

2012 Year End Report

April 2014

Los Angeles County Department of Public Health

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Chapter 1. Introduction

Background

Los Angeles County is home to an estimated 60,050 people living with HIV/AIDS. As of December 31, 2013, there are 50,550 diagnosed HIV/AIDS cases and an additional 9,500 cases are estimated to be undiagnosed, (i.e. people who are unaware of their HIV infection).

The Division of HIV and STD Programs (DHSP) coordinates the overall response to HIV/AIDS in Los Angeles County in collaboration with community-based organizations, governmental bodies, advocates and people living with HIV/AIDS. DHSP's main funding sources are the Health Resources and Services Administration (HRSA) Ryan White Program (RWP Part A and Minority AIDS Initiative [MAI]), the Centers for Disease Control and Prevention (CDC), the State of California Office of AIDS Single Allocation Model (SAM or RWP Part B), and Los Angeles County general funds. Several other funding sources support special projects or research studies. These include funding from Substance Abuse and Mental Health Services Administration (SAMHSA), National Institutes of Health (NIH), and California HIV/AIDS Research Program (CHRP). DHSP utilizes these fiscal resources to manage over 200 contracts within a network of more than 100 community-based organizations and County departments in an effort to maximize access to quality services for people living with HIV/AIDS.

RWP Part A is the largest funding source for HIV care and treatment services. DHSP also receives RWP Part B/SAM Care funds from the California State Office of AIDS for HIV care and treatment services. Additionally, DHSP uses County general funds (Net County Cost or NCC) to support HIV care and treatment services. Table 1.1 describes the funding breakdown in fiscal year (FY) 2012.

Table 1.1: DHSP HIV Care and Treatment Funding Description for FY 2012

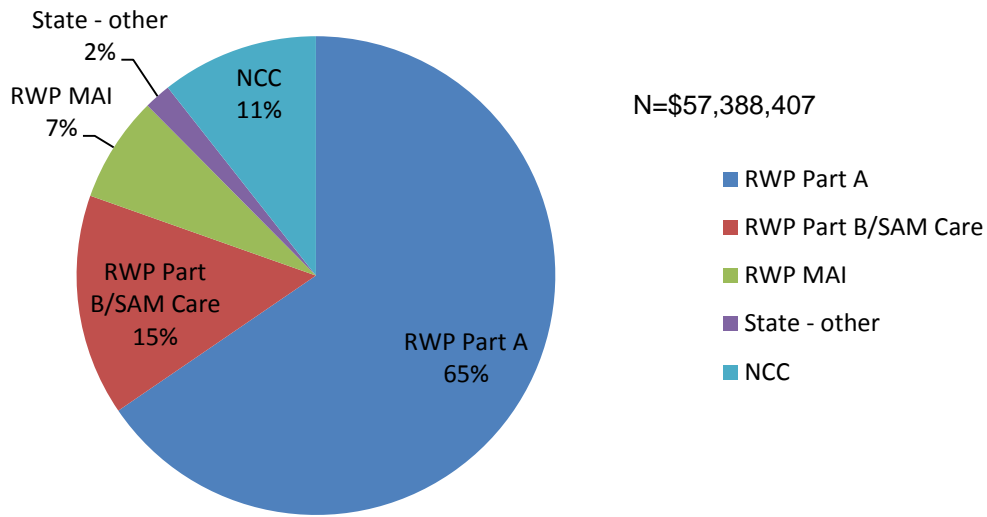
Funding Source	Funding Term	Amount of Funding Available	Amount Used for Direct Services	Percentage of Funds Used for Direct Services
RWP Part A	3/1/2012 – 2/28/2013	\$37,564,716	\$32,232,465	85.8%
RWP Part B /SAM Care	7/1/2012 – 6/30/2013	\$8,582,596	\$7,724,336	90.0%
RWP MAI	3/1/2012 – 2/28/2013	\$4,109,303*	\$3,780,619	92.0%
State – Other	7/1/2012 – 6/30/2013	\$1,038,006*	\$364,754	35.1%
NCC	7/1/2012 – 6/30/2013	\$6,093,786	\$2,463,445	40.4%
Total		\$57,388,407	\$46,565,619	81.1%

Data Source: Summary Consolidated YR 22 – Final Report 2/21/2014, DHSP Financial Services Division.

*The RWP MAI amount includes FY 2012 funding amount and the carryover amount from FY 2011 unspent funds. The State-Other amount includes ADAP enrollment and the Center for Substance Abuse Treatment and Prevention (CSAT/CSAP) grant.

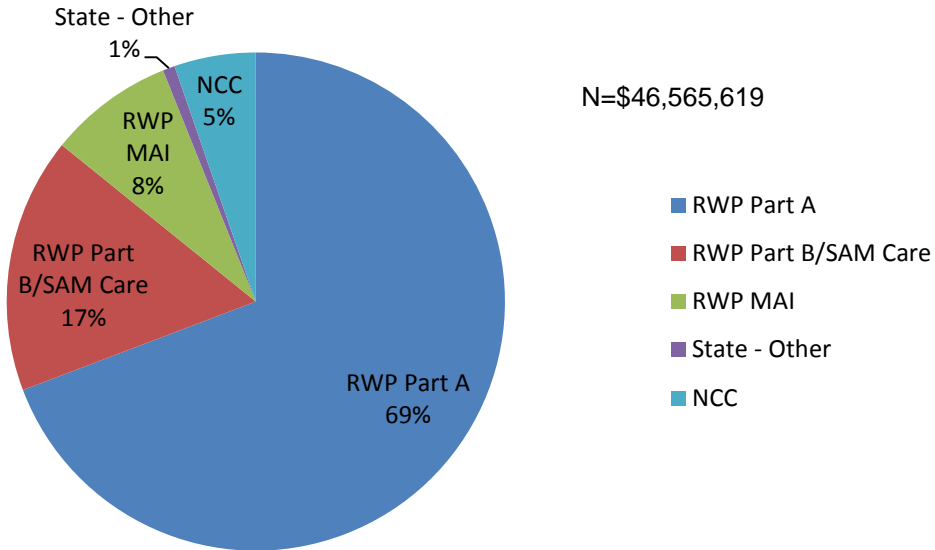
Figure 1.1 provides the percentage of DHSP funds available for HIV care and treatment services by funding source in FY 2012. Figure 1.2 shows the percentage of DHSP direct expenditures by funding source for HIV care and treatment services in FY 2012.

Figure 1.1. Percentage of DHSP HIV Care and Treatment Funds Available, by Funding Source, FY 2012



Data Source: Summary Consolidated YR 22 – Final Report 2/21/2014, DHSP Financial Services Division

Figure 1.2. Percentage of DHSP HIV Care and Treatment Direct Expenditures by Funding Source, FY 2012



Data Source: Summary Consolidated YR 22 – Final Report 2/21/2014, DHSP Financial Services Division

This report presents an overview of the services funded and utilized during FY 2012, and descriptions of clients receiving these services.

Ryan White Program Priorities and Allocations

The RWP requires a local planning council to determine service priorities and allocations. In Los Angeles County, this task is accomplished by the Los Angeles County Commission on HIV (Commission). The Commission determines priorities and allocations for RWP Part A and State RWP Part B/SAM Care funding during a five-month process, primarily at the Planning, Priorities and Allocations (PP&A) Committee meetings. The PP&A decision-making process includes the following steps: 1) framework, paradigms, operating values and funding scenarios; 2) review of the HIV/AIDS epidemiologic profile; 3) presentation of needs assessment and service utilization data; 4) priority-setting; 5) resource allocations; 6) “how best to meet the need” and “other factors to be considered”; and 7) disposition of appeals, if any. The Commission approves the final recommendations made by the PP&A Committee. DHSP then develops contracts and procures services according to the recommendations of the Commission. RWP Minority AIDS Initiative allocations are determined in a separate but similar process.

Services Funded for FY 2012

In LAC, FY 2012 was a transitional year for HIV care and treatment services. California’s early adoption of health care reform enabled Medi-Cal expansion that provided access to health insurance coverage for hundreds of thousands of low income residents. Many HIV-positive patients in the Ryan White care system became eligible for Medi-Cal managed care and Healthy Way LA, the local Low Income Health Program (LIHP) run by the County of Los Angeles Department of Health Services. Because Ryan White Program has a “payer of last resort” mandate, this means that many LIHP-eligible patients could no longer use RWP for their medical visits and prescription drug coverage for their HIV care. This created a massive health system shift requiring significant planning and coordination in order to ensure continuity of care and parity of services across different payer systems. The Commission has also restructured the HIV care and treatment service clusters and categories in order to better align the services with the health care reform environment.

During the same year, DHSP completed its ambulatory outpatient medical (AOM) service solicitation using a performance-based fee-for-service (FFS) payment model for HIV medical services, which transforms the RWP-supported HIV medical care locally. This transition revealed crucial insight on how visits and patients with different insurance payer sources had been accounted for in the electronic reporting system (Casewatch) as each visit, lab or x-ray would now be tied directly to a specific RW-eligible patient. However, the FFS AOM contracts were implemented in January 2013, at the tail end of FY 2012; therefore the impact of the transition was not apparent in the FY 2012 data. This is true for the LIHP transition data as well, since the client transition continued to occur gradually during 2012. We expect to see the result of these changes in the FY 2013 report.

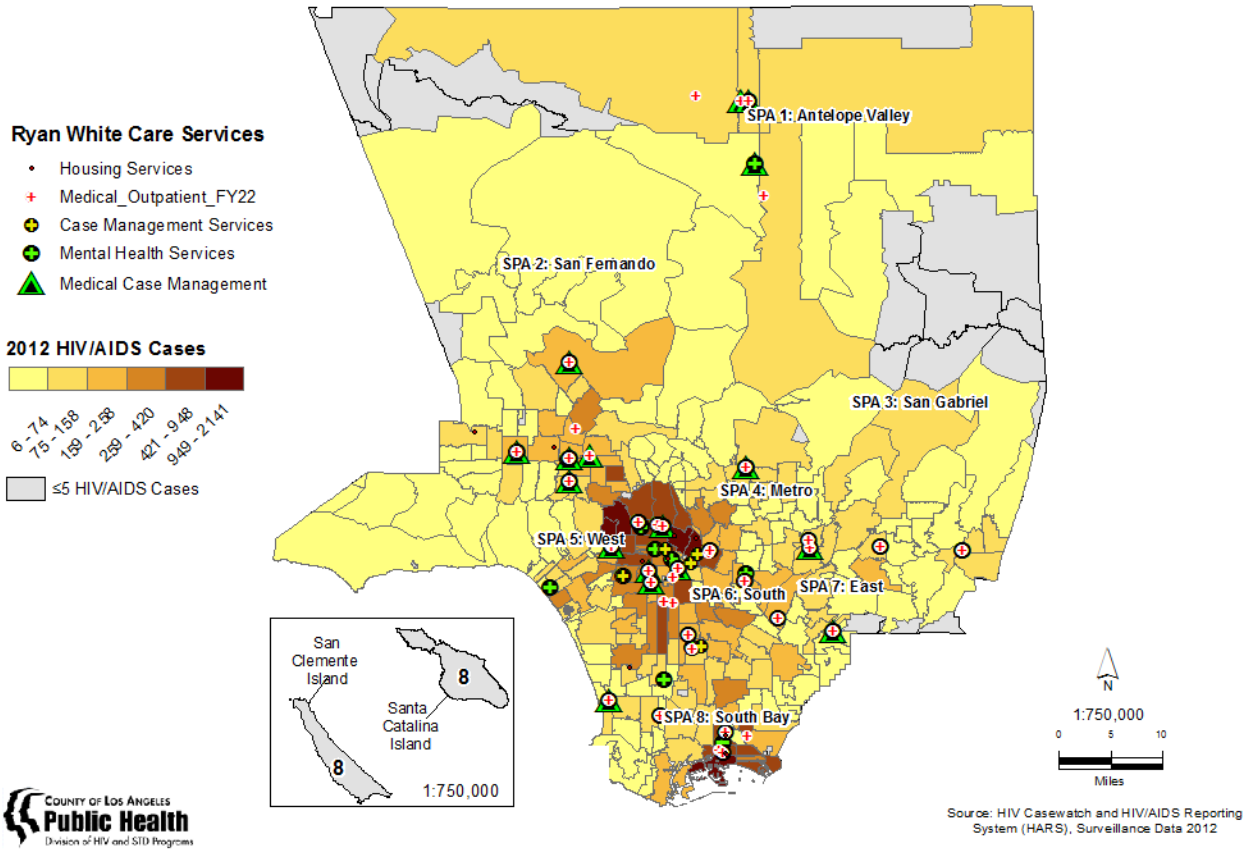
Table 1.2 below lists services that can be supported with HRSA RWP funds, prioritized and allocated by the Commission, and services funded by DHSP in FY 2012. Figure 1.3 illustrates the distribution of service sites and living HIV/AIDS cases by service planning area (SPA).

Table 1.2: Services fundable by HRSA, prioritized and allocated by Commission on HIV, and funded by DHSP in FY 2012

HRSA Service Categories	Prioritized by Commission	Allocated by Commission with RWP Part A/B	Funded by DHSP
Core Medical Services			
<ul style="list-style-type: none"> • Outpatient/ Ambulatory Medical Care • AIDS Drug Assistance Program (ADAP) • AIDS Pharmaceutical Assistance • Oral Health Care • Early Intervention Services • Health Insurance Premium & Cost Sharing Assistance • Home Health Care • Home & Community-based Health Services • Hospice Services • Mental Health Services • Medical Nutrition Therapy • Medical Case Management (including Treatment Adherence) • Substance Abuse Services (Outpatient) 	<ul style="list-style-type: none"> • Medical Outpatient/Medical Specialty • Medication Assistance and Access <ul style="list-style-type: none"> ▪ ADAP/ADAP Enrollment ▪ Local Pharmacy Program/Drug Reimbursement • Oral Health Care • Mental Health Services <ul style="list-style-type: none"> ▪ Mental Health, Psychiatry ▪ Mental Health, Psychotherapy • Linkage to Care Services <ul style="list-style-type: none"> ▪ Treatment Education ▪ Early Intervention Services ▪ Outreach • Medical Care Coordination <ul style="list-style-type: none"> • Case Management, Medical • Medical Nutrition Therapy • Substance Abuse Services <ul style="list-style-type: none"> • Substance Abuse Treatment • Long-Term and Palliative Care <ul style="list-style-type: none"> ▪ Skilled Nursing ▪ Hospice • Home-Based Care <ul style="list-style-type: none"> ▪ Case Management, Home-based (Home and Community-based Health Services) 	<ul style="list-style-type: none"> • Medical Outpatient/Medical Specialty • Medication Assistance and Access <ul style="list-style-type: none"> ▪ ADAP/ADAP Enrollment ▪ Local Pharmacy Program/Drug Reimbursement • Oral Health Care • Mental Health Services <ul style="list-style-type: none"> ▪ Mental Health, Psychiatry ▪ Mental Health, Psychotherapy • Linkage to Care Services <ul style="list-style-type: none"> ▪ Early Intervention Services • Medical Care Coordination <ul style="list-style-type: none"> • Case Management, Medical • Medical Nutrition Therapy • Substance Abuse Services <ul style="list-style-type: none"> • Substance Abuse Treatment • Long-Term and Palliative Care <ul style="list-style-type: none"> ▪ Skilled Nursing ▪ Hospice • Home-Based Care <ul style="list-style-type: none"> ▪ Case Management, Home-based (Home and Community-based Health Services) 	<ul style="list-style-type: none"> • Medical Outpatient • Medical Specialty • ADAP/ADAP Enrollment • Oral Health Care • Mental Health, Psychiatry • Mental Health, Psychotherapy • Case Management, Medical • Early Intervention Services • Medical Nutrition Therapy (SPA 1 only) • Substance Abuse, Treatment • Case Management, Home-based

