

Philadelphia EMA

Ryan White Part A Comprehensive HIV Care Plan 2010

Executive Summary

Prepared for the Philadelphia Eligible Metropolitan Area Ryan White Part A Planning Council and the Health Resources and Services Administration (HRSA) Washington, D.C.

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Philadelphia EMA Comprehensive Care Plan

Executive Summary

The Philadelphia HIV care plan details the work conducted by the Ryan White Part A Planning Council (RWPC) in their efforts to meet their comprehensive goals and those of the Health Services and Resources Administration (HRSA). All decision making is documented through the work of the RWPC's committees. The plan also reviews Philadelphia's epidemiologic profile and notes those services that are most prioritized by persons living with HIV/AIDS in the Philadelphia eligible metropolitan area. Allocation decisions are also reviewed in this summary.

This Executive Summary provides a synopsis of the complete plan which is approximately 181 pages long. Several data sources were evaluated, analyzed, and synthesized to create the document. The plan has four key sections, with each section addressing the various components of the community planning process. The first section addresses where we currently are. The second section discusses where we need to go. The third section reviews how we will get there and the fourth section notes how we will monitor our progress. There is an additional supplemental piece to the plan. The supplemental document to the plan includes an integrated epidemiological profile that is approximately 350 pages, a review of literature on HIV care, and an integrated resource inventory for HIV care and prevention in the Philadelphia Eligible Metropolitan Area. All of this information adds comprehensive insight into the care needs of the community.

The information contained in the Philadelphia HIV care plan was made possible through the dedicated hard work of members of the Philadelphia RWPC and with the assistance of the Philadelphia AIDS Activities Coordinating Office (AACO). Both parties have spent countless hours of commitment in planning for the well-being of their community. This executive summary is a brief reflection of this work. For the full plan and corresponding information, please visit www.hivphilly.org or call the Office of HIV Planning at (215) 574-6760.

The following information provides an overview of each section and highlights key points to consider.



Section I – Where Are We Now?

Overview

- ➔ Provides a description of the Philadelphia EMA and its HIV care system
 - Socio-demographic information on residents
 - Other vital statistics

- ➔ Provides a scope of the current HIV/AIDS epidemic in the Philadelphia EMA
 - Cumulative, incidence and prevalence HIV/AIDS cases
 - Forecasting future AIDS numbers

- ➔ The EMA's response to the epidemic
 - Discussion of current programs in place to meet client's needs

- ➔ Assessment of need in the Philadelphia EMA
 - Local need assessment results

- ➔ Description of the current continuum of care

- ➔ Integrated resource inventory summary for the EMA

- ➔ Profile of Care Act funded providers by service category

- ➔ Barriers to care

Key Points to Consider

Socio-Demographics

- ➔ The general population of the EMA was 55,357,780 persons in 2009.
- ➔ The 2009 census estimates show 69.85% of the population of the EMA was White, 20.37% was Black, 7.12% Hispanic, 4.57% Asian, .15% American Indian and Alaskan Native, and .03% Native Hawaiian and Pacific Islander
- ➔ White females made up the largest percentage of the total EMA population with 35.73% or 1,914,485, and the largest single age category for this group was those 55 and over with 10.76%.
- ➔ Approximately 3.86% of the estimated 3,574,602 persons 25 and older for whom educational attainment was determined had completed less than ninth grade education. An estimated 16.94% of females and 14.64% of males had either a high school or equivalency diploma.
- ➔ Of the 1,934, 804 households within the nine counties of the Philadelphia EMA, 15.45% speak a language other than English at home, and 3.65% are defined as having linguistic isolation.
- ➔ Philadelphia had the highest percentage of individuals living below the poverty level at 23.79%.
- ➔ In 2009, 15% of persons in New Jersey were uninsured, as were 11% in Pennsylvania, as compared to the United States, which had 17%.
- ➔ Philadelphia had the lowest median income of all nine counties with \$28,926.

