part A outreach workers and their organizations
- Ongoing monitoring of outreach activity reports for effective linkage to care
- Support the delivery of enhanced training to outreach workers and provider agencies to facilitate the implementation of outreach for retention in care

**Goal 2: Raise and standardize quality of care and service delivery to improve health outcomes**

Objective 2.1: Improve the quality of customer service in the HIV/AIDS system of care

- Review Client Satisfaction Survey results and survey tool
- Identify needs for customer service improvement through annual Client Satisfaction Survey
- Develop and promote training of the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care with a focus on areas identified as needing improvement
- Develop and promote training in customer service with a focus on areas identified as needing improvement

Objective 2.2: Improve the delivery of medical case management services

- Require attendance at monthly medical case management trainings
- Provide technical assistance, as required based on record reviews, and as requested by agencies

- Develop and promote methods to improve the quality and amount of medical case management supervision, and clarify supervisory responsibilities
- Comply with hours of service as indicated in the Miami-Dade County Ryan White Part A Program System-wide Standards of Care

**Goal 3: Increase the quantity and maximize the effectiveness of resources for care, treatment and prevention of HIV/AIDS**

Objective 3.1: Facilitate improvements in substance abuse treatment for PLWHA

- Improve coordination and collaboration between Part A funded providers and other community resources to assure PLWHA in need of substance abuse treatment are efficiently connected to services
- Increase coordination between substance abuse providers and medical case managers
- Improve compliance with service delivery guidelines for linkages and referrals to assure residential substance abuse treatment clients are connected to outpatient substance abuse treatment or appropriate medical care upon discharge
- Establish reasonable follow up guidelines for residential substance abuse providers referring clients to outpatient counseling
- Publicize through SDIS available residential substance abuse slots

Objective 3.2: Leverage non-Ryan White funding for PLWHA

- Identify funding resources, public and private, that are available for PLWHA and service providers
- Promote optimization of non-Ryan White funds for PLWHA and service providers as available
- Monitor eligibility screening to assure Ryan White funds are used appropriately
- Support Ryan White grantees in creating policies that award extra application points for providers that leverage outside funding for HIV/AIDS related services
- Maximize cooperation with the City of Miami and the HOPWA Program
- Support and promote transitional housing for formerly incarcerated PLWHA reentering Miami-Dade County

Objective 3.3: Promote improved knowledge of the HIV/AIDS continuum of care

- Increase availability of information on HIV/AIDS resources to PLWHA, HIV/AIDS service providers and the general community
- Facilitate training for consumers on patient rights and responsibilities, grievance procedures and the service provider system

## **Goal 4: Respond in a timely and effective manner to changes in the epidemic**

Objective 4.1: Continue to monitor trends and publish an Annual Report on the epidemic

- Develop a simple, easy-to-understand report to communicate trends in incidence and changes in utilization patterns in various formats and in various settings (forums, focus groups, training sessions, etc.)

Objective 4.2: Educate legislators and other officials about HIV/AIDS-related issues

- Develop a legislative education packet

Objective 4.3: Allocate and reallocate resources to populations and services with emerging needs

- Support efforts to tie funding to subgroups and geographic areas that have the most severe need
- Support and promote improved access to resources and capacity building in South Dade, specifically for medical providers

Objective 4.4: Use education and communication to prepare providers for changes in the epidemic

- Update current information on an ongoing basis related to epidemiology, updates in treatment regulation, legal challenges, entitlement programs, insurance issues and demographic shifts within the EMA

## **Conclusion**

The entire community will have to participate in making this plan a success, and all stakeholders will be involved in evaluation and measurement of progress activities. The Miami-Dade HIV/AIDS Partnership will take the lead in collecting information and measuring results. In addition, the Partnership and its committees, particularly the Strategic Planning Committee, assume responsibility for monitoring and measuring specific activities. Periodic provider forums will also be used as a means to monitor and measure implementation.

For the past three years, the Partnership's Strategic Planning Committee has worked to guide the implementation of the Plan goals and objectives and will continue to do so in the future. The committee strives to maintain representation from key stakeholders and consumers from the community and works closely with other standing committees of the Partnership.

The Continuous Quality Improvement Program will continue to measure quality and outcomes in the system and provide feedback to the Partnership and committees. The annual needs assessment process will also gather data on how the plan is progressing.

Regular reporting on the progress, successes and challenges arising from the work of achieving these goals will continue to be part of the Partnership's activities throughout the next three years.

# Preface

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The Miami-Dade HIV/AIDS Partnership (Partnership) is responsible for conducting needs assessment activities and preparing a comprehensive plan for the delivery of HIV/AIDS-related care, treatment, and supportive services in the Miami-Dade County Eligible Metropolitan Area (EMA). The cooperation and collaboration of consumers, service providers, health care planners, and other key stakeholders is integral to these planning activities.

People living with HIV/AIDS face medical, psychosocial, and other challenges that require optimal health service delivery. The mission of the Partnership is to eliminate disparities and improve health outcomes for all people living with or at risk for HIV/AIDS in Miami-Dade County. The Partnership's mission also includes education and enhanced availability of information on HIV/AIDS disease, Miami-Dade County's Continuum of Care, and on the needs of those living with the disease. Today, HIV/AIDS affects 46 out of every 100,000 persons living in the County. The Partnership's goal is to expand the number of strategies and approaches used to identify and create access to service for those persons infected and affected by HIV/AIDS. Integration of cost effective treatment strategies along with appropriate social and support service access is possible when the scope of HIV/AIDS-related issues is defined and understood and the impact is measured and evaluated. This plan, using "data for action" was identified and created by interested stakeholders, practitioners, funders, educators, policy-makers, and consumer advocates and aims to provide new tools for ameliorating identified problems and issues.

The 2009-2011 Comprehensive Plan (Plan) for HIV/AIDS is divided into six sections. Beginning with a description of the current state of the epidemic, the Plan identifies the capacity of the EMA's medical and service delivery system to meet the needs of the population in general and specifically for persons living with HIV/AIDS. Next it identifies service gaps and barriers and the complexities associated with recent trends seen in HIV/AIDS demographic shifts. Finally, the Plan describes the goals, objectives, action plans, and outcome measures for the next three years.

## Guide to Readers

There will be many readers of this Plan, and it will be used for various purposes. Key users include service providers, planners, policy makers, and consumers. The Partnership will utilize the Plan to guide its decision-making related to annual prioritization and allocation processes over the next three years. Other stakeholders, such as service providers, may also use the Plan in the development, alteration, and enhancement of their service delivery planning. Elected officials represent another important constituency that may use this information. The Partnership has tried to ensure that the Plan satisfies federal requirements while also providing an important and useful resource for planning, service delivery, and evaluation.

It is important to note that this Plan, which focuses on HIV care and treatment, coordinates with the State of Florida's Statewide Coordinated Statement of Need and the State of Florida

HIV/AIDS Patient Care Resource Section's Statewide Comprehensive Plan for 2006-2009, as well as the City of Miami's Consolidated Plan for Fiscal Years 2004-2009, as it relates to the Housing Opportunities for Persons living with AIDS (HOPWA) Program. Key stakeholders from both the Partnership and the Miami-Dade County Department of Health (DOH) worked collaboratively to develop and implement the community planning processes.

### Key Points

The 2009-2011 Comprehensive Plan is a product of the Miami-Dade HIV/AIDS Partnership and reflects the Partnership's commitment to evidence-based planning and service delivery.

This document is a compilation of information and data gathered over the period of 2006 through 2008. Discussion of the epidemic is based on epidemiological data provided by the Florida Department of Health's (DOH) HIV/AIDS Surveillance Program. Data is current through December of 2007.

### What it is . . .

Through its planning process, the Partnership was able to assess the community for gaps in the system, quantify unmet service needs, identify access issues, and hear from stakeholders in the community on all of these issues. This document:

- summarizes the epidemic and the populations impacted
- presents a quick view of the Ryan White Part A Program client population
- outlines medical and social services available or still needed
- describes funding sources
- identifies gaps in the system and highlights barriers across PLWHA subpopulations
- gives voice to consumer and community concerns
- provides the roadmap for the Plan and its implementation and evaluation

### Glossary

This document generally uses the descriptor "HIV/AIDS" to represent the entire spectrum of the disease, from infection to the clinical diagnosis/definition of AIDS. For purposes of its annual needs assessment and throughout this document, the Partnership uses the following ethnic identifiers and abbreviations:

#### Ethnic identifiers

- Black = African American, Caribbean Islanders
- Haitian = Part of the Black population, but addressed separately when possible
- Hispanic = White and Black persons who identify as Hispanic
- White = Whites who do not identify as Hispanic

#### Abbreviations

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|---|--|
| <ul style="list-style-type: none"> <li>▪ ADAP = AIDS Drug Assistance Program</li> <li>▪ BSR = Behavioral Science Research</li> <li>▪ CQI = Continuous Quality Improvement Program</li> <li>▪ DHHS = Department of Health and Human Services</li> <li>▪ DOH = Department of Health</li> <li>▪ EMA = Eligible Metropolitan Area (locally, Miami-Dade County)</li> <li>▪ FPL = Federal Poverty Level</li> <li>▪ FQHC = Federally Qualified Health Centers</li> <li>▪ FY = Fiscal Year</li> <li>▪ GR = General Revenue</li> <li>▪ HARS = HIV/AIDS Reporting System</li> </ul> | <ul style="list-style-type: none"> <li>▪ HOPWA = Housing Opportunities for Persons with AIDS Program</li> <li>▪ HRSA = Health Resources and Services Administration</li> <li>▪ IDU = Injection drug use</li> <li>▪ MSM = Men Who Have Sex With Men</li> <li>▪ PHT = Public Health Trust</li> <li>▪ PLWHA = People Living With HIV/AIDS</li> <li>▪ PLWH = People Living With HIV</li> <li>▪ PLWA = People Living With AIDS</li> <li>▪ STI = Sexually Transmitted Infections</li> <li>▪ TGA = Transitional Grant Area</li> </ul> |
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# Section 1

## The HIV/AIDS Epidemic in Miami-Dade County

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### **A. Context of the Epidemic: Miami-Dade County EMA**

Miami-Dade County, at the southeastern tip of the Florida peninsula, is 2,000 square miles in area, 90 miles in length and contains 35 municipalities, suburbs, and rural areas. The population continues to increase and new immigrants continue to arrive in Miami. Geography is a challenge in the County: it is very large, and distances are great from north to south and east to west. In addition to being a major center of banking and tourism, the County is one of the nation's largest growers of vegetables and employers of migrant workers.

Miami-Dade County is racially and ethnically diverse. Of its 2.4 million residents, 62% are Hispanic, 16% are White, and 20% are Black (African American, Haitian and Caribbean). Closer examination of these broad categories reveals even more diversity, including people from every Latin American nation, Haiti and other Caribbean islands, as well as from other parts of the world. More than half (53%) of the population was born in other countries. The undocumented population is estimated at about 225,000 persons.

Miami-Dade County has one of the highest rates of uninsured in the nation. Twenty-five percent of the population under 65 is uninsured, well above Florida's average of 19% (Health Council of South Florida, Inc., *Strategic Plan 2008-2011, 2008*) and the national average of 18% (National Coalition on Health Care, *Facts on Health Insurance Coverage, 2007*).

Among large metropolitan areas in the United States, Miami-Dade County is ranked third highest in inequitable distribution of income. 2006 Census data indicate 16% of EMA residents and 27% of the City of Miami's residents live below the Federal Poverty Level (FPL). These rates are significantly higher than the State average of 12% living below the FPL. Per capita income is \$23,882 compared to approximately \$27,867 for Florida, (Health Council of South Florida, Inc., *Strategic Plan 2008-2011, 2008*). Twenty-six percent of Blacks have incomes well below the FPL, compared to 16% of Hispanics and 13% of Whites. Thus, although the County has a well-developed system of care, the poor, uninsured and underinsured face significant challenges in accessing care.

The health services infrastructure in Miami-Dade County is large and varied. It includes a medical school, a major public hospital and teaching institution, a Veterans Administration medical center, and more than thirty hospitals. It has more physicians per capita than the nation as a whole as well as a network of community-based clinics that serve the poor. Medical care costs are higher in the EMA than in many other cities, and the supply of primary care and safety net physicians and other medical staff appears to be strained.

## **B. Overall Impact and Projections**

### **B.1. Incidence**

According to the Centers for Disease Control and Prevention (CDC), Miami-Dade County was the Statistical Metropolitan Area with the highest rate of reported AIDS cases in 2004 (64.6/100,000), 2005 (52.3/100,000) and 2006 (48.5/100,000), the last year for which this data was available. **Table 1** shows AIDS incidence for 2006 and 2007 combined, total AIDS prevalence, and HIV (regardless of AIDS) prevalence through December 31, 2007. Florida is in the process of implementing an Electronic Laboratory Reporting (ELR) system as mandated by the Florida Legislature in November of 2006. Implementation of the ELR is in its infancy and has caused significant fluctuations in the numbers of newly diagnosed cases of HIV and AIDS from 2006 to 2007 for the County and throughout the State. Nevertheless, Miami-Dade reported a total of 1,953 new AIDS cases in 2006-2007 and 2,659 new HIV (regardless of AIDS) cases. The Florida Department of Health (DOH) HIV/AIDS Surveillance Program reports the number of people living with AIDS (prevalence) in Miami-Dade County as 12,528 and those living with HIV as 10,345. The combined total of those living with HIV/AIDS in the EMA is 22,873 persons. Figures for both incidence and prevalence represent minimal numbers with no adjustments for those diagnosed but not reported or those infected, but undiagnosed and unaware of their HIV status.

Incident AIDS cases reported in 2006 and 2007 totaled 1,150 and 803, respectively. According to the State DOH, the 30% drop in reported AIDS cases is an artifact of reporting and is not to be interpreted as a trend. Despite the atypical numbers reported in 2007, the proportions of incident AIDS cases remain markedly constant across race/ethnicity, gender, and age categories when compared to the prior reporting period, 2005-2006. Newly diagnosed cases of HIV (regardless of AIDS) rose almost 24% from 2006 to 2007, from 1,188 to 1,471, respectively. These numbers may reflect cases of HIV diagnosed prior to mandatory HIV name reporting, (established in July 1997), who are in care and are now being reported via the ELR system which reports CD4 counts and detectable Viral Loads.