HRSA Service Categories	Prioritized by Commission	Allocated by Commission with RWP Part A/B	Funded by DHSP
Support Services			
<ul style="list-style-type: none"> • Case Management (non-medical) • Child Care Services • Emergency Financial Assistance • Food Bank/Home-Delivered Meals • Health Education/Risk Reduction • Housing Services • Legal Services • Linguistic Services • Medical Transportation Services • Outreach Services • Psychosocial Support Services • Referral for Health Care/Supportive Services • Rehabilitation Services • Substance Abuse Services (Residential) • Treatment Adherence Counseling 	<ul style="list-style-type: none"> • Benefits Support <ul style="list-style-type: none"> ▪ Benefits Specialty • Substance Abuse Services <ul style="list-style-type: none"> ▪ Substance Abuse, Residential • Medical Care Coordination <ul style="list-style-type: none"> ▪ Case Management, Non-medical • Medical Transportation • Residential Services <ul style="list-style-type: none"> ▪ Residential, Transitional ▪ Residential, Permanent • Nutrition Support • Case Management, Transitional • Housing Supportive Services <ul style="list-style-type: none"> ▪ Direct Emergency Financial Assistance ▪ Case Management, Housing • Legal Services • Language/Interpretation • Child Care Services • Rehabilitation Services • Health Education/Risk Reduction • Outreach Services • Referral Services • Peer Support • Respite Care • Psychosocial Support 	<ul style="list-style-type: none"> • Benefits Support <ul style="list-style-type: none"> ▪ Benefits Specialty • Substance Abuse Services <ul style="list-style-type: none"> ▪ Substance Abuse, Residential • Medical Care Coordination <ul style="list-style-type: none"> ▪ Case Management, Non-medical • Nutrition Support • Medical Transportation • Case Management, Transitional 	<ul style="list-style-type: none"> • Benefits Specialty • Substance Abuse, Residential • Case Management, Non-medical • Nutrition Support • Medical Transportation • Case Management, Transitional • Language Services • Legal Services • Residential Services

Figure 1.3. Distribution of DHSP-funded HIV Care and Treatment Service Site and HIV/AIDS Cases within Los Angeles County by Service Planning Area and Zip Code, FY 2012



A Few Words about Data

This report represents service utilization among clients receiving DHSP-funded HIV care and treatment services in Los Angeles County during FY 2012 (March 2012 to February 2013). Several data sources were used to present this service utilization profile. The primary data source for this report is Casewatch, DHSP’s client-level data reporting system, extracted and analyzed by the DHSP, Research and Evaluation. Although some providers use Casewatch to track all of their clients, regardless of whether they are funded by DHSP, this report **only** represents those clients who received services funded by DHSP. In this report clients reported in Casewatch are referred to as RWP clients even though funding sources for services received may differ. Service utilization for some Net County Cost (NCC) supported service categories are not tracked in Casewatch; they are collected through individual tracking systems at the funded agencies and reported to DHSP through program reports. These data are provided by DHSP Care Services Division. Data for the state AIDS Drug Assistance Program (ADAP) enrollment are obtained through Ramsell, the State-contracted pharmacy administrator for ADAP.

Financial data for each service category are presented in terms of year-end expenditures and are presented in table form by funding source, (e.g. Part A, Part B/SAM Care, Other) and final combined total expenditures. The Commission allocations for RWP Part A, Part B/SAM Care, and MAI are based on their initial allocation plan. Subsequent allocation revisions are reflected in the expenditures. RWP MAI, NCC, and other expenditures are included in “Other” with footnotes indicating the funding source and year-end expenditures.

For both the utilization data and financial data, multiple time frames are included because of the varied funding cycle for each funding source. Tables 1.3 and 1.4 describe the data periods for service utilization and financial data.

Table 1.3: Service Utilization Data Periods by Funding Source

Funding Source	Data Period
HRSA - RWP Part A	March 1, 2012 – February 28, 2013
HRSA - RWP MAI	
State RWP Part B/SAM Care	July 1, 2012 – June 30, 2013
County NCC	

Table 1.4: DHSP Financial Data Periods by Funding Source

Funding Source	Data Period
HRSA - RWP Part A	March 1, 2012 – February 28, 2013
HRSA - RWP MAI	
State RWP Part B/SAM Care	July 1, 2012 – June 30, 2013
County NCC	

Chapter 2. Client Summary

In FY 2012, 20,236 unduplicated clients receiving DHSP-funded HIV care and treatment services were reported in Casewatch, representing approximately 45% of the estimated number of people diagnosed with HIV/AIDS in Los Angeles County. Of those, 16,587 (82%) had at least one medical visit. During the same year, 2,343 new clients were enrolled in the DHSP-funded system of HIV care. Approximately 70% of new clients accessed DHSP-funded medical care in FY 2012. A detailed demographic profile of the overall clients and clients who accessed DHSP-funded medical care is presented in Appendix A.

The following tables and graphs present further and more in-depth demographic characteristics of clients served in FY 2012, along with their distribution by SPA, and include highlights on services they accessed.

Distribution of Clients by Gender, Race/Ethnicity, Age, and HIV Status

In FY 2012, 86.1% of all DHSP-funded RWP clients were male, 12.2% were female, and 1.7% were transgender. As a percentage, Latino/as accounted for 47.8% of clients, Whites represented 24.5%, African Americans 23.4%, and Asian/Pacific Islanders 3.5%.

Figure 2.1. Gender Distribution of All RWP Clients, FY 2012 (N=20,236)

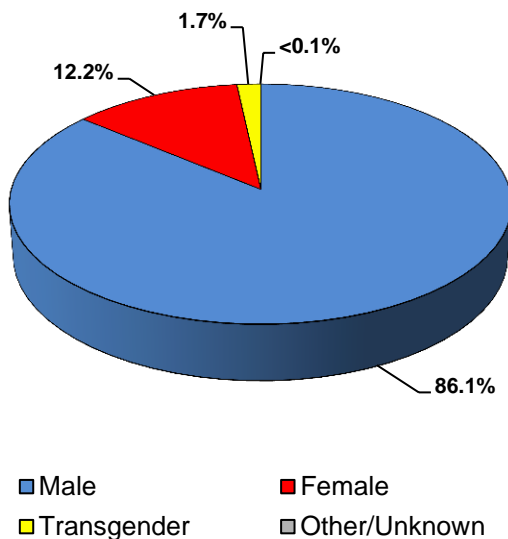
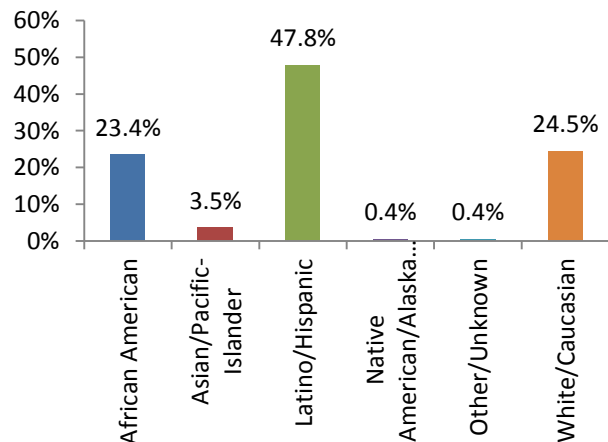


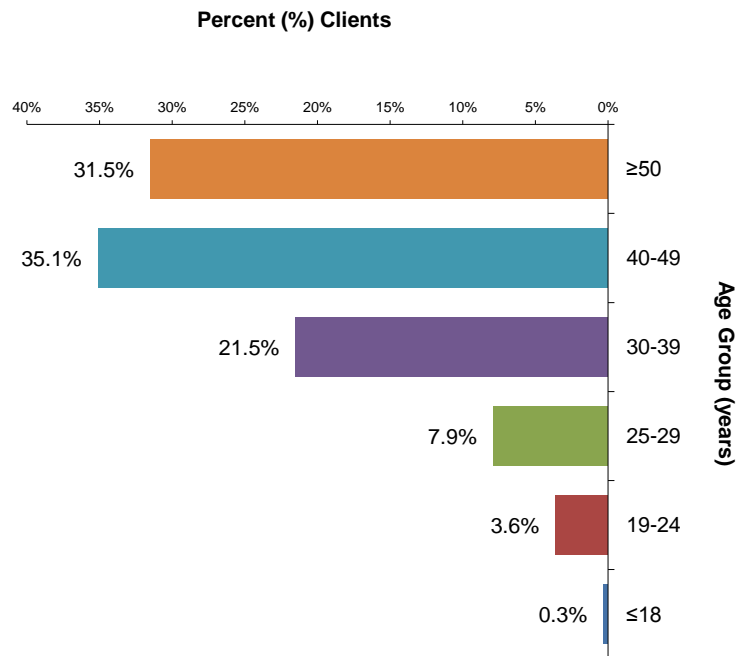
Figure 2.2. Race/Ethnicity of All RWP Clients, FY 2012 (N=20,236)



Data Source: Casewatch FY 2012 (March 2012 - February 2013)

Figure 2.3. Age Group Distribution of All RWP Clients, FY 2012 (N=20,236)

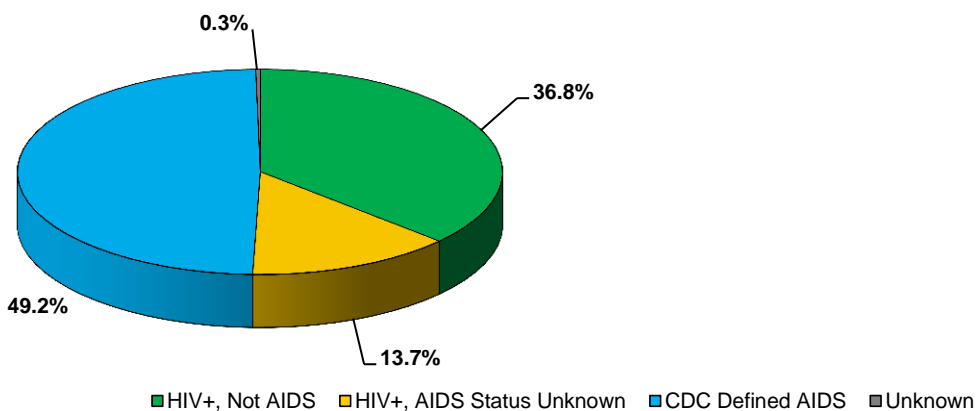
The age distribution of all clients closely mirrors that of the local HIV epidemic. The largest age group was for clients between ages 40-49 (35.1%), followed by 31.5% of clients 50 years and older, and 21.5% between 30-39 years old. Approximately 11.5% of young people, ages 19-29 received local RWP services in FY 2012.



Data Source: Casewatch FY 2012 (March 2012 - February 2013)

Almost half (49.2%) of RWP clients served during FY 2012 had CDC-defined AIDS, while nearly 37% were HIV-positive, but did not have AIDS, and 14% had HIV but an unknown AIDS diagnosis.

Figure 2.4 HIV/AIDS Status of All RWP Clients, FY 2012 (N=20,236)



Data Source: Casewatch FY 2012 (March 2012 - February 2013)

Distribution of Clients by Poverty Level and Medical Insurance Status

The RWP supports the majority of all DHSP-funded HIV care and treatment services. Targeted to serve vulnerable and underserved persons living with HIV and AIDS (PLWHA), the RWP services engage a high proportion of clients who have no medical insurance and who live below the federal poverty level (FPL).

Figure 2.5. Primary Medical Insurance Status of All RWP Clients, FY 2012

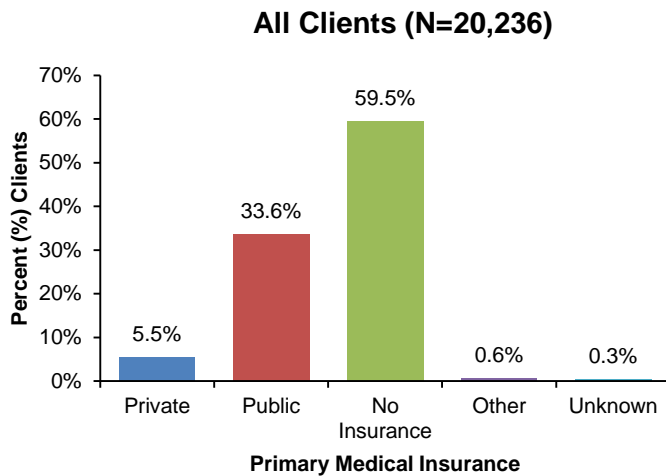
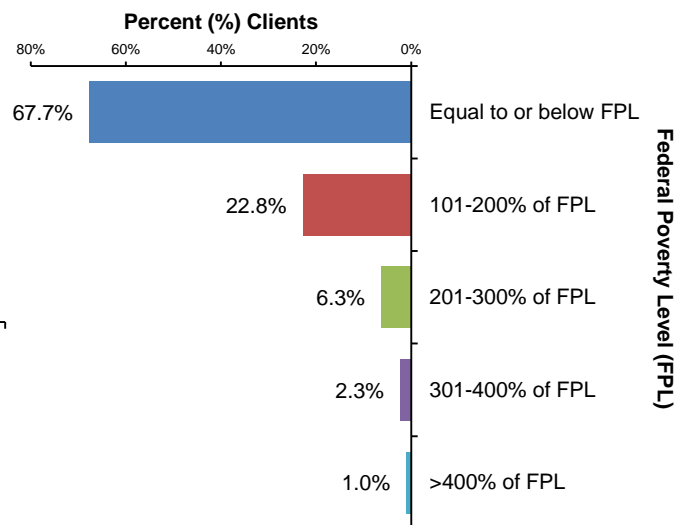


Figure 2.6. Distribution of All RWP Clients by Federal Poverty Level, FY 2012 (N=20,236)



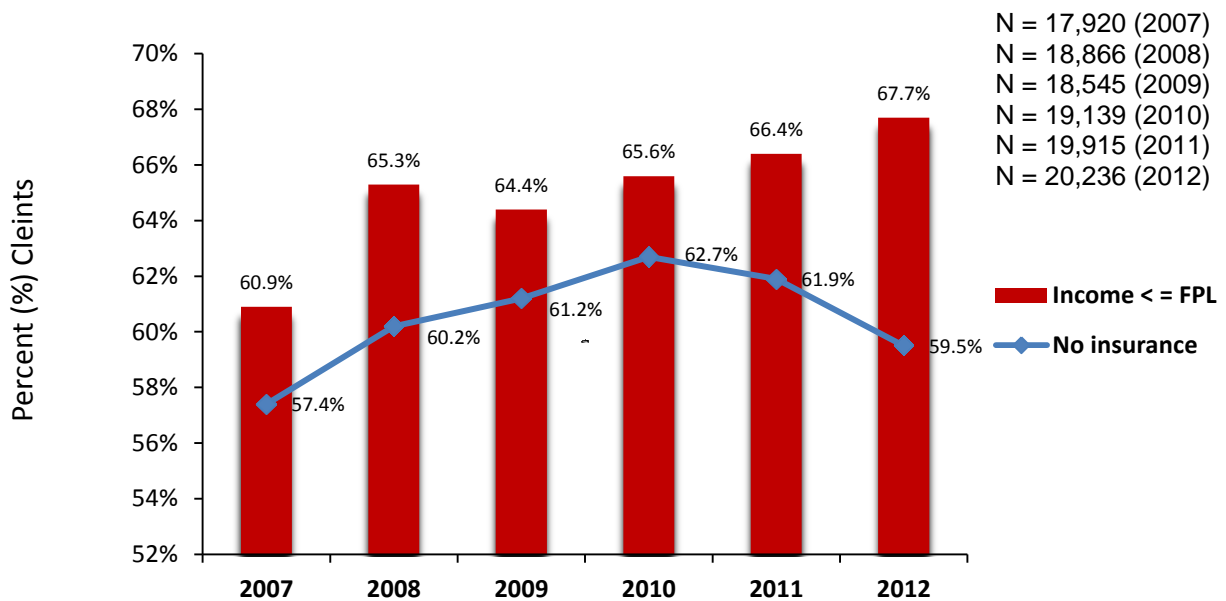
Data Source: Casewatch FY 2012 (March 2012 - February 2013)

The RWP is the payer of last resort; therefore, clients with other insurance may access RWP services only if those services are not covered by their insurance, or if the client received services at a time when they were not covered by the other insurance. Private insurance was not used to pay for RWP services, nor were such clients eligible to receive RWP services for any services which their insurance covered.

