The Status of HIV in Palm Beach County

2023

Presented by

Palm Beach County HIV Elimination Services

&

Palm Beach County HIV CARE Council

July 11th and 12th, 2023

Palm Beach County
Ryan White HIV/AIDS Program

DAY 1 – JULY 11, 2023

HIV System of Care Highlights

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Palm Beach County
Ryan White HIV/AIDS Program

Systems-Level Highlights

- Ryan White Site Visit (HRSA)
- Ryan White Part A Program Manual Revision (HRSA)
- Ryan White Monitoring Standards Revision (HRSA)
- Ryan White/MAI Service Delivery Standards Modernization
- Reciprocal Eligibility between Ryan White Part A & B in Florida
- 12-month RW/MAI Confirmation/Self Attestation Policy
- Health Equity Coordinator Position
- Expanded access to Health Insurance for PWH

Questions?

PBC Ryan White Services Report (RSR)

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Ryan White HIV/AIDS Program

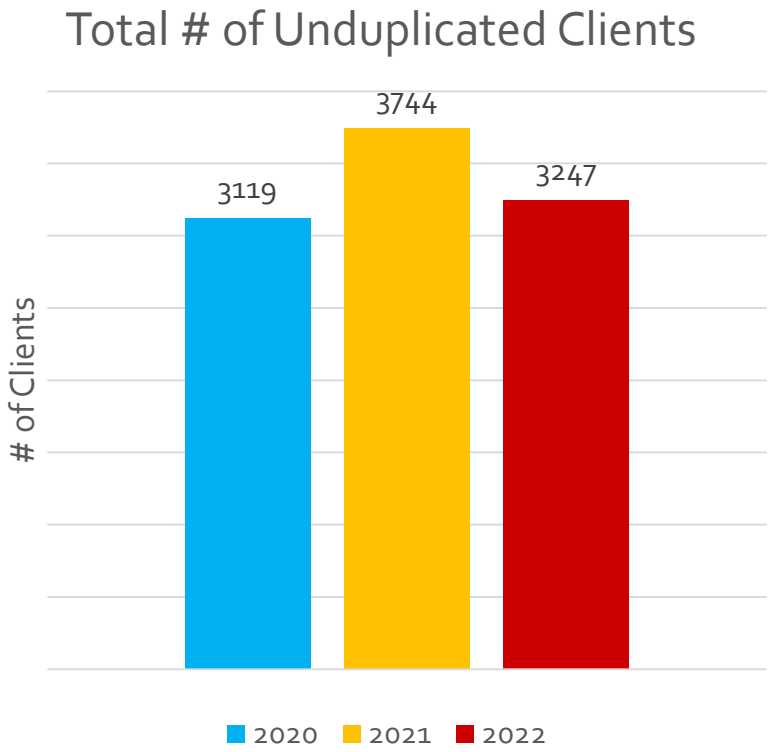
2022 Ryan White HIV/AIDS Program Service Report (RSR)

- The RSR is an annual Client summary report required by our funders Health Resources & Services Administration (HRSA).
- Funded Subrecipients, who provide services under the Part A program, are required to document and submit data on the clients they serve.
- Data is reported on a ***calendar* year** (January-December), not a *grant* year (March-February).
- These data sets are utilized by our program;
  - To understand the types of clients we served,
  - To make informed decisions on prioritizing needed services and allocating funds to services provided,
  - To explain how we are using our funds and supporting health outcomes of our clients, in our annual grant application.

2022 RSR Client Summary Report Data

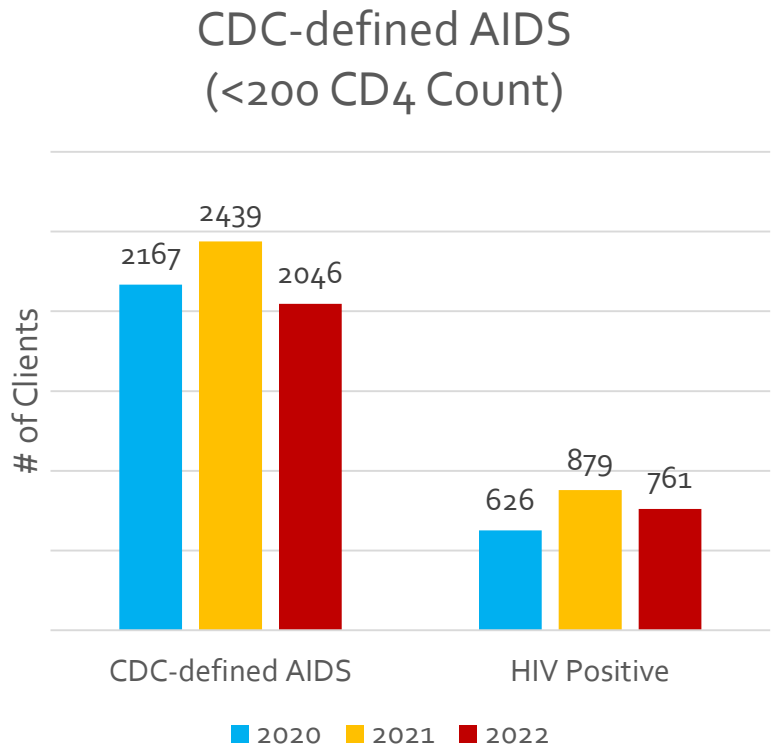
Number of Clients by HIV Status

•Fluctuation through pandemic; Reported an increase of 128 clients between 2020 and 2022



Number of Clients by HIV/AIDS Status

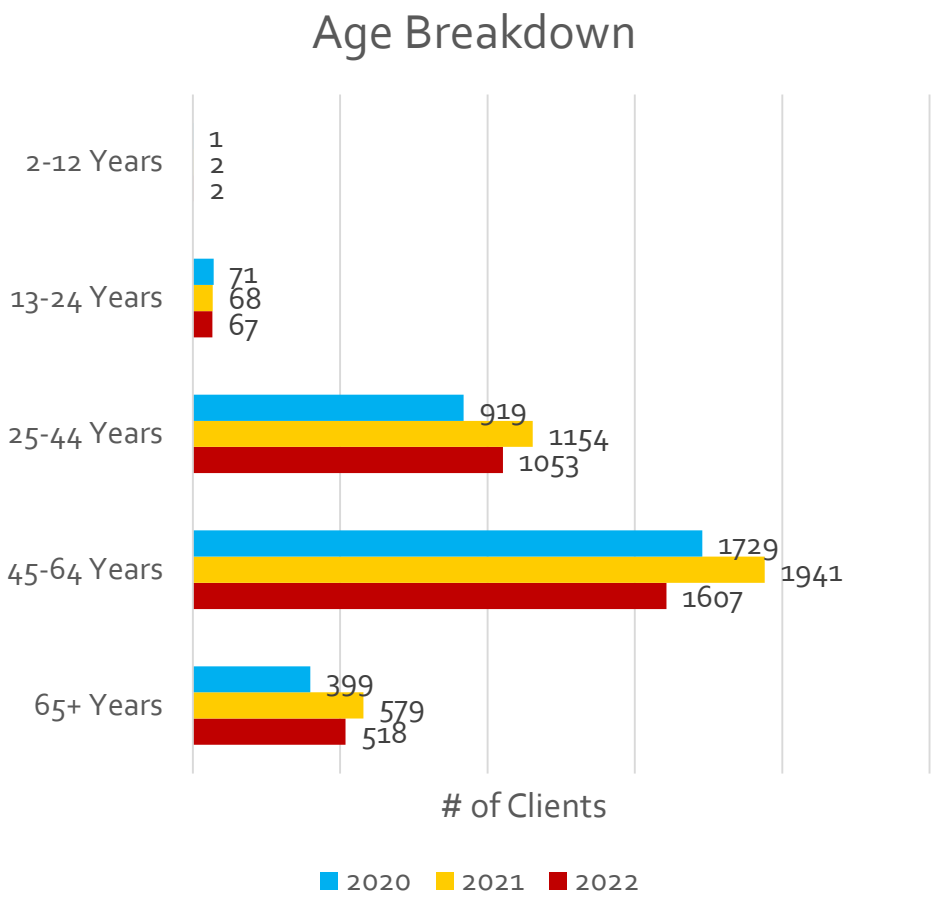
•Reported a decrease of 121 diagnosed with AIDS between 2020 and 2022



2022 RSR Client Summary Report Data cont.

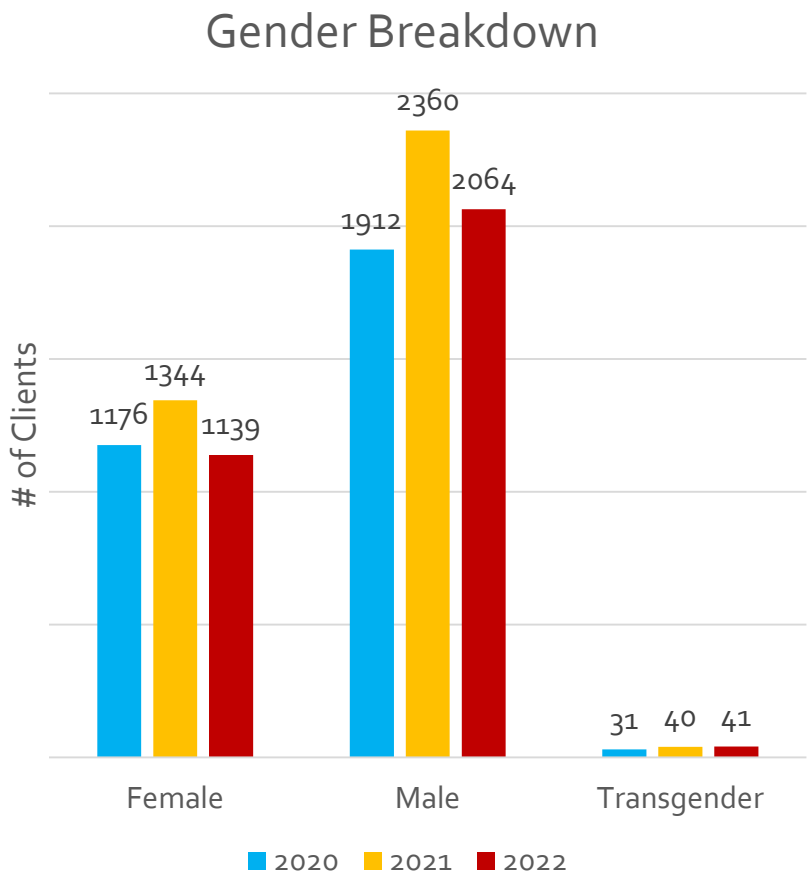
Number of Clients by Age and HIV Status

- Largest group remains 45-64 years old



Number of Clients by Gender and HIV Status

- Largest group remains Males
- Increase of 10 reported Transgender between 2020 and 2022