**Table I  
AIDS Incidence, AIDS Prevalence and HIV (Non-AIDS) Prevalence, Miami-Dade County**

Demographic Characteristics and Exposure Categories <b>Note: RISKS REDISTRIBUTED</b>	AIDS Incidence in 2006 - 2007		AIDS Prevalence through 12/31/07 as of 04/15/08		HIV (non-AIDS) Prevalence through 12/31/07 as of 04/15/08		Total AIDS and HIV (non-AIDS) Prevalence through 12/31/07 as of 04/15/08	
	#	% of Total	#	% of Total	#	% of Total	#	% of Total
<b>Race/Ethnicity</b>								
White, not Hispanic	186	10%	1,546	13%	1,434	14%	2,980	13%
Black, not Hispanic	1,073	55%	6,121	49%	4,851	47%	10,972	48%
Hispanic	664	34%	4,680	37%	3,948	38%	8,628	38%
Asian/Pacific Islander	2	<1%	12	<1%	14	<1%	26	<1%
American Indian/Alaskan Native	0	0%	1	<1%	4	<1%	5	<1%
Not Specified/Other	28	1%	168	1%	94	1%	262	1%
<b>Total:</b>	1,953	100%	12,528	100%	10,345	100%	22,873	100%
<b>Gender</b>								
Male	1,280	66%	8,888	71%	7,055	68%	15,943	70%
Female	673	34%	3,640	29%	3,290	32%	6,930	30%
<b>Total:</b>	1,953	100%	12,528	100%	10,345	100%	22,873	100%
<b>Age at Diagnosis (Incidence)/ Current Age (Prevalence)</b>								
0-12 years	8	<1%	41	<1%	88	1%	129	<1%
13-19 years	34	2%	147	1%	137	1%	284	1%
20-29 years	249	13%	454	4%	1,220	12%	1,674	7%
30-44 years	890	45%	4,407	35%	4,777	46%	9,184	40%
45-59 years	640	33%	6,087	49%	3,371	33%	9,458	42%
60+ years	132	7%	1,392	11%	752	7%	2,144	9%
<b>Total:</b>	1,953	100%	12,528	100%	10,345	100%	22,873	100%
<b>Adult/Adolescent Exposure Category (Risks Redistributed)</b>								
MSM	746	38%	5,553	44%	4,723	46%	10,275	45%
IDU	187	10%	1,463	12%	738	7%	2,201	10%
MSM/IDU	73	4%	447	4%	238	2%	685	3%
Heterosexual	921	47%	4,786	38%	4,462	43%	9,248	41%
Other	18	1%	238	2%	96	1%	335	1%
<b>Total Adult:</b>	1,945	100%	12,487	100%	10,257	100%	22,744	100%
<b>Pediatric (0-12) Exposure Category</b>								
Mother with/at risk for HIV infection	8	100%	40	98%	86	98%	126	98%
Risk not reported/Other	0	0%	1	2%	2	2%	3	2%
<b>Total Pediatric:</b>	8	100%	41	100%	88	100%	129	100%
<b>Total Risk Category:</b>	1,953	100%	12,528	100%	10,345	100%	22,873	100%

<sup>1</sup> HARS = HIV/AIDS Reporting System

<sup>2</sup> DOC = Department of Corrections

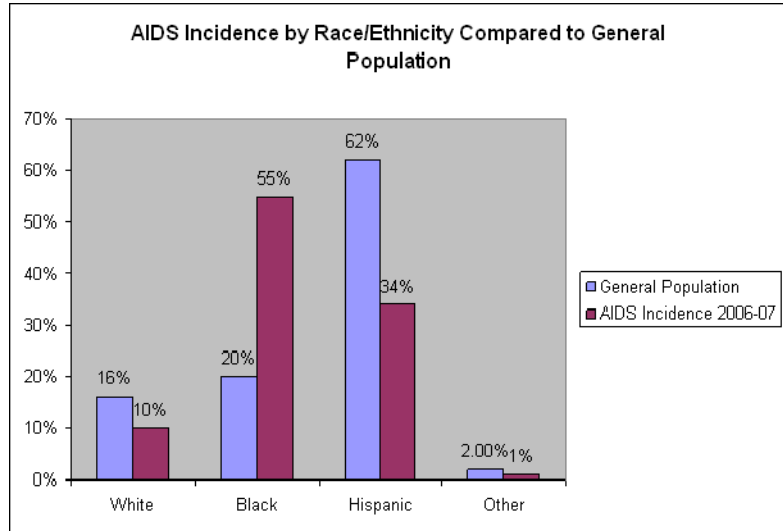
**Note:** In November 2006, the Florida Legislature mandated Electronic Laboratory Reporting (ELR) for all HIV-related CD4 and Viral Load tests, in addition to other forms of conventional surveillance reporting. The Department of Health (DOH) HIV/AIDS Surveillance Program is in the process of implementing an ELR system as the basis for reporting all newly reported cases of HIV and AIDS. The 2007 DOH statistics for new cases of HIV and AIDS in the Miami-Dade EMA depart radically from the incremental yearly changes reported for the last 24 years of mandated AIDS case reporting and the last 10.5 years of mandated HIV case reporting. The EMA's AIDS incidence plummeted 30.2% from 2006 to 2007 while HIV (non-AIDS) for the same period rose 23.8%. Similar atypical changes in 2007 incidence reporting occurred in other EMAs throughout the State and in all Florida counties. DOH has acknowledged these atypical statistics as artifacts in the reporting system, and expects these incongruities will resolve themselves during the next one to two years as the new ELR system is refined.

- **Race/Ethnicity**

In the County, while Blacks comprise 20% of the general population, they represent 55% of AIDS incidence, with a rate of 109/100,000 compared to an overall rate of 46/100,000. **Figure 1** compares AIDS incidence for 2006-2007 by race/ethnicity with the general makeup of the County population.

- **Exposure Category**

In 2007, heterosexual exposure replaced men who have sex with men (MSM) as the largest reported risk factor for incident AIDS cases in the EMA (47% of AIDS incidence in 2006-2007). Blacks, including Haitians and Caribbean Islanders, and Hispanics together account for 89% of the EMA's AIDS incidence in 2006-2007. Surveillance data show no recent change in the rate of AIDS cases



among women, who account for 34% of incident cases, although this is significantly higher than the 29% reported in 2003. AIDS incidence among Hispanics has remained relatively constant in the past few years and now comprises 34% of the total incidence. White incident AIDS cases have remained at 10% since 2004. In 2007, two pediatric AIDS cases were reported. Low pediatric transmission rates are largely the result of studies and interventions conducted by the University of Miami, such as HIV testing and counseling during pregnancy, use of antiretrovirals and other therapies, as well as access to early prenatal care.

## B.2. Prevalence

The HIV/AIDS epidemic disproportionately affects minority populations throughout the nation, and especially in the Miami-Dade County EMA. As **Table I** shows, 22,873 persons are reported to be living with HIV/AIDS in the EMA. Of this total, 12,528 are living with AIDS and 10,345 with HIV (non-AIDS). Of these totals, Blacks represent 48% and Hispanics 38% of the total HIV/AIDS prevalence; combined they represent 86% of total prevalence in the EMA.

- **Exposure Categories**

Men comprise 70% of reported living HIV/AIDS cases, and women 30% with this percentage slowly increasing over time as more women become infected. There have also been changes reported in modes of exposure. The chief exposure category for Persons Living with HIV/AIDS (PLWHA), continues to be MSM (45% of the total). However, heterosexual risk is the second highest exposure category (41% of the total), with 85% of females and 40% of males reporting a heterosexual risk factor. Injection drug use (IDU) as an exposure category has decreased slightly in the HIV/AIDS population, now accounting for 10% of HIV/AIDS prevalence although MSM/IDU cases have shown a slight increase from 3% to 4% of PLWHA.

MSM account for the largest single group (45%) living with HIV/AIDS in the County. According to local studies, there has been growth in the number of young people infected, particularly among MSM of color. According to the National Health Behavioral Study – MSM Cycle (FL DOH, July 2006), 16% of those interviewed were HIV positive. This includes 18% Whites, 12% Black MSM, and 19% “Other”. Men who have sex with men face some unique problems, including widespread methamphetamine abuse and continuing high rates of infectious Syphilis, Gonorrhea, and Hepatitis C. Use of crystal methamphetamine has reached epidemic proportions among gay and bisexual men, and recent studies have shown significantly higher rates of HIV, lower rates of condom use, and a decrease in safe sex behavior.

### **B.3. Deaths**

A total of 625 deaths were reported in 2007 compared to 727 deaths reported in 2006. Deaths declined in 2007 for males and females by 16% and 9%, respectively. Decreases occurred among all races/ethnicities in the EMA, although deaths among Blacks continue to account for a disproportionate (60%) share of the total deaths reported in 2007. The death rate decreased markedly for Hispanic MSM (29%) and for male Haitians (33%). Among women of childbearing age, deaths dropped for Black women by 17% and among Hispanic women by 18%. Deaths increased for White women of childbearing age, White male IDUs, and White and Black female IDUs. Among youths (ages 13-24), Hispanic male deaths rose from three in 2006 to 22 in 2007 and among Black female youth from one death in 2006 to 12 in 2007. AIDS remains the leading cause of death for Black men and women between the ages of 25 and 44. While death rates continue to drop, they remain highest for Black men, followed by Black women.

### **B.4. Trends**

Trends in both gender and exposure category are strongly indicative of the growing impact HIV/AIDS has had on the EMA’s Black community. Blacks, including Haitians and Caribbean Islanders, represent 49% of living AIDS cases and 47% of living HIV cases, although they represent only 20% of the total County population. Blacks also account for 48% of those living with HIV/AIDS. Among subpopulations, Haitians comprise 9% of incident HIV (non-AIDS) cases and 16% of AIDS prevalent cases, although they comprise only about 5% of the County population. Among Blacks, not only is drug use a significant issue but the reported “down low” practice (men who self-identify as heterosexual but have sex with multiple partners, male and female, and who may not disclose this to their sex partners) may be a significant risk factor for both males and females. A CDC study found that 24% of Black MSM identified as heterosexual compared with 6% of White MSM (MMWR. “HIV/STD risks in young MSM and do not disclose their sexual orientation, 1994-2000.” *CDC February 7, 2003/52(05); 81-85*). These men often do not perceive their practices to be risky since they do not consider their sexual practices to be homosexual in nature. Blacks comprise 72% of all PLWHA age 13 to 24 and 73% of infected women of childbearing age (age 15-44) are Black. The great majority (80%) of pediatric cases are among Black, non-Hispanic children.

The impact of HIV/AIDS on Hispanics in the EMA is relatively low compared with their proportion in the general population, although the impact is significant and represents a growing proportion of the infected population. While Hispanics account for 62% of the County’s population, they comprise 38% of PLWHA in 2007. Hispanic MSM are significantly affected, accounting for 23% of prevalent cases and 55% of MSM PLWHA. White, non-Hispanics (16%

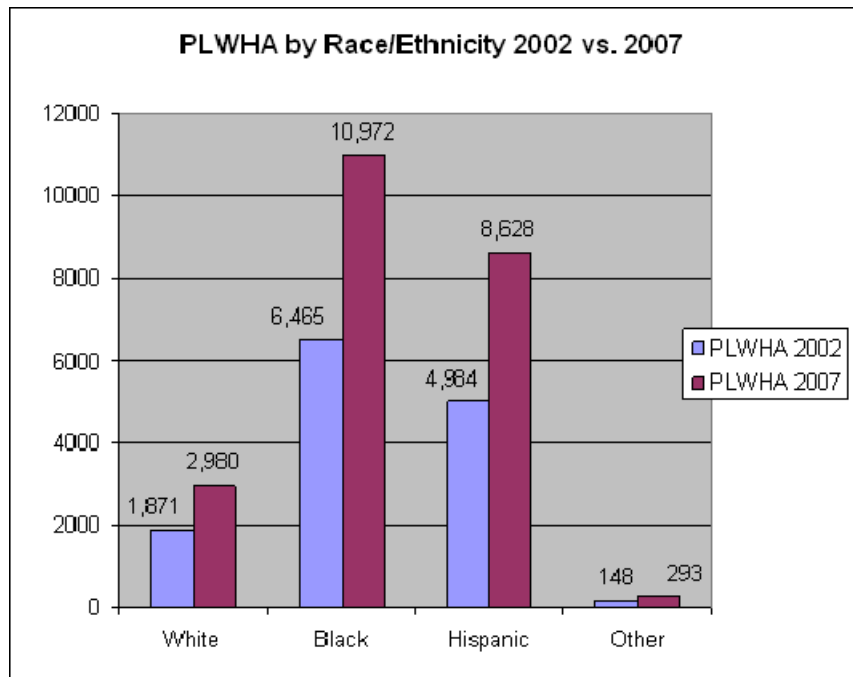
of the general population) have the lowest HIV/AIDS prevalence, accounting for 13% of prevalent HIV/AIDS cases.

The impact of HIV/AIDS on women has significantly increased over time. In 1992, women comprised 22% of AIDS cases. In 2007, they comprised 30% of PLWHA. The disease has disproportionately affected Black and Haitian females. These women accounted for 23% of new incident AIDS cases and 67% of all female AIDS cases reported in 2006-2007. Black and Haitian females account for 67% of all female PLWH and 57% of all female PLWA. Among Haitians, 42% of PLWA and 51% of PLWH are women. African American women comprise 38% of female PLWA and 49% of female PLWH. Women comprise only 16% of Hispanic PLWA and 11% of White (non-Hispanic) PLWA. Young women continue to be at risk; 54% of PLWA age 13 to 24 are females. Eighty percent of females report infection through heterosexual contact.

HIV/AIDS transmission categories follow different patterns among racial/ethnic populations in this EMA. Heterosexual sex is the predominant mode of exposure among Blacks, particularly women. By contrast, HIV/AIDS in the Hispanic and White (non-Hispanic) populations is still mainly seen among MSM. While MSM still comprise the majority of PLWHA (45%), heterosexual risk factor is now the prevailing factor reported for AIDS incidence (47%) and among prevalent cases of PLWHA, heterosexual transmission has risen to 41%.

Figure 2

Although all segments of Miami Dade County's diverse population are affected, HIV/AIDS disproportionately affects certain disadvantaged minority communities in the County. Of the more than 22,000 residents living with the disease today, a disproportionate number also struggle with poverty, homelessness, substance abuse and unemployment. **Figure 2** compares the number of PLWHA by race/ethnicity in 2002 versus 2007.



## C. Overview of Ryan White Program Part A Clients

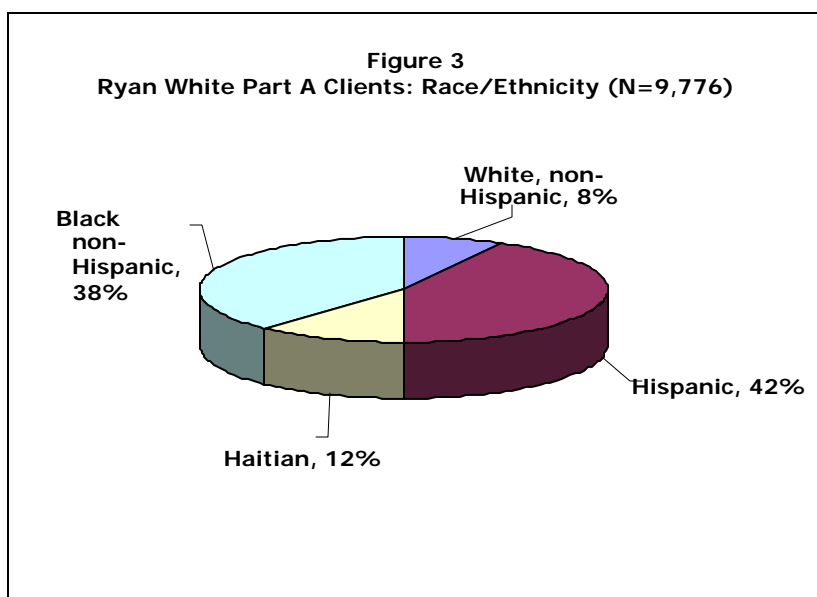
This section provides overall demographic and socio-economic characteristics of Ryan White Part A Program clients. The information provided comes from the Ryan White Part A Service Delivery Information System (SDIS), the centralized computer network system used by all Ryan White funded providers.

The Ryan White Part A Program served 9,826 clients in Fiscal Year 2007-2008, providing outpatient medical care to 7,237 unduplicated clients and medical case management to 7,850 unduplicated clients. Part A provided service to 42% of those living with HIV disease in Miami-Dade County.

### C.1. Ryan White Part A Program Data

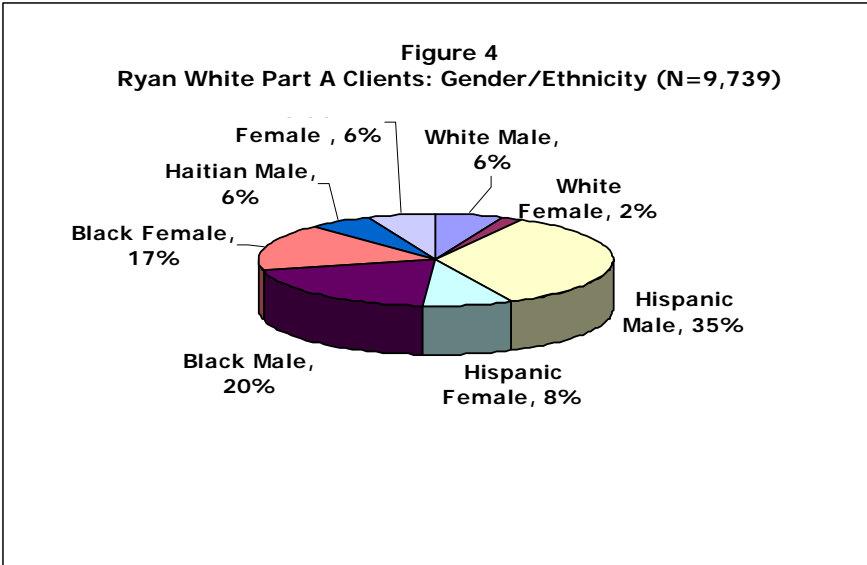
The majority of Part A clients are 30 years and older. Thirteen percent are between 25-34, 50% are between 35 and 49, 26% are between 50 and 64 and 3% are age 65 and older. The majority (67%) of Part A clients are male. This is similar to Miami-Dade County HIV statistics in which 71% of the PLWA are male, and 68% of PLWH are male.