HIV/AIDS Epidemic

- ➔ Philadelphia represented 20,720 or 73.76% of the total AIDS cases in the EMA. The county with the second highest number of cases is Camden with 1,945 cases or 6.92% of the EMA total followed by Delaware with 1,640 cases or 5.83% of EMA total.
- ➔ Philadelphia EMA living HIV/AIDS cases combined by exposure, race, age and gender show:

- By exposure, the majority of persons with an HIV or AIDS diagnosis were heterosexuals with 35% of the total. The second-highest group was men who have sex with men at 31% of the total, followed by injection drug users at 26%, and those with both MSM and IDU as a risk factor were at 3%.
- By race and ethnicity, the majority were Black (Non-Hispanic) at 61%, followed by White (Non-Hispanic) at 25%, Hispanics with 12%, and 2% unknown. By age, the majority were 40-49 (36%), followed by 50 and over (32%), 30-39 (20%), 20-29 (11%), and 13-19 (2%) with 0% were unknown.
- By gender, the majority of cases were male (70%).

Unmet Need

- ➔ According to the Philadelphia health department, 7,029 people or 27% of PLWH/A in the Philadelphia EMA were out of care in 2009 and unmet need was higher for PLWH/non-AIDS, who had an unmet need of 39%, compared to 19% for PLWA.
- ➔ PLWH/non-AIDS, males, African Americans and Latinos are over-represented among people not in care.
- ➔ The median time of linkage to care was eight months in Philadelphia County
- ➔ Patients diagnosed in hospital had significantly delayed linkages compared to those diagnosed in public clinics or private physician offices
- ➔ Individuals most at risk lived in geographic areas that were overwhelmingly and disproportionately affected by crime; overwhelmingly and disproportionately poor; overwhelmingly disadvantaged and/or disenfranchised; overwhelmingly suffering from poor living conditions; and overwhelmingly experiencing higher rates of teen births and AIDS.
- ➔ Service gaps were notable mainly for shelter and transportation services.
- ➔ Educational programs should target those without health insurance, those diagnosed in hospitals, heterosexuals, IDUs, and those without concurrent AIDS.
- ➔ A counseling, testing and referral model was developed by the planning bodies and recommended to the health department. This model depicts how an individual who tests negative can still receive prevention messaging, while directing a positive individual through a number of options that would ultimately lead the consumer into care.

Continuum of Care

- The continuum of care is built around the core services of primary medical care, medications, case management, substance abuse treatment, mental health treatment, dental care, early intervention services, home health care, medical nutrition therapy, hospice services and home and community based health services.
 - Of the above services, seven account for more than 75% of the direct service funds requested for the prioritized services in the EMA in FY 2011.
- According to the AIDS Activities Coordinating Office:
 - There are 51 diverse and geographically spread *primary medical care* sites throughout the EMA that are a significant access mechanism to reach clients.
 - There are 79 separate *medical case management* service locations throughout the EMA with a capacity to serve more than 9,000 clients per year.
 - The EMA's *medications* program provides access through various primary care providers including through the pharmacies at all City of Philadelphia Health Centers, and with a CarePlus program that provides free delivery, and free counseling and education programs for EMA consumers.
 - Clients who are in the HIV/AIDS care system can access *substance abuse* and *mental health* treatment services through multiple other systems such as the City's Coordinating Office of Drug and Alcohol (CODAAP), Community Behavioral Health (CBH), and a new HIV/AIDS drop in center that provides screening and referrals for substance abuse services. Mental health treatment is also provided on site at most primary care sites in the city.
 - In 2010, the Planning Council allocated \$672,500 to fund four (4) programs to meet the growing demands for *dental* care services of HIV/AIDS clients. Most providers are large teaching hospital institutions and all participate in the Ryan White Dental Reimbursement Program.
 - *Early intervention services* are available at over 700 locations. These sites include counseling, testing, and partner counseling and referral services sites as well as sites funded through various state and local programs.
 - Part A funds 12 early intervention programs targeting emerging populations including African-American and Latino MSM, women, youth, the recently release from incarceration, and minority heterosexuals.

- A program has been established to provide rapid testing in medical center emergency departments and to make HIV testing part of routine medical care.
- Philadelphia is a CDC directly-funded jurisdiction, and the grantee coordinates all prevention and care activities. The grantee implemented a substantial new initiative within the City of Philadelphia to dramatically increase counseling and testing in primary care settings.
- Eleven programs have been funded to locate clients, address barriers to care link clients to medical care and assure retention in medical care. The EMA funds 18 agencies through Part A and MAI funds to provide *outreach* services. These programs include services operating in both clinical and community-based settings.
- MAI funds support the operation of a storefront program in a high prevalence neighborhood of Chester PA.
 - The storefront provides *counseling and testing, medical care, substance abuse treatment, mental health care, treatment adherence, care outreach and other supportive services* in non-institutional settings in the heart of a community most affected by HIV.

