NORTHWEST FLORIDA AIDS CONSORTIUM

COMPREHENSIVE HIV/AIDS NEEDS ASSESSMENT

2017-2018

FLORIDA AREA I

ESCAMBIA, SANTA ROSA, OKALOOSA, WALTON COUNTIES

Acknowledgments

The 2017-2018 Comprehensive HIV/AIDS Needs Assessment could not have been accomplished without the valuable contributions of an entire network of dedicated individuals. First and foremost, the people living with HIV/AIDS who participated in the anonymous survey provided indispensable information in the service of improving care for themselves and others. HIV/AIDS care providers in the region also gave selflessly of their time and energy to engage clients in the needs assessment process and provide insight into the needs of their clients. Case managers played a special role through their participation in individual interviews to assess case management workload issues in this needs assessment. The Center for Applied Psychology at the University of West Florida offered valuable expertise in the design and implementation of the systematic analysis of case management workload issues. The consultation of Dr. Steven Vodanovich, Dr. Valerie Moganson, Michael LaFlamme, Michael DeNoia, Stephanie Nucci, and Gage Moyer from the Center for Applied Psychology added an innovative and novel analysis to this needs assessment. Members of the Northwest Florida AIDS Consortium and Lutheran Services Florida provided important direction in the planning and implementation of the needs assessment. Although numerous people made constructive contributions, the individual efforts of Josh Menge, Anne Hall, James Talley, Deborah Carty, Michelle Bradley, and Maurice Moody were particularly noteworthy. To all those who contributed in the effort to make the most of the limited resources available to meet the needs of persons living with HIV and AIDS in Area 1, thank you.

A special note of gratitude is offered in memory of Anne Hall, whose passing on March 1, 2018 represented a significant loss to the Area I HIV/AIDS community. Anne worked tirelessly on behalf of people living with HIV/AIDS in Area I from the beginning of the epidemic until the end of her life. Anne was an important leader for the Northwest Florida AIDS Consortium and she was instrumental in this and prior needs assessments and funding allocations for critical Ryan White services.

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SECTION I

OVERVIEW OF THE COMPREHENSIVE NEEDS ASSESSMENT REPORT

A comprehensive assessment of health care and social service needs of people living with HIV/AIDS (PLWH/A) in Northwest Florida, also known as Florida Area I, was conducted in 2017-2018. The following report provides background on HIV/AIDS in Area I and describes the process and findings of the comprehensive needs assessment for PLWH/A in several sections.

Section II provides a brief description of Florida Area I and its population as well as information on HIV/AIDS incidence, prevalence, and comorbidity. It concludes with an overview of current funding levels for HIV/AIDS care (from public sources).

Section III describes the processes and procedures used to collect the primary source data for the needs assessment, including an anonymous survey of PLWH/A as well as interviews with case managers.

Section IV provides an executive summary of major findings regarding HIV/AIDS service priorities, including service needs and met needs as well as unmet needs and service gaps. Comparisons with prior needs assessment reports are also provided.

Section V provides supporting materials, including epidemiological reports. Copies of the needs assessment client survey and case manager interview instruments and related documents are also provided.

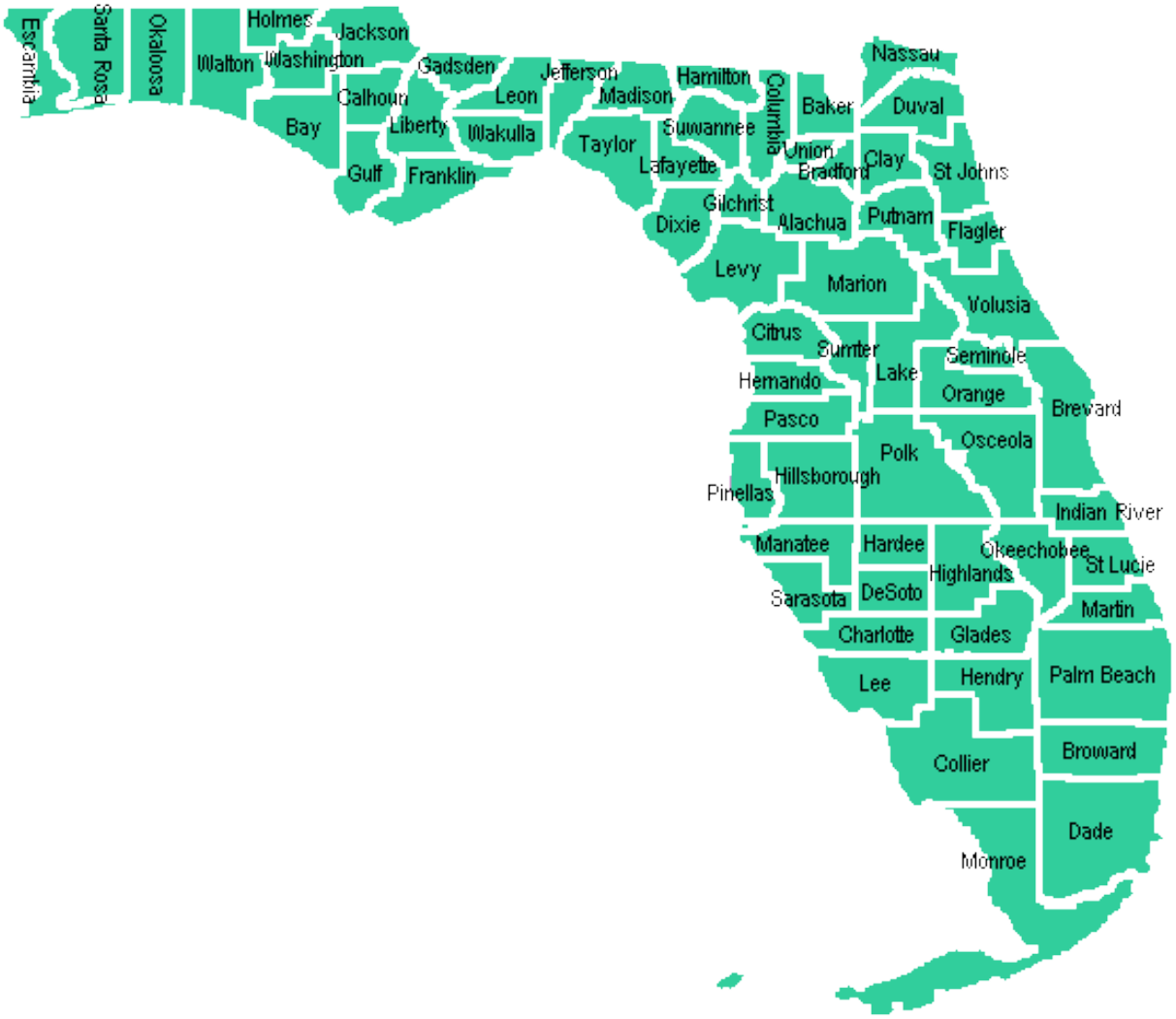
SECTION II

DESCRIPTION OF HIV/AIDS IN AREA I

A. Map of Area I

The needs assessment covered Northwest Florida or Florida Area I. Florida Area I includes the four westernmost counties of Northwest Florida's panhandle: Escambia, Santa Rosa, Okaloosa, and Walton Counties, as shown on the map below.

Florida Counties



Source: http://esetappsdoh2.doh.state.fl.us/DconAids/ClinicSearch.aspx

Mid-year population estimates for Florida Area I in 2016, provided by the HIV/AIDS Section, Bureau of Communicable Diseases, Division of Disease Control and Health Protection of the Florida Department of Health, indicate that there are over 700,000 residents in the region. The table below describes the sex/gender, race/ethnicity, and age breakdown of Area I residents.

Table 1. Gender, Race/Ethnicity, and Age of Area I Residents, 2016

	#	%
Total	732,337	**100.0**
Gender		
Male	367,741	**50.2**
Female	364,866	**49.8**
Race/Ethnicity		
White, non-Hispanic	532,912	**72.8**
Black, non-Hispanic	107,248	**14.6**
Hispanic	64,873	**8.9**
Other	27,304	**3.7**
Age		
0 – 12 years	116,733	**15.9**
13 – 19 years	63,856	**8.7**
20 – 29 years	104,662	**14.3**
30 – 39 years	93,993	**12.8**
40 – 49 years	86,195	**11.8**
50 – 59 years	103,887	**14.2**
60+ years	163,011	**22.3**

B. Epidemiological Profile

The epidemiological profile that follows reports on HIV/AIDS prevalence (number of persons living with HIV/AIDS at a point in time), annual HIV/AIDS incidence (number of new HIV/AIDS cases reported in past year and prior year), and rates of comorbidity between HIV/AIDS, hepatitis, sexually transmitted infections or STIs, and tuberculosis as well as substance abuse, mental illness, and homelessness in the four counties of Area I combined. Although prior needs assessment reports included data on cumulative HIV and AIDS cases, these data are no longer monitored and reported in surveillance efforts. Data reported below were obtained from HIV/AIDS Section, Bureau of Communicable Diseases, Division of Disease Control and Health Protection of the Florida Department of Health (cases reported from within the Florida Department of Corrections and Federal Correctional Institutions were excluded throughout).

Adult HIV/AIDS case rates vary as a function of gender, race/ethnicity, and mode of exposure. Comparisons between HIV cases and AIDS cases indicate trends over time, with HIV cases representing more recent epidemiological patterns. Comparisons to the general population indicate groups possessing a disproportionate burden of infection.

1. HIV/AIDS Prevalence

Combined, the reported HIV/AIDS prevalence as of December 31, 2016 was 2,040 children, adolescents, and adults living with HIV/AIDS in Area I (56.1% AIDS cases, 43.9% HIV cases). The table below displays pediatric, adolescent, and adult HIV and AIDS prevalence as a function of sex/gender, race/ethnicity, and exposure.

Table 2: HIV and AIDS Prevalence by Gender, Race/Ethnicity, and Exposure, as of 12-31-2016

	AIDS		HIV (not AIDS)		HIV/AIDS	
	# of cases	% of AIDS	# of cases	% of HIV	# of cases	% of total
Total	1,144	**100.0**	896	**100.0**	2,040	**100.0**
Gender						
Male	853	**74.6**	657	**73.3**	1,510	**74.0**
Female	291	**25.4**	239	**26.7**	530	**26.0**
Race/Ethnicity						
White	569	**49.7**	417	**46.5**	986	**48.3**
Black	494	**43.2**	407	**45.4**	901	**44.2**
Hispanic	60	**5.2**	46	**5.1**	106	**5.2**
Other	21	**1.8**	26	**2.9**	47	**2.3**
Exposure						
MSM	561	**49.0**	493	**55.0**	1,054	**51.7**
Heterosexual	401	**35.1**	315	**35.1**	714	**35.0**
IDU	95	**8.3**	44	**4.9**	139	**6.8**
MSM/IDU	68	**5.9**	23	**2.9**	91	**4.5**
Other risk	20	**1.7**	14	**1.6**	34	**1.7**
Perinatal	0	**0.0**	8	**0.9**	8	**0.4**

Although men account for only half of the population of Area I, men account for roughly ¾ of AIDS cases and ¾ of HIV cases (74.0% of HIV/AIDS cases). Non-Hispanic Black adults are overrepresented among HIV and AIDS cases. Although non-Hispanic Blacks account for only 15% of the population of Area I, more than 40% of HIV and AIDS cases are among non-Hispanic Blacks (44.2% of HIV/AIDS cases). Similarly, men who have sex with men (MSM) continue to share a disproportionate burden of the epidemic, with more than half of all HIV/AIDS cases attributed to MSM exposure even though MSM are estimated to account for only 6.5% of the male population[1] or approximately 3.2% of the adult population. Approximately 35% of HIV and AIDS cases were attributed to heterosexual exposure. In summary, non-Hispanic Blacks and MSM are disproportionately affected by HIV/AIDS in Area I. These disproportionate burdens of HIV and AIDS among non-Hispanic Blacks and MSM represent longstanding disparities in Area I and throughout the US.