**Figure 3** shows the percent distribution of clients by race/ethnicity. The largest group (50%) is Black (including Black, non-Hispanic and Haitian) 42% are Hispanic, and 8% are White, non-Hispanic. In the County population of PLWH (not AIDS), 47% are Black, 38% are Hispanic, and 14% are White. In the PLWA population, 49% are Black, 37% are Hispanic, and 12% are White.

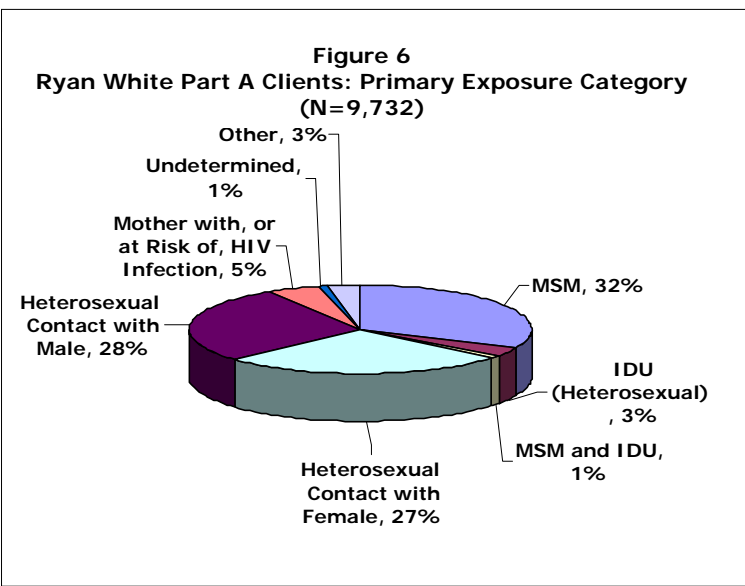
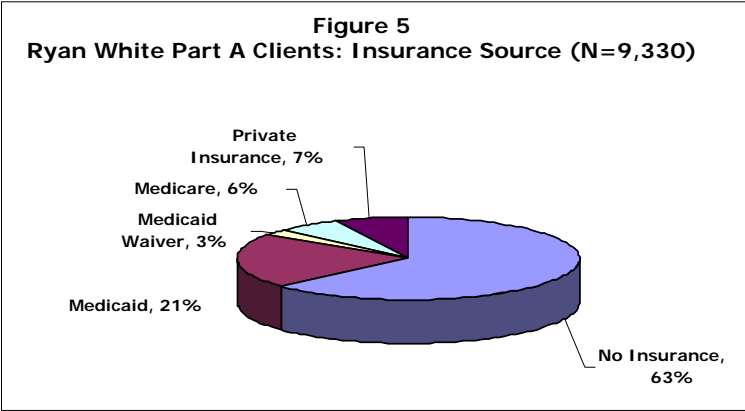


**Figure 4**, below, shows the distribution of Part A clients by ethnicity and gender. Hispanic males comprise the largest group (35%) followed by Black males (20%) and Black females (17%). This again confirms that the HIV/AIDS epidemic disproportionately affects minority populations and shows the relative impact of the epidemic on the Black population. Blacks, including Haitians, represent 48% of PLWHA and 50% of Part A clients, although Blacks only comprise 20% of the County population.

Income data for Part A clients indicate that 100% of clients report incomes at or below 300% of the FPL (income eligibility criteria to receive Part A services).

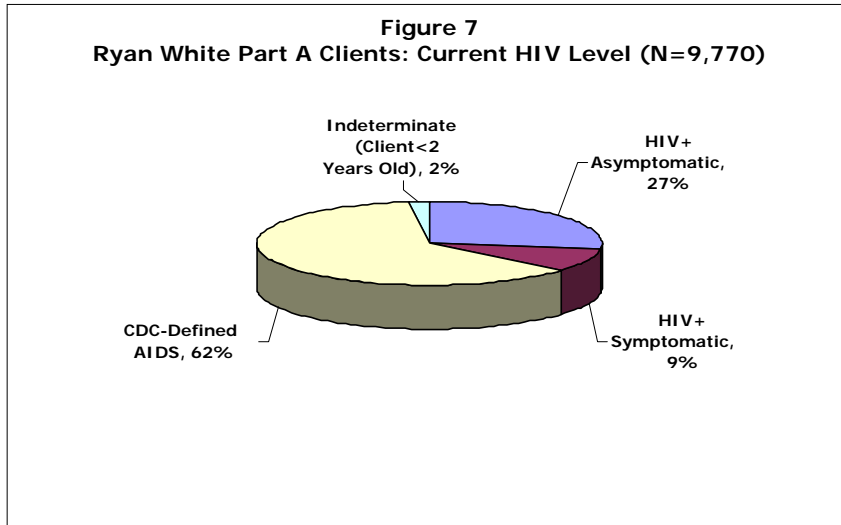


**Figure 5** illustrates the insurance status of Part A clients. The majority (63%) report that they have no insurance and 24% report having Medicaid, including Medicaid Waiver. Seven percent (7%) report having private insurance and 6% report being enrolled in Medicare.



**Figure 6** shows the primary HIV exposure of Part A Program clients. Over half, or 55% of all clients, report having the risk category of heterosexual exposure and 32% state MSM risk. Only 4% report being IDU; however, surveillance data indicate that the actual figure for IDU risk behavior is much higher but many do not want to reveal substance abuse to their doctor or medical case manager.

**Figure 7** shows the current HIV status of Part A Program clients. More than half (62%) have AIDS and another 9% have been symptomatic. Less than a third are HIV-asymptomatic. Thus, the Ryan White Part A Program population closely mirrors the population living with the disease, as shown in Table I earlier in this document.



The figures on the next three pages show geographic distribution of reported AIDS and HIV cases:

- **Figure 8** shows the geographic distribution of AIDS cases reported through 2007 in Miami-Dade County. The greatest occurrence is found in the zip code 33139, the southern end of Miami Beach, among White and Hispanic males. The predominately Black (including Haitian) neighborhoods of Liberty City (zip codes 33142 and 33147), have the next highest incidence of HIV/AIDS.
- **Figure 9** shows the geographic distribution of HIV cases reported through 2007 in Miami-Dade County. Similar to the AIDS distribution, the greatest HIV distribution is also found in the zip code 33139, followed by the northern part of the County, in Liberty City, Little Haiti, and Allapattah. A comparison of the two maps indicates some of the epidemic's movement in the County.
- **Figure 10** shows the geographic distribution of people living with HIV or AIDS (prevalence) through 2007.

Figure 8

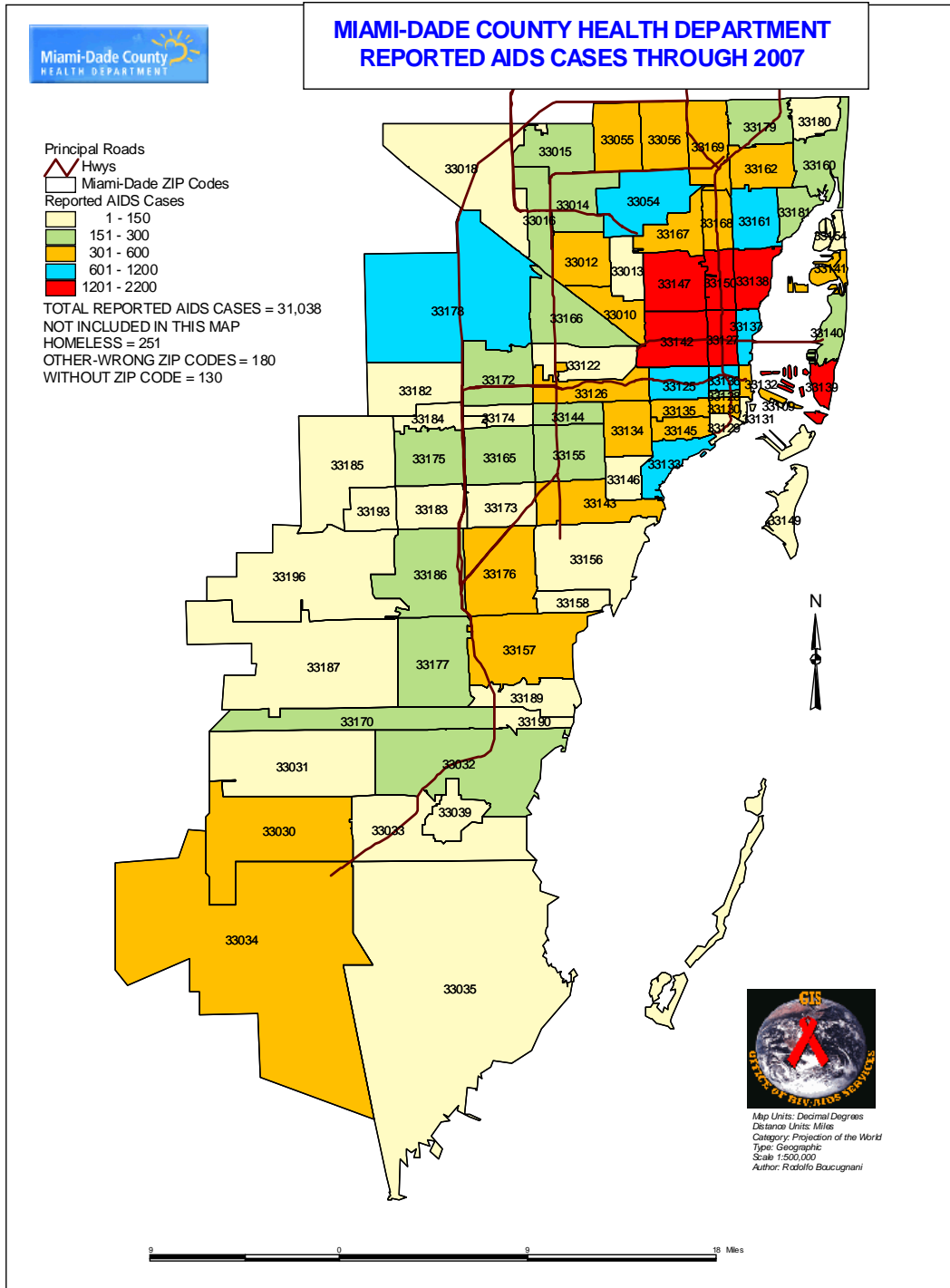


Figure 9

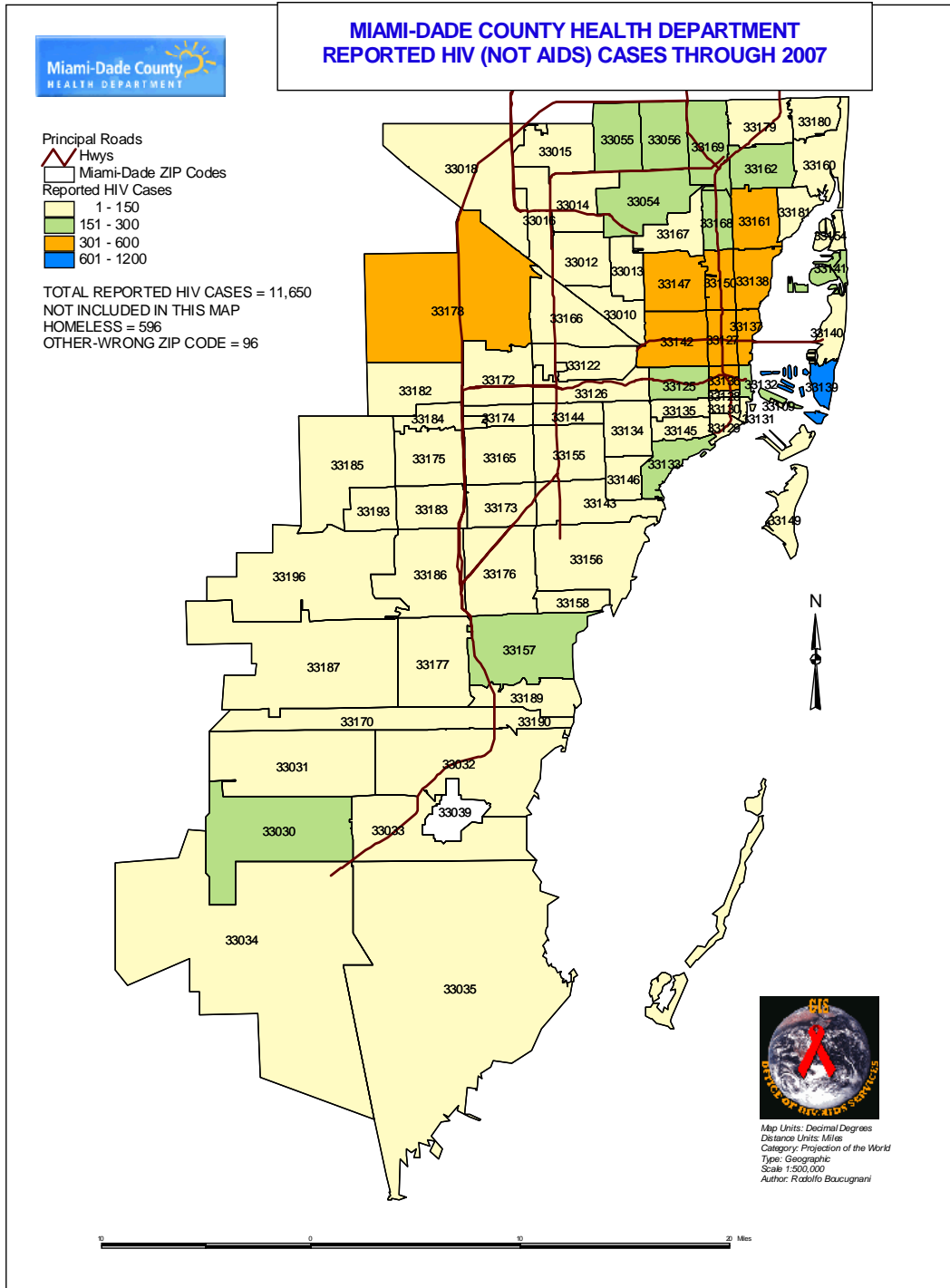
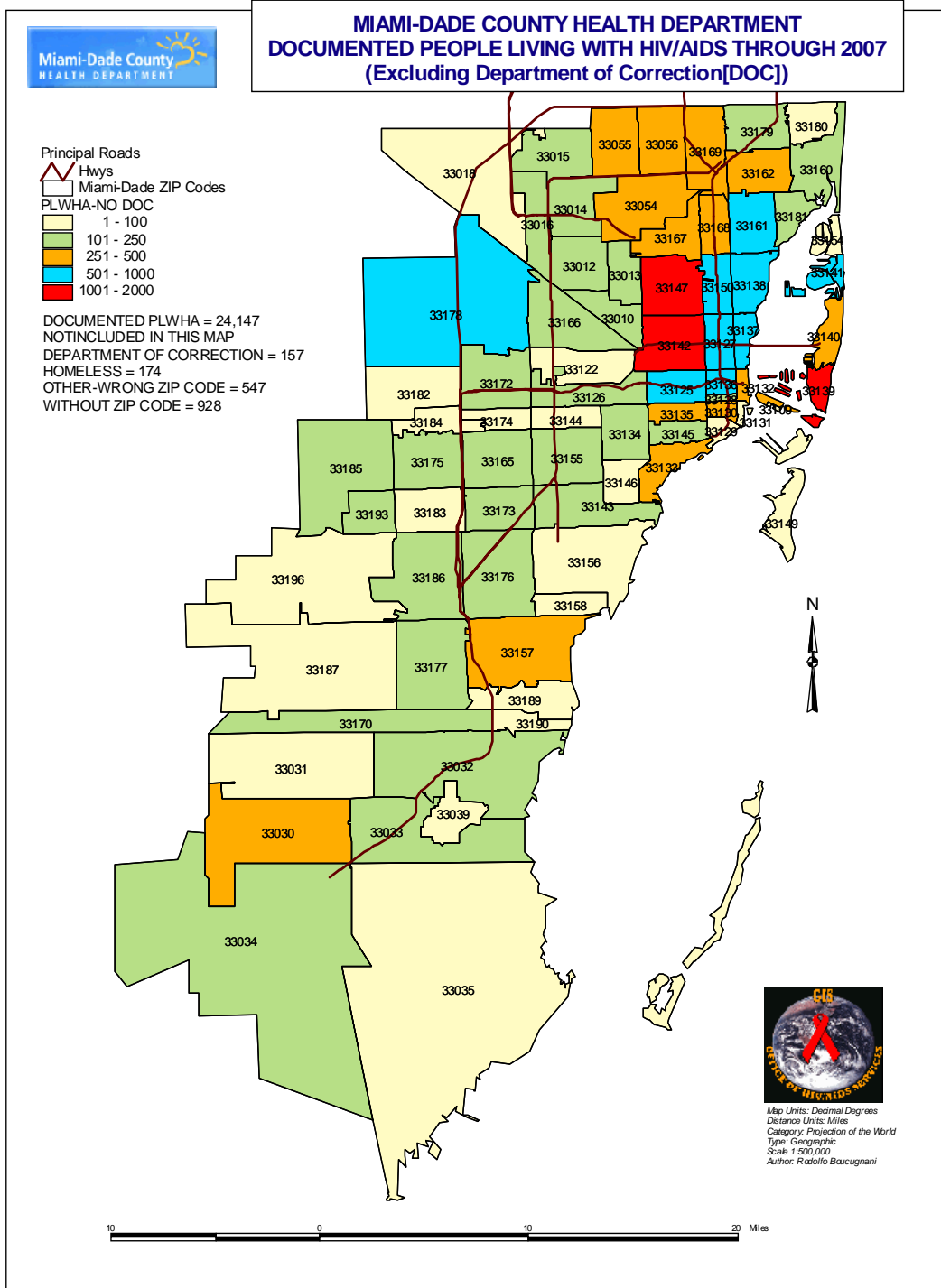