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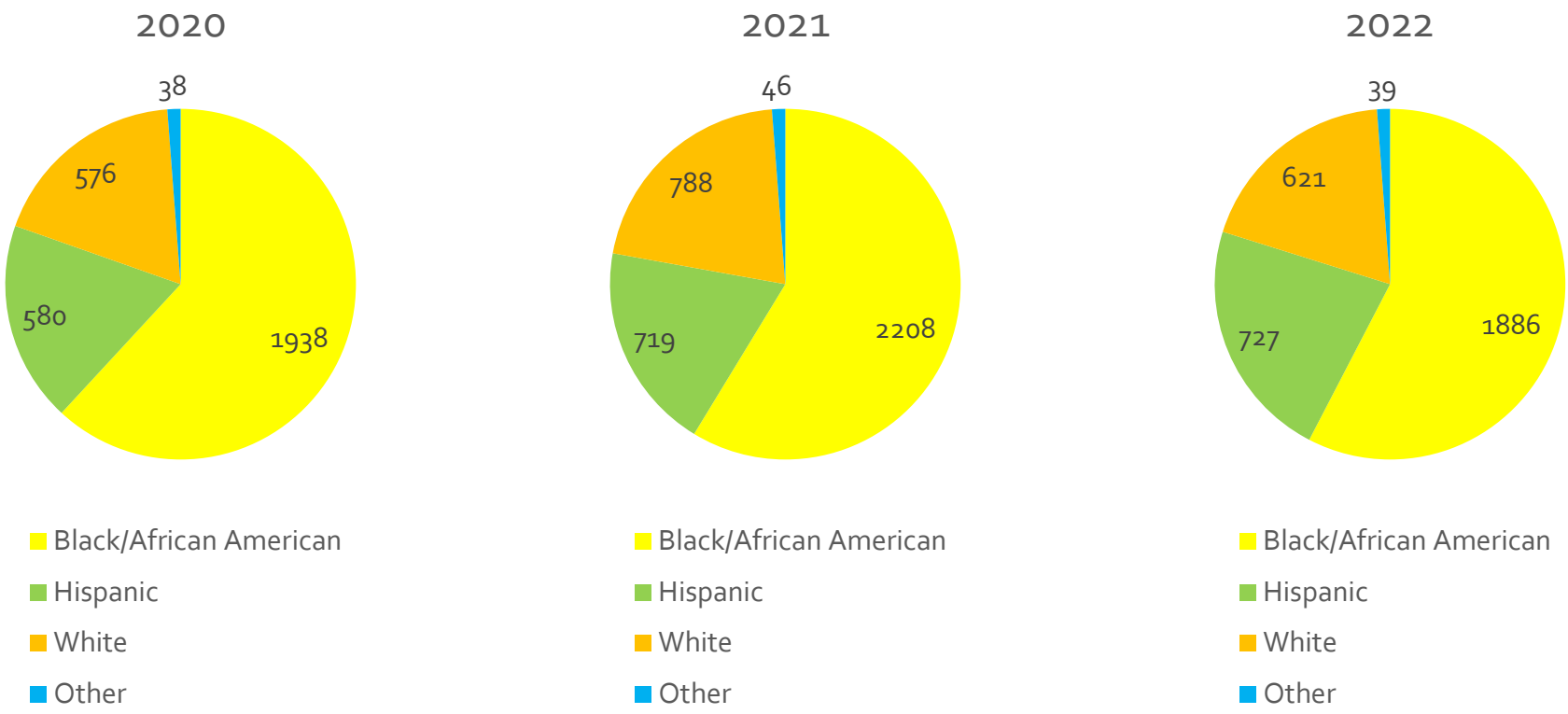
2022 RSR Client Summary Report Data cont.

Number of Clients by Race, Ethnicity and HIV Status

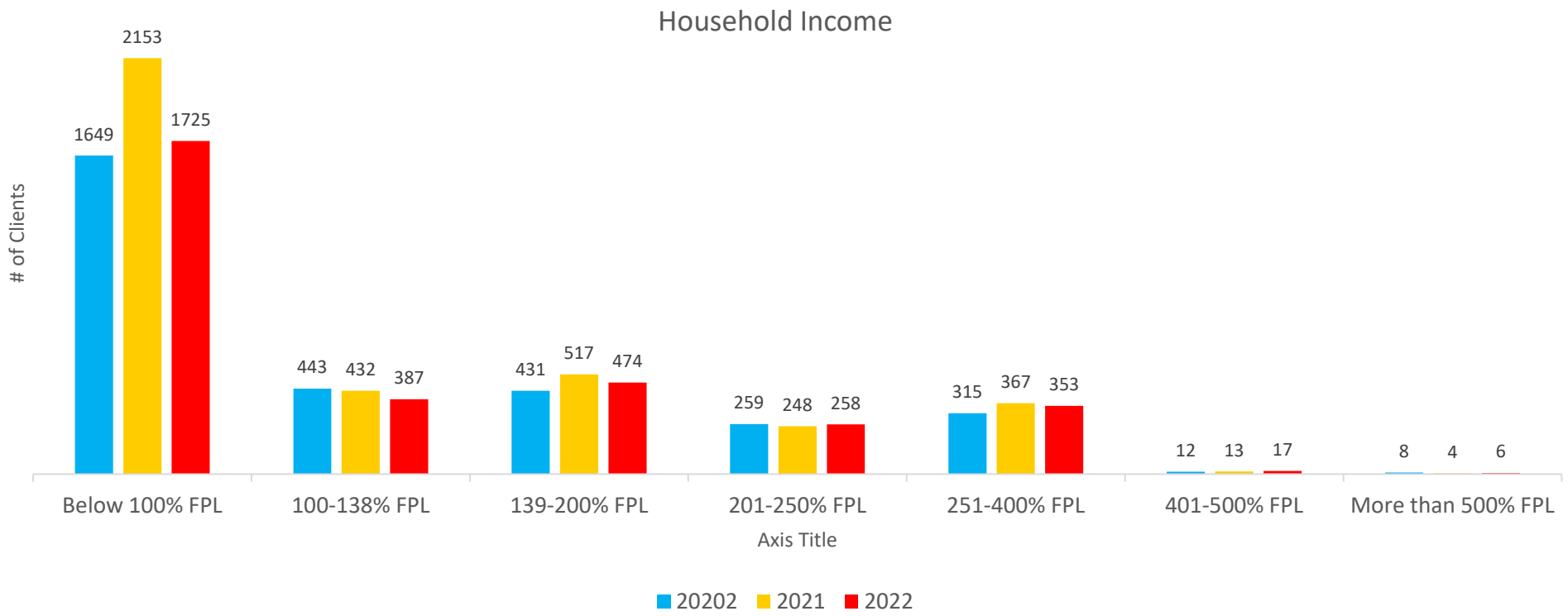
- Largest group remains Black/African American



2022 RSR Client Summary Report Data cont.

Number of Clients by Household Income and HIV Status

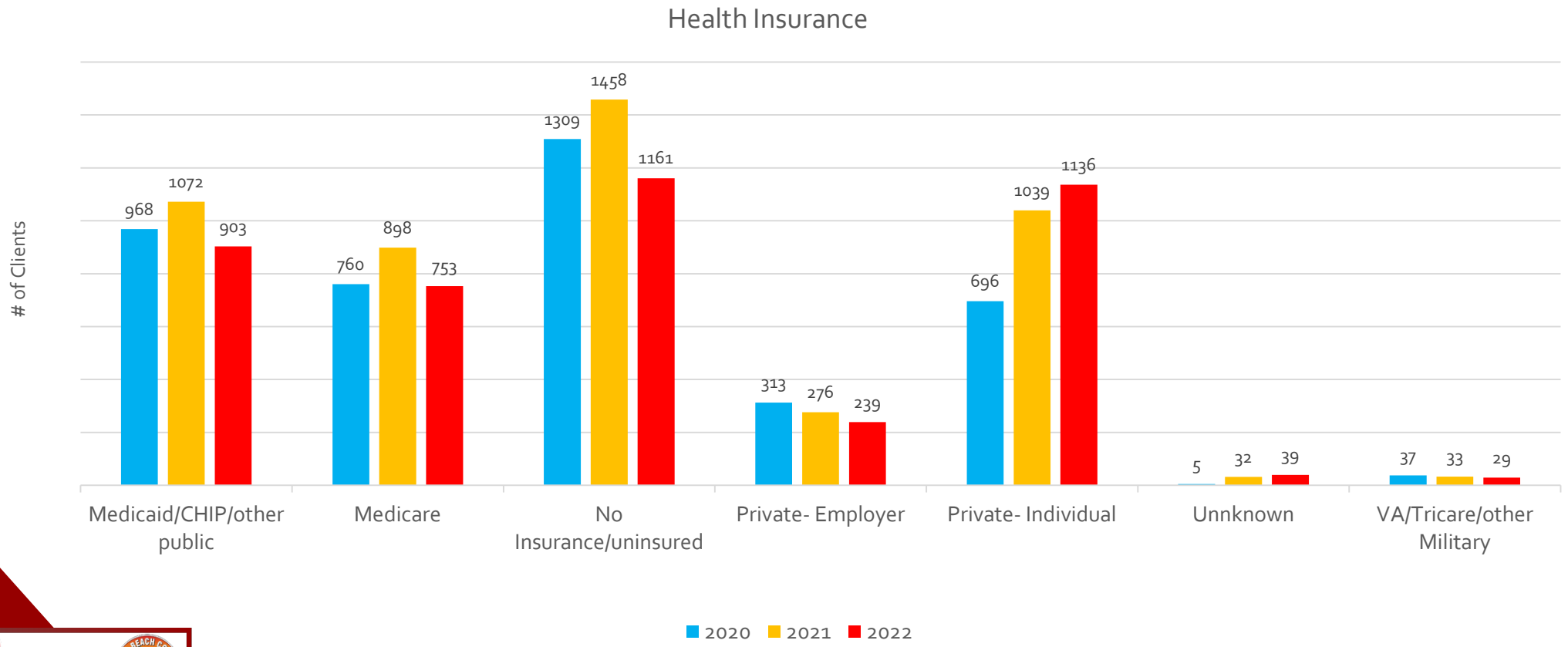
- RSR collects the last documented FPL for clients.
- Largest group remains Below 100% of the Federal Poverty Level (FPL)
- Number of clients below 100% FPL increased by 76 between 2020 and 2022.