Integrated Resource Inventory

- ➡ There are just under 400 care and prevention provider entries (396) in the full resource directory with 59 services in the Pennsylvania suburbs, 201 in New Jersey and 136 in Philadelphia.

Profile of Care Act Funded Providers

- ➡ Service utilization in 2008 was highest for medical case management (10,634) followed by ambulatory/outpatient medical care (9,186) and then food bank/home delivered meals (3,335). The least used service was emergency financial assistance (45).

Barriers to Care

- ➡ Local research noted that barriers to care included:
 - Stigma, addiction, competing needs, language barriers, income restrictions, cultural barriers, lack of transportation, mental health issues, denial, fear, lack of motivation, long waiting lists, and being ineligible, and lack of knowledge on the available resources as reasons for delaying care.



Section II – Where Do We Need To Go

Overview

- Describes the mission, vision and shared values of the RWPC
- Briefly reviews the continuum of care

Key Points to Consider

Mission

- To serve as a resource for the community at large and to use the plan as a dynamic tool to guide the administration and provision of health and supportive services for people with HIV disease.

Vision

- We envision every person with HIV disease will have fair, equitable and inclusive access to healthcare, support services, and information. Furthermore, this planning body anticipates the day when all services will ensure the best possible health and quality of life for people with HIV disease.

Shared Values

- This plan should serve as a guide for continuous improvement in the Philadelphia EMA service system standards and functions. To this end, the Planning Council embraces the following shared values:
 - Ensure all people with HIV disease have fair, equitable and appropriate access to all EMA services;
 - Improve all care and support services to the highest standard of quality;
 - Provide services that skillfully accommodate and respect the individual needs of each person with HIV disease;
 - Maximize the meaningful participation of people with HIV disease in all levels of the design, delivery and evaluation of care services;
 - Diminish perceived or actual barriers to care and provide high-quality services, thereby attracting people with HIV disease, who are not receiving HIV related services, to seek appropriate and needed care; and,
 - Maximize the quality of life of people with HIV.

➤ National HIV/AIDS Strategy For the United States

- Reduce new infections via targeted education and evidence based HIV prevention approaches to those communities most at risk
- Increase access to care and improve health outcomes for persons living with HIV by establishing a seamless, yet diverse linkage system that supports those experiencing co-occurring health conditions and barriers to their most basic needs
- To reduce HIV-related disparities and health inequities such as mortality, stigma and discrimination via community level approaches
- To achieve a more coordinated national response to the HIV epidemic via improved monitoring and collaboration

➤ Healthy People 2020

- Attain high-quality, longer lives free of preventable disease, disability, injury, and premature death
- Achieve health equity, eliminate disparities, and improve the health of all groups
- Create social and physical environments that promote good health for all
- Promote quality of life, healthy development, and healthy behaviors across all life stages

- The EMA's continuum of care encourages those individuals who are newly infected, underserved, hard to reach or and/or disproportionately impacted in their communities, to link to a geographically networked number of programs and helps them to remain in this comprehensive system of care.



Section III – How Will We Get There?

Overview

- ➔ Reviews the working goals and objectives for the comprehensive plan
 - HRSA's goals
 - Comprehensive Planning goals and objectives
 - Needs Assessment Committee goals and objectives
 - Positive Committee goals and objectives
 - Points of Integration workgroup goals
 - Reviews Planning Council training goals

- ➔ Review of committee work
 - RWPC committees
 - Points of Integration workgroup

Key Points to Consider

Goals

➤ HRSA's goals:

- Goal One: Improve Access to Health Care
- Goal Two: Improve Health Outcomes
- Goal Three: Improve the Quality of Health Care
- Goal Four: Eliminate Health Disparities
- Goal Five: Improve the Public Health and Health Care Systems
- Goal Six: Enhance the Ability of the Health Care System to Respond to Public Health Emergencies
- Goal Seven: Achieve Excellence in Management Practices

➤ Comprehensive Planning Committee goals:

- Goal One: Develop and implement system-wide initiatives to improve quality, efficiency, and coordination of services.
- Goal Two: Develop and implement service-specific initiatives to improve the quality of care.
- Goal Three: Remove social, economic, and structural barriers that keep people with HIV disease from accessing and staying in care.

➤ Needs Assessment Committee goals:

- Goal One: Develop plans to gather data that will help the RWPC in planning to meet service needs.
- Goal Two: For the planning and allocation process, use updated information about the population, the epidemic, and care use and service needs.
- Goal Three: Develop linkages with external entities in order to enhance and support the needs assessment process.