Figure 10



## Section 2

# Continuum of Care / Capacity for Service Delivery

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### Fast Facts

- PLWHA access core medical and social services via a broad delivery system
- Outpatient and inpatient care is broadly dispersed across the County
- Miami-Dade County has a safety net of 21 clinics for its most vulnerable residents, including PLWHA
- Language access barriers are low
- Ethnic composition of providers reflects population
- Medicaid is the largest HIV/AIDS payer in the County
- The Ryan White Part A program served 42% of reported PLWHA
- In 2007, \$244,558,448 million from multiple funding sources was spent on HIV/AIDS-related care in the County

### A. System-Wide and HIV/AIDS-Specific Infrastructure in 2007

Service delivery capacity is often measured by examining the supply and accessibility of services in the community. Supply limits are potential barriers to care, along with access and personal behavior barriers. Supply barriers mean there are insufficient services available to meet the need. Access barriers impede the ability of consumers to reach and use those services.

Core medical services for PLWHA are delivered through both the general healthcare delivery system and a specialized network of clinics and service providers focused on the most vulnerable populations in the County. Core medical services (as defined by HRSA and prioritized by the Partnership) for those living with HIV/AIDS include:

- Outpatient medical care
- Prescription drugs
- Medical case management
- Oral health care
- Mental health therapy
- Outpatient substance abuse treatment
- Insurance Services

#### A.1. Supply of Core Services: Physicians, Clinics, and Hospital Care

Several positive dynamics characterize the supply of health services in Miami-Dade County, and services for the indigent and HIV/AIDS populations, in particular. These include the fact that the composition of the physician population generally reflects the rich diversity of ethnic groups represented in the County. In addition, inpatient and outpatient services are broadly dispersed throughout the County. For PLWHA and other vulnerable populations, there are publicly-financed medical clinics located across the County.

- **Physician supply**

Miami-Dade County is one of the nation's richest areas in terms of medical infrastructure. The County's clinically active physician to population ratio is higher than the national average, and there is an oversupply of specialty physicians. The rich supply of physicians locally should mean there is no lack of physicians to treat the indigent. However, anecdotal evidence suggests that the supply of primary care physicians willing to treat the indigent may be more constrained than the supply indicates.

- **Community-based clinic supply**

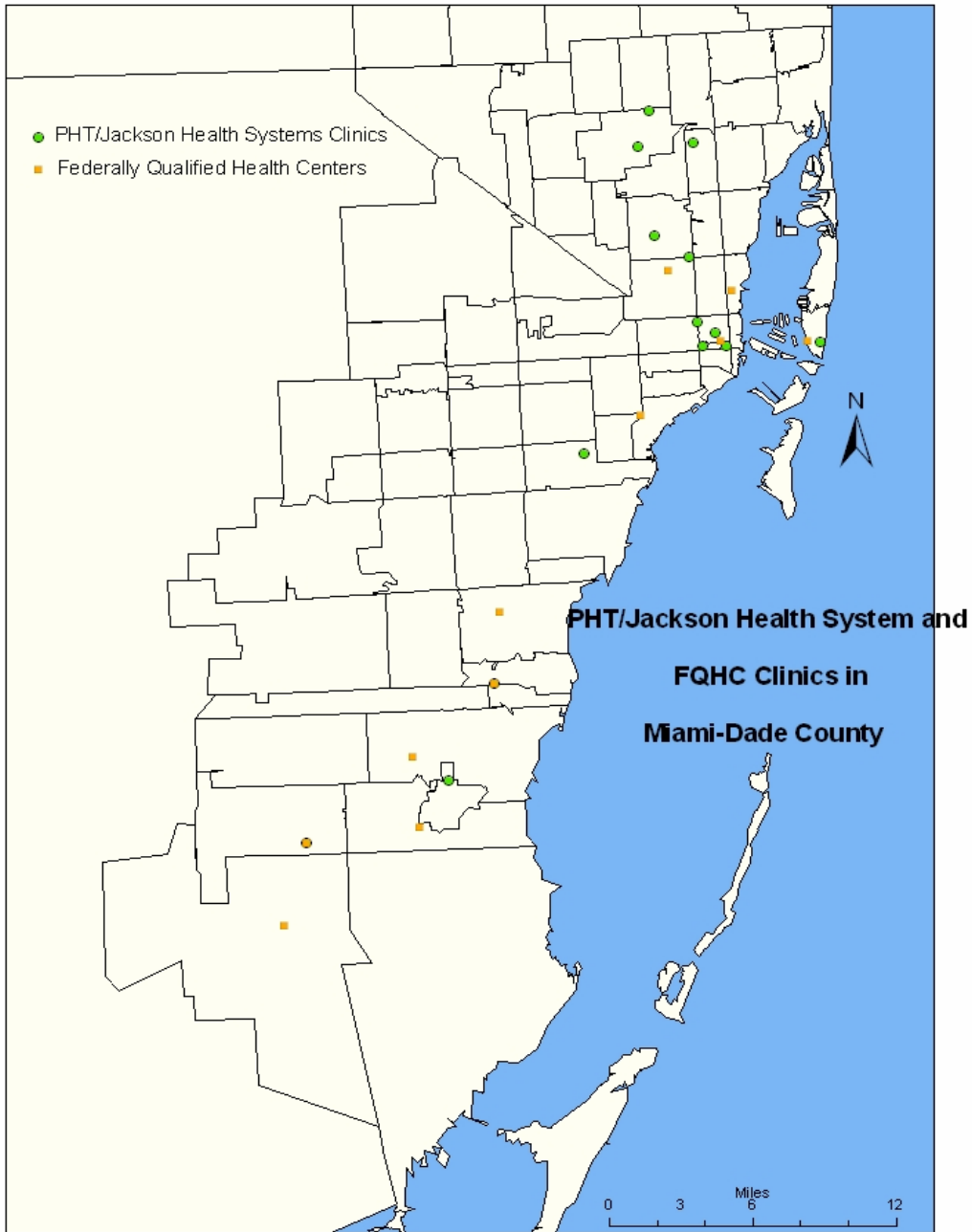
As noted in Section 1, the size and composition of the County pose several challenges. HIV/AIDS cases are concentrated in widely dispersed areas of the County such as the inner city, Miami Beach, and south Miami-Dade which is one of the nation's largest employers of migrant workers. This dispersion creates service delivery challenges, including transportation difficulties due to the EMA's size and lack of transportation infrastructure, particularly in the south and west portions of the County. Primary care services have been decentralized, although the west and south of the County remain underserved.

The County has a number of clinics designed to serve as a healthcare safety net for the poor and uninsured, including PLWHA. These facilities consist of 12 clinics operated by Miami-Dade County's Public Health Trust (PHT) as part of the Jackson Health System and seven FQHCs. The clinics supported by the PHT receive General Revenue (GR) funds from the PHT as well as from third party payers. Both PHT and the FQHCs usually receive funds from other sources, including Department of Health and Human Services (DHHS) programs such as Maternal and Child Health, Ryan White (all Parts), substance abuse, in addition to Medicaid and other commercial insurance sources.

The map in **Figure 11** shows the locations of the PHT/Jackson Health System clinics and the FQHCs which are located in medically underserved areas which are distributed throughout the County with the exception of west Miami-Dade County. The PHT provides management and financial support to the Doris Ison and Martin Luther King clinics of Community Health of South Florida, Inc. (CHI). The Miami Dade County FQHCs are:

- Camillus Health Concern
- Community Health of South Florida, Inc. (multiple sites)
- Jessie Trice Family Health Center
- Helen B. Bentley Family Health Center.
- Miami Beach Community Health Center
- Borinquen Health Care Center
- Citrus Health Network

Figure 11



- **Primary care availability for HIV/AIDS**

HIV/AIDS services are provided at many of the clinics discussed above. HIV/AIDS service providers are widely dispersed throughout the County in order to meet the challenges of the County's geography and diverse populations. The 14 clinics funded by the Ryan White Part A Program include all but one of the FQHCs, four of the PHT/Jackson Health System clinics and two major hospitals. In addition, several community-based HIV-specific clinics are supported in areas of the County with high infection rates.

Primary care is provided at two major hospitals: the University of Miami, which provides primary and specialty care physicians for the Jackson Memorial Hospital Special Immunology Clinic and outpatient clinics; and Mercy Hospital, which also provides primary and specialty care for PLWHA. The University of Miami, connected with Jackson Memorial Hospital, one of the nations' largest and best-known public hospitals, is the single largest provider of HIV care in the County. In addition to HIV specific primary care, adolescent care, and specialty care the University of Miami's Obstetric and Gynecology program treats virtually all HIV positive infants and children, as well as most pregnant women.

All major providers of HIV-related medical care participate in the federally funded Ryan White Part A program. In addition, a number of private physicians participate through contractual agreements with Ryan White-funded providers. In 2007, the Ryan White Part A Program, administered by Miami-Dade County, provided medical and support services to almost 10,000 HIV positive people. The program currently supports 14 medical care providers at approximately 40 locations. Providers range from the University of Miami Medical School and a large public teaching hospital to small community clinics, and include several FQHCs. Providers are located in the most highly affected areas of the County, including minority neighborhoods.

In addition to the Part A Program, the HIV/AIDS community receives services funded by Parts B, C, D and F. Part B supports the State AIDS Drug Assistance Program (ADAP), Part C supports Early Intervention services at five clinics, Part D supports maternal and child health care at the University of Miami Miller School of Medicine Obstetric and Gynecology clinic, and Part F supports oral health care services. Ryan White funds only outpatient services; inpatient services are supported by Medicaid, Medicare, State GR, County indigent care funds, and other payer sources.

## **A.2. Supply of Other HIV/AIDS Core Services**

- **Prescription drugs**

The local ADAP, operated by the Miami-Dade County Health Department, provided HIV/AIDS medications to approximately 3,335 people in 2007 through four dispensing pharmacies. In addition, the Ryan White Part A Program provides medications at six pharmacy locations and can deliver to the homebound, if medically indicated. The Part A drug formulary includes medications covered by the State ADAP as well as other drugs not available through ADAP. The Part A Program provided prescription medications to more than 3,000 PLWHA who were without other payer sources. The Part A Program financially assisted an additional 351 under-insured clients with pharmacy co-payments and insurance premium deductibles. State GR funds

provide medications at the Jackson Memorial Hospital pharmacy. Medicaid-funded prescription drugs are available throughout the County.

- **Oral health care**

Ryan White Part A funds oral health care for PLWHA at eight agencies situated throughout the County. Medicaid no longer pays for adult services other than in emergency situations but oral health care is available through private dental insurance plans. The County has an ample supply of ethnically diverse practicing dentists and oral surgeons.

- **Medical case management**

Medical case management focuses on educating and empowering the client to maintain adherence to care and fully utilize all available funding sources and services. Medical case management is intended to help clients obtain, coordinate, and adhere to medical care and other treatments. Primary sources of medical case management funding are Ryan White Part A and Medicaid Project AIDS Care (PAC) Waiver. Ryan White Parts A, B, C and D, and State GR fund medical case management at 15 agencies. The PAC Waiver program funds 13 case management agencies. In all, about 10,000 clients receive medical case management from these sources.

- **Substance abuse and mental health treatment**

A strong theme in recent needs assessments is an ongoing, acute need to treat PLWHA who have a substance abuse and/or mental health problem. The need is increasing as the epidemic continues to spread within low income, minority communities. In addition, Miami-Dade County has experienced the same increase in methamphetamine (crystal meth) use seen across the country in major urban areas. As with other aspects of the HIV/AIDS epidemic in Miami-Dade County, simple ‘capacity’ for delivering service does not seem to be the primary challenge. To a large extent, the supply of specialty residential and day treatment programs met the demand for services in 2007. However, emergent HIV populations may require new responses from the existing system.

The Ryan White Part A Program supported several mental health treatment/therapy providers and seven substance abuse treatment providers, including three residential treatment providers. Mental health treatment includes therapy and counseling on both an individual and group level. Psychiatric services and several levels of professional psychosocial counseling were available to PLWHA in 2007. This included pastoral counseling, which plays a vital role in the African American community.

- **Insurance assistance**

Part A provides support for insurance premium and drug co-payments to help clients maintain their private insurance, thus saving direct medical and pharmaceutical costs to the program. Part A also sets funds aside to assist with the state-funded AIDS Insurance Continuation Program (AICP), which provides payment of insurance premiums and continued coverage of medical and other covered expenses by private insurance, if necessary.

## B. Targeted HIV/AIDS Resources in 2007

Additional support services are available to PLWHA from many providers, including:

- Outreach
- Food services (food bank and home delivered meals)
- Legal services for HIV-related issues (including eligibility for public programs and other healthcare related concerns)
- Transportation services

**Table II** provides information on HIV/AIDS resources in Miami-Dade County. Some providers offer a wide range of services, while others offer only a few or are single-service providers. As reflected in the table, many support services in addition to medical care and prescription drugs are funded to enable PLWHA to adhere to care and treatment.