[1] Lieb, S., Fallon, S. J., Friedman, S. R., Thompson, D. R., Gates, G. J., Liberti, T. M., & Malow, R. M. (2011). Statewide estimation of racial/ethnic populations of men who have sex with men in the U.S. *Public Health Reports*, *126*, 60-72.

2. HIV/AIDS Incidence

In 2015, 48 cases of AIDS and 74 cases of HIV (regardless of AIDS) were reported. In 2016, the number of new AIDS cases was almost 30% lower and the number of new HIV cases was approximately 15% higher than the number of these cases reported in 2015, with 35 cases of AIDS and 86 cases of HIV (regardless of AIDS) reported in 2016. The following tables display the annual incidence of HIV and AIDS cases in 2015 and 2016, respectively, with breakdowns of cases by sex/gender, race/ethnicity, and exposure and rates per 100,000 (higher rates per 100,000 represent greater burden of infection). Patterns of overrepresentation among non-Hispanic Blacks (rates of HIV and AIDS were roughly five to eight times higher for Blacks than they were for Whites) and MSM were found in incidence data, similar to the patterns found in prevalence data described above.

Table 3: HIV and AIDS Incidence by Gender, Race/Ethnicity, and Exposure, 2015

	AIDS			HIV (regardless of AIDS)		
	# of cases	% of total	Rate per 100,000	# of cases	% of total	Rate per 100,000
Total	48	**100.0**	6.6	74	**100.0**	10.2
Gender						
Male	29	**60.4**	7.9	61	**82.4**	16.8
Female	19	**39.6**	5.2	13	**17.6**	3.6
Race/Ethnicity						
White	17	**35.4**	3.2	35	**47.3**	6.6
Black	28	**58.3**	26.1	34	**45.9**	33.0
Hispanic	2	**4.2**	3.1	3	**4.1**	6.6
Other	1	**2.1**	NA	2	**2.7**	NA
Exposure						
MSM	19	**39.6**	NA	42	**56.7**	NA
Heterosexual	26	**54.2**	NA	28	**37.8**	NA
IDU	4	**8.3**	NA	3	**4.1**	NA
MSM/IDU	0	**0.0**	NA	1	**1.4**	NA
Other risk	0	**0.0**	NA	0	**0.0**	NA
Perinatal	0	**0.0**	NA	0	**0.0**	NA

Table 4: HIV and AIDS Incidence by Gender, Race/Ethnicity, and Exposure, 2016

	AIDS			HIV (regardless of AIDS)		
	# of cases	% of total	Rate per 100,000	# of cases	% of total	Rate per 100,000
Total	35	**100.0**	4.8	86	**100.0**	11.7
Gender						
Male	24	**68.6**	6.6	64	**74.4**	17.4
Female	11	**31.4**	3.0	22	**25.6**	6.0
Race/Ethnicity						
White	18	**51.4**	3.4	31	**36.0**	5.8
Black	16	**45.7**	15.5	47	**54.7**	43.8
Hispanic	1	**2.9**	2.2	6	**7.0**	9.2
Other	0	**0.0**	0.0	2	**2.4**	NA
Exposure						
MSM	18	**51.4**	NA	45	**52.3**	NA
Heterosexual	13	**37.1**	NA	35	**40.7**	NA
IDU	2	**5.7**	NA	6	**7.0**	NA
MSM/IDU	2	**5.7**	NA	0	**0.0**	NA
Other risk	0	**0.0**	NA	0	**0.0**	NA
Perinatal	0	**0.0**	NA	1	**1.7**	NA

3. HIV/AIDS Comorbidity

HIV and AIDS may be comorbid or co-occur with other infectious diseases, especially those with similar transmission routes, such as hepatitis C and other sexually transmitted infections or STIs (i.e., chlamydia, gonorrhea, syphilis), as well as tuberculosis. The table below displays the number of cases of these infectious diseases reported in Area I in 2016 and their rate per 100,000 as well as the number of cases of comorbid infections reported among the 2040 PLWH/A residing in Area I. Hepatitis C represents a significant comorbid infectious disease, with 10.4% of Area I PLWH/A also living with hepatitis C in 2016.

Table 5: HIV/AIDS Comorbidity with Hepatitis C, STI, and TB

Comorbidity	# of cases reported in 2016	Rate/100,000	# and % of cases reported in 2016 among 2040 Area I PLWH/A	
			#	**%**
Hepatitis C	1,156	**157.9**	**213**	**10.4**
Hepatitis B	208	**28.4**	**133**	**6.5**
Chlamydia	3,727	**508.9**	**33**	**1.6**
Gonorrhea	1,153	**157.4**	**31**	**1.5**
Syphilis	72	**9.8**	**14**	**0.7**
Tuberculosis	24	**3.3**	**1**	**0.1**

HIV and AIDS often co-occur with a number of psychological and social conditions of interest, including substance abuse, mental illness, and homelessness. The table below displays the number and percent of 2040 PLWH/A in Area I in 2016 with comorbid homelessness, substance abuse history, and chronic mental illness history as well as the number and percent of PLWH/A in Area I with MSM and IDU risk factors in their history. Again, MSM are disproportionately impacted by HIV, with MSM representing 56.1% of PLWH/A. Substance abuse history and IDU risk represent significant comorbidities among PLWH/A in Area I, with 24.3% and 6.8%, respectively, of PLWH/A with these histories.

Table 6: HIV/AIDS Comorbidity with Homelessness, Substance Abuse, Mental Illness, MSM, and IDU Risk

Comorbidity	cases reported in 2016 among 2040 Area I PLWH/A	
	#	%
MSM or MSM/IDU risk	1,145	**56.1**
Substance abuse history	495	**24.3**
IDU risk	139	**6.8**
Chronic mental illness history	63	**3.1**
Homeless	9	**0.4**

Additional epidemiological data are available in Appendix A. All data reported above and in Appendix A were obtained from the HIV/AIDS Section, Bureau of Communicable Diseases, Division of Disease Control and Health Protection of the Florida Department of Health with the generous assistance of the Florida Department of Health in Escambia County.

C. HIV/AIDS Funding Information

Area I receives federal funding through the State of Florida through the AIDS Drug Assistance Program (ADAP), Ryan White HIV/AIDS Program Part B and Part C, Housing Opportunities for People with AIDS (HOPWA), and through the State of Florida General Revenue providing funding for the Florida Department of Health in Escambia County and the Florida Department of Health in Okaloosa County.

The ADAP Program assists PLWH/A with coverage for HIV-related medication. The program is administered statewide, rather than locally. Funding in the amount of $216,367 for Area I provides for personnel expenses to ensure access to the ADAP for Area I PLWH/A.

The Ryan White HIV/AIDS Program was originally authorized by legislation in 1990 and reauthorized in 1996, 2000, 2006, 2009, and 2013. Part A funds major metropolitan areas; Part B funds States and supports state ADAPs; Part C funds early intervention programs and capacity building grants; Part D funds programs for women, infants, children, and youth; and Part F funds special projects of national significance, AIDS education and training centers, and dental reimbursement programs.

Administered by the Health Resources and Services Administration (HRSA) through the State of Florida with the Northwest Florida AIDS Consortium (NoFLAC) serving as an advisory board, Area I receives federal funding through the Part B and Part C of the Ryan White HIV/AIDS Program for core medical services and support for PLWH/A who are uninsured or underinsured. Area I received just under $1.4

million for 2017-2018 for Part B and $312,147 for Part C to support the HIV/AIDS clinic at the Florida Department of Health in Okaloosa County. The table below describes the allocation of Ryan White Part B funding for Area I for 2017-2018.

Table 7: Ryan White HIV/AIDS Program Part B Funding for Florida Area I (April 1, 2017 – March 31, 2018)

Service	Amount Funded	% of Total
Ambulatory Outpatient Medical Care	$435,000	**31.4**
Case Management (medical)	$235,000	**17.0**
Case Management (non-medical)	$235,000	**17.0**
Oral Health Care	$113,450	**8.2**
Emergency Financial Assistance - emergency housing	$47,200	**3.4**
Emergency Financial Assistance – medications	$25,000	**1.8**
Food Bank/Home Delivered Meals	$19,000	**1.4**
Transportation	$18,000	**1.3**
Mental Health Services	$17,000	**1.2**
Referral for Healthcare/Support Services	$11,500	**0.8**
Medical Nutrition Therapy	$9,000	**0.6**
Health Insurance Premium/Cost Sharing	$7,000	**0.5**
Linguistic Services	$4,000	**0.3**
Psychosocial Support Services	$800	**<0.1**
Housing Assistance	$500	**<0.1**
Substance Abuse Treatment	0	**0.0**
Pharmaceutical Assistance	0	**0.0**
Administration	$103,893	**7.5**
Capacity Building	$69,262	**5.0**
Planning and Development	$34,631	**2.5**
Total	**$1,385,236**	**100.0**

Administered by U.S. Department of Housing and Urban Development through the State of Florida, HOPWA funding is administered locally to assist PLWH/A in meeting housing needs, providing assistance with rent/mortgage and utility payments for eligible PLWH/A. Area I received $432,259 for FY 2017-2018. The table below describes the allocation of HOPWA funds for Area I for 2017-2018.

Table 8: Housing Opportunities for People with AIDS (HOPWA) Funding for Florida Area I (FY17-18)

Service	Amount Funded	% of Total
Rent	$145,000	**33.5**
Case Management	$108,282	**25.0**
Utilities	$70,000	**16.2**
Mortgage	$55,000	**12.7**
Permanent Housing Placement	$12,000	**2.8**
Tenant-Based Rental Assistance	$10,000	**2.3**
Resource Identification	$1,718	**0.4**
Administration	$30,259	**7.0**
Total	**$432,259**	**100.0**

State of Florida General Revenue funding provides $200,000 annually to support HIV/AIDS programs in Area I, with $100,000 administered through the Department of Health in Escambia County and $100,000 administered through the Department of Health in Okaloosa County. Funds are used to supplement Ryan White and ADAP program gaps.

In summary, just under $2.6 million in public HIV/AIDS care funding was designated specifically for Area I PLWH/A in fiscal year 2017-18. In addition to this designated funding, PLWH/A have access to the statewide ADAP.