Between FY 2007 and FY 2012, the proportion of RWP clients who lived in poverty gradually increased to 67.7%. In FY 2007, 60.9% of clients lived at or below 100% FPL; in FY 2011, 66.4% lived at or below 100% FPL.

For the second consecutive year since 2010 there was a downward trend in uninsured status with 59.5% of clients without any form of insurance coverage in FY 2012. This is down from a high of 62.7% of clients without any form of insurance reached in FY 2010, a likely result of Medi-Cal expansion and expanded insurance coverage as part of California's early adoption of health care reform efforts.

Figure 2.7. Proportion of RWP Clients Who Lived At or Below Federal Poverty Level, FY 2007 – 2012 and Who Had No Health Insurance



Data Source: Casewatch FY 2007 - 2012 (March 2007 - February 2013).

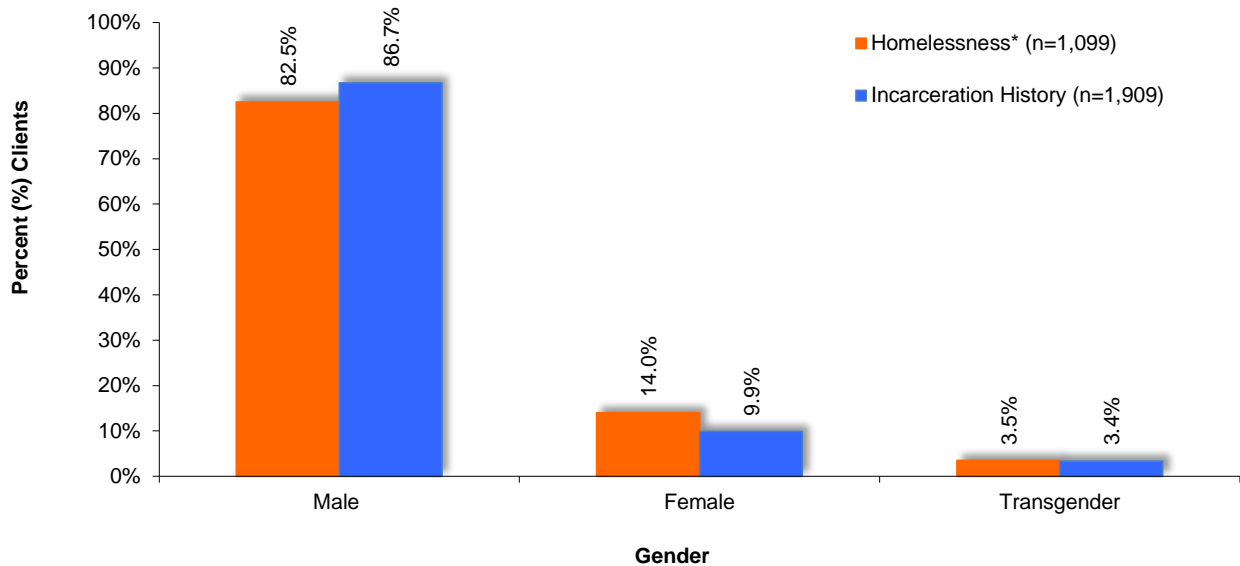
Clients with Special Needs: Homelessness, Incarceration, Mental Illness, and Substance Abuse

Many clients in the care system face additional challenges that could affect their ability to seek care. Nearly 2 in 10 RWP clients have been incarcerated at some point in their life with over 9% of RWP clients reported having been incarcerated in the last 24 months. Another 10% reported incarceration more than two years ago. Almost 5.5% of RWP clients in FY 2012 were homeless, defined as having non-permanent living situations, including homeless, transient or transitional. This does not include those staying in institutions such as residential care/housing, correctional, and health care facilities.

In FY 2012, 6.5% of RWP clients received DHSP-funded psychiatric treatment, while 9.9% of clients received psychotherapy services. Less than 2.5% of all clients received DHSP-funded substance abuse residential services in FY 2012, while the self-reported “current” risk behavior reported in Casewatch indicates that substance use among RWP clients was much more prevalent.

The following graphs illustrate some characteristics of clients with recent incarceration history and those who were homeless in FY 2012. Demographic information for clients in mental health and substance abuse treatment can be found in Chapters 3 and 4.

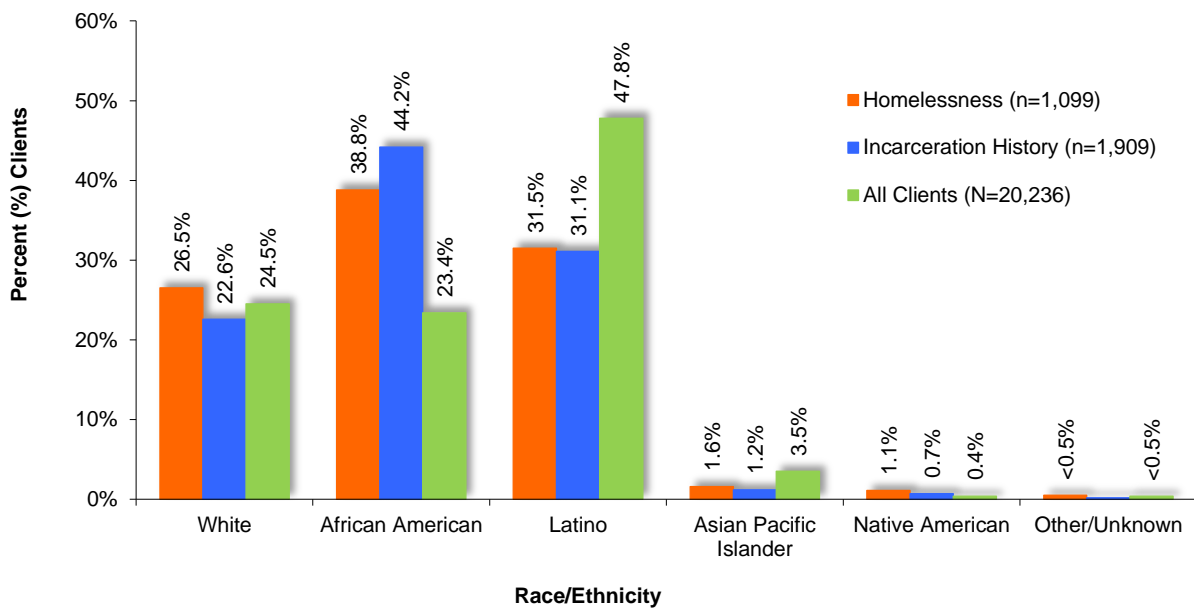
Figure 2.8. Gender Distribution of Homeless and Recently Incarcerated Clients, FY 2012



Data Source: Casewatch FY 2012 (March 2012 - February 2013)

***Note:** Homelessness does not include clients staying at residential, health care or correctional facilities. Incarceration history includes the period within the last 24 months.

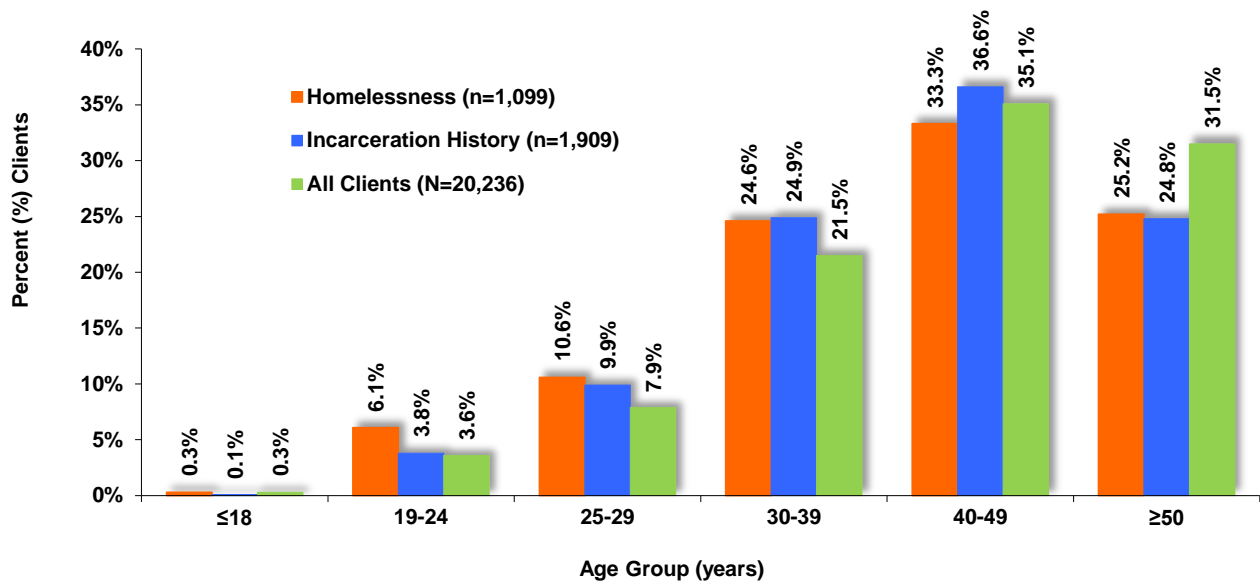
Figure 2.9. Distribution of Clients by Race/Ethnicity among Homeless, Recently-Incarcerated, and All Clients, FY 2012



Data Source: Casewatch FY 2012 (March 2012 - February 2013)

Note: Incarceration history within the last 24 months

Figure 2.10. Distribution of Clients by Age among Homeless, Recently-Incarcerated, and All Clients, FY 2012



Data Source: Casewatch FY 2012 (March 2012 - February 2013)

Note: Incarceration history within the last 24 months

Distribution of Clients by Residence SPA

Table 2.1. Demographic Characteristics of All Clients by Residence Service Planning Area (SPA), FY 2012

Characteristic	SPA 1		SPA 2		SPA 3		SPA 4		SPA 5		SPA 6		SPA 7		SPA 8		Unknown SPA	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
New Client	25	6.9%	264	9.4%	155	11.2%	665	9.6%	83	12.3%	273	9.4%	158	10.6%	387	12.3%	333	62.6%
Returning Client	27	7.4%	88	3.1%	85	6.1%	286	4.1%	22	3.3%	164	5.6%	87	5.8%	158	5.0%	48	9.0%
Gender																		
Female	101	27.7%	357	12.7%	204	14.8%	453	6.5%	62	9.2%	636	21.8%	215	14.4%	413	13.2%	30	5.6%
Male	261	71.7%	2,397	85.4%	1,165	84.2%	6,326	91.2%	607	89.9%	2,232	76.5%	1,259	84.6%	2,673	85.2%	495	93.0%
Transgender	2	0.5%	52	1.9%	14	1.0%	14	0.2%	6	0.9%	50	1.7%	14	0.9%	51	1.6%	7	1.3%
Race/Ethnicity																		
African-American	146	40.1%	421	15.0%	148	10.7%	1,161	16.7%	146	21.6%	1,505	51.6%	100	6.7%	933	29.7%	172	32.3%
Asian/Pacific-Islander	9	2.5%	100	3.6%	137	9.9%	251	3.6%	30	4.4%	20	0.7%	33	2.2%	120	3.8%	12	2.3%
Latino/Hispanic	132	36.3%	1,431	51.0%	852	61.6%	3,218	46.4%	194	28.7%	1,246	42.7%	1,194	80.2%	1,217	38.8%	188	35.3%
Native American/Alaskan Native	3	0.8%	10	0.4%	7	0.5%	32	0.5%	0	0.0%	4	0.1%	2	0.1%	19	0.6%	4	0.8%
Other/Unknown	2	0.5%	16	0.6%	5	0.4%	27	0.4%	3	0.4%	6	0.2%	1	0.1%	17	0.5%	6	1.1%
White/Caucasian	72	19.8%	828	29.5%	234	16.9%	2,244	32.4%	302	44.7%	137	4.7%	158	10.6%	831	26.5%	150	28.2%
Age																		
0-18	2	0.5%	11	0.4%	3	0.2%	13	0.2%	2	0.3%	16	0.5%	0	0.0%	12	0.4%	0	0.0%
19-24	13	3.6%	86	3.1%	64	4.6%	199	2.9%	17	2.5%	136	4.7%	55	3.7%	123	3.9%	37	7.0%
25-29	15	4.1%	214	7.6%	107	7.7%	515	7.4%	42	6.2%	252	8.6%	135	9.1%	250	8.0%	78	14.7%
30-39	64	17.6%	650	23.2%	319	23.1%	1,468	21.2%	129	19.1%	641	22.0%	356	23.9%	580	18.5%	143	26.9%
40-49	134	36.8%	967	34.5%	466	33.7%	2,618	37.8%	218	32.3%	929	31.8%	520	34.9%	1,096	34.9%	157	29.5%
50+	136	37.4%	878	31.3%	424	30.7%	2,120	30.6%	267	39.6%	944	32.4%	422	28.4%	1,076	34.3%	117	22.0%
Primary Insurance																		
No Insurance	134	36.8%	1,864	66.4%	911	65.9%	4,370	63.0%	391	57.9%	1,575	54.0%	999	67.1%	1,545	49.3%	245	46.1%
Other	3	0.8%	12	0.4%	7	0.5%	44	0.6%	6	0.9%	22	0.8%	8	0.5%	19	0.6%	2	0.4%
Private	13	3.6%	147	5.2%	75	5.4%	419	6.0%	57	8.4%	71	2.4%	69	4.6%	228	7.3%	28	5.3%
Public	214	58.8%	782	27.9%	390	28.2%	2,100	30.3%	221	32.7%	1,250	42.8%	412	27.7%	1,345	42.9%	88	16.5%
Unknown	0	0.0%	1	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	169	31.8%
Homeless	19	5.2%	147	5.2%	56	4.0%	394	5.7%	48	7.1%	147	5.0%	66	4.4%	174	5.5%	48	9.0%
In Medical Care	253	69.5%	2,316	82.5%	1,142	82.6%	5,793	83.6%	533	79.0%	2,498	85.6%	1,265	85.0%	2,556	81.5%	231	43.4%
Psychosocial Case Management	93	25.5%	528	18.8%	375	27.1%	835	12.0%	112	16.6%	434	14.9%	233	15.7%	603	19.2%	37	7.0%
Transitional Case Management	36	9.9%	104	3.7%	67	4.8%	498	7.2%	39	5.8%	222	7.6%	69	4.6%	170	5.4%	257	48.3%
TOTAL	364	100%	2,806	100%	1,383	100%	6,933	100%	675	100%	2,918	100%	1,488	100%	3,137	100%	532	100.0%