2022 RSR Client Summary Report Data cont.

Number of Clients by Medical Insurance and HIV Status

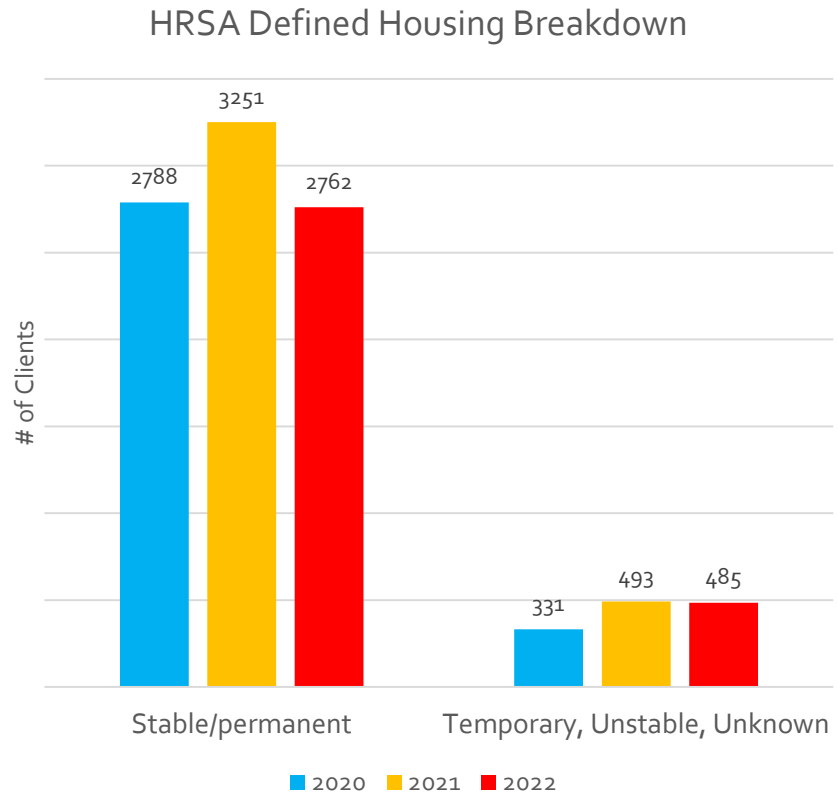
- Largest group remains No Insurance/Uninsured, with only a difference of 25 less enrolled in Private coverage in 2022.
- Increase in Private coverage due to focus on ACA and Off-Market plan enrollments over the past 2 years. Closing the gap of Uninsured clients, there was a decrease of 148 uninsured and an increase of 440 private coverage under ACA/Off-Market over the 3 years.



2022 RSR Client Summary Report Data cont.

Number of Clients by RSR Housing/Living Arrangement and HIV Status

- Largest group remains Stable/permanent, with an increase only in 2021.
- Temporary, Unstable, Unknown Increased from 2020 to 2022 by 154.



Number of Clients and Service Visits by Service Category

- The 3 top services utilized remains NMCM, MCM, and EIS.
- Large decreases evident in LPAP and EFA, while OAHS remained about the same. Health Insurance services had large increase in 2022.

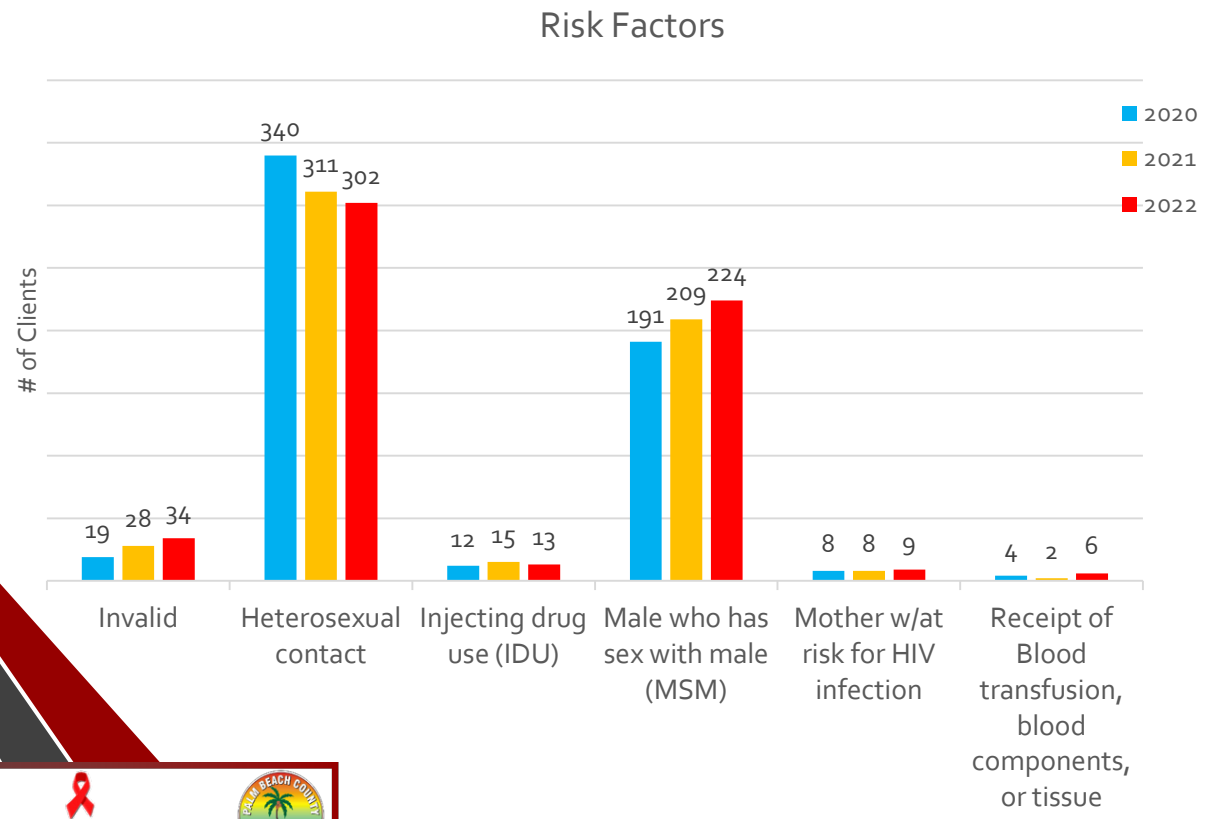
Service Category	# of Clients 2020/2021/2022	# of Visits 2020/2021/2022
Early Intervention Services	871/1669/1189	3954/10,152/5525
Medical Case Management	1614/1584/1362	27,228/25,201/19,490
Mental Health	74/75/74	737/503/369
Oral Health	450/521/525	1099/2157/1850
Outpatient Ambulatory Health Services	555/545/565	2734/2402/2539
Local Pharmacy Assistance Program	144/74/55	700/313/164
Non-Medical Case Management	1866/2287/2299	12,448/17,121/14,534
Emergency Financial Assistance (including EFA-Emergency Medication)	92/79/47	120/112/81
Food Bank (including Nutritional Supplements)	635/658/695	4166/3931/4402
Health Insurance Program	372/355/516	1975/2519/2655
Housing	19/19/24	87/98/164
Medical Transportation	290/235/273	1274/1092/1732
Other Professional Services (Legal)	186/208/260	2180/1480/1666
Psychosocial Support- NO 2020 DATA	-/273/725	-/1055/3946

2022 RSR Clinical Summary Report Data

**The Clinical Summary reports on clients who have had a RW clinical service. Therefore, the numbers from the RSR Client Summary Report and the RSR Clinical Summary Report are different.*

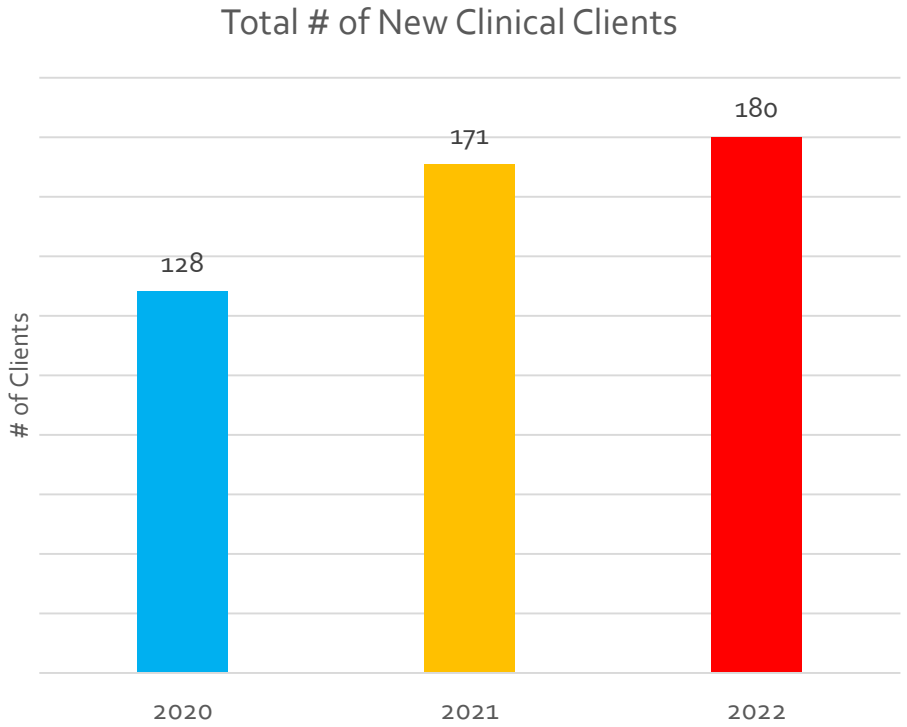
Number of Clients by Risk Factor

- Heterosexual and MSM contacts remain the most common risk factors reported, with an increase in MSM contact over a decrease in Heterosexual contact.
- RSR no longer collects data for Hemophilia/Coagulation Disorder (only 1 reported in 2020).



Number of New Clinical Clients

- Increase continued over 3 years, with 52 clients.