➡ Positive Committee goals:

- Goal One: To increase the skills of people with HIV to enable them to participate in the planning process
- Goal Two: To reach out to the community to increase the number of people with HIV participating in the process.
- Goal Three: To advocate for policies and practices that will encourage and sustain the involvement of people with HIV.

➡ Points of Integration Workgroup goals:

- Add stakeholders from outside the system.
- Needs assessment goals suggested by CDC & HRSA
 - Review epidemiological profile, and look at current provider capacity (hospitals, etc.).
 - Look at HITS information
 - Strategies to incorporate PCRS
 - Collaboration with the Grantee to make suggested actions work within the current HIV/AIDS system of services
 - Review Guidance from both HRSA and the CDC and comprehensive plans from both Planning Council and CPG
 - Where are there overlaps?
 - Look at baselines for data for overlaps?
 - Look at whether there is an influx in prevention system
 - Utilization and relevancy of each intervention?
 - Look at any of the challenges addressing CDC Initiatives
- Looking CDC's indicators, because some of the indicators speak to linkage and share those with Planning Council's Comprehensive Planning.
- Looking beyond just service integration, but also integration through training and CQI.
- Clearly identifying and defining Planning Council's responsibilities, CPG's responsibilities and shared responsibilities.
- Ensuring that all systems are responsive; Making sure where there is intersection there is integration.
- Keep an eye that quality and sensitive services are in place

➡ RWPC training goals:

- Goal One: To maintain the level of knowledge of core competencies (core processes/planning activities, HRSA expectations, HRSA guidance for planning activities, etc.) for Planning Council members.
- Goal Two: To expand the Planning Council knowledge of components of Comprehensive Plan.

- Goal Three: To enrich and enhance the Planning Council knowledge of some of the issues affecting the local HIV continuum of care as identified in the Comprehensive Plan.
- Goal Four: To explore the linkages between HIV prevention, other federally funded Titles of the CARE Act, SAMSHA, CBH, STDs, teen pregnancy initiatives, clinical trials, etc.

Committee Work

- ➔ In 2009-2010, the Comprehensive Planning Committee reviewed epidemiological data, unmet need data, service utilization data, Women Infant Child Youth (WICY) data, the Care Act Data Report (CADR), client services information, housing numbers, and quality management. Discussions topics in 2009-2010 included assessing linkages between care and prevention, reviewing the continuum of care between HIV and behavioral health, examining the Health Insurance Premium/Cost Sharing Assistance service category to determine if it can be utilized to assist in consumer needs, and review of the national HIV/AIDS strategy and the health care reform act. The committee also spent a few months in 2010 reviewing and improving their new data driven priority setting tool.
- ➔ The Finance Committee reviewed reallocation requests throughout the 2009-2010 planning year. Members also evaluated their allocation process and opted to add three additional pieces of data. The first was a category called “payer of last resort to better link allocations to the service priorities list. The second was an average over and under spending category shown regionally over the last six years and the third was an overall percentage of service dollars shown by service category. The resource allocation process was also altered to use HIV/AIDS cases to determine regional percentages. With level funding and a slight increase in the supplemental portion of the monies, the group voted to restore dollars to food bank/home-delivered meals and legal services in New Jersey, to allocate \$50,000 to nutritional services in the Pennsylvania counties and to allocate additional dollars to Early Intervention Services in Philadelphia (to fill a gap caused by the state – Part B funding). Members of the committee were also actively involved in the decision making around 2010 priority setting meetings.
- ➔ In 2009-2010, the Needs Assessment Committee discussed potential topics for consideration. Topics of interest included: food bank/home delivered meals and legal services in New Jersey, immigrant needs and the 50+ HIV positive populations. The committee also received a presentation on the numerous needs assessment activities

conducted over the past few years as a form of review. The committee spent several meetings. Members also spent several meetings working on the annual regional town halls and reviewing possible questions for a focus group on food bank/home delivered meals and legal services in New Jersey. Other activities for this group included: researching the needs of the 50+ HIV positive populations, providing feedback on the results from the New Jersey focus groups, developing a short survey on the immigrant population's needs and sending it out to providers in the region, and creating an online version of the town hall survey. Members of this committee were also actively involved in the 2010 priority setting meetings.