Data Source: Casewatch FY 2012 (March 2012 -February 2013)

Service Utilization by Service Category

Table 2.2. Services Accessed by All RWP Clients, FY 2012

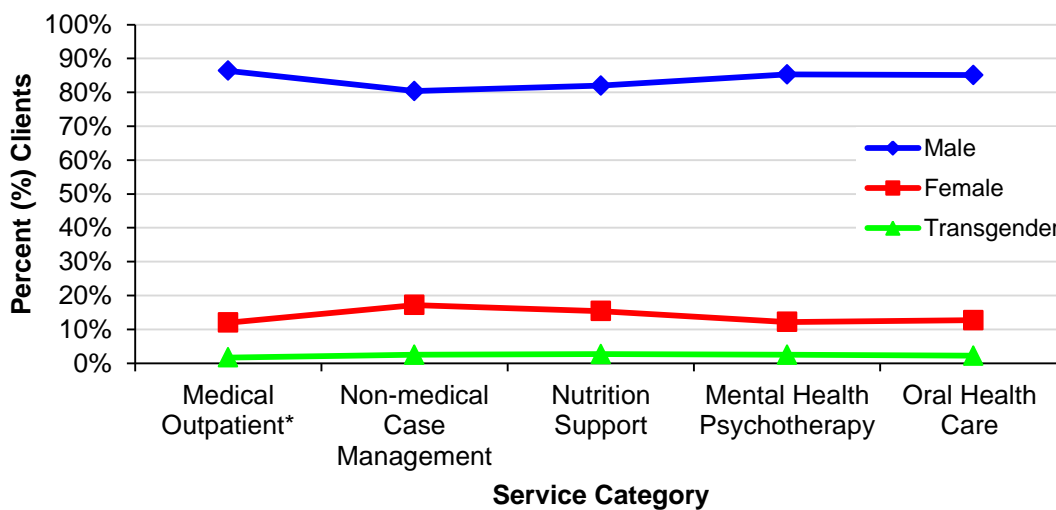
Type of RWP Service	N	%
All Clients	20,236	100.0
Medical Outpatient*	16,587	81.9
Oral Health Care	3,893	19.2
Non-medical Case Management	3,250	16.0
Benefits Specialty	2,935	14.5
Nutrition Support	2,461	12.1
Mental Health Psychotherapy	2,001	9.9
Mental Health Psychiatry	1,310	6.5
Medical Case Management	971	4.8
Transitional Case Management	936	4.6
Early Intervention Services	426	2.1
Substance Abuse Services - Residential	385	1.9
Home-based Case Management	346	1.7
Housing Services	135	0.6
Language Services**	69	0.3
Substance Abuse Services - Outpatient	63	0.3
Medical Nutrition Therapy (SPA 1 only)	52	0.2

Data Source: Casewatch FY 2012 (March 2012 - February 2013)

*Received at least one medical visit within the year

**Includes sign language interpretation clients and direct interpretation service clients

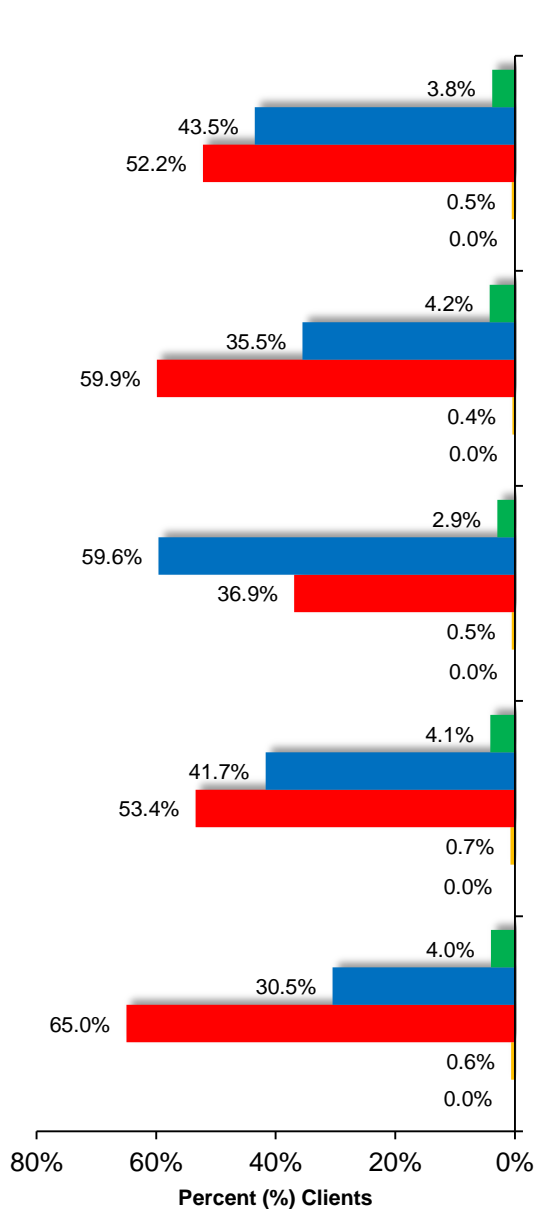
Figure 2.11. Key Services Accessed by Gender, FY 2012



Data Source: Casewatch FY 2012 (March 2012 - February 2013)

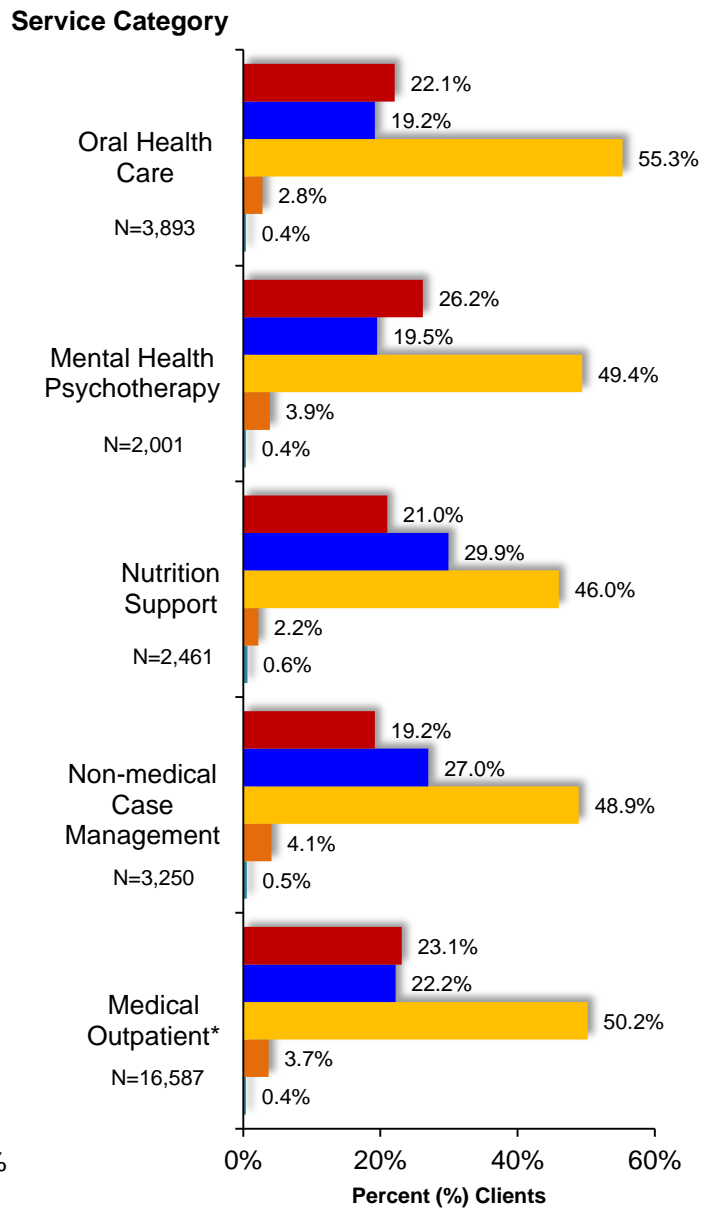
*Clients who received at least one medical visit within the year

Figure 2.12. Key Services Accessed by Type of Insurance, FY 2012



■ Private ■ Public ■ No Insurance ■ Other ■ Unknown

Figure 2.13. Key Services Accessed by Race/Ethnicity, FY 2012†



■ White ■ African American ■ Latino ■ Asian Pacific Islander ■ Native American

Data Source: Casewatch FY 2012 (March 2012 - February 2013)

*Clients who received at least one medical visit within the year

†Other/Unknown not shown.

Chapter 3. Core Medical Services

In FY 2012, DHSP funded the following core medical services for HIV/AIDS care and treatment:

1. Medical Outpatient Services
2. Medical Specialty
3. Oral Health Care
4. Mental Health, Psychiatry
5. Mental Health, Psychotherapy
6. Case Management, Medical
7. Early Intervention Services
8. Substance Abuse Treatment
9. ADAP Enrollment
10. Case Management, Home-based
11. Medical Nutrition Therapy

3.1 Medical Outpatient Services

HRSA Definition: Outpatient/Ambulatory Medical Care is the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting. Settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not outpatient settings. Services include diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history intake, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties). Primary medical care for the treatment of HIV infection includes the provision of care that is consistent with the Public Health Service's guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies.

Commission Definition/Guidance: Medical Outpatient Services are up-to-date educational, preventive, diagnostic and therapeutic medical services provided by licensed health care professionals with requisite training in HIV/AIDS including physicians, physician assistants and/or nurse practitioners licensed to practice by the State of California.

What DHSP Funds: Medical Outpatient Services provide professional diagnostic, preventive and therapeutic medical services by licensed health care professionals with requisite training in HIV/AIDS including physicians, nurses, nurse practitioners and/or physician assistants. Services include diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history intake, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, continuing care and management of chronic conditions, and referral to and provision of specialty care. Often, DHSP provides access to services to patients before they are enrolled in Medi-Cal or other public insurance programs.

Beginning in January 2013, DHSP changed its payment method for Medical Outpatient Services to a performance-based fee-for-service model, which includes HIV medical visits, radiology, lab,

and pharmaceutical assistance. A set of performance measures is tied to potential incentive payments beyond the base rate of reimbursement for medical visits.

Table 3.1. Demographic Characteristics of Clients Receiving Medical Outpatient Services, FY 2012

Demographic Characteristic	Medical Outpatient Services (N=16,587)	
	N	%
Gender		
Male	14,323	86.4%
Female	1,990	12.0%
Transgender	274	1.7%
Race/Ethnicity		
White	3,836	23.1%
African American	3,686	22.2%
Latino	8,325	50.2%
Asian Pacific Islander	614	3.7%
Native American	64	0.4%
Other/Unknown	62	0.4%
Age Group (years)		
≤ 18	16	0.1%
19-24	579	3.5%
25-29	1,396	8.4%
30-39	3,780	22.8%
40-49	6,011	36.2%
≥ 50	4,805	29.0%
Primary Medical Insurance		
Private	661	4.0%
Public	5,052	30.5%
No Insurance	10,781	65.0%
Other	93	0.6%
Unknown	0	0.0%
Receiving Ryan White Funded Medical Care*	16,587	100.0%
New Client to System of Care	1,647	9.9%
Returning Client to System of Care	575	3.5%

Data Source: Casewatch FY 2012 (March 2012 - February 2013)

*Clients who received at least one medical visit within the year

Funding Sources: RWP Part A, and Net County Cost (NCC)

Expenditures and Funding Sources:

Funding Sources	Part A	Part B/SAM Care	Other*	Total
Expenditures	\$21,470,877	\$0	\$217,186	\$21,688,063

*NCC - \$217,186

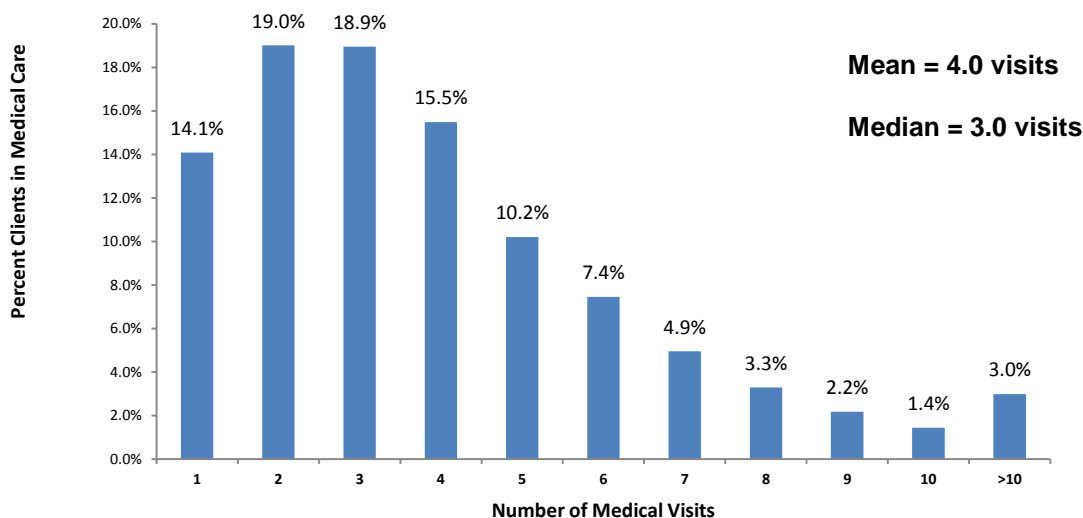
Allocations and Summary:

The Commission allocated 57.8% of RWP Part A Care service funds to Medical Outpatient and Medical Specialty services as one category in FY 2012 (\$22,920,212). This includes support for the therapeutic monitoring program (TMP). A detailed description of MOP clients is included in Appendix A.

Service Utilization:

Total Clients Served	Service Units	Units of Service Provided
16,587	Encounters	66,721

Figure 3.1. Distribution of Clients by Frequency of Medical Visits, FY 2012



Data Source: Casewatch FY 2012 (March 2012 - February 2013)

3.2 Medical Specialty Services

HRSA Definition: HRSA does not have a specific definition for Medical Specialty Services. All medical specialty care is included under HRSA’s definition of Outpatient/Ambulatory Medical Care.

Commission Definition/Guidance: Medical Specialty Services provide consultation, diagnosis and therapeutic services for medical complications beyond the scope of primary medical and nursing care for people living with HIV. Services include cardiology; dermatology; ear, nose and throat specialty; gastroenterology; gynecology; neurology; ophthalmology; oncology; oral health; pulmonary medicine; podiatry; proctology; general surgery; urology; nephrology; orthopedics; and obstetrics.