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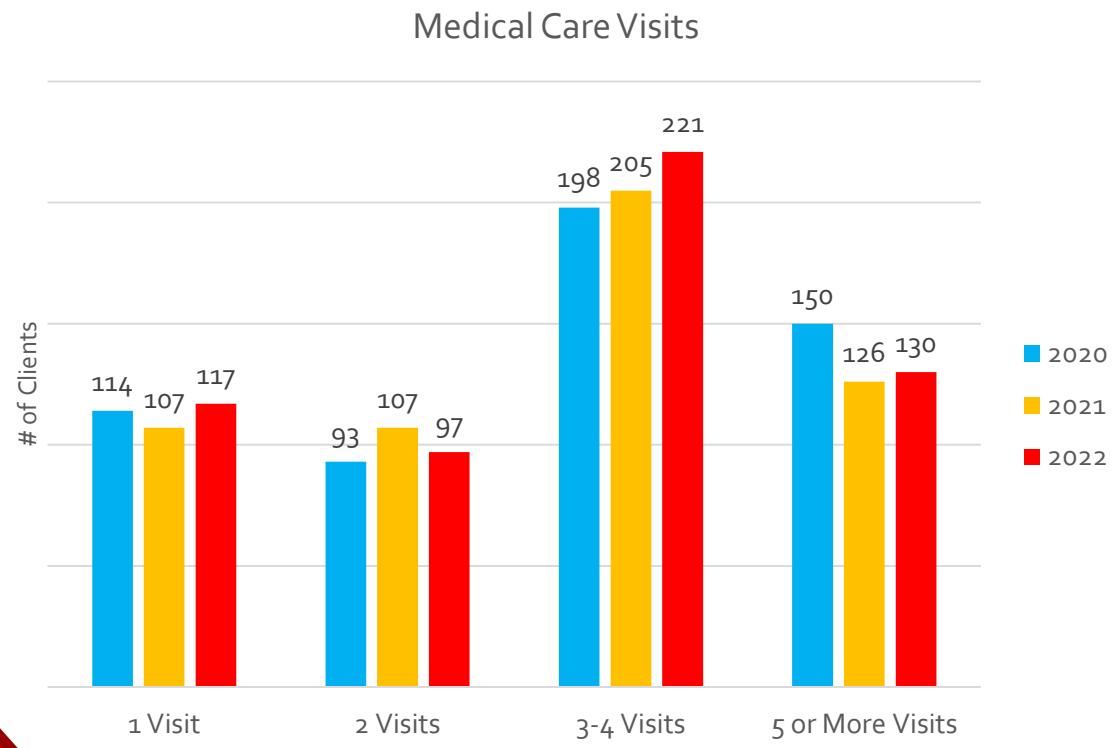
2022 RSR Clinical Summary Report Data cont.

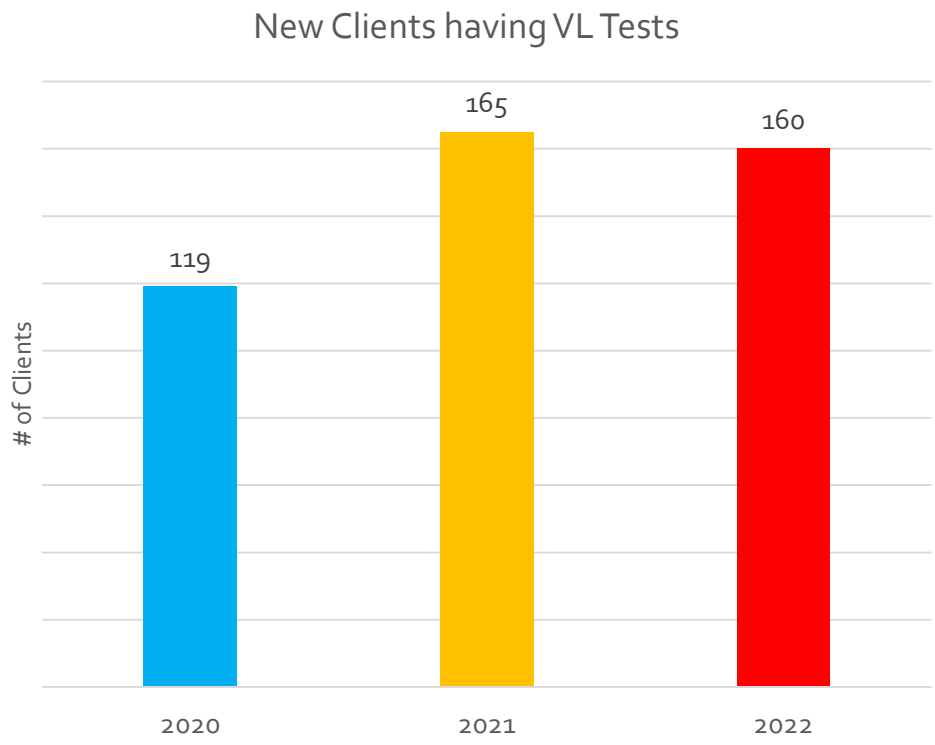
Number of Clients by Number of Medical Care Visits

•The most number of clients had 3-4 visits reported. Medical visits were maintained through the pandemic.



Number of New Clients Having Viral Load Test During Reporting Period

•Increase of 46 during the pandemic. Slight decrease of 5 last year.



2022 RSR Total Clients Served by Zip Code Summary

- The report resulted in a total of 3,271 clients served, within 62 zip codes in Palm Beach County. This compares to previous year of 3,788 clients within 60 zip codes.
- Zip codes are determined by the client profile address information entered into the database.
- Charted to the right are the 5 zip codes with the highest number of clients served, compared to the previous year.
- There were 21 zip codes in Palm Beach County that resulted in 10 or less clients served, compared to 19 last year.

2021 (2020) Zip Code	2021 (2020) Clients Served
33407	319 (302)
33404	290 (230)
33430 (33460)	243 (198)
33460 (33430)	221 (196)
33435	209 (182)
33401	207

2022 Zip Code	2022 Clients Served
33404	284
33407	264
33430 & 33460	192
33435	185
33401	166

Questions?

PBC Minority AIDS Initiative (MAI) Updates

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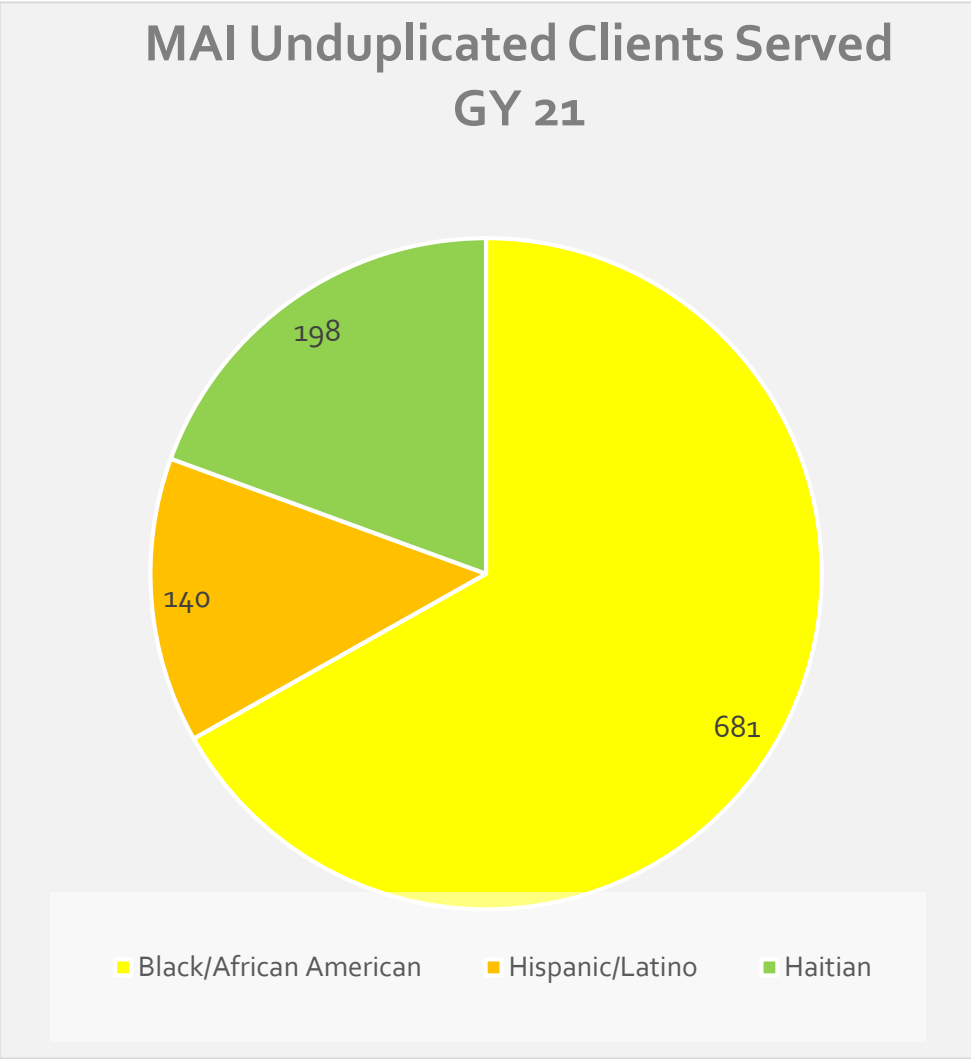
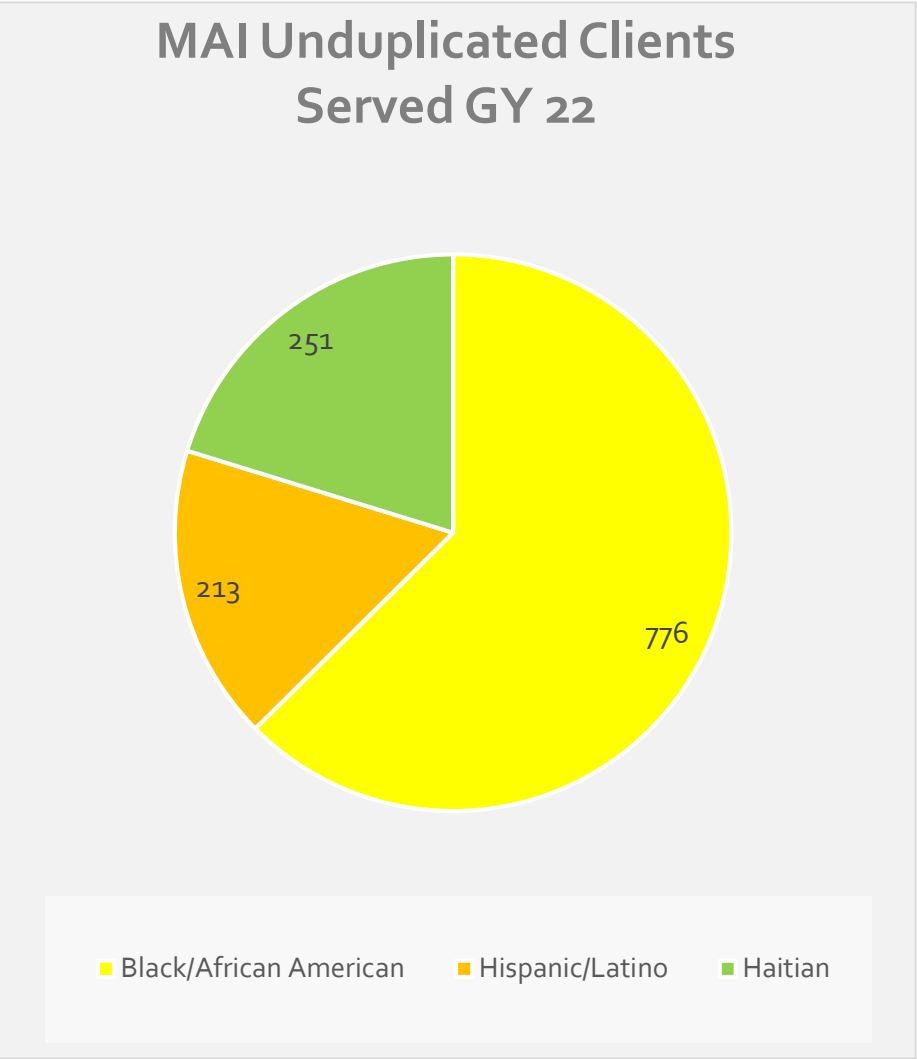
Palm Beach County
Ryan White HIV/AIDS Program