Table 9: Area I Florida HIV/AIDS Funding Summary, 2017-2018

	Escambia County	Okaloosa County	Santa Rosa County	Area I
HOPWA				**$432,259**
Ryan White Part B				**$1,385,236**
Ryan White Part C		$312,147		**$312,147**
ADAP	$168,445	$30,863	$17,059	**$216,367**
Ryan White ADAP rebates	$49,470			**$49,470**
Florida General Revenue	$100,000	$100,000		**$200,000**
Total	**$317,915**	**$443,010**	**$17,059**	**$2,595,479**

The remaining sections of this report describe the needs assessment process and findings that are intended to inform funding allocation decisions.

SECTION III

SUMMARY OF 2017-2018 COMPREHENSIVE NEEDS ASSESSMENT

A. Description of Data Sources and Collection Methods

Data for the comprehensive needs assessment were collected from multiple sources (including both PLWH/A clients/consumers of services and Ryan White case managers) using multiple methods (including surveys and interviews). Findings are summarized separately for client/consumer data and case manager data. Survey and interview tools are appended to the report in Appendices B and C.

Client/consumer data collection methods included an anonymous online survey of client needs. The standardized survey developed by the HIV/AIDS Section, Bureau of Communicable Diseases, Division of Disease Control and Health Protection of the Florida Department of Health and the Institute for Health, Policy, and Evaluation Research between 2004 and 2009 was used (modified from the 2013 version) and administered online by the Florida Department of Health. Clients/consumers were informed of the survey and invited to participate by case managers and other care providers in the area. The survey was anonymous, in an effort to ensure patient confidentiality. A total of 182 clients/consumers from Area I participated in the survey between October 3, 2016 and January 25, 2017.

Case manager data collection methods included detailed, structured individual interviews of Area I Ryan White HIV/AIDS case managers and eligibility specialists from all three of the Area I case management agencies. A brief, second interview was completed with a subset of case managers and eligibility specialists in follow up to the initial interviews. Interviews included statements of purpose, risks/benefits, and use of data to obtain informed, voluntary participation.

The following sections provide a detailed report of findings from PLWH/A client/consumer and case manager data obtained via surveys and interviews in Section III as well as an executive summary of HIV/AIDS service priorities determined from the needs assessment in Section IV.

B. Summary of Data from Anonymous PLWH/A Client Survey

Survey participants included 182 Area I PLWH/A. The sex/gender, race/ethnicity, sexual orientation, age, employment, and county of residence of survey participants are summarized and compared to Area I HIV/AIDS cases in the table below. County and sex/gender distributions of survey participants were comparable to the epidemiological profile of Area I HIV/AIDS cases; there was a modest under-representation of African American/Black and younger participants relative to Area I HIV/AIDS cases.

Table 10: Characteristics of Anonymous PLWH/A Client Survey Participants

Client survey participant characteristics	#	% of total (182)	% of HIV/AIDS cases in Area I
County of residence			
Escambia	124	**68.1**	**65.1**
Okaloosa	22	**12.1**	**18.2**
Santa Rosa	21	**11.5**	**12.9**
Walton	15	**8.2**	**3.8**
Sex/Gender			
Male	147	**80.8**	**74.0**
Female	33	**18.1**	**26.0**
Transgender	1	**0.5**	**NA**
Missing	1	**0.5**	**NA**
Race/ethnicity			
Caucasian/White	108	**59.3**	**48.3**
African American/Black	60	**33.0**	**44.2**
Hispanic/Latino/Latina	4	**2.2**	**5.2**
Multiracial	6	**3.3**	**NA**
Other	5	**2.7**	**1.1**
Age			
29 or under	5	**2.7**	**11.0**
30 – 39 years	14	**7.7**	**17.3**
40 – 49 years	28	**15.4**	**23.1**
50 – 59 years	77	**42.3**	**35.5**
60 or older	39	**21.4**	**13.0**
Missing	19	**10.4**	**NA**
Sexual orientation			
Heterosexual/straight	59	**32.4**	**NA**
Gay, bisexual, MSM (men who have sex with men)	109	**59.9**	**NA**
Missing	14	**7.7**	**NA**
Education level status			
Less than high school graduate	21	**11.5**	**NA**
High school diploma/GED	38	**20.9**	**NA**
Some college	72	**39.6**	**NA**
Completed college	44	**24.2**	**NA**
Post graduate	6	**3.3**	**NA**
Missing	1	**0.5**	**NA**

Most participants (90.1%) reported that they receive care in one of two Area I counties (Escambia and Okaloosa counties). More than ¾ of Area I PLWH/A reported receiving care in Escambia county. Most participants (77.5%) reported receiving care in the county in which they reside. Of the 41 participants reporting that they received care in a county other than the county in which they reside (22.5%), 40.0% reported that services were not available in their county of residence while 21.9% were not satisfied with serviced provided in their county, 14.6% reported that they received care closer to where they lived or worked, and 17.1% reported that they did not want people to know their HIV status (another 14.6% reported other reasons for receiving care in a different county).

Table 11: County in which Medical Care is Received

Location of health care provider	#	% of total (182)
Escambia	139	**76.4**
Okaloosa	25	**13.7**
Santa Rosa	2	**1.1**
Walton	7	**3.8**
Other	2	**1.1**
Missing	7	**3.8**

Survey participants were asked to report on their need for and utilization of 20 services (plus other) for HIV-related concerns. The table below lists the service categories and descriptions of each service.

Table 12: Service Types and Descriptions

Service type	Description
Outpatient Medical Care	Visits to doctor's office or clinic for HIV medical care
Case Management	Case managers help clients receive services and then follow up on their care
Medications	Pills for HIV and related issues
Dental/Oral Health	General teeth and mouth care, dentures, oral surgery, etc.
Health Insurance	Helps pay insurance cost or co-pays if client has insurance
Mental Health Services	Professional counseling, therapy, or support groups
Substance Abuse Treatment	Professional counseling for drug or alcohol addiction
Nutritional Counseling	Professional counseling for healthy eating habits
Early Intervention Services	Assistance getting a doctor's appointment, HIV counseling and testing, linkage and referral to medical care
Home Health Care	Professional health care services in a client's home by a licensed/certified home-health agency
Hospice Services	Nursing and counseling services for the terminally ill and their family
Food Bank/Food Vouchers	Food bags, grocery certificates, home-delivered meals, and nutritional supplements
Transportation	Help getting to the doctor's office and other HIV-related appointments
Outreach	Someone who finds people with HIV not in care and helps them to visit their doctor and get services they may need
Health Educ/Risk Reduction	Someone who tells clients about HIV, how it's spread, current medications, and how to live with HIV
Treatment Adherence	Instructions on how to take HIV medications properly
Legal Support	Help clients with HIV-related legal issues (will, living will, etc.)
Rehabilitation	Physical therapy, occupational therapy, speech therapy, low vision training, etc.
Peer Mentoring	Support and counseling from community members.
Housing	Helping find and/or maintaining a place to live
Other	A service that is not listed above

The table below displays the distribution of responses to items assessing need for, utilization of, and gaps in services for 20 services (plus "other"). Percentages represent the percent of all 182 participants in the survey.

Table 13: Services Needed, Received, and Needed but Not Received (% of All 182 Participants)

Service (182 participants)	Received service without difficulty (met need)		Received service with difficulty (met need)		Needed but unable to get service (unmet need)		Did not need service (unneeded)		Missing or not applicable	
	#	%	#	%	#	%	#	%	#	%
Outpatient Medical Care	146	**80.2**	5	**2.7**	4	**2.2**	21	**11.5**	6	**3.3**
Case Management	143	**78.6**	15	**8.2**	9	**4.9**	12	**6.6**	3	**1.6**
Medications	153	**84.1**	9	**4.9**	2	**1.1**	10	**5.5**	8	**4.4**
Dental/Oral Health	93	**51.1**	17	**9.3**	36	**19.8**	29	**15.9**	7	**3.8**
Health Insurance	72	**39.6**	8	**4.4**	32	**17.6**	59	**32.4**	11	**6.0**
Mental Health Services	49	**26.9**	3	**1.6**	10	**5.5**	108	**59.3**	12	**6.6**
Substance Abuse Treatment	14	**7.7**	1	**0.5**	4	**2.2**	155	**85.2**	8	**4.4**
Nutritional Counseling	36	**19.8**	1	**0.5**	16	**8.8**	124	**68.1**	177	**97.3**
Early Intervention Services	75	**41.2**	5	**2.7**	3	**1.6**	94	**51.6**	5	**2.7**
Home Health Care	18	**9.9**	1	**0.5**	10	5.5	148	**81.3**	5	**2.7**
Hospice Services	11	**6.0**	5	**2.7**	0	**0.0**	159	**87.4**	7	**3.8**
Food Bank/Food Vouchers	64	**35.2**	8	**4.4**	20	**11.0**	85	**46.7**	5	**2.7**
Transportation	29	**15.9**	2	**1.1**	15	**8.2**	130	**71.4**	6	**3.3**
Outreach	23	**12.6**	2	**1.1**	8	4.4	142	**78.0**	7	**3.8**
Health Educ/Risk Reduction	56	**30.8**	1	**0.5**	4	**2.2**	114	**62.6**	7	**3.6**
Treatment Adherence	90	**49.5**	4	**2.2**	0	**0.0**	81	**44.5**	7	**3.8**
Legal Support	30	**16.5**	3	**1.6**	21	**11.5**	118	**64.8**	10	**5.5**
Rehabilitation	24	**13.2**	2	**1.1**	14	**7.7**	137	**75.3**	5	**2.7**
Peer Mentoring	31	**17.0**	5	**2.7**	13	**7.1**	124	**68.1**	9	**4.9**
Housing	35	**19.2**	3	**1.6**	32	**17.6**	103	**56.6**	9	**4.9**
Other	10	**5.5**	1	**0.5**	29	**15.9**	85	**46.7**	57	**31.3**

The table below displays the distribution of met and unmet service needs. Percentages reflect the percent of participants responding to each item.

Table 14: Met and Unmet Service Needs (% of Participants Responding to Service Item)

Service (# responding)	Did not need service (unneeded)		Needed and received service (met need)		Needed but not received (unmet need)	
	#	%	#	%	#	%
Outpatient Medical Care (176)	21	**11.9**	151	**85.8**	4	**2.3**
Case Management (179)	12	**6.7**	158	**88.3**	9	**5.0**
Medications (174)	10	**5.7**	162	**93.1**	2	**1.1**
Dental/Oral Health (175)	29	**16.6**	110	**62.9**	36	**20.6**
Health Insurance (171)	59	**34.5**	80	**46.8**	32	**18.7**
Mental Health Services (170)	108	**63.5**	52	**30.6**	10	**5.9**
Substance Abuse Treatment (174)	155	**89.1**	15	**8.6**	4	**2.3**
Nutritional Counseling (177)	124	**70.1**	37	**20.9**	16	**9.0**
Early Intervention Services (177)	94	**53.1**	80	**45.2**	3	**1.7**
Home Health Care (177)	148	**81.3**	19	**10.7**	10	**5.6**
Hospice Services (175)	159	**90.9**	11	**6.3**	5	**2.9**
Food Bank/Food Vouchers (177)	85	**48.0**	72	**40.7**	20	**11.3**
Transportation (176)	130	**73.9**	31	**17.6**	15	**8.5**
Outreach (175)	142	**81.1**	25	**14.3**	8	**4.6**
Health Educ/Risk Reduction (175)	114	**65.1**	57	**32.6**	4	**2.3**
Treatment Adherence (175)	81	**46.3**	90	**51.4**	4	**2.3**
Legal Support (172)	118	**68.6**	33	**19.2**	21	**12.2**
Rehabilitation (177)	137	**77.4**	26	**14.7**	14	**7.9**
Peer Mentoring (173)	124	**71.7**	36	**20.8**	13	**7.5**
Housing (173)	103	**59.5**	38	**22.0**	32	**18.5**
Other (125)	85	**68.0**	11	**8.8**	29	**23.2**

The table below displays the distribution of met and unmet service needs. Percentages reflect the percent of all participants responding who reported a need for each service.