What DHSP Funds: A medical specialty network that includes culturally and linguistically appropriate diagnostic and therapeutic medical services provided by a licensed physician and/or surgeon who is board certified or board eligible in his or her respective medical specialty and/or subspecialty. Such medical subspecialties include, but are not limited to: cardiology; dermatology; ear, nose, and throat (ENT) specialty; endocrinology; gastroenterology,

hepatology, gynecology, neurology, ophthalmology, oncology, optometry, pulmonary medicine, podiatry, proctology, general surgery, orthopedics and urology. Referral to a Registered Dietician (RD) may be appropriate for nutritional counseling.

Funding Sources: RWP Part A and NCC

Expenditures and Funding Sources:

Funding Sources	Part A	Part B/SAM Care	Other*	Total
Expenditures	\$1,317,514	\$0	\$932	\$1,318,446

*NCC - \$932

Allocations:

The Commission allocation for Medical Specialty services was included in the 57.8% RWP Part A and RWP Part B/SAM Care allocation for Medical Outpatient and Medical Specialty services.

Service Utilization:

Total Clients Served	Service Units	Units of Service Provided
2,167	Initial and follow-up visits	4,721

3.3 Oral Health Care

HRSA Definition: Oral Health Care includes diagnostic, preventive, and therapeutic services provided by general dental practitioners, dental specialists, dental hygienists and auxiliaries, and other trained primary care providers.

Commission Definition/Guidance: Same as above.

What DHSP Funds: Oral health services provided under contract with DHSP include diagnostic, prophylactic, and therapeutic services rendered by dentists, dental hygienists, registered dental assistants, and other similarly trained professional practitioners. Services also include obtaining a comprehensive medical history and consulting primary medical providers as necessary; providing medication appropriate to oral health care services, including all currently approved drugs for HIV-related oral health conditions; providing or referring patients, as needed, to specialists including, but not limited to, periodontists, endodontists, oral surgeons, oral pathologists and oral medicine practitioners, and patient education.

Funding Sources: RWP Part A, Part B/SAM Care, MAI, and NCC

Expenditures and Funding Sources:

Funding Sources	Part A	Part B/SAM Care	Other*	Total
Expenditures	\$43,231	\$1,652,236	\$2,188,132	\$3,883,599

*MAI expenditures - \$2,117,430; NCC expenditures - \$70,702.

Allocations and Summary:

The Commission allocated 7.5% of RWP Part A and RWP Part B/SAM Care service funds (\$2,974,076) and 30% of RWP MAI service funds (\$1,709,904) to Oral Health services for FY 2012. In addition to the FY 2012 RWP MAI allocation, this year also included unspent funds carried forward from FY 2011 in the amount of \$822,455. The Commission allocated all of the carryover funds to Oral Health services. Some of the contract expenditures were shifted mid-year between funding sources to maximize the grant expenditures.

Table 3.2. Demographic Characteristics of Clients Receiving Oral Health Care, FY 2012

Demographic Characteristic	Oral Health Care (N=3,893)	
	N	%
Gender		
Male	3,311	85.1%
Female	496	12.7%
Transgender	86	2.2%
Race/Ethnicity		
White	861	22.1%
African American	747	19.2%
Latino	2,154	55.3%
Asian Pacific Islander	110	2.8%
Native American	15	0.4%
Other/Unknown	6	0.2%
Age Group (years)		
≤ 18	2	0.1%
19-24	61	1.6%
25-29	167	4.3%
30-39	685	17.6%
40-49	1,450	37.2%
≥ 50	1,528	39.2%
Primary Medical Insurance		
Private	147	3.8%
Public	1,695	43.5%
No Insurance	2,032	52.2%
Other	19	0.5%
Unknown	0	0.0%
Receiving Ryan White Funded Medical Care*	3,060	78.6%

Data Source: Casewatch FY 2012 (March 2012 - February 2013)

*Clients who received at least one medical visit within the year

Service Utilization:

Total Clients Served	Service Units	Units of Service Provided
3,893	Encounters	39,260

3.4 Mental Health, Psychiatry

HRSA Definition: HRSA does not have a specific definition for Mental Health, Psychiatry. It groups both psychiatry and psychotherapy or counseling under a broad Mental Health Services category. Under the HRSA definition, Mental Health Services include both psychological and psychiatric treatment and counseling services offered to individuals with a diagnosed mental illness, conducted in a group or individual setting, and provided by a mental health professional, licensed or authorized within the State to render such services. This typically includes psychiatrists, psychologists, and licensed clinical social workers.

COMMISSION Definition/Guidance: Mental Health, Psychiatry is a service that attempts to stabilize mental health conditions while improving and sustaining quality of life. It is provided by professionals who are licensed to treat psychiatric disorders in the State of California. Service components include client registration/intake, psychiatric assessment, treatment provision (psychiatric medication assessment, prescription and monitoring), and crisis intervention.

What DHSP Funds: Mental Health, Psychiatric services provide psychiatric diagnostic evaluation and psychotropic medication by a psychiatrist, psychiatric resident, or registered nurse/nurse practitioner under the supervision of a psychiatrist. Service components include client registration/intake; psychiatric assessment; treatment provision (psychiatric medication assessment, prescription and monitoring); and crisis intervention.

Funding Sources: RWP Part A and Net County Cost

Expenditures and Funding Sources:

Funding Sources	Part A	Part B/SAM Care	Other*	Total
Expenditures	\$917,608	\$0	\$28,199	\$945,807

*NCC - \$28,199

Allocations:

The Commission allocated 2.9% (\$1,149,976) of RWP Part A and RWP Part B/SAM Care service funds to Mental Health, Psychiatry for FY 2012.

Service Utilization:

Total Clients Served	Service Units	Units of Service Provided
1,310	Hours	2,936

Table 3.3. Demographic Characteristics of Clients Receiving Mental Health, Psychiatry, FY 2012

Demographic Characteristic	Mental Health Psychiatry (N=1,310)	
	N	%
Gender		
Male	1,113	85.3%
Female	171	12.2%
Transgender	26	2.5%
Race/Ethnicity		
White	428	26.2%
African American	270	20.6%
Latino	549	41.9%
Asian Pacific Islander	56	4.3%
Native American	5	0.4%
Other/Unknown	2	0.5%
Age Categories		
≤ 18	3	0.2%
19-24	52	4.0%
25-29	95	7.3%
30-39	268	20.5%
40-49	517	39.5%
≥ 50	375	28.6%
Primary Medical Insurance		
Private	52	4.0%
Public	476	36.3%
No Insurance	771	58.9%
Other	11	0.8%
Unknown	0	0.0%
Receiving Ryan White Funded Medical Care*	1,166	89.0%

Data Source: Casewatch FY 2012 (March 2012 - February 2013)

*Clients who received at least one medical visit within the year

3.5 Mental Health, Psychotherapy

HRSA Definition: HRSA does not have a specific definition for Mental Health, Psychotherapy. It groups both psychiatry and psychotherapy or counseling under a broad Mental Health Services category. (See HRSA definition of Mental Health Services above.)

Commission Definition/Guidance: Mental Health, Psychotherapy is a service that attempts to improve and sustain a client's quality of life. It includes client intake; bio-psychosocial assessment; treatment planning; treatment provision in individual, family, conjoint or group modalities; drop-in psychotherapy groups; and crisis intervention.

What DHSP Funds: Mental health, psychotherapy services provide comprehensive mental health assessments, treatment plans, and psychotherapy by licensed mental health professionals or graduate students in training under the supervision of licensed mental health professionals. Services include client intake; bio-psychosocial assessment; treatment planning; treatment provision in individual, family, conjoint or group modalities; drop-in psychotherapy groups; and crisis intervention.

Table 3.4. Demographic Characteristics of Clients Receiving Mental Health, Psychotherapy, FY 2012

Demographic Characteristic	Mental Health Psychotherapy (N=2,001)	
	N	%
Gender		
Male	1,707	85.3%
Female	244	12.2%
Transgender	50	2.5%
Race/Ethnicity		
White	524	26.2%
African American	390	19.5%
Latino	989	49.4%
Asian Pacific Islander	78	3.9%
Native American	9	0.5%
Other/Unknown	11	0.2%
Age Categories		
≤ 18	8	0.8%
19-24	95	4.1%
25-29	185	7.8%
30-39	427	22.8%
40-49	674	34.7%
≥ 50	612	29.9%
Primary Medical Insurance		
Private	134	4.1%
Public	710	41.7%
No Insurance	1,198	53.4%
Other	8	0.7%
Unknown	1	0.0%
Receiving Ryan White Funded Medical Care	1,594	73.4%

Data Source: Casewatch FY 2012 (March 2012 - February 2013).

Funding Sources: Ryan White Program Part A and Net County Cost

Expenditures and Funding Sources:

Funding Source:	Part A	Part B/SAM Care	Other*	Total
Expenditures	\$1,925,612	\$0	\$85,292	\$2,010,904

*NCC expenditures - \$85,292

Allocations:

The Commission allocated 5.3% of RWP Part A and RWP Part B/SAM Care service funds to Mental Health, Psychotherapy for FY 2012, equivalent to \$2,101,680.

Service Utilization:

Total Clients Served	Service Units	Units of Service Provided
2,001	Encounters	28,416

3.6 Medical Case Management

HRSA Definition: Medical Case Management (including Treatment Adherence) is a range of client-centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client’s and other key family members’ needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include: 1) initial assessment of service needs, 2) development of a comprehensive, individualized service plan, 3) coordination of services required to implement the plan, 4) client monitoring to assess the efficacy of the plan, and 5) periodic re-evaluation and adaptation of the plan as necessary. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact, and other forms of communication.

Commission Definition/Guidance: Following the development of the standards of care for Medical Care Coordination (MCC), the Commission began to prioritize and allocate for MCC in 2011. MCC services cover what was historically funded as medical case management and psychosocial case management. Medical case management services (including treatment adherence) are a range of client-centered services that link clients with health care, psychosocial and other services. The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client’s and other key family members’ needs and personal support systems. Medical case management services, as defined locally, are consistent with the key activities described in the HRSA definition. The services include the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments.

What DHSP Funds: Organized as a component of medical care coordination, medical case management services facilitate and support access, utilization, retention and adherence to primary health care services through intake and assessment, diagnosis, case management service planning, coordination, monitoring and evaluation by a registered nurse. In FY 2011, DHSP started the process of implementing medical case management as part of a MCC program. However, medical case management only began to operate as a fully integrated MCC program in early 2013.

Funding Sources: RWP Part A, Net County Cost, and RWP Minority AIDS Initiative

Expenditures and Funding Sources:

Funding Source:	Part A	Part B/SAM Care	Other*	Total
Expenditures	\$1,473,063	\$0	\$1,128,629	\$2,601,692

*NCC - \$178,727; MAI - \$949,902

Allocations and Summary:

In FY 2011, the Commission began to allocate RWP funds to Medical Care Coordination (MCC) consisting of Medical Case Management and Non-medical Case Management. In FY 2012, this

total allocation included 7.7% (\$3,053,384) of RWP Part A and RWP Part B/SAM Care and 45% (\$1,331,173) of RWP MAI funds. An allocation of 1.2% or \$1,807,025 of RWP Part A funds was specifically made for Medical Case Management in FY 2012. Non-medical Case Management is discussed in Chapter 4.

Service Utilization:

Total Clients Served	Service Units	Units of Service Provided
971	Hours	7,712

Table 3.5. Demographic Characteristics of Clients Receiving Medical Case Management Services, FY 2012

Demographic Characteristic	Medical Case Management (N=971)	
	N	%
Gender		
Male	836	86.1%
Female	117	12.0%
Transgender	18	1.9%
Race/Ethnicity		
White	249	25.6%
African American	235	24.2%
Latino	453	46.7%
Asian Pacific Islander	31	3.2%
Native American	1	<1%
Other/Unknown	2	<1%
Age Categories		
≤ 18	1	<1%
19-24	32	3.3%
25-29	73	7.5%
30-39	268	27.6%
40-49	344	35.4%
≥ 50	253	26.1%
Primary Medical Insurance		
Private	13	1.3%
Public	332	34.2%
No Insurance	616	63.4%
Other	10	1.0%
Unknown	0	0.0%
Receiving Ryan White Funded Medical Care*	840	86.5%

Data Source: Casewatch FY 2012 (March 2012 - February 2013)

*Clients who received at least one medical visit within the year

3.7 Early Intervention Services

HRSA Definition: Early Intervention Services (EIS) include counseling individuals with respect to HIV/AIDS; testing (including tests to confirm the presence of HIV, tests to diagnose extent of immune deficiency, tests to provide information on appropriate therapeutic measures); referrals; other clinical and diagnostic services regarding HIV/AIDS; periodic medical evaluations for individuals with HIV/AIDS; and providing therapeutic measures.

Commission Definition/Guidance: Early Intervention Services include counseling individuals with respect to HIV/AIDS; testing (including test to confirm the presence of the disease, tests to diagnose extent of immune deficiency, tests to provide information on appropriate therapeutic measures); referrals; other clinical and diagnostic services regarding HIV/AIDS; periodic medical evaluations for individuals with HIV/AIDS; and providing therapeutic measures.

What DHSP Funds: Early intervention services provided under contract with DHSP include: mental health and psychosocial support; health education; case management and referral; medical evaluation, monitoring and treatment; nutrition assessment and referral; HIV risk assessment and reduction; and outreach.

Funding Sources: RWP Minority AIDS Initiative and Net County Cost

Expenditures and Funding Sources:

Funding Sources	Part A	Part B/SAM Care	Other*	Total
Expenditures	0	\$0	\$830,048	\$830,048

* MAI expenditures - \$713,287; NCC - \$116,761

Allocations and Summary:

The Commission allocated 1.0% of RWP Part A and RWP Part B/SAM Care service funds (\$396,543) and 25% of MAI service funds (\$739,541) to early intervention services (EIS) for FY 2012 bringing the total Commission allocated amount to \$1,136,084. In an effort to fully maximize RWP MAI grant resources, the majority of EIS expenditures were reported under the Minority AIDS Initiative and no expenditures were recorded under Part A. The service utilization data is reported on a July 1, 2012 – June 30, 2013 term.

Service Utilization:

Total Clients Served	Early Intervention Service	Service Units	Units of Service Provided
1	Major Medical Assessment	Hours	1
89	Transmission Risk Reduction Assessment	Hours	74
123	Mental Health/Psychological Assessment	Hours	357
114	Health Education Assessment	Hours	99
137	Case Management Assessment	Hours	778
66	Outreach	Hours	64

Table 3.6. Demographic Characteristics of Clients Receiving Early Intervention Services, FY 2012

Demographic Characteristic	Early Intervention (N=426)	
	N	%
Gender		
Male	366	85.9%
Female	48	11.3%
Transgender	12	2.8%
Race/Ethnicity		
White	9	2.1%
African American	216	50.7%
Latino	184	43.2%
Asian Pacific Islander	15	3.5%
Native American	0	0.0%
Other/Unknown	2	0.5%
Age Categories		
≤ 18	0	0.0%
19-24	35	8.2%
25-29	61	14.3%
30-39	115	27.0%
40-49	131	30.8%
≥ 50	84	19.7%
Primary Medical Insurance		
Private	7	1.6%
Public	144	33.8%
No Insurance	274	64.3%
Other	1	0.2%
Unknown	0	0.0%
Receiving Ryan White Funded Medical Care*	368	86.4%

Data Source: Casewatch FY 2012 (March 2012 - February 2013)

*Clients who received at least one medical visit within the year

3.8 Substance Abuse, Treatment

HRSA Definition: Substance Abuse Services (Outpatient) is the provision of medical or other treatment and/or counseling to address substance abuse problems (i.e., alcohol and/or legal and illegal drugs) in an outpatient setting, rendered by a physician or under the supervision of a physician, or by other qualified personnel.