Minority AIDS Initiative (MAI)

- MAI formula grants provide core medical and related support services to improve access and reduce disparities in health outcomes in metropolitan areas hardest hit by HIV/AIDS.
- Our local MAI program supported intensive targeted Medical Case Management (MCM) services, which were prioritized for African Americans (including Haitians) and Hispanic/Latino(a) clients that had elevated viral loads.
- Clients in these 3 populations with complex health issues were enrolled in MAI services. Staff worked closely with a team of the clients' medical providers, to determine the best approach to assist the client in becoming healthier and maintaining better health.
- The CARE Council also allocated MAI funding to Early Intervention Services (EIS), Medical Case Management (MCM), Non-Medical Case Management (NMCM), and Psychosocial Support Services (PSS).

MAI Utilization Data Comparison





* Haitian clients will count in more than one category on these reports.

Optimized Care Continuum Health Outcome Definitions

Viral Suppression:

- Denominator: Clients that are HIV+ and received at least one service from the selected service category(s) in the reporting period from the selected agency(s)
- Numerator: HIV+ clients whose most recent viral load Test Result record is less than 200 and the test result is from the reporting period.

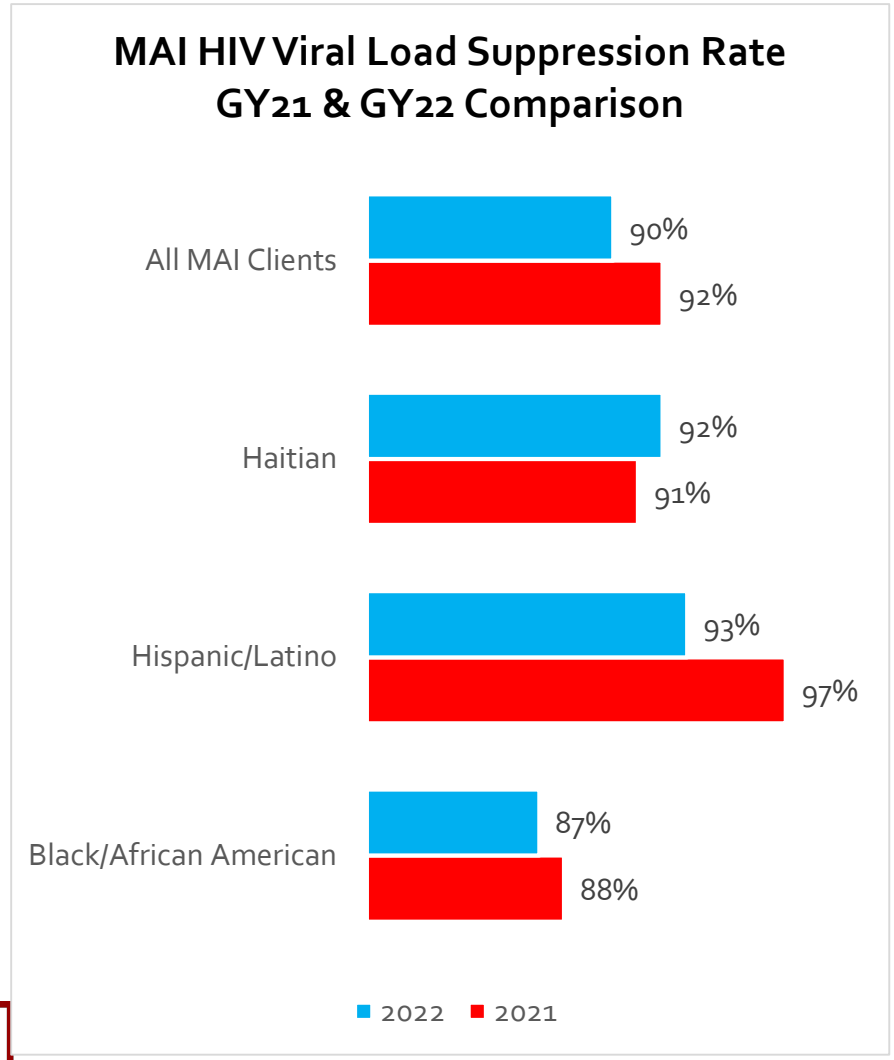
Retention in Care:

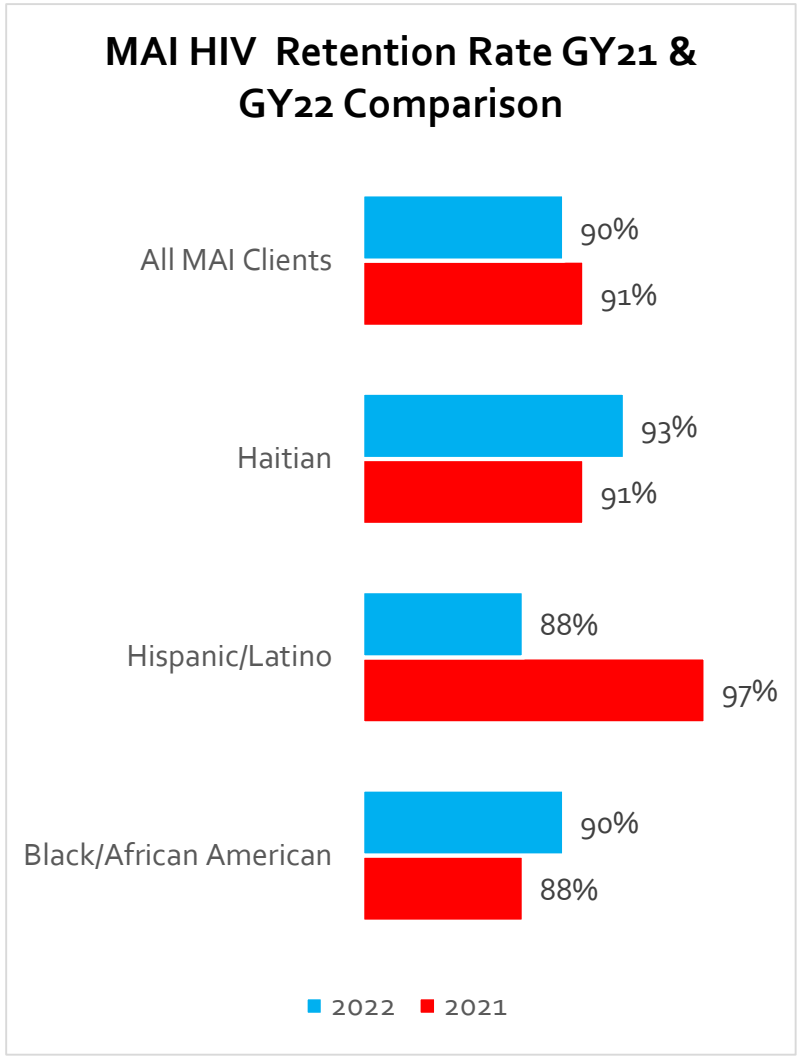
- Denominator: Clients that are HIV+ and received at least one service from the selected service category(s) in the first 6 months of the reporting period from the selected agency(s).
- Numerator: Number of clients that are HIV+ who had two or more medical care services at least three months apart in the reporting period (12 months).

An HIV medical care encounter is a medical visit with a provider with prescribing privileges or an HIV viral load test

MAI Health Outcomes Comparison GY21 & GY22

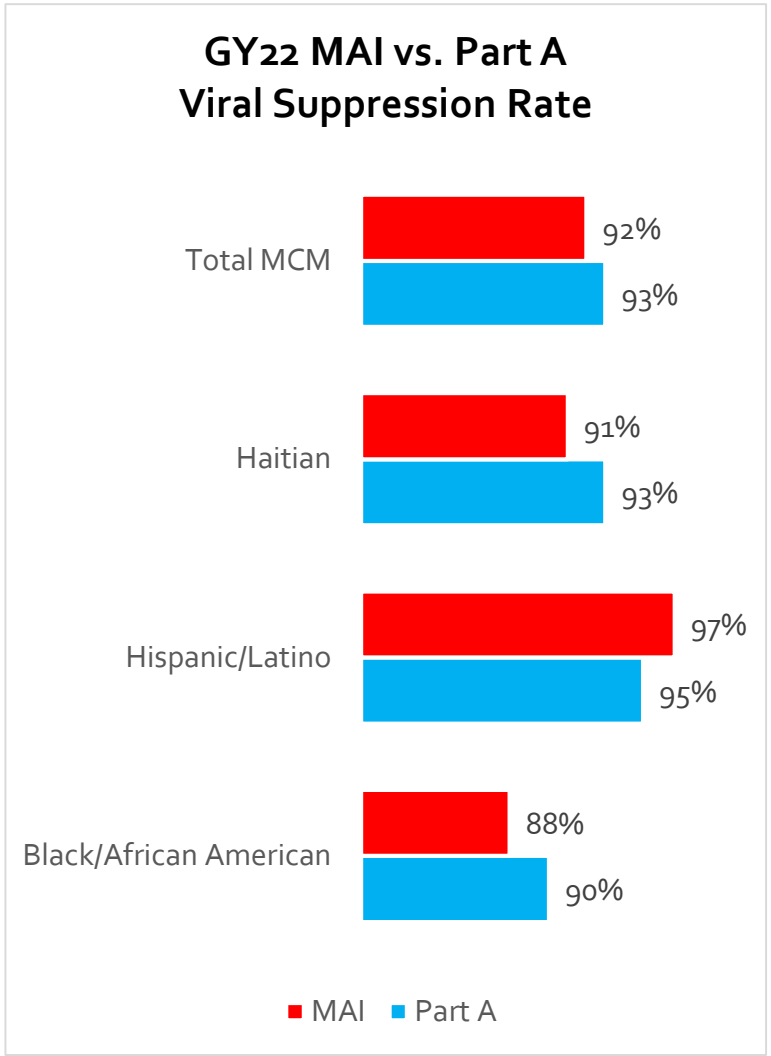
- A slight difference in rates for both Viral Suppression and Retention in GY21 &22.