Table 15: Met and Unmet Service Needs (% of Participants Reporting Need for Service)

Service (# responding)	Needed service		Needed and received service (met need)		Needed but not received (unmet need)	
	#	%	#	%	#	%
Outpatient Medical Care (176)	155	**88.1**	151	**97.4**	4	**2.6**
Case Management (179)	167	**93.3**	158	**94.6**	9	**5.4**
Medications (174)	164	**94.3**	162	**98.8**	2	**1.2**
Dental/Oral Health (175)	146	**83.4**	110	**75.3**	36	**24.7**
Health Insurance (171)	112	**65.5**	80	**71.4**	32	**28.6**
Mental Health Services (170)	62	**36.5**	52	**83.9**	10	**16.1**
Substance Abuse Treatment (174)	19	**10.9**	15	**78.9**	4	**21.1**
Nutritional Counseling (177)	53	**29.9**	37	**69.8**	16	**30.2**
Early Intervention Services (177)	83	**46.9**	80	**96.4**	3	**3.6**
Home Health Care (177)	29	**16.4**	19	**65.5**	10	**34.5**
Hospice Services (175)	16	**9.1**	11	**68.8**	5	**31.2**
Food Bank/Food Vouchers (177)	92	**52.0**	72	**78.3**	20	**21.7**
Transportation (176)	46	**26.1**	31	**67.4**	15	**32.6**
Outreach (175)	33	**18.9**	25	**75.8**	8	**24.2**
Health Educ/Risk Reduction (175)	61	**34.9**	57	**93.4**	4	**6.6**
Treatment Adherence (175)	94	**53.7**	90	**95.7**	4	**4.3**
Legal Support (172)	54	**31.4**	33	**61.1**	21	**38.9**
Rehabilitation (177)	40	**22.6**	26	**65.0**	14	**35.0**
Peer Mentoring (173)	49	**28.3**	36	**73.5**	13	**26.5**
Housing (173)	70	**40.5**	38	**54.3**	32	**45.7**
Other (125)	40	**32.0**	11	**27.5**	29	**72.5**

The table below ranks service needs from the most frequently needed service to the least frequently needed service, as reported by participants on the anonymous client survey. Participants who did not respond to an item were not included in percentages.

Table 16: Ranking of Service Needs (% of Participants Responding to Service Item)

Service (# responding)	# reporting need	% reporting need
1. Medications (174)	164	**94.3**
2. Case Management (179)	167	**93.3**
3. Outpatient Medical Care (176)	155	**88.1**
4. Dental/Oral Health (175)	146	**83.4**
5. Health Insurance (171)	112	**65.5**
6. Treatment Adherence (175)	94	**53.7**
7. Food Bank/Food Vouchers (177)	92	**52.0**
8. Early Intervention Services (177)	83	**46.9**
9. Housing (173)	70	**40.5**
10. Mental Health Services (170)	62	**36.5**
11. Health Educ/Risk Reduction (175)	61	**34.9**
12. Other (125)	40	**32.0**
13. Legal Support (172)	54	**31.4**
14. Nutritional Counseling (177)	53	**29.9**
15. Peer Mentoring (173)	49	**28.3**
16. Transportation (176)	46	**26.1**
17. Rehabilitation (177)	40	**22.6**
18. Outreach (175)	33	**18.9**
19. Home Health Care (177)	29	**16.4**
20. Substance Abuse Treatment (174)	19	**10.9**
21. Hospice Services (175)	16	**9.1**

One way to examine the level of unmet need is to examine the percent of participants who reported that they did not receive a needed service. The table below provides the percent of participants with an unmet service need, ranked from those with the most participants reporting unmet need to the least participants reporting unmet need. Frequently needed services with frequent unmet need rise to the top of the list.

Table 17: Ranking of Unmet Need (% of Respondents Responding to Service Item)

Service (# responding)	# reporting unmet need	% reporting unmet need
1. Other (125)	29	**23.2**
2. Dental/Oral Health (175)	36	**20.6**
3. Health Insurance (171)	32	**18.7**
4. Housing (173)	32	**18.5**
5. Legal Support (172)	21	**12.2**
6. Food Bank/Food Vouchers (177)	20	**11.3**
7. Nutritional Counseling (177)	16	**9.0**
8. Transportation (176)	15	**8.5**
9. Rehabilitation (177)	14	**7.9**
10. Peer Mentoring (173)	13	**7.5**
11. Mental Health Services (170)	10	**5.9**
12. Home Health Care (177)	10	**5.6**
13. Case Management (179)	9	**5.0**
14. Outreach (175)	8	**4.6**
15. Hospice Services (175)	5	**2.9**
16. Substance Abuse Treatment (174)	4	**2.3**
17. Health Educ/Risk Reduction (175)	4	**2.3**
18. Treatment Adherence (175)	4	**2.3**
19. Outpatient Medical Care (176)	4	**2.3**
20. Early Intervention Services (177)	3	**1.7**
21. Medications (174)	2	**1.1**

Another way to examine unmet service needs is to consider the percent of participants reporting unmet need from among only those participants reporting a need for the service. The table below provides the percent of participants who did not get a service that they needed from among only those who needed the service. Infrequently needed services that are very rarely met rise to the top of the list.

Table 18: Ranking of Unmet Need (% of Participants Reporting Need for Service)

Service (# reporting need)	# reporting unmet need	% reporting unmet need
1. Other (40)	29	**72.5**
2. Housing (70)	32	**45.7**
3. Legal Support (54)	21	**38.9**
4. Rehabilitation (40)	14	**35.0**
5. Home Health Care (177)	10	**34.5**
6. Transportation (46)	15	**32.6**
7. Hospice Services (16)	5	**31.2**
8. Nutritional Counseling (53)	16	**30.2**
9. Health Insurance (112)	32	**28.6**
10. Peer Mentoring (49)	13	**26.5**
11. Dental/Oral Health (146)	36	**24.7**
12. Outreach (33)	8	**24.2**
13. Food Bank/Food Vouchers (92)	20	**21.7**
14. Substance Abuse Treatment (19)	4	**21.1**
15. Mental Health Services (62)	10	**16.1**
16. Health Educ/Risk Reduction (61)	4	**6.6**
17. Case Management (167)	9	**5.4**
18. Treatment Adherence (94)	4	**4.3**
19. Early Intervention Services (83)	3	**3.6**
20. Outpatient Medical Care (155)	4	**2.6**
21. Medications (164)	2	**1.2**

The figure below graphically displays need, met need, and unmet need. The gray areas reflect the level of need for a service across participants, with the darker gray areas reflecting met need and the lighter gray areas reflecting unmet need. The white areas of the bars indicate the proportion of participants reporting that the service is not needed.

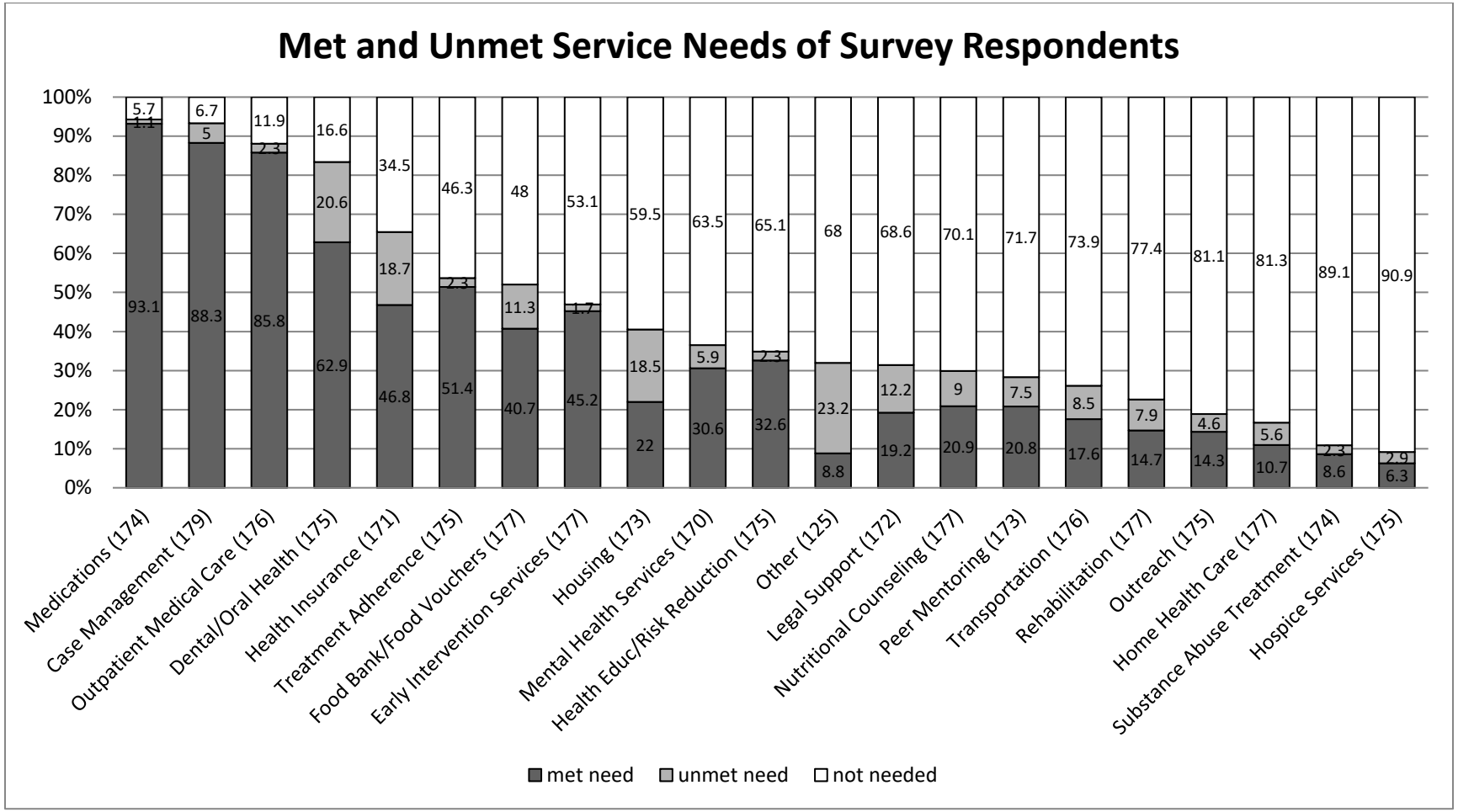


Figure 1: Met and Unmet Service Needs of Survey Participants (*N* = 182)

Overall, 159 (87.4% of all survey participants) responded to questions related to problems or barriers to receiving needed services. While 23 survey participants (12.6%) did not provide any response to these questions and 96 participants (52.7% of all survey participants) reported that they experienced no problems receiving needs services, 63 of the 182 participants (34.6% of all survey participants; 39.6% of survey participants responding to the questions about problems or barriers) indicated one or more barriers to access and utilization of needed services, as described in the table below in descending order of frequency. Among a dozen items representing possible barriers to care, nine specific barriers (plus "other" problems receiving care) were reported by one or more survey participants. However, only two barriers or problems were reported by more than 10% of survey participants responding to the items: inability to pay for services and not knowing where to get services.