- ➔ The Nominations Committee discussed strategies and timelines for recruiting new members in 2009-2010, members also had a co-chair election during the term and conducted a membership satisfaction survey for the Planning Council. Also, a small process change was to recommend adding language to the bylaws requiring the Office of HIV Planning to report any member resignations to the committee.
- ➔ The Positive Committee began their planning cycle by holding elections for a new co-chair. There were also numerous educational presentations for members of this committee. Some brainstorming activities by the group included discussing articles and submissions for the Positive Committee Newsletter, reviewing the Positive Committee brochure, and dialogue on future meeting topics, outreach possibilities, and volunteer opportunities. Another group activity conducted in 2010 was a consumer empowerment training workshop.
- ➔ The Policies and Procedures Committee met in April 2010 to review language in their bylaws and make some housekeeping changes as opposed to policy changes. An issue to be discussed in the near future is sub-committee attendance.
- ➔ In 2009-2010, the Points of Integration workgroup presented the work they had conducted at the All Titles Conference meeting in Pennsylvania. Members also reviewed the work of the health department's integration workgroup and discussed the release of their White Paper on integration. Ongoing data sharing and dialogue is occurring with the health department and the Hepatitis delivery system. Members also discussed in detail Dr. Fenton's grand rounds presentation at Drexel University on Program Collaboration and Service Integration (PCSI). Another key discussion for the group was the prevention with positives best practices guide. Some next steps for the group are to continue with this best practices guide and a collaboration resource list.



Section IV – How Will We Monitor Our Progress?

Overview

- Implementation Plan
- Description of the priority setting and resource allocation process

Key Points to Consider

- The FY2010 Implementation Plan was used by the Planning Council and the Comprehensive Planning Committee during their 2011 fiscal year's priority setting and allocations process. The table reflects service goals and actual services provided for the 2010 fiscal year, which ran from March 1, 2009 through February 28, 2010.
- The priority setting tool developed in 2008-2009 used six factors by which each service category would be reviewed. The factors were as follows:
 - Payer of last resort
 - There are no other sources of funding available to support the services
 - Service Utilization
 - The data supporting the utilization of the service under Part A during a given time period.
 - Consumer priority
 - Based on needs assessment and consumer input
 - Access to or maintenance in care
 - Does the service assist in accessing services or helping to maintain the client in a system of care?
 - Specific gaps or emerging needs
 - Has the service been identified as a service delivery gap or emerging consumer need?
 - Core Service
 - Is the service defined as a core service?
- Each factor had a group assigned weight applied to it. Consumer priority and access to/maintenance in care were given a 25% weight each, service utilization 10%, specific gaps/emerging needs 15%, payer of last resort 20%, and core services was given 5%

- ➔ Worksheets defined each service category and then listed the six factors with their corresponding 1 to 8 scale (1 = low value and 8 = high value). Members individually assigned a value for each factor under each service category
- ➔ A score card that reflected trend and needs assessment data was used to aid in the decision making
- ➔ Three committees participated in scoring the worksheets. The scoring methodology used proportional representation when there are differences that prevent the group from reaching consensus. The services were then arranged from the highest total score to the lowest. See results in table below:

Philadelphia EMA-Wide Priorities for FY 2011

FY10	Service Category	FY11	Service Category
1	Medical Case Management (including treatment adh.)	1	Medical Case Management (including treatment adh.)
2	Oral Health Care (Dental)	2	Medications (Drug Reimbursement program)
3	Medical Transportation	3	Outpatient/Ambulatory Health Services
4	Medications (Drug Reimbursement program)	4	Oral Health Care (Dental)
5	Housing (Assistance) Services	5	Food Bank/Home Delivered Meals
6	Outpatient/Ambulatory Health Services	6	Medical Transportation
7	Food Bank/Home Delivered Meals	7	State ADAP
8	Outreach Services (Care Outreach)	8	Housing (Assistance) Services
9	Mental Health Services	9	Outreach Services (Care Outreach)
10	Psychosocial Support Services	10	Health Insurance Premium & Cost Sharing Assistance
11	Health Insurance Premium & Cost Sharing Assistance	11	Mental Health Services
12	Substance Abuse Services (Outpatient)	12	Psychosocial Support Services
13	State ADAP	13	Early Intervention Services
14	Legal Services	14	Substance Abuse Services (Outpatient)
15	Emergency Financial Assistance (DEFA)	15	Medical Nutrition Therapy
16	Medical Nutrition Therapy	16	Referral for Health Care/Support Service
17	Early Intervention Services	17	Legal Services
18	Linguistics Services (Translation and Interpretation)	18	Linguistics Services (Translation and Interpretation)
19	Home & Communitybased Health Services	19	Home Health Care
20	Treatment Adherence Counseling	20	Emergency Financial Assistance (DEFA)
21	Home Health Care	21	Treatment Adherence Counseling
22	Child Care Services (Day care)	22	Case Management (non-medical)
23	Health education/Risk reduction	23	Health education/Risk reduction
24	Substance Abuse Services (Residential)	24	Child Care Services (Day care)
25	Respite Care	25	Home & Communitybased Health Services
26	Case Management (non-medical)	26	Substance Abuse Services (Residential)
27	Hospice Services	27	Respite Care
28	Referral for Health Care/Support Service	28	Hospice Services
29	Rehabilitation Services	29	Rehabilitation Services
30	Program Support	30	Program Support