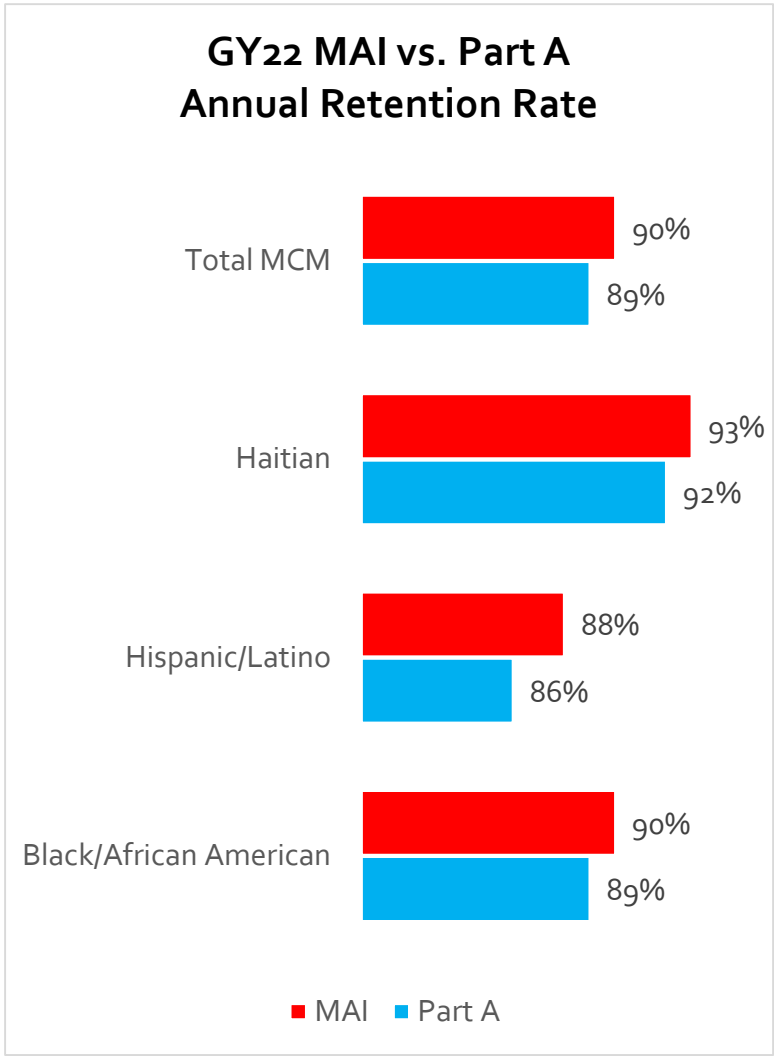




MAI Health Outcomes Comparison
MAI vs. Part A

- Similar rates for Viral Suppression between the 2 funding sources.
- Similar rate of Retention among clients provided MAI funded services.





NMAC ESCALATE Learning Collaborative

- ESCALATE: Ending Stigma through Collaboration and Lifting All To Empowerment.
- The Learning Collaborative NMAC has been funded by the Health Resources and Services Administration (HRSA), and HIV/AIDS Bureau (HAB) to implement the Minority HIV/AIDS fund initiative - Ending Stigma through Collaboration and Lifting All to Empowerment (ESCALATE) project, which seeks to reduce stigma for people with HIV on multiple levels throughout the health care delivery system, including on an individual client level.
- The project focuses on implementing various stigma-reducing approaches with an emphasis on cultural humility, particularly for addressing HIV stigma faced by transgender/gender-nonconforming individuals, men who have sex with men, and the Black/African-American community.

NMAC ESCALATE Learning Collaborative

- ESCALATE activities support Ryan White HIV/AIDS Program (RWHAP) grantees in reducing HIV stigma by providing Training, Technical Assistance (TA), and Learning Collaborative
- NMAC has partnered with NORC at the University of Chicago to facilitate this 16-month-long Learning Collaborative.
- Our team selected a stigma reduction population of focus: The Haitian community. Stigma Reduction Team concise of 4-6 participants, including someone in a leadership position to implement changes at the organization and assign resources to the Initiative.
- Palm Beach County Stigma Reduction team members concise of Gecica Tibert, Health Equity Contract Grant Coordinator (Change agent), Geneve Simeus, Health Planner I, Jasmine Rohoman, Quality Management Clinician, Carline Blanc, Case Manager (PL Care), Remus Emile, Core team Case Manager, and a community participant of lived experience of Haitian descent

NMAC Training

- A continuation of the ESCALATE Stigma Reduction Learning Collaborative. ESCALATE Training facilitates transformative and relational change in RWHAP by increasing participants' knowledge and skills to recognize and address HIV-related stigma within the organizations and communities they serve.
- This happens through a deepening awareness of and practices for cultural humility amongst people with HIV.
- Through training, individuals will learn how to facilitate transformative and relational change in RWHAP and the communities they serve through deepening awareness of and practices for cultural humility amongst people with HIV and RWHAP providers and professionals.

NMAC Training

- 5 participants will be traveling to the ESCALATE 5-day training in Queen, NY July 16-21, 2023.
- The participants are 3 Ryan White Part A/MAI Staff, 1 Staff from FoundCare Glades area, and a person with lived experience.
- ESCALATE will cover hotel, Flight, and food accommodations for all participants.
- There's a total of at least 15 other organizations throughout the United States who will be attending the training in Queens, New York.

Questions?

PBC RWHAP Service Utilization & Cost Analysis

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Palm Beach County
Ryan White HIV/AIDS Program

GY 22 Grant Award Overview

Award Information	Current GY	Carryover	Total
Part A Formula	$4,400,118	473,826	$4,873,944
MAI	$647,581	$106,254	$753,835
Part A Supplemental	$2,553,268	-	$2,553,268
Total	$7,600,967	$580,080	$8,181,047

GY22
Grant Expenditure Overview

Expenditure Categories	Amount	Percent
Core Medical Services	$5,291,105	65%
Support Services	$1,492,794	18%
Administration	$976,726	12%
Total	$7,760,625	95%

GY22 Award & Expenditure Summary

Award Category	Award	Expenditure	Balance
Part A	$7,427,212	$7,106,657	$320,555
MAI	$753,835	$653,968	$99,867
Total	$8,181,047	$7,760,625	$420,422

GY22 Core Medical Services Expenditures by Service Category

Core Medical Service Category	Amount	Percent
AIDS Pharmaceutical Assistance (LPAP)	$3,500	0.05%
Early Intervention Services-Part A	$579,102	7.46%
Early Intervention Services-MAI	$231,833	2.99%
Health Insurance Premium & Cost Sharing Assistance	$2,220,978	28.62%
Laboratory Diagnostic Testing	$125,430	1.62%

GY22 Core Medical Services Expenditures by Service Category…cont.

Core Medical Service Category	Amount	Percent
Medical Case Management	$1,024,910	13.21%
Medical Case Management - MAI	$177,745	2.29%
Mental Health Services	$127,588	1.64%
Oral Health Care	$315,615	4.07%
Outpatient/Ambulatory Medical Care	$197,086	2.54%
Specialty Outpatient Medical Care	$287,318	3.70%

GY22 Support Services Expenditures by Service Category

Support Service Category	Amount	Percent
EFA-Prior Authorizations	$4,742	0.06%
Emergency Financial Assistance	$21,897	0.28%
Emergency Housing Services	$214,286	2.76%
Food Bank/Home Delivered Meals	$250,022	3.22%
Food Bank/Nutritional Supplements	$2,309	0.03%
Legal Services	$280,009	3.61%

GY22 Support Services Expenditures by Service Category…cont.

Support Service Category	Amount	Percent
Medical Transportation	$80,171	1.03%
Non-Medical Case Management	$466,335	6.01%
Non-Medical Case Management-MAI	$65,545	0.84%
Psychosocial Support Services-MAI	$107,479	1.38%

Service Category Ordered by Expenditure

Health Insurance	28.62%
Medical Case Management	13.21%
Early Intervention Services	7.46%
Non-Medical Case Management	6.01%
Oral Health Care	4.07%
Specialty Outpatient Medical Care	3.70%
Legal Services	3.61%
Food Bank/Home Delivered Meals	3.22%
Early Intervention Services-MAI	2.99%
Emergency Housing Services	2.76%
All other service categories	24.36%

Service Category cost per unit- Part A

Core Medical Service Category	Amount	Persons Served	Cost/Person	Units of Service	Cost/Unit
Health Insurance	$2,220,978.42	449	$4,946.50	1,934	$1,148.39
Medical Case Management	$1,024,910.36	1206	$849.84	50,810	$20.17
Early Intervention Services	$579,102.45	752	$770.08	11,228	$51.58
Non-Medical Case Management	$466,334.77	2,223	$209.78	40,402	$11.54
Oral Health Care	$315,614.75	483	$653.45	1,611	$195.91
Specialty Outpatient Medical Care	$287,317.80	157	$1,830.05	385	$746.28

Service Category cost per unit- Part A cont.

Core Medical Service Category	Amount	Persons Served	Cost/Person	Units of Service	Cost/Unit
Early Intervention Services-MAI	$231,832.84	201	$1,153.40	2,535	$91.45
Outpatient/Ambulatory Medical Care	$197,085.91	420	$469.25	1,718	$114.72
Medical Case Management - MAI	$177,745.13	303	$586.62	10,114	$17.57
Mental Health Services	$127,587.55	58	$2,199.79	302	$422.48
Laboratory Diagnostic Testing	$125,429.90	366	$342.70	6,224	$20.15

Service Category cost per unit- Part A cont.

Support Service Category	Amount	Persons Served	Cost/Person	Units of Service	Cost/Unit
Legal Services	$280,009.00	284	$985.95	1,953	$143.37
Food Bank/Home Delivered Meals	$250,021.59	738	$338.78	7,566	$33.05
Emergency Housing Services	$214,286.16	27	$7,936.52	2,082	$102.92
Psychosocial Support Services-MAI	$107,479.38	663	$162.11	6,315	$17.02
Medical Transportation	$80,171.30	294	$272.69	4,093	$19.59

Service Category cost per unit- Part A cont.