Table 19: Barriers to Needed Services (% Responding to Barrier Items)

Barrier (159 responses)	#	% reporting any reason for service gap
I could not pay for services	17	**10.7**
I did not know where to get services	17	**10.7**
Other (please specify)	14	**8.8**
Services not available in my county	12	**7.5**
I did not qualify for services	12	**7.5**
I could not get transportation	10	**6.3**
I could not get an appointment	9	**5.7**
I did not want people to know that I have HIV	8	**5.0**
I had a bad experience with the staff	4	**2.5**
I could not get time off work	1	**0.5**
I could not get someone to watch my children	0	**0.0**
Services were not in my language	0	**0.0**

C. Systematic Analysis of Case Management Caseload

A consulting team of master's students from the Center for Applied Psychology at the University of West Florida, under the direction of Dr. Valerie Morganson and Dr. Stephen Vodanovich, completed an empirically based job analysis of the Case Manager position for Ryan White in Northwest Florida. The purpose of the job analysis was to provide a data-driven analysis of the position in order to support recommendations to achieve an optimal staff-client ratio (i.e., case load) for HIV/AIDS case managers in the Northwest Florida Region.

The job analysis was conducted over 2 months in the Winter of 2018. Eight subject-matter experts (SMEs) on Ryan White staff (e.g., case managers, eligibility specialists) were interviewed to understand the nature of the work performed by case managers. Data from the interviews were used to create task statements that describe specific job responsibilities for the case manager position. These 39 task statements were organized into the following seven groups of related task statements (i.e, clusters): 1) Documentation (In-Person), 2) Documentation (CareWare/Online), 3) Documentation (General), 4) Referrals, 5) Client Interactions, 6) Organization With Other Agencies, 6) Miscellaneous, and 7) Eligibility. After grouping tasks together, four case managers were interviewed again and asked to rate 1) the *time spent* on each group of tasks and 2) the *criticality* of performing each group of tasks on a 5-point scale.

Case managers reported spending the majority of their time interacting with clients (*M = 4.50*), documenting client interactions in CareWare (*M = 4.50*), and providing referrals for clients (*M = 4.00*). Similarly, client interactions (*M = 4.75*) and referrals (*M = 4.75*) were rated as most critical to the job, followed by documenting details of in-person interactions with clients (*M = 4.50*). Based on these ratings, it can be seen that this is a multi-faceted position that encompasses a broad scope of job duties. In addition, the high quantity of task statements (39) supports the variability of the job, discussed by the SMEs in the interviews.

In the local area, there are 7 case managers and 3 eligibility specialists who serve approximately 675 clients. Case managers reported having between 100-120 in their caseload. This is more than double the suggested amount for best practice. Almost all case managers reported that their current caseload (*M = 110*) is higher than what they estimated to be a reasonable caseload (*M = 94*). It is important to note that certain clients have variable levels of needs at different times, so fewer clients does not always reflect a lighter caseload. Interviews also indicated that caseload overflows from eligibility specialist workload.

Due to the nature of the job, there is not a specified staff-client ratio but it is helpful to take into account certain standards. Prior to being repealed, the standard caseload of continued care management for the state of Florida was 40 active clients per case manager [65E-15.032(2)]. This number is slightly higher than the standards provided by the AIDS Institute for a case management team, with a recommendation of 30-35 for a team of 3.

Based upon our interactions and discussions with the SMEs during the project, we recommend the following:

1) Reduce caseloads for case managers by:
    a) Hiring an additional case manager so that the caseload is more lightly distributed among the case managers
    b) Hiring an additional eligibility specialist so that the case managers can focus on their specific job duties rather than complete tasks of the eligibility specialist when one is not available
2) Create a fully electronic documentation process, as documentation was highly rated on both *time spent* and *criticality (4.50 on a 5-point scale)*

3) A more streamlined documentation process will help with caseload issues as it will free up time and energy for case managers to spend with clients
    a) Keeping all documentation online will also promote better organization and security of sensitive files
4) Monitor and track the current number of *Ryan White* clients in the region
    a) Knowing how the size of this population is trending over time will help the organizations to be prepared to match the needs of the clients
5) Strive for lower client to case-manager ratios
    a) Based upon staff responses to this project, 75-100 clients per case manager would be an improvement over current client to case manager ratios. This may be a reasonable short-term goal.
    b) As a long-term goal, best practice supports that the number of active cases to case managers should aim to be below 75, depending on case complexity

SECTION IV

HIV/AIDS SERVICE PRIORITIES

A. Service Needs and Met Needs

Quantitative data from people living with HIV/AIDS in Area I offered a clear message regarding the services most commonly needed by PLWH/A, likely representing the most critical or important service needs for Area I, collectively. Roughly 9 out of 10 PLWH/A survey participants reported needing medications, case management, and outpatient medical care services. Approximately 8 out of 10 PLWH/A survey participants reported needing dental/oral health services. Approximately 2 out of 3 PLWH/A survey participants reported needing assistance with health insurance. A notable mark of success was observed, with 95%or more of PLWH/A survey participants reporting receipt of needed medications, case management, and outpatient medical care. Continued funding emphasis should be placed on these nearly universally-needed services. On the other hand, 25-30% of those reporting a need for dental/oral health or health insurance assistance services reported that they were unable to obtain these needed services. Additional funding emphasis is likely needed to better meet these common service needs. Only approximately half or fewer PLWH/A survey participants reported needing each of the remaining service categories. Although the remaining services may not be needed by a majority of PLWH/A, these are important services for those who need them, and attention should be paid to ensuring the availability of these other services when the need arises. Examination of unmet needs or service gaps can inform the allocation of funding for less commonly needed services.

Most Frequently Needed Services (% reporting need for service)

1. Medications (94.3%)
2. Case Management (93.3%)
3. Outpatient Medical Care (88.1%)
4. Dental/Oral Health (83.4%)
5. Health Insurance (65.5%)

Met Needs for Most Frequently Needed Services (% receiving service if needed)

1. Medications (98.8%)
2. Outpatient Medical Care (97.4%)
3. Case Management (94.6%)
4. Dental/Oral Health (75.3%)
5. Health Insurance (71.4%)

B. Unmet Needs and Gaps in Service

Quantitative data from people living with HIV/AIDS in Area I were also clear regarding the greatest unmet needs for service or service gaps for Area I. On way to assess unmet need is to identify services for which the largest percentage of PLWH/A reported an unmet need or the most frequent unmet service needs (or the number of PLWH/A reporting unmet need divided by the total number or PLWH/A, regardless of need). Another way to assess unmet need is to identify services for which the greatest percentage of PLWH/A who needed the service but were unable to obtain the service or the highest rates of unmet service needs (or the number of PLWH/A reporting unmet need divided by the number of PLWH/A reporting a need for the service). Additional funding emphasis may be warranted for these services, particularly to address unmet needs for dental/oral health and health insurance, as these also represent services that are commonly needed by PLWH/A, as noted above. Likewise, housing services

and legal support services represent services for which 1 in 5 or 1 in 8, respectively, of all PLWH/A survey participants reported an unmet need, with approximately 40-50% of those who needed these services reporting a service gap.

Most Frequent Unmet Service Needs (% reporting unmet need among all participants)

1. Other service (23.2%)
2. Dental/Oral Health (20.6%)
3. Health Insurance (18.7%)
4. Housing (18.5%)
5. Legal Support (12.2%)

Highest Rates of Unmet Service Needs (% reporting unmet need among those who needed service)

1. Other service (72.5%)
2. Housing (45.7%)
3. Legal Support (38.9%)
4. Rehabilitation (35.0%)
5. Home Health Care (34.5%)

It is worth noting that the anonymous client needs assessment inquires about 20 specific service types but did not specifically list specialty medical care, a type of service eligible for coverage under Ryan White. The high ranking of "other" services as an unmet need may, in part, reflect the absence of this service type from the survey. Qualitative data from prior needs assessments have revealed that specialty medical care needs were common and frequently unmet. Data from the current needs assessment suggest that specialty medical care needs continue to be common and difficult to access.

C. Changes in Service Needs and Utilization Over Time

Examination of the service needs, met needs, and unmet needs reveal some striking consistencies and a few changes from prior needs assessments. The consistencies over time regarding service needs and met needs add substantial weight to the validity of maintaining several service funding priorities. The changes over time regarding unmet needs appear to reflect some improvement in access to needed services and suggest opportunities to modify some service funding priorities.

Not surprisingly, the five most frequently reported service needs in the 2017-2018 needs assessment were fully consistent with the top five service needs identified in the 2013-2014 needs assessment for Area I, with identical rankings and very similar rates of reported need, as noted below. A greater percentage of PLWH/A survey participants reported a need for dental/oral health services in 2017-2018 (83.4%) than in 2013-2014 (71.9%). Interestingly, a slightly lower percentage of survey respondents reported a need for outpatient medical care in 2017-2018 (88.1%) than in 2013-2014 (94.5%).

Most Frequently Needed Services (% reporting need for service)

2017-2018

1. Medications (94.3%)
2. Case Management (93.3%)
3. Outpatient Medical Care (88.1%)
4. Dental/Oral Health (83.4%)
5. Health Insurance (65.5%)

2013-2014

1. Medications (96.4%)
2. Case Management (94.9%)
3. Outpatient Medical Care (94.5%)
4. Dental/Oral Health (71.9%)
5. Health Insurance (61.3%)

As in 2013-2014, the most frequently reported service needs were also widely received by those who needed the service. Medications, outpatient medical care, and case management services, each of which was reported as needed by almost all PLWH/A survey participants, were reported as received by 95% or more of those participants who needed these services. Also like 2013-2014, although dental/oral health and health insurance services were needed by most, but not all, PLWH/A survey participants, these services were received by a lower percentage of PLWH/A survey participants who needed them. However, there was improvement in both service categories, with receipt of dental/oral health services among those who needed it increasing from 64.2% in 2013-2014 to 75.3% in 2017-2018 and receipt of health insurance assistance among those who needed it increasing from 60.8% in 2013-2014 to 71.4% in 2017-2018. Although there is still room for more improvement in meeting these service needs, the increases suggest progress toward meeting these needs.