Provider Name	ADAP Enrollment Site	ADAP Pharmacy Site	AICP Enrollment Site	Food Bank	Health Insurance Services	HIV Testing	Home Delivered Meals	Legal Assistance	Medical Case Management	Mental Health Therapy/Counseling	Oral Health Care	Outpatient Medical Care	Outreach Services	Prescription Drugs	Psychosocial Support Services	Substance Abuse Counseling - OP	Substance Abuse Counseling – Res.	Transportation Services (Vans)	Transportation Services (Vouchers)
AIDS Healthcare Foundation														x					
Better Way of Miami						x										x	x		
Borinquen Health Care Center	x					x			x		x	x							x
Care Resource	x					x			x	x	x	x	x			x			x
Center for Haitian Studies	x					x							x						
Center for Positive Connections															x				
Citrus Health Network						x			x			x		x					
Community Case Management													x						
Community Health of South Florida (CHI)	x	x				x			x		x	x	x					x	x
Empower U, Inc.						x			x				x						
Food for Life Network				x			x												
Helen B. Bentley Family Health Center	x	x				x			x			x	x						x
Jessie Trice Community Health Center	x					x			x	x	x	x			x	x			x
Legal Services of Greater Miami								x											
Liberty City Health Service Center/Juanita Mann Health Center	x					x			x			x							x
Mercy Hospital-Special Immunology Services	x		x			x			x	x		x		x			x		x

**Table II  
Miami-Dade County Part A Provider Resource Inventory**

Services																				
Provider Name	ADAP Enrollment Site	ADAP Pharmacy Site	AICP Enrollment Site	Food Bank	Health Insurance Services	HIV Testing	Home Delivered Meals	Legal Assistance	Medical Case Management	Mental Health Therapy/Counseling	Oral Health Care	Outpatient Medical Care	Outreach Services	Prescription Drugs	Psychosocial Support Services	Substance Abuse Counseling - OP	Substance Abuse Counseling - Res.	Transportation Services (Vans)	Transportation Services (Vouchers)	
Miami Beach Community Health Center	x					x			x		x	x		x						x
North Dade Health Center	x					x			x	x	x	x								x
Rafael Peñalver Clinic												x								x
Prevention, Education, and Treatment (PET) Center	x					x			x		x	x								x
South Florida AIDS Network (SFAN)	x					x			x	x	x	x	x	x	x					x
University of Miami Comprehensive AIDS Program						x				x			x		x					
The Village South						x			x							x	x			x

## C. 2007 HIV/AIDS Care and Treatment

### C.1. The Uninsured in Miami-Dade County

Miami-Dade County has the highest rate of uninsured in the state and among the highest in the nation (see discussion of ‘barriers’ below for more information on the uninsured). The 2007 Florida Health Insurance Study revealed that 25% of the County’s population lacks any form of health insurance, including Medicaid.

### C.2. Sources of Funds

Funds from a variety of public programs cover a wide range of services. Inpatient care for the indigent is partially funded by a County indigent care tax and State GR in addition to traditional sources, such as Medicaid, Medicare, and commercial insurance. Funding for all services in the above-described Resource Inventory is captured in **Table III** and **Figure 12**, below. In some instances, such as legal services, it was not possible to identify and estimate other funding sources, although they undoubtedly exist. Medicaid, the largest payer, pays primarily for medical services, though

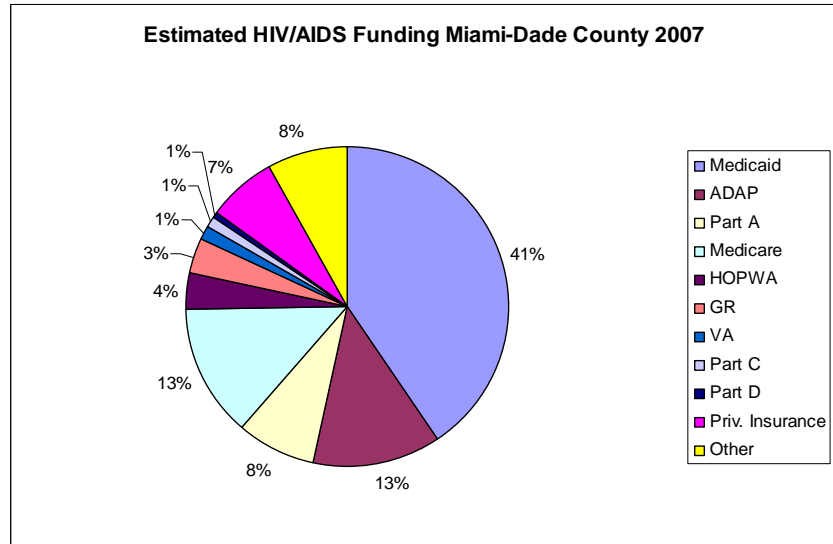
Source	Funds	Percent
Medicaid	\$ 99,428,091	41%
ADAP	\$ 31,155,078	13%
Ryan White Part A	\$ 19,902,672	8%
Medicare	\$ 32,000,000	13%
Private Insurance	\$ 17,578,761	7%
HOPWA	\$ 9,475,246	4%
General Revenue	\$ 8,318,245	3%
Veterans Administration	\$ 3,528,686	1%
Ryan White Part C	\$ 2,736,832	1%
Ryan White Part D	\$ 1,429,361	1%
Other	\$ 19,005,476	8%
<b>Total</b>	<b>\$ 244,558,448</b>	<b>100.0%</b>

Prepared by Behavioral Science Research, Inc.

the Medicaid PAC Waiver Program, pays for support services including case management, home health, meals, and transportation services.

Medicaid is financed 57 % by the federal government and 43 % by the state of Florida. Similarly, Medicaid and the Veterans Administration pay primarily for medical care, as does private health insurance. Ryan White and State GR pay for medical and certain support services, including medical case management, substance abuse treatment and mental health therapy. HOPWA is the only non-medical provider, as it provides only housing and housing-related services. Ryan White, Medicaid PAC Waiver, and GR sources paid for all medical case management services. See **Figure 12**.

**Figure 12**



- **Medicaid is the largest payer for HIV/AIDS care and treatment in the County**

In 2007, Medicaid provided care and treatment to 5,022 people with AIDS-defining diagnoses in Miami-Dade County. Expenditures totaled \$99,428,091 million including \$38,718,350 in prescription drugs and \$25,335,811 in inpatient care costs. In 2004, Medicaid provided care and treatment to 6,972 people with AIDS-defining diagnoses with expenditures that totaled \$187 million including \$105 million in prescription drugs, and \$35 million in inpatient care costs. While Medicaid absorbs a significant amount of the financial burden for AIDS care and treatment in the County, serving approximately 40% of all PLWA, the reductions in services as noted between 2004 and 2007 are significant and expectations are that more decreases in funding and services will occur in future years.

In Florida, only people with an AIDS-defining diagnosis and a physician-documented disability are eligible for Medicaid, leaving thousands of AIDS and HIV positive residents ineligible. In addition, many Medicaid recipients receive care at hospital outpatient clinics, where Medicaid places annual limits on services. As payer of last resort, the Part A Program can step in to cover needed care after limits have been reached and State GR and other funds are exhausted. In addition, Ryan White pays for medical case management (except for PAC Waiver clients), and several services Medicaid does not cover, including services for undocumented residents and substance abuse treatment.

- **Ryan White is the second largest payer for HIV/AIDS care and treatment in the County**

Ryan White, including Part A care and treatment and Part B ADAP, is a major payer in the HIV/AIDS arena, particularly for outpatient care and treatment, including prescription drugs. As

reflected in **Table III**, Ryan White Part A spent \$19.9 million for all services in 2007, including medical care, prescription drugs, and other services described earlier in this document. Part B of the Ryan White Program, ADAP, spent \$31 million for prescription drugs for PLWHA in 2007. Parts C and D of the Ryan White Program pay for, respectively, early intervention services, including medical care, and medical care for women, infants, children, and youth.

There is general consensus among providers that the supply of HIV/AIDS primary medical care is sufficient in Miami-Dade County, and that anyone who wishes to receive care can do so. Client interviews support this; rarely is medical care mentioned as an unmet need. Client surveys also reflect generally positive views of their medical care providers. There are, however, issues regarding institutional inefficiencies that are frustrating to both clients and medical professionals efficiencies, such as long waiting times and/or return visits for lab work and other follow-up procedures.

Multiple funding and administrative entities that manage prescription medication services (GR, ADAP, Ryan White Part A, and Medicaid) result in several pick-up locations for medications. This is perceived by clients, physicians, and other service providers as inconvenient and a barrier to proper adherence to medication regimens. As many clients rely on public transportation, it can take an entire day just to obtain an individual's medications. If clients are employed, the amount of time to obtain medications interferes with their job attendance and performance. Complaints were noted through surveys and focus groups that needed medications are not available and clients are asked by pharmacies to return later. This further complicates an already inefficient and inconvenient system. Multiple funding sources for medications may also create duplication and potential waste.

## Section 3

# Service Challenges and Unmet Needs

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Miami-Dade County has the highest number of HIV and AIDS cases of any metropolitan area in Florida, comprising 25% of all HIV cases in Florida and 21% of all AIDS cases statewide. In Fiscal Year (FY) 2008, 5,739 persons, or 25% of reported PLWHA, were estimated to be out of care. Unmet need was higher for PLWH (31%) than for PLWA (19%). In addition, there are several dynamics in the EMA that contribute to the high cost and complexity of providing care and present unique challenges to service providers:

- a. Community factors;
- b. PLWHA complexity factors; and
- c. Special populations

These are issues that the Miami-Dade HIV/AIDS Partnership has sought to address in the 2009-2011 Comprehensive Plan.

### **A. Community Factors**

Miami-Dade County faces a number of problems related to the social organization of the EMA, including the high cost of medical care, lack of adequate affordable housing, significant internal and external migration, widespread poverty, lack of insurance, and higher than State averages of other diseases (e.g., Sexually Transmitted Infection (STIs), diabetes, and heart disease), and lower income levels for residents.

#### **A.1. Cost of Care**

The cost of medical care in the EMA is among the highest in the nation; 25% of people under the age of 65 are uninsured, and the per capita cost of Medicare in Miami-Dade County is 25% higher than in Florida as a whole. AIDS-related Medicaid costs in the EMA were almost \$100 million in 2007. At the same time, the Medicaid reimbursement rates are unreasonably low, relative to the actual cost of care, which is a major disincentive for physicians practicing in Miami-Dade County.

#### **A.2. Housing**

Miami-Dade County's affordable housing supply imbalance, along with other economic pressures, make the cost of living one of the highest in the nation. According to the 2008 Miami-Dade County Workforce Housing Needs Assessment (*May 2008*), the increases in home prices, taxes, and homeowner's insurance in the EMA have made housing unaffordable for approximately 85% of Miami-Dade County's households.

#### **A.3. Immigration and Migration**

Miami-Dade County has one of the highest immigration rates in the nation. As of the 2000 Census, updated in 2004, 53% of the population in Miami is foreign born, making it the largest

percent of immigrants of any U.S. city. Net domestic migration has been negative with an average of 30,400 residents migrating out of the County annually since the 2000 Census. At the same time, net immigration has been over 40,000 residents annually since 2000. In effect, every year Miami loses 1.3% of its population to outbound domestic migration, and gains 1.7% of its population from other countries.

A majority of the one million legal immigrants in the EMA are not eligible for most public assistance programs, leaving the Part A Program as the only source of care for a significant portion of the County’s HIV positive population. In Florida, only people with an AIDS-defining diagnosis plus a documented disability are eligible for Medicaid. This policy excludes a significant number of legal immigrants living with AIDS who are not disabled and thousands of HIV positive clients. Many immigrants are not connected to care and lack basic knowledge of the American health care system. A majority of Part A Program clients in the EMA are foreign-born and among Haitians and Hispanic MSMs almost 90% are foreign-born. Large numbers of immigrants increase the need to provide services in three languages; 36% of Part A clients are Spanish-speaking and 11% speak Creole.

**A.4. Undocumented Population**

The undocumented population in the EMA is estimated at 225,000 persons and an estimated 10% of PLWHA not in care are undocumented and ineligible for most public assistance programs. This places additional pressure on Ryan White programs and creates challenges for getting people tested and into treatment. In addition, undocumented immigrants are often reluctant to seek care largely because they fear deportation. When they do seek care, they are likely to be late presenters who are sicker and thus more costly to treat. While the EMA’s large Hispanic population helps many Spanish speakers overcome language access barriers, other immigrant populations, including Haitians and non-Spanish-speaking indigenous Central Americans, experience both language and cultural barriers.

**B. PLWHA Complexity Factors**

When community-wide health care and economic challenges are linked to PLWHA, they become complexity factors and treatment challenges. **Figure 13** shows the number of PLWHA in care in the Part A Program with complexity factors that increase the cost of care, and – more importantly –

**Figure 13**  
**Number of Part A Clients with Various Complexity Factors**  
**Miami-Dade County, FY 07-08**

Specific Complexity Factor	PLWHA Clients with Co-morbid Complexity	% with Co-morbidity	Average Cost per Client	Total Cost for PLWHA with Co-Morbidity
Substance Abuse	1,864	19%	\$3,366	\$ 6,274,838
Mental Illness	3,217	33%	\$2,856	\$ 9,188,202
Homeless	290	3%	\$2,839	\$ 823,432
No insurance	5,862	60%	\$2,429	\$14,239,690
CDC-AIDS	6,050	62%	\$1,960	\$11,855,194
Late Presenters	3,925	40%	\$1,738	\$ 6,819,698

serve to limit access or to have an impact on service delivery. The total cost of care for the 9,826 clients served by the Part A Program in FY 07-08 was \$19,902,672, yielding a per capita cost of care of \$2,026 for each

PLWHA client. For most PLWHA, complexity factors contribute to a greater than average cost of treatment and the majority of Part A clients is complicated by more than one complexity factor, increasing the cost and the challenges of delivering services.

The proportion of PLWHA with multiple complexity factors is rising, as can be seen in **Figure 14**. Data from the Service Delivery Information System (SDIS) indicates that only 5% of Part A clients in 2007-2008 had only one factor that would increase the cost of care (compared to 9% in 2006-2007), and 78% had three or more factors (as compared to 58% in 2006-2007). The rising proportion of PLWHA clients with multiple complexity factors shown in Figure 14 is consistent with the rising poverty and immigration levels described previously.

**Figure 14**  
**Increase in Proportion of High-Complexity PLWHA**  
**in the Part A Program**  
**Miami-Dade County, FY 06-08**

<b>Number of Treatment Complexity Factors</b>	<b>2006-2007 Clients with Factors</b>	<b>2006-2007% with Factors</b>	<b>2007-08 Clients with Factors</b>	<b>2007-08% with Factors</b>
None or One	847	9%	475	5%
Two	3,497	34%	1,677	17%
Three	3,599	35%	3,717	38%
Four	1,744	17%	2,501	25%
Five or More	580	6%	1,455	15%

### **B.1. Substance Abuse Among PLWHA**

In 2007, 1,864 clients in care in the Part A Program had identifiable substance abuse problems, requiring allocation of funds to residential and outpatient substance abuse treatment. The addition of substance abuse to an HIV/AIDS treatment profile significantly increases the cost of care and reflects a high likelihood of recidivism (and therefore a high re-infection potential).

### **B.2. Mental Illness among PLWHA**

Chronic mental illness affected 3,217 PLWHA receiving care in the Part A Program. Mental illness contributes to an inadequate knowledge and understanding of risk factors and difficulty navigating the health care system. Physician visits with dually-diagnosed clients frequently require increased consultation time, increased coordination of care, increased provision of treatment education, and more follow-up to ensure adherence to both psychiatric and HIV-related treatment.

### **B.3. Homelessness**

There are significant overlaps between homelessness, mental illness, and substance abuse among Part A Program clients, and homeless clients are three times as likely to drop out of care during the first year of treatment as are other Part A Program clients. Homeless clients present many challenges to the practitioner, including increased consultation time, intensive medical case management, increased needs for follow-up and/or outreach, high likelihood of being lost to care, and increased needs for other support services, such as transportation assistance and food bank.