Support Service Category	Amount	Persons Served	Cost/Person	Units of Service	Cost/Unit
Non-Medical Case Management-MAI	$65,544.92	303	$216.32	4,443	$14.75
Emergency Financial Assistance	$21,897.15	23	$952.05	25	$875.89
EFA-Prior Authorizations	$4,741.52	32	$148.17	123	$38.55
AIDS Pharmaceutical Assistance	$3,499.90	48	$72.91	166	$21.08
Food Bank/Nutritional Supplements	$2,308.70	7	$329.81	34	$67.90

Service Category cost per unit - MAI

Core Medical Service Category	Amount	Persons Served	Cost/Person	Units of Service	Cost/Unit
Early Intervention Services	$231,832.84	201	$1,153.40	2,535	$91.45
Medical Case Management	$177,745.13	303	$586.62	10,114	$17.57

Support Service Category	Amount	Persons Served	Cost/Person	Units of Service	Cost/Unit
Non-Medical Case Management	$48,689	303	$216.32	4,443	$14.75
Psychosocial Support	$107,479.38	663	$162.11	6,315	$17.02

Service Category Ordered by Persons Served

Category	Persons Served
Non-Medical Case Management	2223
Medical Case Management	1206
Early Intervention Services	752
Food Bank/Home Delivered Meals	738
Psychosocial Support Services-MAI	663
Oral Health Care	483
Health Insurance	449
Outpatient/Ambulatory Medical Care	420
Laboratory Diagnostic Testing	366
Medical Case Management - MAI	303
Non-Medical Case Management-MAI	303
Medical Transportation	294
Legal Services	284
Early Intervention Services-MAI	201
Specialty Outpatient Medical Care	157
Mental Health Services	58
AIDS Pharmaceutical Assistance	48
EFA-Prior Authorizations	32
Emergency Housing Services	27
Emergency Financial Assistance	23
Food Bank/Nutritional Supplements	7

Service Category Ordered by Cost/Person – Top 10

Category	Cost Per Person	YTD Exp.
Emergency Housing Services	$7,936.52	$214,286.16
Health Insurance	$4,946.50	$2,220,978.42
Mental Health Services	$2,199.79	$127,587.55
Specialty Outpatient Medical Care	$1,830.05	$287,317.80
Early Intervention Services-MAI	$1,153.40	$231,832.84
Legal Services	$985.95	$280,009.00
Emergency Financial Assistance	$952.05	$21,897.15
Medical Case Management	$849.84	$1,024,910.36
Early Intervention Services	$770.08	$579,102.45
Oral Health Care	$653.45	$315,614.75

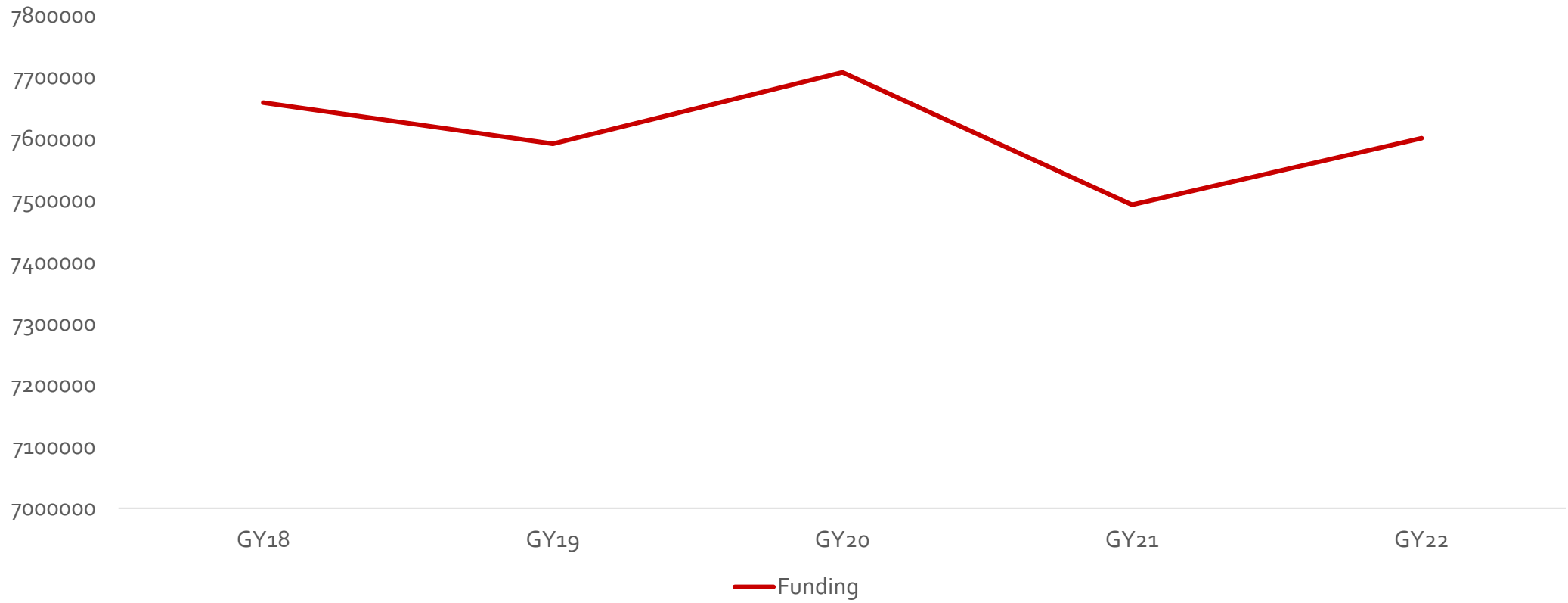
Service Category Ordered by Cost/Unit – Top Ten

Category	Cost Per Person	YTD Exp.
Health Insurance	$1,148	$2,220,978.42
Emergency Financial Assistance	$876	$21,897.15
Specialty Outpatient Medical Care	$746	$287,317.80
Mental Health Services	$422	$127,587.55
Oral Health Care	$196	$315,614.75
Legal Services	$143	$280,009.00
Outpatient/Ambulatory Medical Care	$115	$197,085.91
Emergency Housing Services	$103	$214,286.16
Early Intervention Services-MAI	$91	$231,832.84
Food Bank/Nutritional Supplements	$68	$2,308.70