Met Needs for Most Frequently Needed Services (% receiving service if needed)

2017-2018

1. Medications (98.8%)
2. Outpatient Medical Care (97.4%)
3. Case Management (94.6%)
4. Dental/Oral Health (75.3%)
5. Health Insurance (71.4%)

2013-2014

1. Outpatient Medical Care (100.0%)
2. Case Management (99.0%)
3. Medications (98.1%)
4. Dental/Oral Health (64.2%)
5. Health Insurance (60.8%)

As noted above, dental/oral health and health insurance represent service needs of a large proportion of PLWH/A survey participants. Despite the progress toward meeting these needs, these two service needs are among the most commonly reported unmet service needs. Along with "other" services, housing, and legal support, dental/oral health and health insurance services ranked among the top five unmet service needs in both 2013-2014 and 2017-2018. With the exception of changes in ranking as a result of an increase in unmet needs for "other" services, the pattern of the most common unmet service needs was quite similar from 2013-2014 to 2017-2018 needs assessments. While unmet needs or service gaps for "other" services increased from 12.7% in 2013-2014 to 23.2% in 2017-2018, the percentage of PLWH/A survey participants reporting service gaps decreased by several percentage points for dental/oral health, health insurance, and legal support. The very slight increase in the percentage of participants reporting unmet need for housing assistance should be interpreted with caution, as small variations are to be expected merely due to chance and sampling.

Most Frequent Unmet Service Needs (% reporting unmet need among all participants)

2017-2018

1. Other service (23.2%)
2. Dental/Oral Health (20.6%)
3. Health Insurance (18.7%)
4. Housing (18.5%)
5. Legal Support (12.2%)

2013-2014

1. Dental/Oral Health (25.7%)
2. Health Insurance (24.1%)
3. Legal Support (20.9%)
4. Housing (15.7%)
5. Other service (12.7%)

On the population level, it is important to note the service categories where the most people have unmet needs, as above. This approach tends to highlight services that are needed by a great number of PLWH/A. However, it is also important to be able to identify services that may be needed only by a minority of PLWH/A, or infrequently needed, yet frequently unmet. Examination of rates of met and unmet service needs among only those reporting a need for a service allows for the identification of service gaps for less frequently needed services. In both 2013-2014 and 2017-2018, almost 3 out of 4 PLWH/A survey participants who needed "other" services reported that these services needs were unmet. These high rates are likely an artifact of measurement related to the fact that the statewide needs assessment lacks an item assessing specialty medical care, despite the fact that this service category is fundable under the Ryan White HIV/AIDS Program. Hence, "other" services rises to the top of both the most frequently reported unmet needs and the highest rates of unmet service needs. Housing assistance likewise appears on both lists of unmet needs in the 2017-2018 needs assessment, suggesting that the slight increase in unmet housing service needs noted above may represent more than chance or artifact. Among those with needs for housing assistance services in 2017-2018, nearly half (45.7%) reported that they did not receive such services. On the other hand, among those in need of rehabilitation services or legal support services, the percent of PLWH/A survey participants reporting a service gap is much lower in 2017-2018 than in 2013-2014. Likewise, unmet service needs for hospice and peer mentoring services have dropped substantially between the 2013-2014 and 2017-2018 needs assessments. The 2013-2014 needs assessment noted substantial improvements in service gaps in transportation and food bank assistance identified in the prior needs assessment and these appear to have stood the test of time. It appears that concentrated efforts to reduce gaps in peer mentoring services identified in the 2013-2014 needs assessment have paid dividends in reducing service gaps in this area as well.

Highest Rates of Unmet Service Needs (% reporting unmet need among those who needed service)

2017-2018

1. Other service (72.5%)
2. Housing (45.7%)
3. Legal Support (38.9%)
4. Rehabilitation (35.0%)
5. Home Health Care (34.5%)

2013-2014

1. Other service (71.4%)
2. Rehabilitation (70.0%)
3. Legal Support (59.2%)
4. Hospice Services (54.5%)
5. Peer Mentoring (50.0%)

Overall, there appears to be continued success at meeting the top three greatest service needs (medications, outpatient medical care, and case management services). However, some partially met needs remain, most notably in the areas of specialty medical care, dental/oral health, health insurance, and housing assistance. There are encouraging signs of trends toward improvement in meeting previously identified service gaps (dental/oral health, housing, and legal support services). There are also signs of substantial or sustained improvement in several service gaps (transportation, food bank assistance, peer mentoring, rehabilitation, legal support, and hospice services).

SECTION V

APPENDICES

Appendix A

Epidemiological Data for Area I

Epidemiological data are available from the HIV/AIDS Section, Bureau of Communicable Diseases, Division of Disease Control and Health Protection of the Florida Department of Health at:
http://www.floridahealth.gov/diseases-and-conditions/aids/surveillance/epi-profiles/index.html

Appendix B

Anonymous Client Survey Forms (English Language Version)

1. What is your gender?

Male
Female
Transgender Male to Female
Transgender Female to Male

2. How do you identify yourself?

Straight
Gay
Lesbian
Bisexual
MSM (Men who have sex with men)

3. What is your ethnicity?

Hispanic/Latino/a
Non – Hispanic/Latino/a
Haitian

4. What is your race?

White/Caucasian
Black or African American
Asian
American Indian or Alaskan Native
Native Hawaiian or Pacific Islander
Mixed/more than one race

5. What Year were you born? **[[TextEntry]]**

6. What is your education level?

Less than high school graduate
High school diploma/GED
Some college
Completed college

7. What county do you live in currently? **[[TextEntry]]**

8. What best describes your current work situation?

Working full-time job
Working part-time job
Student
Looking for a job/unable to find employment
Retired
Not currently working

9. How old were you when you first tested positive for HIV? **[[TextEntry]]** Years of age

10. Where were you living when you first tested positive for HIV?

In the same county I live in now
In another county in Florida. County: **[[TextEntry]]**
In another state: **[[TextEntry]]**
Outside of the United States. Country: **[[TextEntry]]**

11. Were you in care for HIV/AIDS **between June 1st 2015 and May 31st 2016**?

Yes
No

If not in care, please skip to question 15

12. In which county or counties did you get your HIV/AIDS medical care **between June 1st 2015 and May 31st 2016**? **[[TextEntry]]**

13. If you get your HIV/AIDS medical care in a different county than you live, please indicate why. **Please mark only one answer.**

This does not apply to me. I got medical care in the same county I live in.
Services were not available in my county
I did not want people to know that I have HIV
I got care at a clinic that is located closer to where I live or work
Other: **[[TextEntry]]**

14. Where did you regularly receive your HIV/AIDS medical care **between June 1st 2015 and May 31st 2016**? **Please mark only one answer**.

Walk-in /Emergency clinic
Doctor's office
Hospital emergency room
Veteran's Administration
Public clinic/Health Department
HIV specialty clinic
Other: **[[TextEntry]]**

15. In your last blood sample test, was your viral load undetectable?

Yes
No, but it has been going down
No
I don't know

16. In the past month, how often did you smoke cigarettes?

Every day
Some days
Not at all

17. In the past month, how often did you consume marijuana?

Every day
Some days
Not at all

18. In the past month, how often did you consume illegal drugs other than marijuana (cocaine, crack, meth, etc.)?

Every day
Some days
Not at all

19. In the past month, how often did you share needles?

Every day
Some days
Not at all

20. In the past month, how often did you have unsafe sex?

Every day
Some days
Not at all

21. Have you been hospitalized for an HIV/AIDS related condition **between June 1st 2015 and May 31st 2016**? If so, what was it for?

Yes: **[[TextEntry]]**
No

22. Did you miss any of your HIV medications over the past week?

Yes
No

23. What are some of the reasons why you missed taking your HIV medication? Mark all that apply.

This does not apply to me. I took all of my medication
Cost
Needed to get my prescription renewed
Forgot
I had side-effects
Other: **[[TextEntry]]**

The services below **MAY** or **MAY NOT** be available in your area. Please fill in the boxes next to the services that you have used or needed **between June 1st 2015 and May 31st 2016**	I received this service	I needed this service but was unable to get it	I did not need this service
24. **Outpatient Medical Care**: Visits to doctor's office or clinic for HIV medical care	☐	☐	☐
25. **Case Management**: Case managers help clients receive services and then follow-up on their care	☐	☐	☐
26. **Medications**: Pills for HIV and related issues	☐	☐	☐
27. **Dental/Oral Health**: General teeth and mouth care, dentures, oral surgery, etc.	☐	☐	☐
28. **Health Insurance**: Helps pay insurance costs or co-pays if client has private insurance	☐	☐	☐
29. **Mental Health Services**: Professional counseling, therapy, or support groups	☐	☐	☐
30. **Substance Abuse Treatment**: Professional counseling for drug or alcohol addiction	☐	☐	☐
31. **Nutritional Counseling**: Professional counseling for healthy eating habits	☐	☐	☐
32. **Early Intervention Services**: Assistance getting a doctor appointment, HIV counseling and testing, linkage and referral to medical care	☐	☐	☐
33. **Home Health Care**: Professional healthcare services in a client's home by a licensed/certified home-health agency	☐	☐	☐
34. **Hospice Services**: Nursing and counseling services for the terminally ill and their family	☐	☐	☐
35. **Food Bank or Food Vouchers**: Food bags, grocery certificates, home-delivered meals, and nutritional supplements	☐	☐	☐
36. **Transportation**: Help getting to the doctor's office and other HIV-related appointments	☐	☐	☐
37. **Outreach**: Someone who finds people with HIV not in care and helps them to visit their doctor and get services they may need	☐	☐	☐
38. **Health Education/Risk Reduction**: Someone who tells clients about HIV, how it's spread, current medications, and how to live with HIV	☐	☐	☐
39. **Treatment Adherence**: Instructions on how to take HIV medications properly	☐	☐	☐
40. **Legal Support**: Help clients with HIV-related legal issues (will, living will, etc)	☐	☐	☐
41. **Rehabilitation**: Physical therapy, occupational therapy, speech therapy, low vision training, etc.	☐	☐	☐
42. **Peer mentoring**: Support and counseling from community members	☐	☐	☐
43. **Housing**: Helping find and/or maintaining a place to live	☐	☐	☐
44. **Other**: A service that is not listed above _____ _____	☐	☐	☐

45. If you had problems receiving services **between June 1st 2015 and May 31st 2016**, what were some of the barriers? **Mark all that apply**.