Commission Definition/Guidance: HIV substance abuse treatment services include: the provision of medical or other treatment and/or counseling to address substance abuse problems (i.e., alcohol and/or legal and illegal drugs) in an outpatient setting rendered by a physician or under the supervision of a physician, or by other qualified personnel.

What DHSP Funds: HIV substance abuse treatment services provided under contract with DHSP in FY 2012 include substance abuse day treatment and substance abuse residential detoxification according to the standards of care. However, these services are reported under

substance abuse residential due to the differences between the standards of care and HRSA service definitions.

Substance abuse day treatment services are non-residential therapeutic services that provide a minimum of five hours of planned activities per day. Programs are designed to be more intensive than outpatient visits, but less extensive than 24 hour residential services. At minimum, services (including individual and group sessions and structured therapeutic activities) should be offered at least five hours per day, five days per week. The length of stay in HIV substance abuse day treatment services is not to exceed 90 days. Extensions can be made if the client meets continuing stay criteria in accordance with the American Society of Addiction Medicine (ASAM) and DHSP approves the request for extension.

Substance abuse residential detoxification programs must be licensed and approved by the State of California Department of Health Services as a Chemical Dependency Recovery Hospital and operate in accordance with Chapter 11, Title 22 of the California Code of Regulations. The maximum length of stay for substance abuse residential detoxification services is 14 days, although extensions can be granted under special circumstances with a physician's order. Services include: initial screening; client intake; client assessment; treatment planning; providing medication prescribed by a medical professional; crisis intervention; counseling; support groups; education; and treatment linkages and referral.

See Substance Abuse, Residential, for overall Substance Abuse Services Funding Allocations, Contract Investment, Expenditures, and Service Utilization. Demographic characteristics of clients receiving Substance Abuse Treatment Services can be seen on pages 34.

3.9 AIDS Drug Assistance Program (ADAP) Enrollment

HRSA Definition: HRSA does not have a specific service category called ADAP Enrollment.

Commission Definition/Guidance: ADAP Enrollment assists clients with enrolling in the State-administered program authorized under Part B of the RWP. ADAP provides FDA-approved medications to low-income individuals with HIV disease who have limited or no coverage from private insurance, Medi-Cal, or Medicare. Enrollment coordinators supervise ADAP services at individual sites.

What DHSP Funds: Fee-for-service reimbursements for ADAP enrollment based on client enrollment and recertification in ADAP.

Funding Sources: State of California, Office of AIDS (ADAP)

Expenditures and Funding Sources:

Funding Sources	Part A	Part B/SAM Care	Other**	Total
Expenditures	0	0	\$300,765	\$300,765

*State ADAP - \$300,765 (ADAP Enrollment)

Allocations:

The California Office of AIDS provides funding for ADAP certifications and re-certifications. The Commission allocation for ADAP Enrollment in FY 2012 is included as part of the Medical Outpatient/Medical Specialty allocation of 57.8%.

Service Utilization:

Services	Total Clients Served
New enrollment	1,964
Re-certification	17,553

Data Source: Ramsell Monthly Data Report (March 2012 – February 2013)

3.10 Case Management, Home-Based

HRSA Definition: HRSA does not have a specific category called “Home-based Case Management.” The standards of care and currently funded services in Los Angeles County fit under HRSA’s definition of Home and Community-based Health Services.

Home and Community-based Health Services (a core service) include skilled health services provided to the individual in the individual’s home, based on a written plan of care established by a case management team that includes appropriate health care professionals. Services include durable medical equipment; home health aide services and personal care services in the home; day treatment or other partial hospitalization services; home intravenous and aerosolized drug therapy (including prescription drugs administered as part of such therapy); routine diagnostic testing administered in the home; and appropriate mental health, developmental, and rehabilitation services. Inpatient hospital services, nursing home and other long term care facilities are NOT included.

Commission Definition/Guidance: Case Management, Home-based, includes client-centered case management and social work activities that focus on care for persons living with HIV who are functionally impaired and require intensive home and/or community-based services. Services are conducted by qualified registered nurse case managers and master’s level social workers who facilitate optimal health outcomes for functionally impaired people living with HIV through advocacy, support and collaboration.

What DHSP Funds: Home-based Case Management services provided under contract with DHSP include: intake; assessment; service planning; attendant care; homemaker services; psychosocial case management; mental health services; and provision of durable medical equipment and nutritional supplements.

Funding Sources: RWP Part A, RWP Part B/SAM Care and NCC

Expenditures and Funding Sources:

Funding Sources	Part A	Part B/SAM Care	Other*	Total
Expenditures	\$298,076	\$2,350,997	\$70,102	\$2,719,175

*NCC - \$70,102

Allocations and Summary:

Case Management, Home-based, services were supported with direct funding from the State Office of AIDS to community agencies through June 2009. In June 2009 significant State budget cuts were enacted and direct State funding for these services were eliminated. To avoid major service cuts DHSP increased funding support for these services using State Single Allocation Model (SAM) Care grant and some NCC revenue. Since then, the services have been primarily supported with the RWP Part B/SAM Care grant funds.

The Commission allocated 6.8% of RWP Part A and RWP Part B/SAM Care funds to Case Management, Home-Based, services for FY 2012 (\$2,696,495). While the majority of FY 2012 expenditures were RWP Part B/SAM Care, in mid-year, DHSP shifted grant expenditures to the RWP Part A grant in order to fully and effectively expend all grant funds.

Table 3.7. Demographic Characteristics of Clients Receiving Home-based Case Management Services, FY 2012

Demographic Characteristic	Home-based Case Management (N=346)	
	N	%
Gender		
Male	277	81.0%
Female	64	17.7%
Transgender	5	1.3%
Race/Ethnicity		
White	119	35.9%
African American	59	19.5%
Latino	159	42.8%
Asian Pacific Islander	6	1.0%
Native American	1	0.3%
Other/Unknown	2	0.5%
Age Categories		
≤ 18	1	0.3%
19-24	3	0.8%
25-29	6	1.8%
30-39	39	11.1%
40-49	93	28.9%
≥ 50	204	57.2%
Primary Medical Insurance		
Private	33	10.4%
Public	184	59.0%
No Insurance	128	30.1%
Other	1	0.5%
Unknown	0	0.0%
Receiving Ryan White Funded Medical Care*	211	65.8%

Data Source: Casewatch FY 2012 (March 2012 - February 2013)

*Clients who received at least one medical visit within the year

Service Utilization:

Services	Total Clients Served*	Service Unit Definition	Service Units Provided
Attendant care	66	Attendant care hours	21,006
Homemaker services	121	Homemaker hours	33,889
Case management	338	Case management hours	12,998
Psychotherapy	48	Psychotherapy hours	1,495
Nutrition	40	Nutrition encounters	3,348
Durable medical equipment	7	Durable medical equipment items	120

Note: Clients may be counted in more than one category if they accessed services in multiple categories during FY 2012.

3.11 Medical Nutrition Therapy

HRSA Definition: Medical Nutrition Therapy is provided by a licensed registered dietitian outside of a primary care visit and includes the provision of nutritional supplements. Medical nutrition therapy provided by someone other than a licensed/registered dietitian should be reported under psychosocial support services.

Commission Definition/Guidance: Same as above.

What DHSP Funds: Medical nutrition therapy provides assessment, interventions and treatment by registered dietitians to maintain and optimize nutrition status and self-management skills to help treat HIV disease through evaluation of nutritional needs and nutrition care planning, nutrition counseling, therapy and education. Services also include distributing nutritional supplements when appropriate; providing nutrition and HIV trainings to clients and their providers; and distributing nutrition-related educational materials to clients. Medical nutrition therapy is only funded as part of a one-stop shop medical model.

Funding Sources: Net County Cost

Expenditures and Funding Sources:

Funding Sources	Part A	Part B/SAM Care	Other*	Total
Expenditures	\$0	\$0	\$29,947	\$29,947

* Net County Cost - \$29,947

Allocations:

In 2012, Medical Nutrition Therapy was funded as part of one-stop service model for SPA 1. There was no Commission allocation for this service category.

Service Utilization:

Total Clients Served	Service Units	Units of Service Provided
52	Encounters	129

Table 3.8. Demographic Characteristics of Clients Receiving Medical Nutrition Therapy, FY 2012

Demographic Characteristic	Medical Nutritional Therapy (N=52)	
	N	%
Gender		
Male	35	67.3%
Female	16	30.8%
Transgender	1	1.9%
Race/Ethnicity		
White	5	9.6%
African American	27	51.9%
Latino	19	36.5%
Asian Pacific Islander	1	1.9%
Native American	0	0.0%
Other/Unknown	0	0.0%
Age Categories		
≤ 18	0	0.0%
19-24	2	3.8%
25-29	2	3.8%
30-39	11	21.2%
40-49	14	26.9%
≥ 50	23	44.2%
Primary Medical Insurance		
Private	1	1.9%
Public	40	76.9%
No Insurance	11	21.2%
Other	0	0.0%
Unknown	0	0.0%
Receiving Ryan White Funded Medical Care*		
	37	71.2%

Data Source: Casewatch FY 2012 (March 2012 – February 2013)

*Clients who received at least one medical visit within the year

Chapter 4. Support Services

In FY 2012, DHSP funded the following list of support services for HIV/AIDS care and treatment:

1. Case Management, Non-Medical
2. Substance Abuse, Residential
3. Nutrition Support
4. Residential, Transitional
5. Medical Transportation
6. Language Services
7. Case Management, Transitional
8. Benefits Specialty
9. Legal Services

4.1 Case Management, Non-Medical

HRSA Definition: Case Management (Non-Medical) includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatments, as medical case management does.

Commission Definition/Guidance: Following the development of the standards of care for Medical Care Coordination (MCC), the Commission began to prioritize and allocate for MCC in 2011. MCC services cover what was historically funded as medical case management and psychosocial case management. Medical care coordination services are patient-centered activities which focus on access, utilization, retention and adherence to primary health care services, as well as coordinating and integrating all services along the continuum of care for patients living with HIV. All medical care coordination services will be patient-driven, aiming to increase a patient's sense of empowerment, self-advocacy and medical self-management, as well as enhancing the overall health status of people living with HIV. Medical care coordination services include: outreach; intake; comprehensive assessment/reassessment; patient acuity assessment; comprehensive treatment plan; implementation and evaluation of comprehensive treatment plan; referral, coordination of care and linkages; case conferences; benefits specialty services; HIV prevention, education and counseling; and patient retention services.

What DHSP Funds: As a component of medical care coordination, non-medical case management services provided under contract with DHSP can include: intake and assessment of available resources and needs; development and implementation of service plans; coordination of services; interventions on behalf of the client or family; linked referrals; active, ongoing monitoring and follow-up; and periodic assessment of status and needs. In 2012, Non-medical case management has not yet been a fully integrated MCC program. The fully integrated MCC program began serving clients in early 2013.

Funding Sources: RWP Part A and Net County Cost (NCC)

Expenditures and Funding Sources:

Funding Sources	Part A	Part B/SAM Care	Other*	Total
Expenditures	\$1,397,022	\$0	\$51,894	\$1,448,916

*NCC - \$51,894

Allocations:

Of the total 7.7% of RWP Part A and RWP Part B/SAM Care allocation for Medical Care Coordination, a large portion of the allocation went to Non-Medical Case Management for FY 2012 (\$2,577,532). The additional MCC allocation was used for Medical Case Management, discussed in Chapter 3.

Table 4.1. Demographic Characteristics of Clients Receiving Non-Medical Case Management Services, FY 2012

Demographic Characteristics	Non-Medical Case Management (N=3,250)	
	N	%
Gender		
Male	2,612	80.4%
Female	558	17.2%
Transgender	80	2.5%
Race/Ethnicity		
White	624	19.2%
African American	879	27.0%
Latino	1,590	48.9%
Asian Pacific Islander	132	4.1%
Native American	17	0.5%
Other/Unknown	8	0.2%
Age Categories		
≤18	27	0.8%
19-24	132	4.1%
25-29	252	7.8%
30-39	740	22.8%
40-49	1,128	34.7%
≥50	971	29.9%
Primary Medical Insurance		
Private	134	4.1%
Public	1,356	41.7%
No Insurance	1,736	53.4%
Other	23	0.7%
Unknown	1	0.0%
Receiving Ryan White Funded Medical Care*	2,386	75.5%

Data Source: Casewatch FY 2012 (March 2012 - February 2013)

*Clients who received at least one medical visit within the year

Service Utilization:

Total Clients Served	Service Units	Units of Service Provided
3,250	Case Management Hours	50,689

4.2 Substance Abuse, Residential

HRSA Definition: Substance Abuse Services (Residential) is the provision of treatment to address substance abuse problems (including alcohol and/or legal and illegal drugs) in a residential health service setting (short-term).

Commission Definition/Guidance: Substance Abuse, Residential, includes residential rehabilitation and transitional housing services that assist clients achieve and maintain a lifestyle free of substance abuse and to transition to permanent, stable housing.

Substance abuse residential rehabilitation services provide 24-hour, residential *non-medical* services to individuals recovering from problems related to alcohol and/or drug abuse and who need alcohol and/or drug abuse treatment or detoxification services.

Substance abuse transitional housing services provide interim housing with supportive services for up to four months for recently homeless persons living with HIV in various stages of recovery from substance abuse. The purpose of the service is to facilitate continued recovery from substance abuse and movement toward more traditional, permanent housing through assessment of the individual's needs, counseling and case management.

What DHSP Funds: Substance abuse residential services provided under contract with DHSP include substance abuse residential rehabilitation and substance abuse transitional housing. Residential detoxification services are reported here due to HRSA service definitions.