### **B.4. The Uninsured**

Although national studies estimate that 21% of PLWHA lack any type of health insurance, the rate of uninsured and/or under-insured clients served by the Part A Program is 63 %. Of Haitian

Part A Program clients, 72% are uninsured, and over half of all other racial/ethnic groups lack insurance. This places significant strain on the Part A Program as payer of last resort. The Part A Program assisted 442 under-insured clients with pharmacy co-payments and deductibles at a cost of \$490,846 in FY 2007, an 18% increase over FY 2006. Finally, since the State ADAP does not cover the under-insured, Part A absorbs additional prescription drug costs averaging \$1,035 per client per year.

#### **B.5. AIDS at Diagnosis / Late Presenters**

Nearly half of all AIDS diagnoses in 2007 occurred in the EMA's public hospital, indicating that a large part of the PLWHA population enter the system as late presenters. Of PLWHA enrolled in the Part A Program in 2007, 40% had AIDS at the time of intake, and 62% of current Part A clients have an AIDS diagnosis. Outreach efforts now focus on strengthening connections with key points of entry and working in cooperation with DOH-funded programs such as Emergency Room rapid testing and partner notification programs.

### **C. Special Populations**

Miami-Dade County Part A Program clients are predominantly from minority communities (48% Black, non-Hispanic, including 12% Haitian/Caribbean Islander, and 38% Hispanic), and are seeking care in a metropolitan area characterized by high levels of unemployment and poverty, high levels of STD infection and substance abuse, a population growth dominated by international in-migration (both documented and undocumented), and large numbers of non or under-insured persons. Due to the ethnic and racial diversity seen in the community, the Miami-Dade HIV/AIDS Partnership did not prioritize service dollars toward specific ethnic populations for FY 09, but rather prioritized services identified as being greatly needed by all racial and ethnic communities.

Still, planning for service delivery has focused on five high-risk groups identified as requiring particular attention and focus:

1. Haitians
2. Substance abusers, both IDU and non-IDU
3. African-Americans
4. Hispanic MSM
5. Women of childbearing age

These populations were identified as "Special Need" groups due to a higher than average likelihood of falling out of care (African-Americans), high complexity factors (substance abusers), higher than average costs of care (Haitians, substance abusers, African-Americans, Hispanic MSM), cultural barriers to engagement and retention in treatment (Hispanic MSM, Haitians), and complex patterns of HIV/AIDS care utilization that extend across multiple funding streams and providers (women of childbearing age).

**Figure 15** shows the specific levels of complexity factors for these five populations. As outlined above, most Part A Program clients had two or more complexity factors, and 40% of PLWHA have four or more. PLWHA within the five special need populations average more than three complexity factors.

**Figure 15**  
**Incidence of Co-morbidities and Complexity Factors Among Five Special Need Populations**  
**Ryan White Part A Clients, FY 07-08**

Special Populations	2007 Part A Clients	AIDS Diagnosis	TB	Homeless	Substance Abuse	Mental Illness	Poverty (<135 % FPL)	No Health Insurance	Average # of Complexity Factors
All RW Part A Clients	9,826	62%	5%	3%	19%	33%	75%	60%	3.3
Haitians (12%)	1,178	66%	8%	1%	4%	18%	78%	70%	3.2
Substance Abuser (19%)	1,864	61%	7%	8%	100%	63%	78%	62%	4.5
Black/African-American (36%)	3,688	64%	5%	5%	27%	35%	86%	49%	3.4
Hispanic MSM (23%)	2,230	56%	4%	1%	14%	33%	59%	69%	3.2
Women of Childbearing Age (17%)	1,631	59%	4%	2%	17%	34%	83%	59%	3.3

Note that the populations are not mutually exclusive: of the 3,688 African-Americans receiving Ryan White Part A-funded services in 2007, 1,007 (27%) are also substance abusers and 874 (24%) are also women of childbearing age.

The intensity of treatment complexities varies across population groups. As an example, African-Americans and Haitians are more likely to have an AIDS diagnosis than the average client enrolled in the Part A Program. Additionally, African-American PLWHA are more likely to have substance abuse issues; substance abusers are more likely to have concomitant mental illness; and Haitians and Hispanic MSM are more likely to have no health insurance.

### **C.1. Haitians**

The 2000 Census found that about 100,000 people of Haitian origin live in Miami-Dade County. However, because a large proportion are undocumented, the total population is estimated at 150,000 to 200,000 by the Miami-Dade County Planning Department (MDCPD). Providing services to this population can be extremely complicated, given the community's mistrust of government activities and apprehension in accessing the medical care system. Focus groups convened by Behavioral Science Research (BSR) and a Special Projects of National Significance (SPNS) project, conducted by the University of Miami indicate that a persistent feeling of stigma about HIV/AIDS exists in this population, a sense of vulnerability to deportation and/or incarceration, and a complex non-western system of beliefs about health behavior, all of which make treatment of HIV/AIDS difficult. This has resulted in particular attention toward cultural sensitivity issues in the Plan.

Eighty percent of Haitians in the EMA have less than a high school degree and 45% do not speak English. Although written materials are often translated into Creole, data from the Miami-Dade County Public Schools estimate that 35% of Haitian adults cannot read or write in either Creole

or English. This translates into late entry into care and difficulty in keeping appointments and following treatment instructions. Most Haitians are diagnosed in the public hospital inpatient or emergency room units where they present with serious illness. A significant number of older persons of this population use non-traditional healing methods such as Haitian herbalists and spiritual healers before seeking western medical care, and then only when their symptoms have seriously progressed. Haitians in the BSR focus groups professed beliefs that certain poultices and herb teas would remove HIV from their bodies, as well as stating that night sweats, thrush, and other early indicators of HIV progression were normal and not signs of disease.

### **C.2. Substance Abusers**

Miami-Dade County is a significant gateway for drugs entering the U.S. Although Drug Enforcement Agency statistics indicate that cocaine, heroin, and methamphetamine are large components of the incoming Caribbean-Central American drug stream, local use includes domestically produced “party drugs” as well, such as Ecstasy. Both injection and non-injection drug activity is prevalent in the EMA. About 10% of PLWHA, or 2,239, are IDUs. Based on DOH estimates, approximately 12% of the County population over age 13, or 236,702 persons, have a non-injection drug abuse problem. Approximately 3,441 of those are infected with HIV/AIDS (Health Council of South Florida, Inc., *Community Health Survey, 2006*) which corresponds to approximately 15% of all reported HIV/AIDS cases, and 19% of the PLWHA enrolled in the Part A Program.

Substance abuse is most common in poor, inner-city neighborhoods, where there are intersecting epidemics of HIV, STIs, and homelessness. Among IDUs living with HIV/AIDS, Blacks comprise 58% and Hispanics comprise 30%. Of the substance-abusing PLWHAs in care funded by the Part A Program, over 50% are Black. Use of crystal methamphetamine has reached epidemic proportions among gay and bisexual men, with half of all MSM in the EMA using non-injection drugs (*MMWR Survey Summaries July 7, 2006/55 (SS06); 1-16*) and engaging in risky sexual behavior. These factors have led to new HIV infections as well as outbreaks of infectious syphilis and hepatitis among these populations.

Treatment for drug abuse is often a necessary precursor to medical care, yet most drug treatment providers make little accommodation for HIV treatment and its regimens. Female substance abusers with dependent children have special needs, as drug use complicates care and follow-through with treatment. Other complications arising from substance abuse include exposure to other infections through the sharing of needles and/or from trading sex for money or drugs. The Plan includes several activities aimed at facilitating improvements in substance abuse treatment for PLWHA.

### **C.3. African-Americans**

Racial disparities in care have been well documented nationally and locally, and AIDS mortality rates are highest among African-American men and women age 25-44 (*Florida Vital Statistics Report, 2007*) with African-Americans accounting for 60% of AIDS deaths in the EMA (Florida Department of Health, 2008). The African-American community is the poorest racial/ethnic group in the EMA, with 59% of the community at or below 300% of the FPL and 28% at or below 150% of the FPL. Almost 30% of the African-American population is uninsured,

compared with 12% of Whites. African-Americans comprise 49% of prevalent AIDS cases and 47% of prevalent HIV cases in the EMA.

HIV/AIDS service provision to the African-American community is complicated by two major trends: demographic shifts of middle-and upper-income African-Americans leaving Miami and being replaced by poorer immigrants from the Caribbean (Florida International University, *Status of the Black Community, 2006*), and the documented “down low” phenomenon among African-American men that contributes to increased STI and HIV infections in the community for both men and women. The economic and social ramifications of poverty in this community contribute to high levels of substance abuse (27% of African-American PLWHA in the Part A Program are also substance abusers), diagnosis at a later stage of illness, and other collateral problems. Stigma and lack of insurance are additional complicating factors that often result in late entry into care. African-Americans are also significantly more likely to drop out of care than other racial/ethnic groups, with 17% of African-Americans in care and treatment in FY 2006 no longer receiving care and treatment in FY 2007. African-Americans comprise 33% of new Part A Program clients who entered care in FY 2007, but are also 55% of the PLWHA who required outreach efforts to either be retained in and/or re-connected to care in FY 2007. Re-connection to care is an important part of the Plan.

#### **C.4. Hispanic MSM**

Hispanics are the dominant ethnic group in the EMA, comprising 62% of the population. Data released in 2007 (Florida Department of Health, *MSM Estimated Population Sizes and Mortality, December 2007*) estimate that of the 63,000 MSM in Miami-Dade County, 54% are of Hispanic background. Contrary to conventional wisdom concerning the predominance of Cubans in Miami, the Hispanics in the EMA are a varied population from all parts of Central and South America and fall into all income levels. Of the Hispanic MSM enrolled in the Part A Program in FY 07, 88% are foreign-born. Cuban-born PLWHA account for 40% of the Hispanic MSM in care; Central and South Americans account for 45%; and Mexican-born comprise three percent. Some Hispanic MSM from Mexico, Central, and South America travel back and forth from the United States to their homeland, complicating care and follow-up to treatment thereby increasing the cost of care.

BSR focus group studies conducted in 2005 indicate a high level of stigma related to homosexuality and HIV/AIDS in the Hispanic population which can result in problems accessing care and treatment. Although Hispanic MSM exhibit lower “dropout” rates than other racial/ethnic groups once they are engaged in care, getting them into care in the first place can be difficult. Similar to the Haitian population, there is a reliance on folk medicines and healers (botanicas and curanderas) as a means of treatment and there is substantial misinformation concerning the transmission of HIV/AIDS along with a high incidence of “no symptom, no problem” thinking in this population. More than half (56%) of the Hispanic MSM in the Part A Program in FY 07 have a current AIDS diagnosis, 60% are low income, 69% are uninsured, and 47% had diagnosed substance abuse or mental illness as co-morbidities.

#### **C.5. Women of Childbearing Age (15-44)**

According to the 2005 Census estimates, Miami-Dade has 604,670 women between 15 and 44 years of age; 32% of female-headed families with children in the County live well below the

FPL. There are 3,664 female PLWHA of childbearing age in the EMA. FY 07 DOH data for Miami-Dade County indicate that women age 15 to 44 comprise 17% of PLWHA, 14% of PLWA, and 19% of PLWH. Seventeen percent of the PLWHA in care and treatment funded through the Part A Program are women of childbearing age. Within the Part A Program population, 72% of the women of childbearing age client group is Black or Haitian, and 23% are Hispanic females. Eighty-three percent of the Part A Program's women of childbearing age group live in poverty, 34% have mental illness issues, and 17% have concomitant substance abuse problems.

Women face many barriers to care and experience many factors that complicate their care. Poverty, limited education, lack of health insurance, immigration status, and lack of transportation continue to be significant problems for women. BSR focus group research among women living with HIV/AIDS indicate infection patterns arising from high-risk sexual behavior and injection drug use, with limited understanding of HIV transmission modes. Many of the women in the focus group reported feeling disempowered in their relationships with men, are not well informed about HIV/AIDS, or did not feel the need for testing until well after they had been infected and became symptomatic. There are high rates of reported stigma attached to HIV/AIDS, creating a culture of denial that results in low-income minority women not learning they were HIV positive until they become pregnant. Fifty-one percent of the women of childbearing age in the Part A Program have dependent children. A zip code analysis shows significant numbers of female PLWHA in this group living in inner-city areas with high rates of poverty, crime, and unemployment.

Women of childbearing age are also at high risk for dropping out of care (21% of the women age 15 - 44 receiving services in FY 2006 had fallen out of care in FY 2007), despite the high need for pre- and post-natal care, preventive care, screening, and other services, as well as HIV-related adherence counseling. The UM Family Care Program reported that at least 25% of their pregnant HIV clients had psychiatric symptoms including depression, anxiety disorders, post-traumatic stress syndrome, conduct disorders, psychosis, and attention deficit disorder. Many continue to struggle with family rejection and the stigma of HIV, which affects adherence to medical regimens as well as their ability to disclose their HIV status to family, friends, or sexual partners. Additional factors such as partner domestic violence compounds safety, security, and preventive health behaviors.

## **D. Unmet Needs**

Miami-Dade County considers PLWHA to have an unmet need for care (or to be out of care) when there is no evidence that they received any of the following three components of HIV primary medical care during a defined twelve month time frame:

1. Viral Load testing;
2. CD4 count; and/or
3. Anti-retroviral therapy (ART).

Data used to generate the unmet need estimate are provided by the DOH and disseminated to the six Florida EMA/TGAs (Transitional Grant Areas). The same formulas used to estimate

prevalence and care patterns are applied to the State and to each of the EMA/TGAs to ensure uniformity in the data. The methodology also allows for local input to adjust care patterns as needed. See Tables IV and V, Demographic Analysis of People In and Out of Care and Unmet Need Framework Estimate.

Category	HIV/AIDS Population by Category	Number with Met Need	Number with Unmet Need	Percent of Unmet Need Population	Unmet Need as Percent of Category	Category as % of Total HIV/AIDS Population
<b>HIV or AIDS</b>						
PLWA	12,773	10,325	2,448	43%	19%	55%
PLWH/non-AIDS	10,481	7,190	3,291	57%	31%	45%
<b>Gender</b>						
Male	16,264	14,374	1,890	33%	12%	70%
Female	6,990	3,141	3,849	67%	55%	30%
<b>Race</b>						
White (non-Hispanic)	3,082	1,977	1,105	19%	36%	13%
African American (Non-Hispanic)	11,093	8,051	3,042	53%	27%	48%
Hispanic	8,778	7,196	1,582	28%	18%	38%
Other	301	291	10	<1%	3%	1%
<b>Total</b>	<b>23,254</b>	<b>17,515</b>	<b>5,739</b>	<b>100%</b>	<b>25%</b>	<b>100%</b>

<sup>1</sup> Data Source: Florida Department of Health, in care data, 2008

Row	Population Sizes	Value		Data Source(s)
<b>A</b>	Number of persons living with AIDS (PLWA) for the period 01/01/07 – 12/31/07	12,773		HARS and Out of State (OOS) data sets plus matches with ADAP, Medicaid, and Lab databases
<b>B</b>	Number of persons living with HIV/non-AIDS (PLWH) for the period 01/01/07 – 12/31/07	10,481		HARS and OOS data sets plus matches with ADAP, Medicaid, and Lab databases
<b>C</b>	Total number of PLWA/PLWH for the period 01/01/2007 – 12/31/07	23,254		
Row	Care Patterns	Value	%	Data Source(s)
<b>D</b>	Number of PLWA who <b>DID</b> receive the specified HIV primary care medical services within the 12-month period	10,325	81%	HARS and OOS data sets plus matches with ADAP, Medicaid, and Lab databases (Value D/Value A)
<b>E</b>	Number of PLWH/non-AIDS who <b>DID</b> receive the specified HIV primary care medical services within the 12-month period	7,190	74%	HARS and OOS data sets plus matches with ADAP, Medicaid, and Lab databases (Value E/Value B)
<b>F</b>	Total number of PLWA/PLWH who <b>DID</b> receive the specified HIV primary care medical services within the 12-month period	17,515	78%	(Value F/Value C)
Row	Calculated Results	Value	%	Calculations
<b>G</b>	Number of PLWA who did <b>NOT</b> receive primary care medical services within the 12-month period	2,448	19%	Value: Value A – Value D Percent: Value G/Value A
<b>H</b>	Number of PLWH/non-AIDS who did <b>NOT</b> receive primary care medical services within the 12-month period	3,291	31%	Value: Value B – Value E Percent: Value H/Value B
<b>I</b>	Total number of PLWA/PLWH who did <b>NOT</b> receive primary care medical services within the 12-month period (quantified estimate of unmet need)	5,739	25%	Value: Value G + Value H Percent: Value I/Value C

<sup>1</sup> Data from Florida DOH HIV/AIDS Surveillance database for the period 01/01/07 – 12/31/07 as of 04/15/08

## Section 4

# Achieving the Partnership's Mission

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### **A. Shared Mission and Priorities**

The mission of the Partnership is to eliminate disparities and improve health outcomes for all people living with or at risk for HIV/AIDS. To successfully achieve this mission, the Partnership draws on the cooperation and collaboration of consumers, service providers, health care planners, and other key stakeholders.