This does not apply to me. I had no problems receiving services
I did not know where to get services
I could not get an appointment
I could not get transportation
I could not get childcare
I could not pay for services
I did not want people to know that I have HIV
I could not get time off work
I was depressed
I had a bad experience with the staff
Services were not in my language
I did not qualify for services
Other:_____

46. Has your health insurance status or plan changed **between June 1st 2015 and May 31st 2016**?

Yes from uninsured to insured
Yes from insured to uninsured
Yes, I changed insurance plan
No I have been insured for all that period
No I have been uninsured for all that period

47. What are some of the reasons why you do not have health care insurance? Mark all that apply.

This does not apply to me. I have health care insurance
I have not looked into it
My employer does not offer insurance
I am in the Medicaid gap (i.e. earn too much to qualify for Medicaid and not enough to qualify for subsidies)
I find the premiums too expensive
It didn't look worth it
Other: _____

If you do not currently have health care insurance, skip to question 51

48. What type of health care insurance do you have?

Employer-sponsored private insurance
Market place insurance through the ACA (Obamacare)
Medicaid
Medicare
AIDS Drug Assistance Program (ADAP)
Ryan White (specific program for HIV/AIDS)

49. How would you rate your satisfaction with the health care insurance that you have currently?

I am very satisfied
I am satisfied
Neutral
I am dissatisfied
I am very dissatisfied

50. If you rated your satisfaction with your insurance as neutral or below, what are some aspects of your insurance are you dissatisfied with? **Mark all that apply**

This does not apply to me. I am satisfied with my health insurance
The co-pays on visits/medications are too high
My premiums are too high
My deductible is too high
It does not cover all the services that I need
I am not able to see the providers I want (eg. I had to change doctors)
I do not like my doctor but I cannot find another one in my area that my insurance will cover

51. Do you have a usual doctor that you see for your HIV medical care?

Yes
No **(skip to question 54)**

52. How would you rate your satisfaction with the health care provider that you usually see for your HIV/AIDS care?

I am very satisfied
I am satisfied
Neutral
I am dissatisfied
I am very dissatisfied

53. If you rated your satisfaction with your provider as neutral or below, what are some reasons why you are not fully satisfied with the health care provider that you usually see for your HIV/AIDS care (if you do not have a usual provider, than think about the last provider that you saw)? **Mark all that apply**

This does not apply to me. I am satisfied with my health care provider
I feel like my health care provider judges me
I feel like my health care provider doesn't know enough about HIV/AIDS
I feel like I cannot trust my health care provider
I feel like my health care provider doesn't really listen to me
I feel like my health care provider doesn't care about me
The duration of the visit is too short and rushed
It takes a long time to get an appointment
It is far to go for the appointment
Other: _____

Between **June 1st 2015 and May 31st 2016**, have you had difficulty getting HIV medications for any of the following reasons?	Yes	No	Not Applicable
54. Long wait to get an appointment with my Case Worker or Doctor	☐	☐	☐
55. I am on the Aids Drug Assistance Program (ADAP) Waiting List	☐	☐	☐
56. Difficulty with the ADAP application process	☐	☐	☐
57. Difficulty seeing my Case Worker or Doctor at least twice a year to remain enrolled in ADAP	☐	☐	☐
58. Unenrolled from ADAP without an explanation	☐	☐	☐
59. Are you aware that ADAP funds may cover costs associated with a health insurance policy, including co-payments, deductibles, or premiums to purchase or maintain health insurance coverage	☐	☐	☐
60. Have you been made aware of the "hardship exemptions" that can pay for health insurance coverage based on hardships which affect your ability to pay for health insurance coverage	☐	☐	☐

61. Have you disclosed your HIV status to anyone other than your health care provider?

Yes
No

62. Who have you disclosed your HIV status to? **Mark all that apply**

This does not apply to me. I have not disclosed my HIV status to anyone other than my health provider
Current partner
Friends
Family
Everyone I have a sexual encounter with

63. Did you talk to your partner about pre-exposure prophylaxis?

Yes and he/she is taking prophylaxis
Yes but he/she decided not to take prophylaxis
No, but he/she is also HIV positive
No, I do not know what prophylaxis is
No, I have not yet had that conversation

64. How much do you feel you are engaged with your care?

Not much, I am still figuring out my diagnosis
I have to go to my appointments because of the Ryan White requirements
Quite engaged, I try to go to all my appointments, take all my medication, etc.
Very engaged, I do all I can to be healthy and I have great support from providers and from my friends/family/partner

65. Were you in jail **between June 1st 2015 and May 31st 2016**?

Yes
No **(continue to question 68)**

66. Did the jail medical staff know you had HIV/AIDS?

Yes
No

67. When you were released from jail, which of the following did you receive? **Mark all that apply**

Information about finding housing
Referral to medical care
Referral to case management
A supply of HIV medication to take with you
Other:_____
None of the above

68. Were you in prison **between June 1st 2015 and May 31st 2016**?

Yes
No **(continue to question 71)**

69. Did the prison medical staff know you had HIV/AIDS?

Yes
No

70. When you were released from prison, which of the following did you receive? **Mark all that apply**

Information about finding housing
Referral to medical care
Referral to case management
A supply of HIV medication to take with you
Other:_____
None of the above

71. Have you moved two or more times in the past six months?

Yes
No

72. If you moved two or more times in the past six months, why did you have to move? **Mark all that apply**

This does not apply to me. I did not have to move twice or more during the past six months
I didn't have enough money for the deposit
I could not find affordable housing
I had bad credit
I was put on a waiting list
I had a mental/physical disability
I had a criminal record
I feel I was discriminated against
I had no transportation to search for housing
I didn't qualify for housing assistance

I had substance use issues
Other (specify:_____)

73. Think about your housing situation now: do any of the following stop you from doing what you need to do to stay healthy? **Mark all that apply**

I don't have a private room
I don't have a place to store my medications
I don't have a telephone where someone can call me
I don't have enough food to eat
I don't have money to pay for rent
I don't have heat and/or air conditioning
I don't want anyone to know I have HIV
I can't get away from drugs (in the neighborhood)
None of the above

74. Approximately how long have you lived at your current residence?

Less than 1 month
1 -2 months
3 – 6 months
6 months – 1 year
More than 1 year
Don't know

75. Do you currently own or rent (eg: own house/apartment/trailer)?

I rent
I own
Neither

76. If you rent, did you receive housing assistance between **June 1st 2015 and May 31st 2016**? **Mark all that apply**

This does not apply to me. I own my own housing
Yes and I still currently receive housing assistance
Yes but I do not receive assistance any more
I have not received assistance between June 1st 2015 and May 31st 2016

77. If you do not own or rent your own housing, which of the following best describes your current living situation?

This does not apply to me. I own or rent my own housing
Staying at someone else's place (parent/relative/friend) –TEMPORARY
Staying at someone else's place (parent/relative/friend)—PERMANENT
Rooming or boarding house
In a "supportive living" facility (Assisted Living Facility)
Homeless/Homeless shelter
Other:_____

78. How much do you and/or your household pay monthly to the rent or mortgage? (If you receive assistance, this is not necessarily the amount of your rent, but how much you and your household members **ACTUALLY PAY**):_____

79. In the past year, have you had to do any of these things to have a place to sleep? **Mark all that apply**

Sleep in a car
Trade sex for a place to spend the night or money for rent
Sleep at a family member/friend's house
Seep on the streets, in a park, or in another outdoor place
Sleep in a shelter
None of these

80. What was your total income last month? (Include all of the money you received, plus the money anyone else who lives with you received. Include money from government assistance, except food stamps.)

No income ($0.00)
Under $500
$500-$749
$750-$999
$1,000 - $1,249
$1250 - $1,499
$1,500 - $1,749
$1,750 - $1,999
$2,000 - $2,249
$2,250 - $2,499
$2,500 - $2,999
$3,000 - $3,499
$3,500 - $3,999
$4,000 or more

81. How many people in are supported by this income? (total number of household members including yourself)

1
2
3
4
5 or more

82. Including yourself, how many adults (18+) in your household are HIV positive?

1
2
3
4
5 or more

83. Is there anything else you would like to tell us about your housing situation or healthcare services that was not covered in this survey?

Appendix C

Case Management Caseload Analysis: Final Report

Case Management Caseload Analysis: Final Report

Introduction

A consulting team of masters students from the Center for Applied Psychology at the University of West Florida, under the direction of Dr. Valerie Morganson and Dr. Stephen Vodanovich, completed an empirically based job analysis of the Case Manager position for Ryan White in Northwest Florida. The purpose of the job analysis was to provide a data-driven analysis of the position in order to support recommendations to achieve an optimal staff-client ratio (i.e., caseload) for HIV/AIDS case managers in the Northwest Florida Region.

In the local area, there are 7 case managers and 3 eligibility specialists who serve approximately 675 clients. Due to the nature of the job, there is not a specified staff-client ratio; however, we were able to identify some points of comparison: Prior to being repealed, the standard caseload of continued care management for the state of Florida was 40 active clients per case manager [65E-15.032(2)]. This number is slightly higher than the standards provided by the AIDS Institute for a case management team, with a recommendation of 30-35 for a team of 3.

Approach

The consulting team took an empirical approach to determine a reasonable staff-client ratio by collecting both qualitative and quantitative data. This was done through the use of a job analysis that was tailored to fit the issue of assessing caseload for the case manager position. Job analysis is a purposeful, systematic process for gathering information on the important work-related aspects of a job.

- This includes identifying *what* actions the workers perform, *to whom or what* these actions are directed, *how* the actions are performed, and *why* the action is performed.
- This information is obtained by interviewing a representative sample of workers who are knowledgeable about the position being analyzed (subject-matter experts SMEs).
- Information from interviews is used to construct a comprehensive list of job tasks. These tasks are rated on specified dimensions. with our focus on both the time demands and nature of the work.
- The benefit of a job analysis is that it generates data to identify core job information and requirements necessary for successful job performance.

Through our tailored job analysis, the team was able to capture all aspects of the job in order for us to understand caseload in the larger scope of job demands. This allowed the team to provide a rigorous analysis of the issue, while removing subjectivity to the extent possible.

Method

Data were collected through semi-structured interviews with eight Ryan White staff who are knowledgeable about the case manager position (i.e., subject matter experts). This group of subject matter experts (SMEs) included 3 case managers, 3 eligibility specialists, and 2 case manager supervisors. The average tenure of this group of SMEs was 7.65 years. Refer to Appendix A for the full interview tool.

The information gathered during the interviews was used to write 39 *task statements* that describe specific job responsibilities that case managers perform (e.g., "records notes into CareWare to document client visits"). These 39 task statements were organized into the following 7 groups of related task statements (i.e., task clusters): 1) Documentation (In-Person), 2) Documentation (CareWare/Online), 3) Documentation (General), 4) Referrals, 5) Client Interactions, 6) Organization With Other Agencies, 7) Miscellaneous, and 8) Eligibility. Refer to Appendix B for a list of task statements and groups.

After creating task statements and organizing them into groups, a second round of interviews was conducted with 4 SMEs. Each participant individually reviewed the task groups and then rated 1) the *time spent* on each group of tasks and 2) the *criticality* (importance) of performing each group of tasks. Refer to Appendix C for the rating worksheet. Ratings for *time spent* and *criticality* were made on a 5-point scale:

Time Spent:

1 = "I spend <u>much less</u> time on these tasks than I do on other tasks"

5 = "I spend <u>much more</u> time on these tasks than I do on other tasks"

Criticality:

1 = "Extremely critical"

5 = "Not at all critical"

In two follow-up questions, we asked SMEs 1) to report their current caseload and 2) to estimate a reasonable sized caseload that could be successfully managed within allotted hours.

Results

Means and standard deviations were calculated for ratings of each task group. A mean is computed as the average of all individual ratings. Higher ratings (closer to 5) are interpreted as "more time spent" or "greater importance". Whereas the mean is a measure of central tendency, a standard deviation reflects variability in responses. In this report, standard deviations reflect variability in respondents' ratings. Therefore, standard deviations are indicators of inter-rater agreement. Smaller standard deviations represent greater agreement between SMEs. Standard deviations above 1.00 should be interpreted as disagreement between SMEs.