Service Categories in RED are core services

Source: Office of HIV Planning, 2010

- The Philadelphia EMA Ryan White Part A Planning Council FY 2011 allocation is based on percentages of the 2008 Living HIV and AIDS cases in each of the regions. The 2008 living HIV and AIDS cases are:

18,634	75.84%	Philadelphia
3,270	13.31%	PA Counties
2,666	10.85%	NJ Counties
<hr/>		
24,570	100%	EMA Wide

- The Pennsylvania Suburban Counties Allocation group noted that Transportation services have been under-spent in the last 3 years. Additionally, Nutritional Services had not been procured at the time the allocation meeting took place as noted by the grantee.
- The New Jersey Counties Allocation group's *Instructions to the Grantee* were:
 - That after the 2011-2012 award is received, the extent of the changes to ADAP are to be reviewed to determine if additional funding is required to meet the needs of consumers in the New Jersey region. Any shift in funding to ADAP in New Jersey would occur in the event of an increase in funding for the region.
- The Philadelphia County Allocation group's *Instructions to the Grantee* were:
 - For the grantee to assess the need and feasibility of the implementation of Health Insurance Premium & Cost Sharing in this EMA by looking at other EMA's plans. The results are to be reported back to Needs Assessment Committee. (Note for Comp Planning and Needs Assessment to possibly look at conducting a needs assessment activity)
 - Based on the outcomes from the OHP's research, (taking into consideration the recent CDC research that indicates that heterosexuals in poverty are at a greater risk), and to apply services so that they go to the populations shown to be at risk in this EMA. What are their service needs? The results to be reported back to Needs Assessment Committee.

Ryan White Part A Philadelphia EMA: Total Allocations in Dollars and Funding Percent (FY 2010-11 Level)

Core Service Categories	Allocations	Funding (%)
AIDS Drug Assistance Program (ADAP)	\$5	0.00%
Ambulatory Care	\$5,688,249	29.23%
Case Management	\$6,224,564	31.98%
Drug Reimbursement Program	\$1,785,984	9.18%
Early Intervention Services	\$1,229,262	6.32%
Health Insurance Premium & Cost Sharing Assistance	\$5	0.00%
Home & Comm-based Hlth Srvcs/Home Health Care /Hospice Srvcs	\$0	0.00%
Mental Health Therapy/Counseling	\$279,665	1.44%
Nutritional Services	\$50,000	0.26%
Oral Health Care	\$701,312	3.60%
Substance Abuse Treatment-Outpatient	\$340,198	1.75%
Core Service Allocation %		83.74%
Support Service Categories		
Care Outreach	\$709,642	3.65%
Case Management (Non-Medical)	\$0	0.00%
Child Care Services & Day or Respite Care	\$0	0.00%
Emergency Financial Assistance	\$66,858	0.34%
Food Bank/Home-Delivered Meals	\$246,934	1.27%
Health Education/Risk Reduction	\$0	0.00%
Housing Assistance	\$556,632	2.86%
Information & Referral (System-wide 1.63%)	\$0	1.63%
Legal Services	\$312,760	1.61%
Psychosocial Support Services	\$0	0.00%
Rehabilitation Care	\$0	0.00%
Substance Abuse (Residential)	\$0	0.00%
Translation & Interpretation	\$0	0.00%
Transportation	\$705,254	3.62%
Treatment Adherence (Case Management)	\$248,257	1.28%
Subtotal		16.25%
	\$19,145,500	100.00%

Source: Office of HIV Planning, 2010