Input was gathered from committee meetings, consumer and provider forums, and analyses of consumer surveys, provider surveys, and needs assessment data to form the core Plan goals:

1. Eliminating barriers to care and treatment to ensure all PLWHA are in care
2. Raising and standardizing quality of care and service delivery to improve health outcomes
3. Increasing the quantity and maximizing the effectiveness of resources for care, treatment and prevention of HIV/AIDS
4. Responding in a timely and effective manner to changes in the epidemic

### **B. Established Continuum of HIV/AIDS Care**

Miami-Dade County has developed a broad continuum of comprehensive services through a widespread and diverse network of providers serving all demographic groups and all geographic areas. The continuum consists of 23 medical and support service providers, anchored by three major medical centers which, along with community health centers and other medical clinics form the backbone of HIV/AIDS primary care throughout the County. Specialty care completes the continuum at larger facilities throughout the County, including specialized clinics for women, children, and adolescents. The primary care system includes multi-lingual, multi-cultural and multi-national staff.

- Medical care is available throughout the County at 14 provider locations. Prescription drugs are available at 6 provider locations; 3 providers offer an ADAP pharmacy.
- Medical case management to assist with access to medical care is available at the medical centers and other locations throughout the County.
- Psychosocial support services, residential and outpatient substance abuse counseling and mental health therapy and counseling are available throughout the County.
- Outreach services are structured to strengthen the continuum of care by keeping clients engaged in treatment and returning clients lost to care back into the service system. Service

providers who do not staff outreach workers are linked with outreach workers at other provider agencies to ensure clients are not lost to care.

- Legal assistance is provided to ensure that clients obtain eligibility for other programs, and emergency food services help with treatment adherence and unforeseen crises.

### **C. Turning Challenges into Opportunities**

Today, HIV/AIDS affects approximately 46 out of every 100,000 person living in Miami-Dade County. The system of care is extensive and varied, and is equipped to serve most populations. However, surveys, focus groups, and key informant interviews often point to a fundamental lack of collaboration among providers, inconsistent coordination and information transfer, and lack of friendliness in HIV/AIDS care. Uneven quality of care raises issues of disparities in care, depending on where that care is received.

It is vital to the health and quality of life of people living with HIV/AIDS that we approach these challenges as an opportunity to ensure that improvements are made to the system. The Comprehensive Plan goals address those concerns and lay out achievable objectives such as developing and promoting National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care, developing and promoting training in customer service, providing technical assistance, and continued monitoring of outreach activity reports for effective linkage to care.

Although providers are most often targeted for needing improvement, consumer forums have demonstrated a need to empower consumers by assuring they understand their rights and responsibilities and are able to navigate within a complex system of care.

The Plan includes objectives such as facilitating training for consumers on client rights and responsibilities, grievance procedures and the service provider system, and developing a simple, easy-to-understand report to communicate trends in the epidemic.

Poverty, homelessness, lack of affordable housing options, lack of transportation and co-morbidities such as substance abuse and mental illness further complicate the lives of people living with HIV/AIDS and the delivery of services upon which they rely.

By supporting efforts to tie funding to subgroups and geographic areas that have the most severe need, maximizing cooperation with the HOPWA Program and the City of Miami (local HOPWA grantee), and identifying public and private funding resources available for PLWHA and service providers, the Plan seeks to address the broader socio-economic and social realities within the EMA.

The Partnership and the community must ensure that care and treatment are of the highest possible quality and that clients can receive the same standard of care regardless of where they receive it within the Ryan White continuum.

## Section 5 Ensuring That We Get There

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### A. Comprehensive Plan Development

The Partnership, through the Strategic Planning Committee (Committee), tracked the progress of the 2006-2008 Comprehensive Plan over the past three years; activities were assigned and monitored, and updates were presented regularly.

Because the Plan's four goals still address the needs of the community, they were kept in place. Likewise, many of the activities are ongoing, such as, *Identifying gaps and needs for collaboration in the HIV/AIDS provider community (Activity 1.1.1)*, and the Committee agreed these activities should stay on the Plan to ensure continued monitoring over the next three years.

#### Comprehensive Plan Goals

- **Goal 1** Eliminate barriers to care and treatment to ensure all PLWHA are in care
- **Goal 2** Raise and standardize quality of care and service delivery to improve health outcomes
- **Goal 3** Increase the quantity and maximize the effectiveness of resources for care, treatment and prevention of HIV/AIDS
- **Goal 4** Respond in a timely and effective manner to changes in the epidemic

As the Plan was monitored, areas that were not directly identified in the 2006-2008 Plan were noted for inclusion in the 2009-2011 Plan, such as to *Create and implement strategies for data sharing agreement with ADAP (Activity 1.2.3)*, and to *Improve effectiveness of outreach programs (Objective 1.4)*.

Needs assessment data, survey results, legislative and programmatic updates, community forums, and special presentations over the past three years informed the development of the Plan's goals, objectives, activities and desired outcomes, as detailed below. Prior to final review and approval by the full Partnership, two community forums with specific emphasis on PLWHA input were held. The Committee reviewed the consumer input from these forums and updated the Plan accordingly.

### B. Principles Followed in Developing the Plan

In developing the Plan, the Partnership reviewed the Health Resources and Services Administration (HRSA) guidance to ensure compliance with HRSA principles for HIV care and treatment programs:

1. Focus on primary care and treatment;
2. Increased flexibility to target resources; and
3. Accountability using sound fiscal management and tools to evaluate program effectiveness.

The Partnership was mindful of the need to balance these priorities with what can realistically be accomplished by a volunteer organization. The Partnership also recognized the need for

outcomes to inform and relate to the annual prioritization and allocation process and therefore be evidence-based and data-driven. Though the Plan's goals are ambitious, due to specified activities and desired outcomes, the Strategic Planning Committee will be able to monitor progress to make sure tasks are on track for completion.

The Partnership will continue to work closely with the Miami-Dade County Office of Grants Coordination (Grantee) to monitor fiscal management, and with the Ryan White Continuous Quality Improvement (CQI) Program for evaluation of program effectiveness.

## C. Comprehensive Plan Goals

**Goal 1** Eliminate barriers to care and treatment to ensure all PLWHA are in care

**Objective 1.1** Improve collaboration among HIV/AIDS providers across the continuum of care

Activities	Measurement	Long Term Impact
<b>1.1.1</b> Identify gaps and needs for collaboration in the HIV/AIDS provider community	<b>1.1.1</b> Surveys, focus groups and key informant interviews are completed annually	<b>1.1.1</b> Annual reduction in percent of clients lost to care
<b>1.1.2</b> Create and implement strategies for sustained provider collaboration	<b>1.1.2</b> Level of collaboration among organizations is assessed and monitored	<b>1.1.2</b> Increased collaboration among providers
<b>1.1.3</b> Plan and deliver seminars on referrals and eligibility screening	<b>1.1.3a</b> Minimum of one (1) medical case management training focused on referrals and eligibility screening is completed annually and  <b>1.1.3b</b> One (1) Provider Forum includes an agenda item on referrals & eligibility screening is completed annually	<b>1.1.3</b> Understanding of and adherence to eligibility requirements and understanding of referral processes
<b>1.1.4</b> Develop and administer a survey to identify each Part A provider's referral process	<b>1.1.4</b> Referral processes are documented and made available to all providers	<b>1.1.4</b> Written documentation of referral processes resulting in better communication between providers and more streamlined service delivery to PLWHA
<b>1.1.5</b> Facilitate linkages and enhance collaboration between outreach providers and non-outreach providers to ensure client retention in care	<b>1.1.5a</b> All medical providers without outreach services have executed linkage agreement with outreach provider  <b>1.1.5b</b> Quarterly monitoring of SDIS for clients linked to care is ongoing	<b>1.1.5</b> Increased collaboration resulting in more clients returned to care

**Goal 1** Eliminate barriers to care and treatment to ensure all PLWHA are in care

**Objective 1.2** Improve collaboration among funding sources across the continuum of care

Activities	Measurement	Long Term Impact
<b>1.2.1</b> Create and implement strategies for enhanced collaboration among all funding sources	<b>1.2.1</b> Funding options are understood by providers and utilized appropriately	<b>1.2.1</b> Increased collaboration among funding sources
<b>1.2.2</b> Streamline and simplify data collection screens in SDIS	<b>1.2.2</b> Periodic progress report to the Partnership	<b>1.2.2</b> Streamlined intake and referral process

**Goal 1** Eliminate barriers to care and treatment to ensure all PLWHA are in care

**Objective 1.2** Improve collaboration among funding sources across the continuum of care

Activities	Measurement	Long Term Impact
<b>1.2.3</b> Create and implement strategies for data sharing agreement with ADAP	<b>1.2.3</b> Written agreement between the County and the State for Part A and ADAP data-sharing	<b>1.2.3</b> Appropriate use of funds and ability to track outcome measures

**Goal 1** Eliminate barriers to care and treatment to ensure all PLWHA are in care

**Objective 1.3** Improve linkages between key points of entry and the continuum of care

Activities	Measurement	Long Term Impact
<b>1.3.1</b> Key Points of Entry Survey is developed and administered to identify gaps in linkages, especially between the key points of entry, medical case management, and the HIV/AIDS service system	<b>1.3.1a</b> Survey findings are collected and analyzed  <b>1.3.1b</b> Increased awareness of Part A services, through training and informational materials, is disseminated to entry points throughout the EMA	<b>1.3.1</b> Development of intervention and action steps to address identified gaps and decrease barriers to access to service at key points of entry
<b>1.3.2</b> Support the design of improved linkages, including the development of protocols, as needed, for areas identified in the key points of entry analysis	<b>1.3.2</b> Suggested protocols for linkage are documented and disseminated to key points of entry	<b>1.3.2</b> Increase in number of PLWHA who enter and remain in care after first contact

**Goal 1** Eliminate barriers to care and treatment to ensure all PLWHA are in care

**Objective 1.4** Improve effectiveness of outreach programs

Activities	Measurement	Long Term Impact
<b>1.4.1</b> Conduct a systematic survey of outreach programs in Miami-Dade County and other EMAs to develop an enhancement and training program for Part A outreach workers and their organizations	<b>1.4.1</b> Survey findings are collected and analyzed in order to develop enhanced training programs for outreach workers and provider agencies	<b>1.4.1</b> Established curriculum with modules available for outreach training.
<b>1.4.2</b> Ongoing monitoring of outreach activity reports for effective linkage to care	<b>1.4.2</b> Quarterly reports are reviewed to identify agencies exceeding and agencies not meeting outcome measures: to bring at least 25% of people contacted into medical care and/or other core service	<b>1.4.2</b> Increase of outreach program effectiveness in linking clients to care
<b>1.4.3</b> Support the delivery of enhanced training to outreach workers and provider agencies to facilitate the implementation of outreach for retention in care	<b>1.4.3a</b> One (1) outreach training is completed annually by all outreach provider agencies  <b>1.4.3b</b> Targeted training is made available to providers not meeting outcome measures	<b>1.4.3</b> Providers maintain and demonstrate improved knowledge of outreach requirements and techniques

**Goal 2** Raise and standardize quality of care and service delivery to improve health outcomes

**Objective 2.1** Improve the quality of customer service in the HIV/AIDS system of care

Activities	Measurement	Long Term Impact
<b>2.1.1</b> Review Client Satisfaction Survey results and survey tool	<b>2.1.1</b> Survey instrument is updated	<b>2.1.1</b> More reliable survey results

**Goal 2** Raise and standardize quality of care and service delivery to improve health outcomes

**Objective 2.1** Improve the quality of customer service in the HIV/AIDS system of care

Activities	Measurement	Long Term Impact
<b>2.1.2</b> Identify needs for customer service improvement through annual Client Satisfaction Survey	<b>2.1.2a</b> Survey results are collected and disseminated to community  <b>2.1.2b</b> Areas for improvement are identified and prioritized	<b>2.1.2</b> Improved customer service throughout the system of care
<b>2.1.3</b> Develop and promote training of the <i>National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care</i> with a focus on areas identified as needing improvement	<b>2.1.3</b> All direct service providers complete training	<b>2.1.3</b> Increase in reported improvements of cultural competency among direct service providers
<b>2.1.4</b> Develop and promote training in customer service with a focus on areas identified as needing improvement	<b>2.1.4</b> All direct service providers complete training	<b>2.1.4</b> Increased awareness of customer service needs among direct service providers

**Goal 2** Raise and standardize quality of care and service delivery to improve health outcomes

**Objective 2.2** Improve the delivery of medical case management services

Activities	Measurement	Long Term Impact
<b>2.2.1</b> Require attendance at monthly medical case management trainings	<b>2.2.1</b> Medical case management record reviews demonstrate understanding of and adherence to medical case management responsibilities	<b>2.2.1</b> More effective medical case management services in the EMA, improved compliance with program guidelines and improved client health outcomes
<b>2.2.2</b> Provide technical assistance, as required based on record reviews, and as requested by agencies	<b>2.2.2a</b> Written summaries are provided detailing areas and strategies for improvement  <b>2.2.2b</b> Medical case managers demonstrate understanding of and adherence to medical case management responsibilities/standards	<b>2.2.2</b> More effective medical case management services in the EMA, improved compliance with program guidelines and improved client health outcomes
<b>2.2.3</b> Develop and promote methods to improve the quality and amount of medical case management supervision, and clarify supervisory responsibilities	<b>2.2.3a</b> SDIS is monitored for input of medical case management supervisor codes  <b>2.2.3b</b> Quarterly collection of internal medical case management record reviews is ongoing	<b>2.2.3</b> More effective medical case management services in the EMA, improved compliance with program guidelines and improved client health outcomes
<b>2.2.4</b> Comply with hours of service as indicated in the <i>Miami-Dade County Ryan White Part A Program System-wide Standards of Care</i>	<b>2.2.4a</b> Medical care, pharmacy and medical case management are accessible for a minimum of 40 hours per week including 4 hours outside of regular business hours  <b>2.2.4b</b> 24-hour on-call access to pharmacy services and emergency medical care crisis counseling are available	<b>2.2.4a</b> Reduction in barriers to service  <b>2.2.4b</b> Reduction in PLWHA lost to care due to urgent need and crisis situations

**Goal 3** Increase the quantity and maximize the effectiveness of resources for care, treatment and prevention of HIV/AIDS