The results of the ratings for *Time Spent* are displayed in Table 1. Case managers reported spending the majority of their time interacting with clients ($M = 4.50$, $SD = .58$), documenting client interactions in CareWare ($M = 4.50$, $SD = .58$), and providing referrals for clients ($M = 4.00$, $SD = .82$). Case managers spend less time performing general documentation tasks ($M = 1.75$, $SD = .50$) and miscellaneous tasks ($M = 0.75$, $SD = .50$).

The results of the ratings for *criticality* are displayed in Table 2. Client interactions (*M = 4.75*, SD = .50) and referrals (*M = 4.75, SD* = .50) were rated as most critical to the job, followed by documenting details of in-person interactions with clients (*M = 4.50, SD* = .58).

Table 1. Means and standard deviations for *Time Spent* ratings

Task Group	Mean	Standard Deviation
Client Interactions	4.50	0.58
Documentation (CareWare/Online)	4.50	0.58
Referrals	4.00	0.82
Documentation (In-Person)	3.00	0.82
Organization With Other Agencies	3.00	0.82
Eligibility	2.75	0.96
Documentation (General)	1.75	0.50
Miscellaneous	0.75	0.50

Table 2. Means and standard deviations for Criticality ratings

Task Group	Mean	Standard Deviation
Client Interactions	4.75	0.50
Referrals	4.75	0.50
Documentation (In-Person)	4.50	0.58
Documentation (General)	4.25	0.96
Organization With Other Agencies	4.25	0.96
Documentation (CareWare/Online)	4.25	0.96
Eligibility	4.0	1.42
Miscellaneous	2.25	2.22

Means, standard deviations, and ranges of SME's responses to the two open-ended questions are provided below:

1) What is your current caseload?

- Responses ranged from 100 cases per individual case manager to 200 cases, shared between two case managers.
    - The mean of the responses was 110 cases (*SD* = 10 cases).
    - The mean of the two responses wherein caseload was shared was 100 cases (*SD* = 0 cases).
    - The mean of the two responses wherein caseload was individual (i.e., not shared) was 120 cases (*SD*= 0 cases).

2) What is a reasonable number of cases that you could successfully manage within your allotted hours?

- Responses ranged from 75 cases per individual case manager to 200 cases, shared between two case managers. The mean of the responses was 94 cases (*SD* = 10.83 cases).
- Case Managers emphasized that what can reasonably be managed depends upon clients' depth of need.

Recommendations

Based upon data provided by SMEs and research into standards and best practices for caseload management, we recommend the following:

1) Reduce caseloads for case managers by:
    a) Hiring an additional case manager so that the caseload is more lightly distributed among the case managers
    b) Hiring an additional eligibility specialist so that the case managers can focus on their specific job duties rather than complete tasks of the eligibility specialist when one is not available
2) Create a fully electronic documentation process, as documentation was highly rated on both *time spent* and *criticality (4.50 on a 5-point scale)*
3) A more streamlined documentation process will help with caseload issues as it will free up time and energy for case managers to spend with clients
    a) Keeping all documentation online will also promote better organization and security of sensitive files
4) Monitor and track the current number of *Ryan White* clients in the region
    a) Knowing how the size of this population is trending over time will help the organizations to be prepared to match the needs of the clients
5) Strive for lower client to case-manager ratios
    a) Based upon staff responses to this project, 75-100 clients per case manager would be an improvement over current client to case manager ratios. This may be a reasonable short-term goal
    b) As a long-term goal, best practice supports that the number of active cases to case managers should aim to be below 75 per case manager, depending on case complexity

The technique used in this report, job analysis, produces useful data for a variety of subsequent work-related practices that extended beyond the issue of caseload. As examples: the task analysis information reported in Appendix B may be useful to inform accurate job descriptions, as a basis for training, and to verify that performance appraisal content is comprehensive and job-related.

Conclusion

Ryan White is opening more cases than they are closing, and case managers must handle increasing caseloads over time. The typical number of cases currently being managed by Ryan White CMs exceeds national standards for best practice. It also exceeds their own estimates of what a reasonable caseload should be. Ryan White can prevent burnout among CMs and promote quality care for clients by hiring one or more additional case managers or eligibility specialists.

Appendix A: Interview Tool

Case Manager Interview Date:

Demographics:

Name:

Role:

Gender:

Tenure:

Location:

Questions:

Task analysis questions

1. Tell us about a typical day at work. (*make note of the types of tasks being performed. When discussing tasks more specifically, try to get a sense for the amount of time spent on each major task.)*
2. What do you spend the majority of your time doing?
    a. Primary duties?
    b. Secondary duties?
        i. Note: You will likely need to go back through these and keep probing. Is that is? Is there anything else? What else is involved? Can you tell me more about…?

Caseload questions

Group 1: Caseload

3. Although I have some familiarity now with your job, can you explain in your own words why caseload is an important issue?
4. In what ways does case load impact
    a. you?
    b. your office?
    c. the quality of care your clients receive?
5. How many hours do you typically work each week?
6. How many cases do you currently manage?
7. How are clients distributed among case managers?

Group 2: Time Meeting with Clients

8. Where do you meet with your clients?
9. How much travel is involved in your work?
10. Do you ever transport clients? What does this consist of? Is it strictly for medical visits or also social/everyday activities? (e.g. going to WalMart)
11. How often do you interact with a client during the week?
12. How much time do you currently spend taking care of clients?
    a. How much time do you need to take care of a client?

Group 3: Nature of Meeting with Clients

13. How much variability is there in the time you spend with clients?
14. Which factors make the client more needing of your time?
15. Which aspects of your work, if any, are more/most demanding of your time and effort?
16. Do you assist clients with activities not directly related to their health/disease? (e.g. applying for social services, finding housing)

Group 4: Other

17. How long have you worked as a case manager?
18. What does your job consist of when you are not directly working with a client?
19. How do you communicate with your clients?
    a. With coworkers? With supervisors? With those outside of your organization?

Other Questions (to consider)

1. How do you obtain clients? Do they seek you out or do you recruit them from the community/centers?
2. How do you know the client's background?
3. Do you provide the client with educational material about their health or teach/facilitate groups?
4. Do you perform any medical tasks or evaluations on clients? (e.g. heart rate, blood pressure, immunizations, first aid)
5. How does what you do differ, based on the demographics of the client? (e.g. sex, age, ethnicity)
6. Is there any special equipment that you use? Or provide to your clients?
7. Do you create treatment plans for clients?
8. How do you ensure that clients are adhering to their treatment plans?
9. When you are doing documentation, what tasks do you have to perform?

Appendix B: Task Statements/Clusters

Task Cluster 1: Documentation (In-person)

1. Verifies that clients sign consent forms to ensure proper recordkeeping and following of procedures
2. Witnesses paperwork to make sure of proper reporting
3. Gathers demographic information of clients to ensure proper documentation

Task Cluster 2: Documentation (CareWare/online)

1. Faxes documents as necessary
2. Enters client information into CareWare to maintain proper recordkeeping
3. Updates and maintain status of clients in CaseWare (eligible, ineligible, enrolled, closed case, deceased)
4. Scans and update documents into CareWare to maintain proper recordkeeping
5. Uploads and maintain case notes to CareWare to ensure proper documentation
6. Uploads and maintain client file on CareWare to make sure of proper reporting

Task Cluster 3: Documentation (other)

1. Completes monthly reports to maintain proper recordkeeping
2. Writes report on client list to maintain proper documentation (new clients, number active, number seen for the month)
3. Completes billing report on clients to ensure proper documentation

Task Cluster 4: Referrals

1. Writes referrals to relevant individual/organization to ensure client's needs are met (mental health, dental, housing, transportation, etc.)
2. Calls client, agencies, and referral services as necessitated to serve the client
3. Coordinates referrals (dental, mental health, transportation, food) in order to meet client need
4. Follows proper channels for approval of referrals for clients

Task Cluster 5: Client Interactions

1. Assesses needs of client and make referrals accordingly to establish quality care
2. Calls client to remind of appointments to maintain client standing
3. Meets client face-to-face to assess needs/ build rapport
4. Explains process to new clients in order to reassure them/ build rapport
5. Explains documents to client as they are signed to guarantee understanding
6. Communicates expectations to clients about requirements upon visits
7. Provides information/education to clients to inform them of procedures
8. Provides emotional support for clients

Task Cluster 6: Organization with Other Agencies

1. Generates a report of upcoming clients to maintain an organized schedule
2. Conducts research to find resources to provide the best care for client
3. Collaborates with other case managers to ensure quality of care for client
4. Communicates with other agencies to help support well-being of the client
5. Assists in scheduling client appointments (physician, mental health, social security)
6. Organizes and schedules transportation to guarantee client's ability to reach scheduled appointments

Task Cluster 7: Other

1. Travels outside office to meet with client to ensure needs are met (update, medication, food, etc.)
2. Assists client connection and transition to other locations
3. Conducts testing for client if tester out of office

Task Cluster 8: Eligibility

1. Generates reports listing required visits to make sure the client does not lose eligibility
2. Prints and assemble paper copies of necessary documents to re-establish eligibility
3. Updates status of clients in Careware to show client's current status
4. Writes and send letters to clients entailing details of re-eligibility visits
5. Explains benefits of eligibility and elaborate on steps necessary to re-establish eligibility
6. Communicates with Case managers about client's needs to ensure fluidity of care

Appendix C: Rating Instructions and Form

Instructions For Completing Job Task Ratings

Refer to your list of task statement clusters to answer the following two questions. If you are an employee in the job under review answer the questions based upon what you do on your individual job. If you supervise employees that perform this job under review, answer the questions according to your subordinates' job.

In column "A": For each task cluster, rate the amount of time that you spend performing those tasks relative to the amount of time you spend on other job tasks:

5 = I spend much more time on these tasks than I do on other tasks

4 = I spend more time on these tasks than I do on other tasks

3 = I spend as much time on these tasks as I do on other tasks

2 = I spend less time on these tasks than I do on other tasks

1 = I spend much less time on these tasks than I do on other tasks

In column "B": For each task cluster, rate the degree to which incorrect performance would lead to negative consequences:

5 = extremely critical

4 = very critical

3 = critical

2 = somewhat critical

1 = not at all critical

Task Cluster Rating Form

Job category under review: _____

	A Time Spent 5 = I spend much more time on these tasks than I do on other tasks 4 = I spend more time on these tasks than I do on other tasks 3 = I spend as much time on these tasks as I do on other tasks 2 = I spend less time on these tasks than I do on other tasks 1 = I spend much less time on these tasks than I do on other tasks	B Criticality 5 = extremely critical 4 = very critical 3 = critical 2 = somewhat critical 1 = not at all critical
Task Cluster 1		
Task Cluster 2		
Task Cluster 3		
Task Cluster 4		
Task Cluster 5		
Task Cluster 6		
Task Cluster 7		
Task Cluster 8		

Follow-up Questions:

1. What is your current number of clients assigned to your caseload?

2. What would be a reasonable number of clients assigned to your caseload so that you could fully meet their needs within your allotted hours?