Funding Sources: RWP Part A and Part B/SAM Care, and State (pass-through from SAMSHA Center for Substance Abuse Treatment/Center for Substance Abuse Prevention)

Expenditures and Funding Sources: RWP Part B/SAM Care and State (pass-through) CSAT/CSAP

Funding Sources	Part A	Part B/SAM Care	Other*	Total
Expenditures	\$0	\$1,996,181	\$63,989*	\$2,060,170

*State CSAT/CSAP expenditures - \$63,989

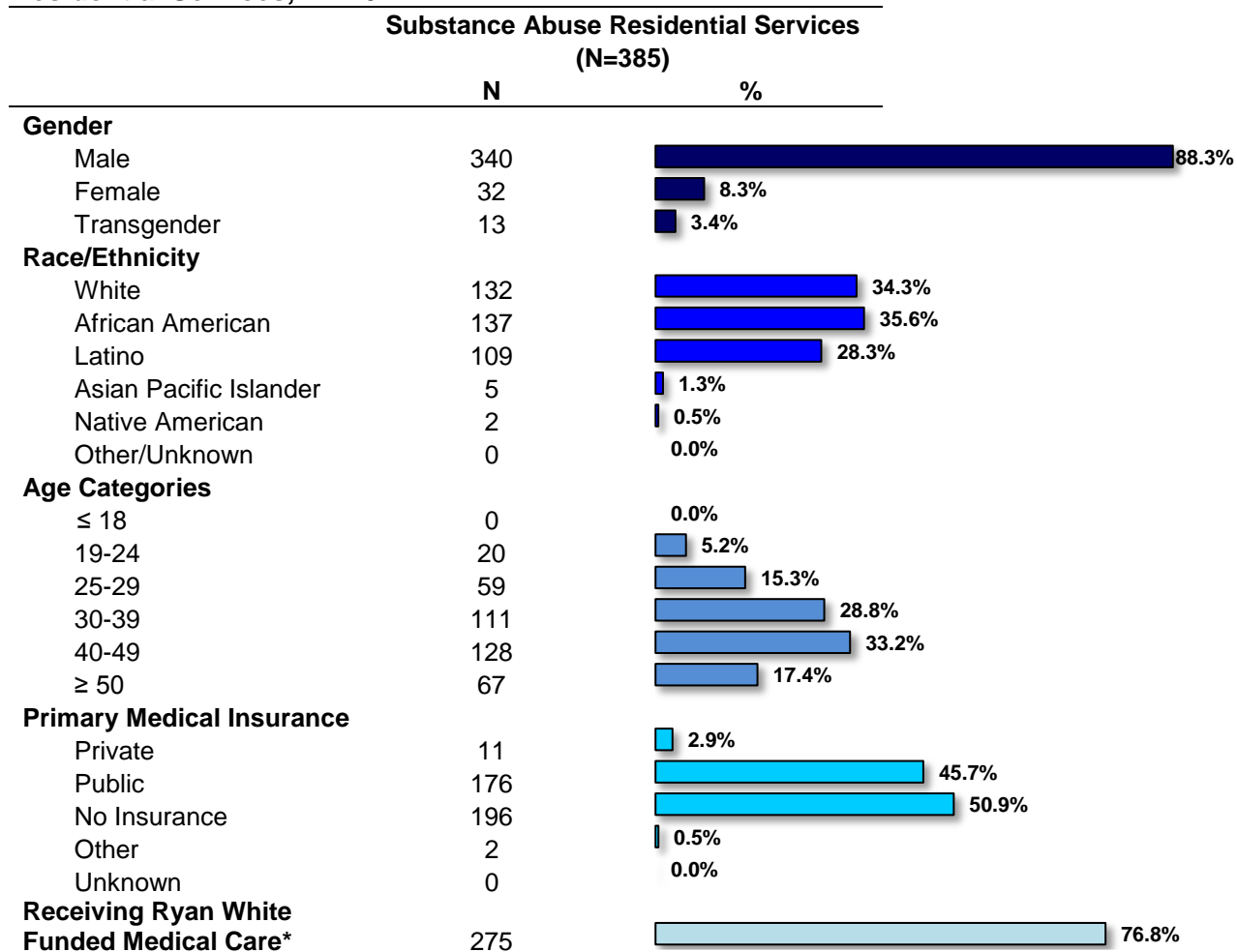
Allocations and Summary:

The Commission allocated 4.6% (\$1,824,100) of RWP Part A and Part B/SAM Care service funds to Substance Abuse, Residential services for FY 2012. Additional support for this service comes from the SAMSHA CSAT/CSAP grant through the State.

Service Utilization: Data include substance abuse residential and day treatment.

Total Clients Served	Service Units	Units of Service Provided
385 (Residential Clients)	Residential Days	24,039
63 (Day Treatment Clients)	Treatment Days	1,421

Table 4.2. Demographic Characteristics of Clients Receiving Substance Abuse Residential Services, FY 2012



Data Source: Casewatch FY 2012 (March 2012 - February 2013)

*Clients who received at least one medical visit within the year

Table 4.3. Demographic Characteristics of Clients Receiving Substance Abuse Day Treatment Services, FY 2012

Substance Abuse Treatment Services (N=63)		
	N	%
Gender		
Male	56	88.9%
Female	6	9.5%
Transgender	1	<5%
Race/Ethnicity		
White	28	44.4%
African American	11	17.5%
Latino	24	38.1%
Asian Pacific Islander	0	0.0%
Native American	0	0.0%
Other/Unknown	0	0.0%
Age Categories		
≤ 18	0	0.0%
19-24	2	3.2%
25-29	5	7.9%
30-39	29	46.0%
40-49	18	28.6%
≥ 50	9	14.3%
Primary Medical Insurance		
Private	5	<5%
Public	28	44.4%
No Insurance	30	47.6%
Other	0	0.0%
Unknown	0	0.0%
Receiving Ryan White Funded Medical Care*	45	67.8%

Data Source: Casewatch FY 2012 (March 2012 - February 2013)

*Clients who received at least one medical visit within the year

4.3 Nutrition Support

HRSA Definition: Food Bank/Home-Delivered Meals include the provision of actual food or meals. It does not include financial assistance to purchase food or meals. The provision of essential household supplies such as hygiene items and household-cleaning supplies should be included in this service definition. This service allows for the provision of vouchers to purchase food.

Commission Definition/Guidance: Nutrition Support includes the provision of actual food or meals. It does not include funds to purchase food or meals. The provision of essential household supplies such as hygiene items and household cleaning supplies should be included in this service definition. Nutrition Support also includes vouchers to purchase food.

What DHSP Funds: Nutrition support services provided under contract with DHSP include home delivered meals and food banks/pantry services. Home delivered meals are provided for clients experiencing physical or emotional difficulties related to HIV/AIDS that render them

incapable of consistently preparing meals for themselves. These services are offered to medically indigent (uninsured and/or ineligible for health care coverage) persons with HIV/AIDS and their eligible family members residing within Los Angeles County. Food bank/pantry services are distribution centers that warehouse food and related grocery items.

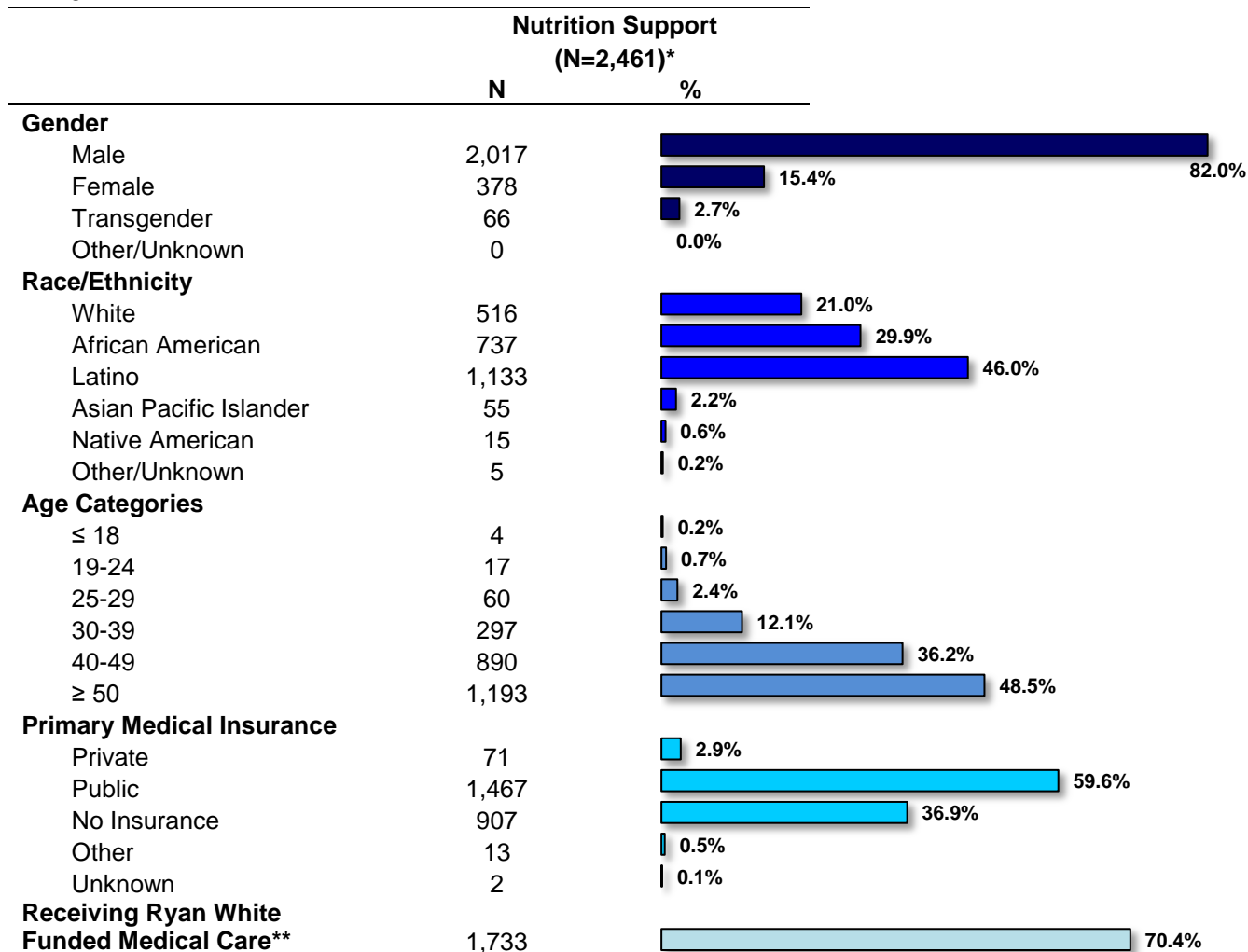
Funding Sources: RWP Part A and Net County Cost

Expenditures and Funding Sources:

Funding Sources	Part A	Part B/SAM Care	Other	Total
Expenditures	\$550,931	0	\$9,520*	\$560,451

*NCC - \$9,520

Table 4.4. Demographic Characteristics of Clients Receiving Nutrition Support Services, FY 2012



Data Source: Casewatch FY 2012 (March 2012 - February 2013)

*It is possible for clients to receive both type of services within one year.

**Clients who received at least one medical visit within the year

Allocations and Summary:

The Commission allocated 1.0% of RWP Part A and Part B/SAM Care service funds to Nutrition Support for FY 2012 (\$396,543). Part A savings in other service categories offset Nutrition Support expenditures that exceeded the allocated amount.

Service Utilization:

Total Clients Served*	Service Units	Units of Service Provided
2,248	Bagged groceries	18,149
279	Home delivered meals	80,873

*The total unduplicated number of clients receiving services from both service types were 2,461.

4.4 Residential Services

HRSA Definition: Housing Services are the provision of short-term assistance to support emergency, temporary or transitional housing to enable an individual or family to gain or maintain medical care. Housing-related referral services include assessment, search, placement, advocacy, and the fees associated with them. Eligible housing can include both housing that does not provide direct medical or supportive services and housing that provides some type of medical or supportive services, such as residential mental health services, foster care, or assisted living residential services.

Commission Definition/Guidance: The Commission developed standards of care for residential care and housing services. As part of the Residential Care and Housing cluster, Residential, Transitional services include Transitional Residential Care Facilities (TRCF) and Residential Care Facilities for the Chronically Ill (RCFCI). Services include the provision of short-term assistance to support emergency, temporary or transitional housing to enable an individual or family to gain or maintain medical care. Eligible housing can include both housing that does not provide direct medical or supportive services and housing that provides some type of medical or supportive services such as residential mental health services, foster care, or assisted living residential services. Includes emergency shelter, transitional housing, Adult Residential Facility and Residential Care Facility for the Chronically Ill.

What DHSP Funds: DHSP only funds residential care services and not housing services. Residential, Transitional services under contract with DHSP include:

Transitional Residential Care Facilities (TRCF): TRCFs provide interim housing with ongoing supervision and assistance with Independent Living Skills (ILS) for homeless individuals living with HIV/AIDS in a non-institutional, homelike environment. The purpose of TRCFs is to facilitate movement towards a more traditional and permanent living situation through assessment of a person's needs, counseling, case management, and other supportive services.

Residential Care Facilities for the Chronically Ill (RCFCI): Any housing arrangement maintained and operated to provide licensed care and supervision to adults, emancipated minors or family units living with HIV. An RCFCI may not exceed 50 beds.

Funding Sources: RWP Part A and Net County Cost

Expenditures and Funding Sources:

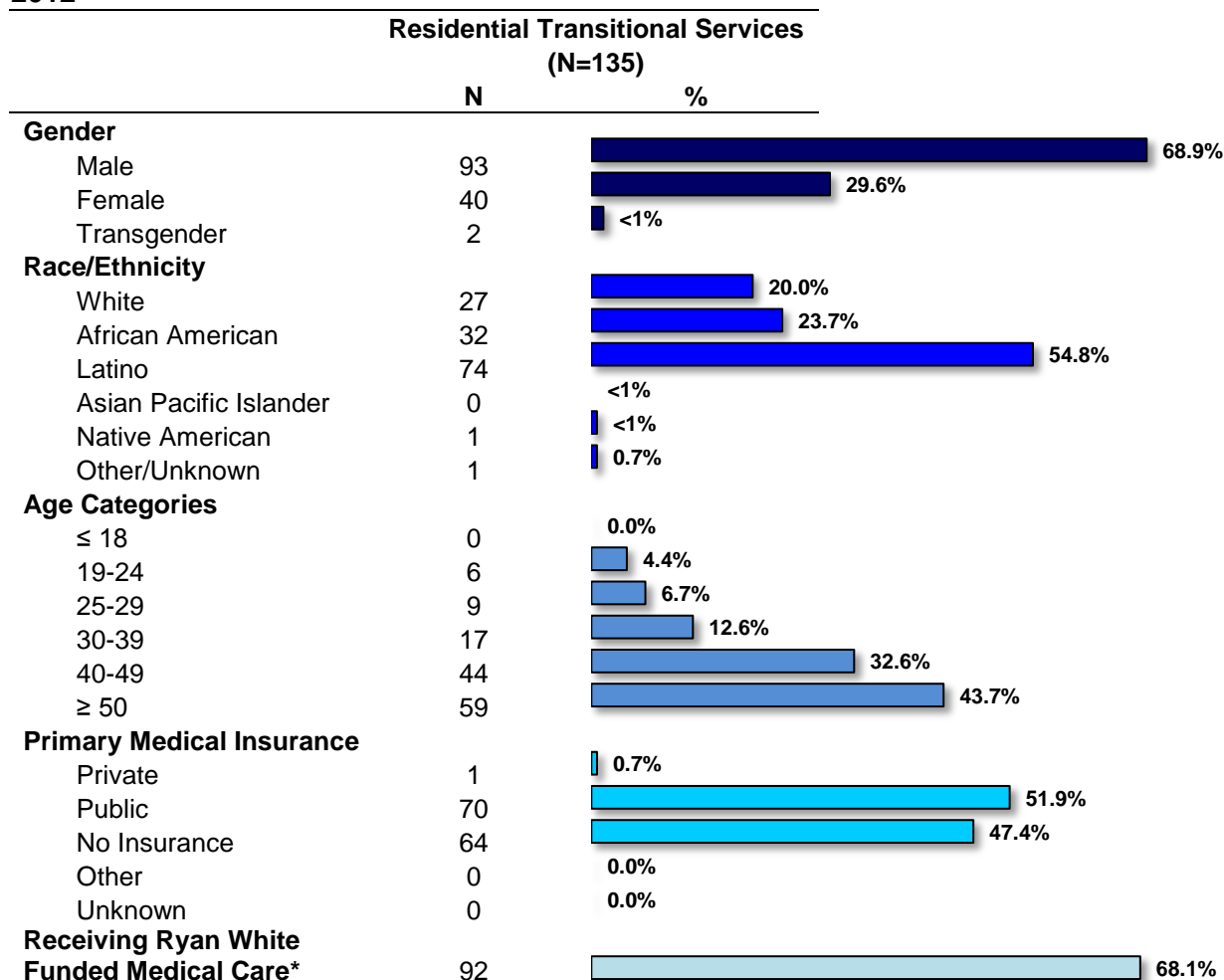
Funding Sources	Part A	Part B/SAM Care	Other*	Total
Expenditures	\$1,495,117	\$1,175,431	\$1,388,472	\$4,059,020

*NCC - \$1,388,472

Allocations and Summary:

The Commission did not allocate RWP Part A or SAM Care/Part B funds to housing/residential services for FY 2012 because NCC supported these services. However, in order to fully maximize grant funds and with the agreement of the Commission, DHSP shifted costs mid-year to Part A and Part B/SAM Care funds to provide support for this category.