**Objective 3.1** Facilitate improvements in substance abuse treatment for PLWHA

Activities	Measurement	Long Term Impact
<b>3.1.1</b> Improve coordination and collaboration between Part A funded providers and other community resources to ensure PLWHA in need of substance abuse treatment are efficiently connected to services	<b>3.1.1</b> Information on all residential and outpatient programs is identified and disseminated	<b>3.1.1</b> Improved and more timely client access to substance abuse services
<b>3.1.2</b> Increase coordination between substance abuse providers and medical case managers	<b>3.1.2</b> Coordination is monitored through SDIS, targeted surveys and focus groups	<b>3.1.2</b> Improved and more timely client access to substance abuse services
<b>3.1.3</b> Improve compliance with service delivery guidelines for linkages and referrals to ensure residential substance abuse treatment clients are connected to outpatient substance abuse treatment or appropriate medical care upon discharge	<b>3.1.3</b> Record review and SDIS monitoring demonstrate discharge to outpatient substance abuse treatment with follow up to ensure clients access services	<b>3.1.3</b> Increase in number of clients leaving residential substance abuse treatment who access outpatient treatment and reduction in recidivism
<b>3.1.4</b> Establish reasonable follow up guidelines for residential substance abuse providers referring clients to outpatient counseling	<b>3.1.4</b> Monitor number of clients completing residential substance abuse treatment and continuing to outpatient substance abuse treatment	<b>3.1.4</b> Reduction in recidivism
<b>3.1.5</b> Publicize through SDIS available residential substance abuse slots	<b>3.1.5</b> Information on available Part A funded substance abuse residential resources is disseminated weekly	<b>3.1.5</b> Improved client match with available resources

**Goal 3** Increase the quantity and maximize the effectiveness of resources for care, treatment and prevention of HIV/AIDS

**Objective 3.2** Leverage non-Ryan White funding for PLWHA

Activities	Measurement	Long Term Impact
<b>3.2.1</b> Identify funding resources, public and private, that are available for PLWHA and service providers	<b>3.2.1</b> Training for medical case managers in non-Ryan White funding is ongoing	<b>3.2.1</b> Providers within the HIV/AIDS service system are more aware of available resources and access those resources more readily
<b>3.2.2</b> Promote optimization of non-Ryan White funds for PLWHA and service providers as available	<b>3.2.2</b> Provider access to non-Ryan White funds is increased	<b>3.2.2</b> Increased coordination and utilization of available community resources
<b>3.2.3</b> Monitor eligibility screening to ensure Ryan White funds are used appropriately	<b>3.2.3</b> Technical assistance, quarterly internal record reviews and monitoring through SDIS is ongoing	<b>3.2.3</b> Improved utilization of available community resources

**Goal 3** Increase the quantity and maximize the effectiveness of resources for care, treatment and prevention of HIV/AIDS

**Objective 3.2** Leverage non-Ryan White funding for PLWHA

Activities	Measurement	Long Term Impact
<b>3.2.4</b> Support Ryan White grantees in creating policies that award extra application points for providers that leverage outside funding for HIV/AIDS related services	<b>3.2.4</b> 90% of Ryan White providers have at least one other funding source for HIV/AIDS services	<b>3.2.4</b> Funding for PLWHA is expanded
<b>3.2.5</b> Maximize cooperation with the City of Miami and the HOPWA Program	<b>3.2.5</b> Housing Committee Comprehensive Plan goals are incorporated into the Miami-Dade County Comprehensive Plan for HIV/AIDS	<b>3.2.5</b> Coordination between funding sources and planning bodies provides improved client services

**Goal 3** Increase the quantity and maximize the effectiveness of resources for care, treatment and prevention of HIV/AIDS

**Objective 3.2** Leverage non-Ryan White funding for PLWHA

Activities	Measurement	Long Term Impact
<b>3.2.6</b> Support and promote transitional housing for formerly incarcerated PLWHA reentering Miami-Dade County	<b>3.2.6</b> Agencies and development companies with capacity for housing are targeted and made aware of the need for transitional housing	<b>3.2.6</b> Better facilitation of formerly incarcerated reentry to community and care network

**Goal 3** Increase the quantity and maximize the effectiveness of resources for care, treatment and prevention of HIV/AIDS

**Objective 3.3** Promote improved knowledge of the HIV/AIDS continuum of care

Activities	Measurement	Long Term Impact
<b>3.3.1</b> Increase availability of information on HIV/AIDS resources to PLWHA, HIV/AIDS service providers and the general community	<b>3.3.1a</b> Resource materials are distributed at meetings throughout the year	<b>3.3.1</b> Improved knowledge of the HIV/AIDS continuum of care throughout the EMA
	<b>3.3.1b</b> Weekly community notices are distributed via email	
	<b>3.3.1c</b> Updates to and promotion of the Partnership's website (AIDSNET) is ongoing	
	<b>3.3.1d</b> Collaboration and participation in community planning, community events and health fairs is ongoing	
<b>3.3.2</b> Facilitate training for consumers on client rights and responsibilities, grievance procedures and the service provider system	<b>3.3.2</b> Consumers report better understanding of client rights and responsibilities, provider grievance procedures and provider services	<b>3.3.2</b> Empowerment of consumers

**Goal 4** Respond in a timely and effective manner to changes in the epidemic

**Objective 4.1** Continue to monitor trends and publish an Annual Report on the epidemic

Activities	Measurement	Long Term Impact
<b>4.1.1</b> Develop a simple, easy-to-understand report to communicate trends in incidence and changes in utilization patterns in various formats and in various settings (forums, focus groups, training sessions, etc.)	<b>4.1.1</b> <i>Annual Report</i> is disseminated to Partnership, service providers, Miami-Dade County Mayor and Board of County Commissioners, and made available to the community at large	<b>4.1.1</b> Increased awareness and knowledge of the impact of the epidemic in the EMA and ability to respond quickly to changing trends

**Goal 4** Respond in a timely and effective manner to changes in the epidemic

**Objective 4.2** Educate legislators and other officials about HIV/AIDS-related issues

Activities	Measurement	Long Term Impact
<b>4.2.1</b> Develop a legislative education packet	<b>4.2.1</b> Packet is available online and made available to anyone communicating with government officials	<b>4.2.1</b> Increased understanding of the epidemic and greater support for increased funding

**Goal 4** Respond in a timely and effective manner to changes in the epidemic

**Objective 4.3** Allocate and reallocate resources to populations and services with emerging needs

Activities	Measurement	Long Term Impact
<b>4.3.1</b> Support efforts to tie funding to subgroups and geographic areas that have the most severe need	<b>4.3.1</b> Changes in funding for specific services and in specific venues are monitored throughout the year	<b>4.3.1</b> Increased ability to shift resources to areas of emerging need
<b>4.3.2</b> Support and promote improved access to resources and capacity building in South Dade, specifically for medical providers	<b>4.3.2</b> Additional medical provider agency is available in South Dade	<b>4.3.2</b> Increased ability to shift resources to areas of emerging need

**Goal 4** Respond in a timely and effective manner to changes in the epidemic

**Objective 4.4** Use education and communication to prepare providers for changes in the epidemic

Activities	Measurement	Long Term Impact
<b>4.4.1</b> Update current information on an ongoing basis related to epidemiology, updates in treatment standards, legal challenges, entitlement programs, insurance issues, and demographic shifts within the EMA	<b>4.4.1a</b> Partnership minutes reflect programmatic and legislative updates  <b>4.4.1b</b> Monthly epidemiology reports are disseminated at Partnership and committee meetings  <b>4.4.1c</b> Updates to information available through AIDSNET is ongoing  <b>4.4.1d</b> Coordination with Project SHARE to disseminate research findings.	<b>4.4.1</b> Providers and PLWHA are better prepared to handle changes in the epidemic and changes to available resources and services

## **Section 6**

### **Monitoring and Evaluating Our Progress**

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#### **A. Guiding Criteria for Measuring and Supporting the System of Care**

As detailed in the previous section, the 2009-2011 Comprehensive Plan includes a measurable “Long Term Impact” for each of the designated activities. Under the guidance of the Strategic Planning Committee, each activity will be assigned to the appropriate Partnership committee and annual review dates will be established. Based on review dates, staff will report the status of activities, including achievements and challenges, to ensure the Partnership is on target for meeting desired outcomes and long term goals. As necessary, outside input and buy-in from consumers, the local health department, service providers, and other community stakeholders will be sought.

The committee will work closely with the Continuous Quality Improvement (CQI) Program to track progress and challenges regarding objectives related to service delivery. The CQI conducts in-depth record reviews of specific core services and will expand in 2010 to include an annual record review of a selected support service. In addition, the Grantee conducts extensive contract monitoring activities. The results of these assessments are reported to the Partnership and committees and guide the completion of the goals.

The Partnership will refer to the newly published *State of Florida Statewide Coordinated Statement of Need (SCSN) 2009-2012* as it relates to completion of Partnership activities.

Analysis of the epidemic, including review of incidence, prevalence and demographic data, regular updates on Ryan White Program and other funding expenditures, and data collected from consumer and provider surveys will be reported regularly to the Partnership and committees to assist in decision making and activity and goal completion.

Community forums and educational seminars will be held throughout each year to ensure PLWHA are receiving the best information, high quality care and treatment, and focus on unmet needs as seen by people navigating through the continuum of care.

#### **B. Monitoring and Measuring Implementation Activities**

For the past three years, the Committee has worked to guide the implementation of the Plan’s goals and objectives and will continue to do so in the future. See Table VI for the progress report of the 2006-2008 Plan.

The Committee strives to maintain representation from key stakeholders and consumers from the community and works closely with other standing committees of the Partnership.

The CQI Program will continue to measure quality and outcomes in the system and provide feedback to the Partnership, the grantee, and committees. The annual needs assessment process will also gather data on how the plan is progressing.

In addition to monthly monitoring, the Committee will produce a biannual report to be distributed to the Partnership and committees on the progress, successes and challenges of meeting desired outcomes.

The entire community will have to participate in making this plan a success, and all stakeholders will be involved in evaluation and measurement of progress activities. The Partnership will take the lead in collecting information and measuring results. In addition to the Partnership and its committees, particularly the Strategic Planning Committee, will assume responsibility for monitoring and measuring specific activities. Periodic provider forums will also be used as a means to monitor and measure implementation.

<b>Goal 1: Eliminate barriers to care and treatment to ensure all PLWHA are in care</b>	<b>Activities</b>	<b>Status</b>
Objective 1.1: Improve collaboration among HIV/AIDS providers across the Continuum of Care	1.1.1 Identify gaps and needs for collaboration in the HIV/AIDS provider community	Completed
	1.1.2 Create and implement strategies for sustained provider collaboration	Completed
	1.1.3 Plan and deliver seminars on 'keys to effective collaboration', 'efficient referral and linkage systems', 'sustaining provider relationships'	Completed/Ongoing <sup>1</sup>
	1.1.4 Create 24-hour access to medical care	Completed/Ongoing
<b>Goal 1: Eliminate barriers to care and treatment to ensure all PLWHA are in care</b>	<b>Activities</b>	<b>Status</b>
Objective 1.2: Improve effectiveness of outreach programs	1.2.1 Identify the training needs of frontline HIV/AIDS workers and their organizations	Ongoing
	1.2.2 Support the delivery of enhanced training to outreach providers and individual frontline workers	Ongoing
	1.2.3 Explore, develop or promote training that results in certification of outreach workers	Ongoing
<b>Goal 1: Eliminate barriers to care and treatment to ensure all PLWHA are in care</b>	<b>Activities</b>	<b>Status</b>
Objective 1.3: Create and strengthen linkages between key points of entry and the Continuum of HIV/AIDS care system	1.3.1 Identify gaps in linkages, especially between the key points of entry, case management, and the HIV/AIDS care system	Ongoing
	1.3.2 Support the design of improved linkages, including the development of protocols as needed, for areas identified in the gap analysis	Ongoing
<b>Goal 2: Raise and standardize quality of care/ service delivery to improve health outcomes</b>	<b>Activities</b>	<b>Status</b>
Objective 2.1: Evaluate one-stop shopping models to raise and standardize the quality of care for PLWHA	2.1.1 Identify effective models of one-stop shopping for HIV/AIDS service delivery	Ongoing
	2.1.2 Explore one-stop model; implement and evaluate model	Ongoing
	2.1.3 Support case management organizations in their efforts to design a 'service hub' that results in coordinated service models	Ongoing

<b>Goal 2: Raise and standardize quality of care/ service delivery to improve health outcomes</b>	<b>Activities</b>	<b>Status</b>
Objective 2.2: Improve the quality of customer service in the HIV/AIDS system of care	2.2.1 Identify needs for customer service improvement	Completed/Ongoing
	2.2.2 Promote coordinated provider models and support implementation of standard training on 'excellent customer service' guidelines	Ongoing
	2.2.3 Cooperate with the community to implement 'cultural competence' training	Completed
<b>Goal 2: Raise and standardize quality of care/ service delivery to improve health outcomes</b>	<b>Activities</b>	<b>Status</b>
Objective 2.3: Improve the delivery of case management services	2.3.1 Support data sharing among funders (including Medicaid, ADAP, VA, etc.)	Ongoing
	2.3.2 Develop streamlined, simplified data transfer on PLWHA	Ongoing
	2.3.3 Require compliance with attendance at case management trainings that are required and that meet the minimum standard for 'quality of care' coordination	Completed/Ongoing
	2.3.4 Develop methods to improve the quality and amount of case management supervision, and clarify supervisory responsibilities	Ongoing
	2.3.5 Support the availability of 24-hour emergency case management service in the AIDS/HIV network	Ongoing
<b>Goal 3: Increase the quantity and maximize the effectiveness of resources for care, treatment, and prevention of HIV/AIDS</b>	<b>Activities</b>	<b>Status</b>
Objective 3.1: Increase substance abuse capacity for PLWHA	3.1.1 Identify all available substance abuse service delivery capacity	Completed
	3.1.2 Identify barriers to entry for PLWHA who require substance abuse residential care	Completed
<b>Goal 3: Increase the quantity and maximize the effectiveness of resources for care, treatment, and prevention of HIV/AIDS</b>	<b>Activities</b>	<b>Status</b>
Objective 3.2: Leverage non-Ryan White funding for PLWHA	3.2.1 Identify funding resources, public and private, that are available for PLWHA and service providers	Completed/Ongoing
	3.2.2 Promote optimization of non-Ryan White funds with PLWHA and providers (Activity revised in 2007)	Completed/Ongoing
	3.2.3 Support Ryan White grantees in creating policy that gives 'incentives' for providers that leverage outside funding for HIV/AIDS related services	Ongoing

<b>Goal 3: Increase the quantity and maximize the effectiveness of resources for care, treatment, and prevention of HIV/AIDS</b>	<b>Activities</b>	<b>Status</b>
Objective 3.3: Promote improved knowledge of the HIV/AIDS Continuum of Care	3.3.1 Increase availability of information on HIV/AIDS resources to PLWHA and the provider community; promote 'health literacy' and use of 'AIDSNET' website	Completed/Ongoing
	3.3.2 Support the development of substance abuse "best practice" documentation and dissemination strategies	Completed/Ongoing
	3.3.3 Cooperate on the development of a <i>next-generation communication plan</i> (defined as a new way to communicate to the masses such as social marketing, media placement or internal information sharing) to promote access to care	Completed/Ongoing
<b>Goal 4: Respond in a timely and effective manner to changes in the epidemic</b>	<b>Activities</b>	<b>Status</b>
Objective 4.1: Continue to Monitor trends and publish a semi-annual trend report	4.1.1 Develop a simple, easy-to-understand report to communicate trends in incidence and changes in utilization patterns in various formats and in various settings (forums, focus groups, training sessions, etc.)	Ongoing
<b>Goal 4: Respond in a timely and effective manner to changes in the epidemic</b>	<b>Activities</b>	<b>Status</b>
Objective 4.2: Educate legislators and other officials about HIV/AIDS-related issues	4.2.1 Develop a 'legislative education' packet	Ongoing
<b>Goal 4: Respond in a timely and effective manner to changes in the epidemic</b>	<b>Activities</b>	<b>Status</b>
Objective 4.3: Allocate and reallocate resources to populations and services with emerging needs	4.3.1 Support efforts to tie funding to subgroups and geographic areas that have been found to have the most severe need	Ongoing
<b>Goal 4: Respond in a timely and effective manner to changes in the epidemic</b>	<b>Activities</b>	<b>Status</b>
Objective 4.4: Use education and communication to prepare providers for changes in the epidemic	4.4.1 Update current information on an ongoing basis related to medical issues, insurance, legal challenges, and demographic shifts within the EMA epidemic	Completed/Ongoing
<sup>1</sup> Ongoing refers to the activities which the Committee agreed should remain on the Plan to ensure continued monitoring over the next three years.		