Table 4.5. Demographic Characteristics of Clients Receiving Residential Services, FY 2012



Data Source: Casewatch FY 2012 (March 2012 - February 2013)

*Clients who received at least one medical visit within the year

Service Utilization:

Total Clients Served	Service Units	Units of Service Provided	
31	Residential Days	Transitional Residential Care Facilities (TRCF)	6,806
110		Residential Care Facilities for the Chronically Ill (RCFCI)	25,999

Note: It is possible for a client to receive both types of Residential Services (TRCF and RCFCI) in a given year. The number of unduplicated, unique clients in FY 2012 was 135.

4.5 Medical Transportation

HRSA Definition: Medical Transportation Services include conveyance services provided, directly or through vouchers, to a client so that he or she may access health care services. This service definition does not preclude grantees from providing transportation for clients who need assistance to get to a support service appointment.

Commission Definition/Guidance: Medical Transportation includes conveyance services provided, directly or through voucher, to a client so that s/he may access health care services, including taxi vouchers, bus passes and bus tokens. HIV transportation services are provided to medically indigent clients living with HIV and their immediate families for the purpose of providing transportation to medical and social services appointments. Transportation services will not be provided for recreational and/or entertainment purposes.

What DHSP Funds: Transportation services in Los Angeles County include: taxi services; public transit services (bus tokens, bus passes and MetroLink tickets) and disabled ID cards.

Funding Sources: RWP Part A and Net County Cost

Expenditures and Funding Sources:

Funding Sources	Part A	Part B/SAM Care	Other*	Total
Expenditures	\$653,602	\$0	\$227	\$653,829

*NCC - \$227

Allocations:

The Commission allocated 1.7% of RWP Part A and Part B/SAM Care service funds (\$674,124) to Medical Transportation services for FY 2012.

Service Utilization:

Services	Total Clients Served	Service Unit	Service Units Provided
Taxi service	789	Taxi rides	2,689
Bus passes	2,763	Number of monthly passes	26,552
MetroLink	14	Train rides	27

Bus tokens	365	Bus tokens	3,170
Disabled ID cards	100	Number of ID cards	100

4.6 Language Services

HRSA Definition: Linguistics Services include the provision of interpretation and translation services.

Commission Definition/Guidance: Language Services are part of the Los Angeles County Commission Retention in Care Services cluster. They are designed to provide language and sign language interpretation services for limited English proficiency (LEP) people living with HIV and their immediate families, who require special assistance in accessing HIV/AIDS services. Language interpretation services must be provided by a qualified interpreter who is able to communicate fluently in both English and the native language of the client. Sign language provided for deaf and/or hard of hearing people living with HIV must be provided by a qualified interpreter who is fluent in American Sign Language. Services include the provision of interpretation and translation services. Services include healthcare interpretation training; language translation; and American Sign Language interpretation.

What DHSP Funds: Language services provided under contract with DHSP consist of health care interpretation training, healthcare interpreter re-certification, (document) translation services, and American Sign Language interpretation.

Funding Sources: Net County Cost

Expenditures and Funding Sources:

Funding Sources	Part A	Part B/SAM Care	Other*	Total
Expenditures	0	0	\$202,015	\$202,015

*NCC expenditures - \$202,015

Allocations and Summary:

No RWP Part A or Part B/SAM Care funds were allocated to Language services in FY 2012. The service was supported solely by NCC.

Service Utilization:

Services	Clients Served	Service Units	Service Units Provided
Sign language interpretation	9	Sign interpretation hours	282
Interpreter training	34	Interpreter training hours	120
Interpreter re-certification	Not a contract goal	Re-certification trainings	Not a contract goal
Translation services	N/A	Translated words	107,342
Direct interpretation services	60	Direct interpretation hours	406

Total Unduplicated Clients	69*	
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*The total unduplicated clients include only clients receiving sign language interpretation and direct interpretation services, and do not include clients receiving interpreter training.

4.7 Case Management, Transitional

HRSA Definition: HRSA does not have a specific category for Case Management, Transitional. The service falls under the category Case Management (Non-Medical).

Commission Definition/Guidance: HIV Case Management, Transitional services are part of the Los Angeles County Commission cluster of Linkage to Care. They encompass two distinct and varied populations – persons making the transition from incarceration to mainstream HIV services; and youth, especially those who are runaways, homeless and emancipating/emancipated. HIV case management, transitional services are client-centered activities through which care for special transitional populations living with HIV is coordinated.

What DHSP Funds: Case Management, Transitional services provided under contract with DHSP can include: intake and assessment of available resources and needs; development and implementation of individual release plans or transitional independent living plans; coordination of services; interventions on behalf of the client or family; linked referrals; active, ongoing monitoring and follow-up; and periodic assessment of status and needs. The goals of case management, transitional services for incarcerated and post-incarcerated people living with HIV include: reducing re-incarceration; improving the health status of incarcerated or recently released inmates; easing a client’s transition from incarceration to community care; increasing self-efficacy; facilitating access and adherence to primary health care; ensuring access to appropriate services and to the continuum of care; increasing access to HIV information and education; and developing resources and increasing coordination between providers.

For homeless, runaway and emancipating/emancipated youth living with HIV, the goals of case management, transitional services include: reducing homelessness; reducing substance use/abuse; improving the health status of transitional youth; easing a youth’s transition from living on the streets or in foster care to community care; increasing access to education; increasing self-efficacy and self-sufficiency; facilitating access and adherence to primary health care; ensuring access to appropriate services and to the continuum of care; increasing access to HIV information and education; and developing resources and increasing coordination between providers.

Funding Sources: RWP Part B/SAM Care

Expenditures and Funding Sources:

Funding Sources	Part A	Part B/SAM Care	Other*	Total
Expenditures	\$0	\$549,491	\$6,465	\$555,956

*NCC - \$6,465

Allocations:

The Commission allocated 1.2% of RWP Part A and RWP Part B/SAM Care service funds to Case Management, Transitional, for FY 2012 (\$475,852).

Service Utilization:

Total Clients Served	Service Units	Units of Service Provided
818 – incarcerated	Hours	5,530
118 – youth	Hours	2,427

Table 4.6. Demographic Characteristics of Incarcerated Clients Receiving Transitional Case Management Services, FY 2012

Demographic Characteristics	Transitional Case Management for Incarcerated Individuals (N=818)	
	N	%
Gender		
Male	715	87.4%
Female	73	8.9%
Transgender	30	3.7%
Race/Ethnicity		
White	181	22.1%
African American	408	49.9%
Latino	208	25.4%
Asian Pacific Islander	8	1.0%
Native American	8	1.0%
Other/Unknown	5	0.6%
Age Categories		
≤18	1	0.1%
19-24	40	4.9%
25-29	92	11.2%
30-39	223	27.3%
40-49	288	35.2%
≥50	174	21.3%
Primary Medical Insurance		
Private	7	0.9%
Public	249	30.4%
No Insurance	496	60.6%
Other	5	0.6%
Unknown	7	0.9%
Receiving Ryan White Funded Medical Care*		
	308	37.7%

Data Source: Casewatch FY 2012 (March 2012 - February 2013)

*Clients who received at least one medical visit within the year

Table 4.7. Demographic Characteristics of Youth Clients Receiving Transitional Case Management Services, FY 2012

Demographic Characteristics	Transitional Case Management for Youth (N=118)	
	N	%
Gender		
Male	108	91.5%
Female	9	7.6%
Transgender	1	0.8%
Race/Ethnicity		
White	12	10.2%
African American	45	38.1%
Latino	57	48.3%
Asian Pacific Islander	3	2.5%
Native American	0	0.0%
Other/Unknown	1	0.8%
Age Categories		
≤18	7	5.9%
19-24	98	83.1%
25-29	13	11.0%
Unknown	0	0.0%
Primary Medical Insurance		
Private	10	8.5%
Public	45	38.1%
No Insurance	62	52.5%
Other	1	0.8%
Unknown	0	0.0%
Receiving Ryan White Funded Medical Care*		
	80	67.8%

Data Source: Casewatch FY 2012 (March 2012 - February 2013)

*Clients who received at least one medical visit within the year

4.8 Benefits Specialty

HRSA Definition: HRSA does not have a specific category for Benefits Specialty. The service falls under the category Case Management, Non-Medical.

Commission Definition/Guidance: Benefits Specialty services facilitate a client's access to public/private health and disability benefits and programs. Benefits specialty services work to maximize public funding by assisting clients to identify all available health and disability benefits supported by funding streams other than RWP Part A funds. Benefits specialty services facilitate a client's entry into and movement through the care service delivery network. Benefits specialty services are designed to educate people living with HIV about public and private benefits and entitlement programs and to provide assistance in accessing and securing these benefits.

What DHSP Funds: Benefits specialty services can include assessment of benefit need and eligibility, assistance with completing benefits paperwork, appeals counseling and facilitation, and assistance and management of benefits issues for clients who are enrolled in health and disability programs.

Funding Sources: RWP Part A

Expenditures and Funding Sources:

Funding Sources	Part A	Part B/SAM Care	Other	Total
Expenditures	\$689,812	\$0	\$0	\$689,812

Allocations:

The Commission allocated 2% (\$793,087) RWP Part A funds to Benefits Specialty services for 2012.

Service Utilization:

Total Clients Served	Service Units	Units of Service Provided
2,935	Benefits Specialty Counseling Hour	14,960

Table 4.8. Demographic Characteristics of Clients Receiving Benefits Specialty Services, FY 2012

Demographic Characteristics	Benefits Specialty (N=2,935)	
	N	%
Gender		
Male	2,512	85.6%
Female	380	12.9%
Transgender	43	1.5%
Race/Ethnicity		
White	858	29.2%
African American	605	20.6%
Latino	1,357	46.2%
Asian Pacific Islander	94	3.2%
Native American	13	0.4%
Other/Unknown	8	0.3%
Age Categories		
≤18	6	0.2%
19-24	72	2.5%
25-29	152	5.2%
30-39	513	17.5%
40-49	1,031	35.1%
≥50	1,161	39.6%
Primary Medical Insurance		
Private	343	11.7%
Public	1,196	40.7%
No Insurance	1,372	46.7%
Other	23	0.8%
Unknown	1	0.0%
Receiving Ryan White Funded Medical Care*	1,932	65.8%

Data Source: Casewatch FY 2012 (March 2012 - February 2013)

*Clients who received at least one medical visit within the year

4.9 Legal Services

HRSA Definition: Legal Services are the provision of services to individuals with respect to powers of attorney, do-not-resuscitate orders and interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the RWP. It does not include any legal services that arrange for guardianship or adoption of children after the death of their caregiver.

Commission Definition/Guidance: Same as above.

What DHSP Funds: Legal services funded by DHSP are services that resolve HIV-related legal services for individuals with respect to powers of attorney, do-not-resuscitate orders and interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the RWP. HIV legal services do not include guardianship or adoption of children after the death of their legal caregiver, criminal defense, discrimination or class action litigation unrelated to RWP services.

Funding Sources: Net County Cost

Expenditures and Funding Sources:

Funding Sources	Part A	Part B/SAM Care	Other*	Total
Expenditures	\$0	\$0	\$7,004	\$7,004

*NCC expenditures - \$7,004

Allocations:

The Commission did not allocate RWP Part A and Part B/SAM Care service funds to Legal services for FY 2012.

Service Utilization:

Due to State budget cuts, this service was terminated as of February 2010. In January 2012, DHSP, with the concurrence of the Commission, signed a contract to address open, continuing cases remaining from the prior Contractor.

Appendix A

Table A.1. Demographic Characteristics of All Ryan White Program Clients and Clients in Medical Care, FY 2012

Characteristic	All RW Clients		RW Clients in Medical Care	
	n	%	n	%
New Client*	2,343	11.6%	1,647	9.9%
Returning Client**	965	4.8%	575	3.5%
Gender				
Male	17,415	86.1%	14,323	86.4%
Female	2,471	12.2%	1,990	12.0%
Transgender	350	1.7%	274	1.7%
Race/Ethnicity				
African-American	4,732	23.4%	3,686	22.2%
Asian/Pacific-Islander	712	3.5%	614	3.7%
Latino/Hispanic	9,672	47.8%	8,325	50.2%
White/Caucasian	4,959	24.5%	3,836	23.1%
Native American/Alaskan Native	81	0.4%	64	0.4%
Other/Unknown	83	0.4%	62	0.4%
Age				
0-18	59	0.3%	16	0.1%
19-24	730	3.6%	579	3.5%
25-29	1,608	7.9%	1,396	8.4%
30-39	4,350	21.5%	3,780	22.8%
40-49	7,105	35.1%	6,011	36.2%
≥50	6,384	31.5%	4,805	29.0%
HIV/AIDS Status				
CDC Defined AIDS	9,948	51.5%	8,123	49.0%
HIV+, Not AIDS	7,447	36.4%	6,334	38.2%
HIV+, AIDS Status Unknown	2,757	11.8%	2,128	12.8%
HIV Negative (High Risk)	6	0.0%	0	0.0%
Unknown	68	0.3%	2	0.0%
Primary Insurance				
Private	1,107	5.5%	661	4.0%
Public	6,802	33.6%	5,052	30.5%
No Insurance	12,034	59.5%	10,781	65.0%
Other	123	0.6%	93	0.6%
Unknown	68	0.3%	0	0.0%

Income Level				
≤ Federal Poverty Level	13,692	67.7%	11,184	67.4%
101-200% of FPL	4,608	22.8%	3,744	22.6%
201-300% of FPL	1,267	6.3%	1,082	6.5%
301-400% of FPL	460	2.3%	393	2.4%
> 400% FPL	209	1.0%	184	1.1%
Living Situation				
Permanent	17,598	87.0%	14,987	90.4%
Homeless/Transitional	1,099	5.4%	831	5.0%
Institution (residential/health care/correctional)	903	4.5%	475	2.9%
Other	266	1.3%	179	1.1%
Unknown	370	1.8%	115	0.7%
Incarceration History				
Incarcerated ≤ 24 mo.	1,909	9.4%	1,229	7.4%
Incarcerated > 2 yrs.	2,040	10.1%	1,563	9.4%
Never Incarcerated	16,117	79.6%	13,795	83.2%
Unknown	170	0.8%	0	0.0%
TOTAL	20,236	100.0%	16,587	100.0%

Data Source: Casewatch FY 2012 (March 2012 - February 2013)

*New client refers to a client who entered the care system for the first time during FY 2012.

**Returning client refers to a client who returned to the care system during FY 2012 after not having accessed services in the last 12 months.