5 Year Trend Analysis

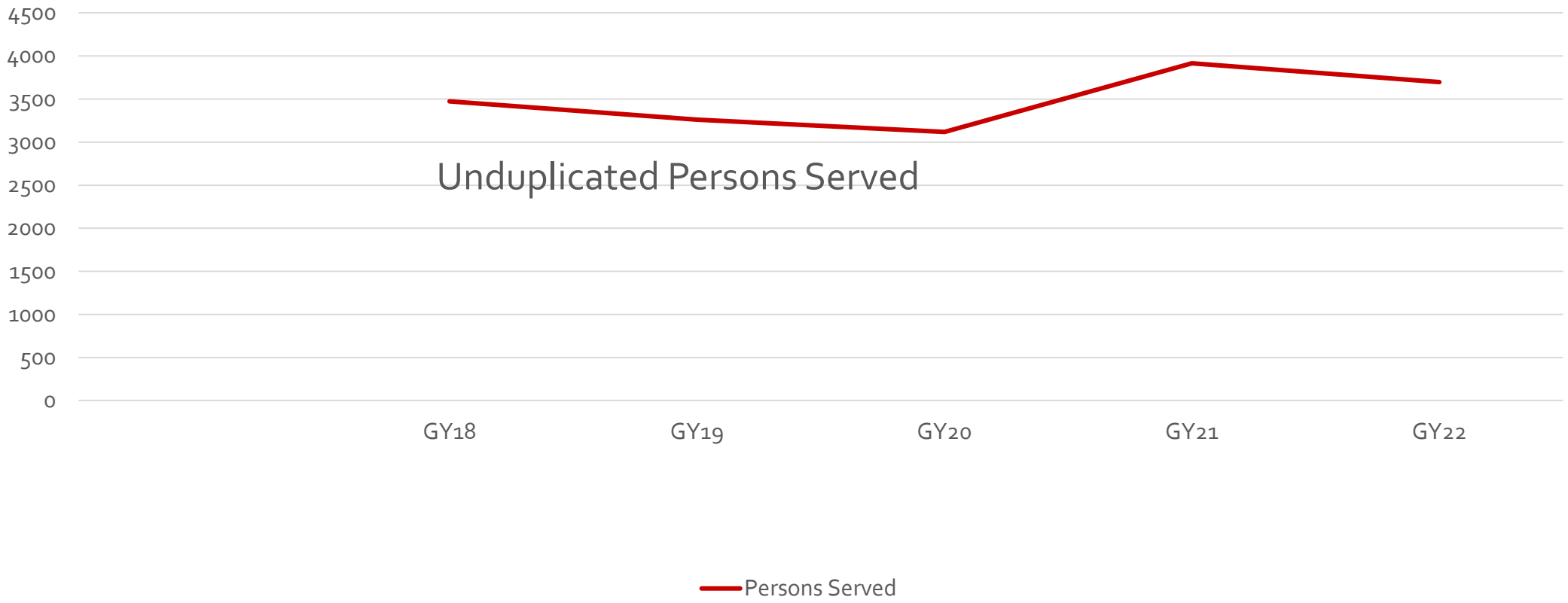
GY 18 – GY 22

5 Year Trends-RW Funding



- 0.8% Funding from GY18 to GY22

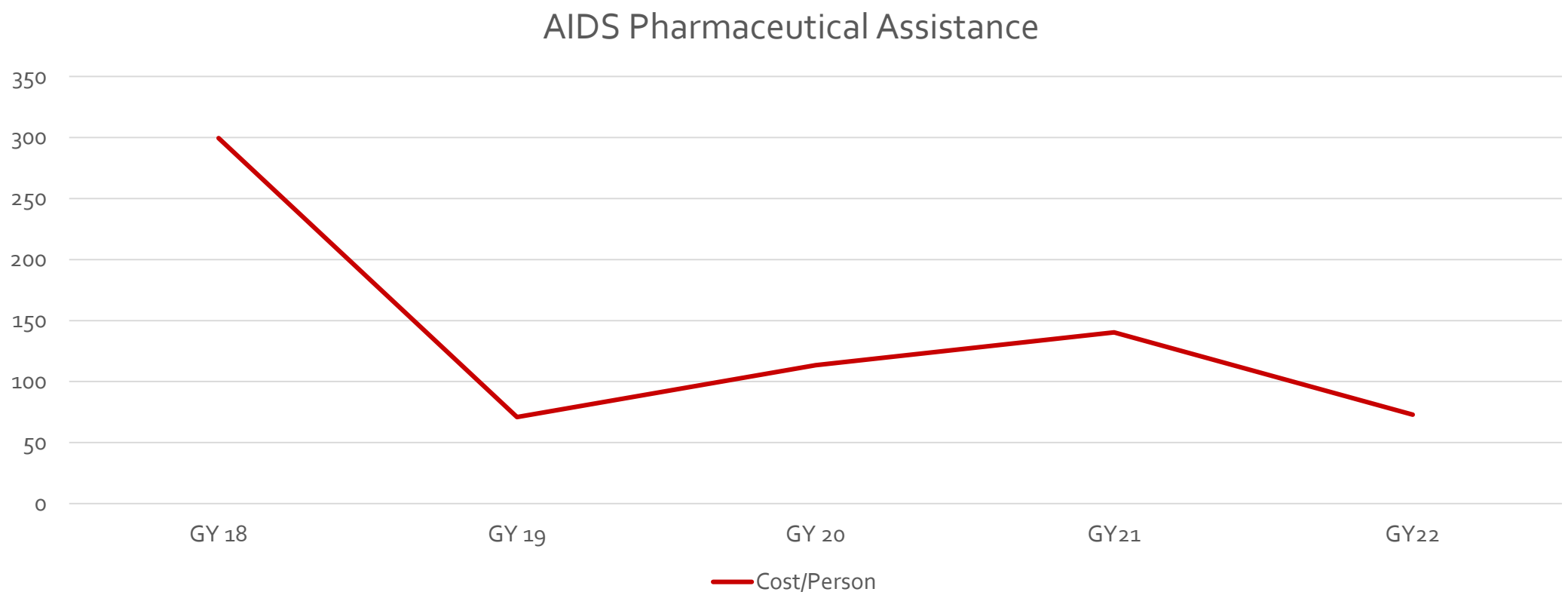
5 Year Trend-Persons Served



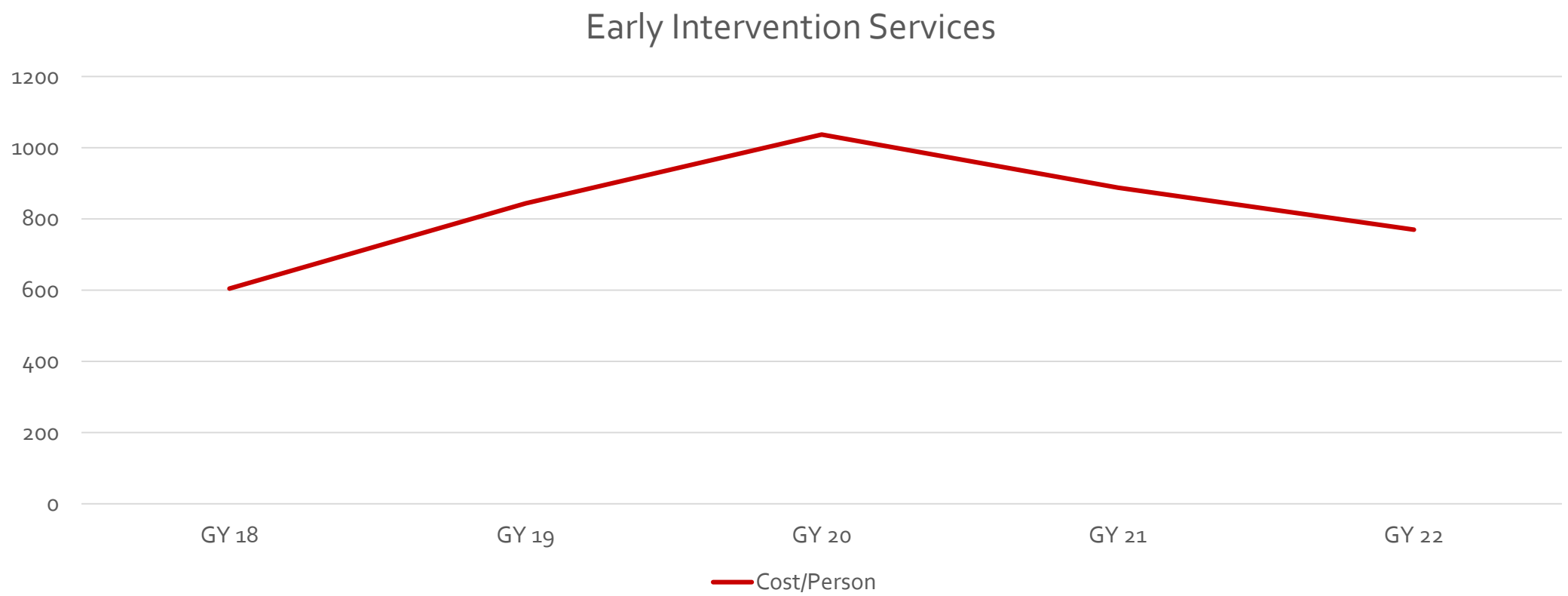
+6.4 % Persons Served from GY 18 - GY 22

Palm Beach County
Ryan White HIV/AIDS Program

5 Year Trends-Cost/Person by Service Category



5 Year Trends-Cost/Person by Service Category



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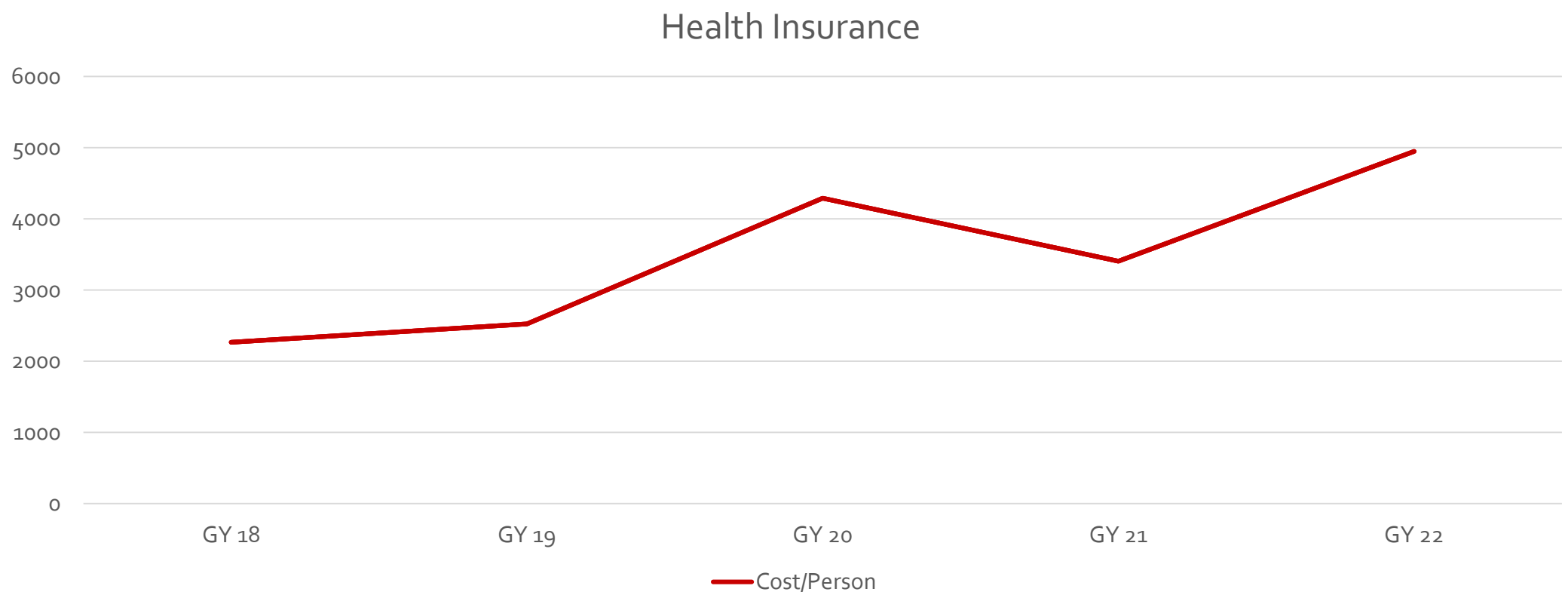

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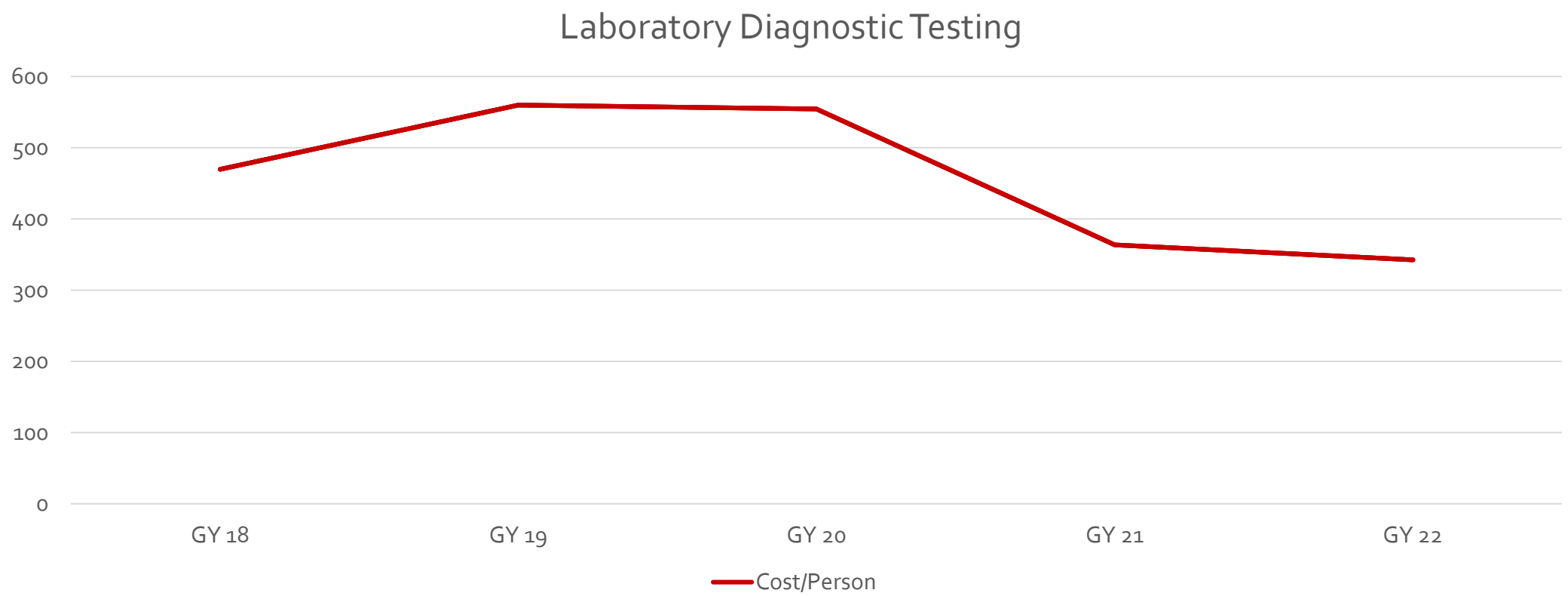
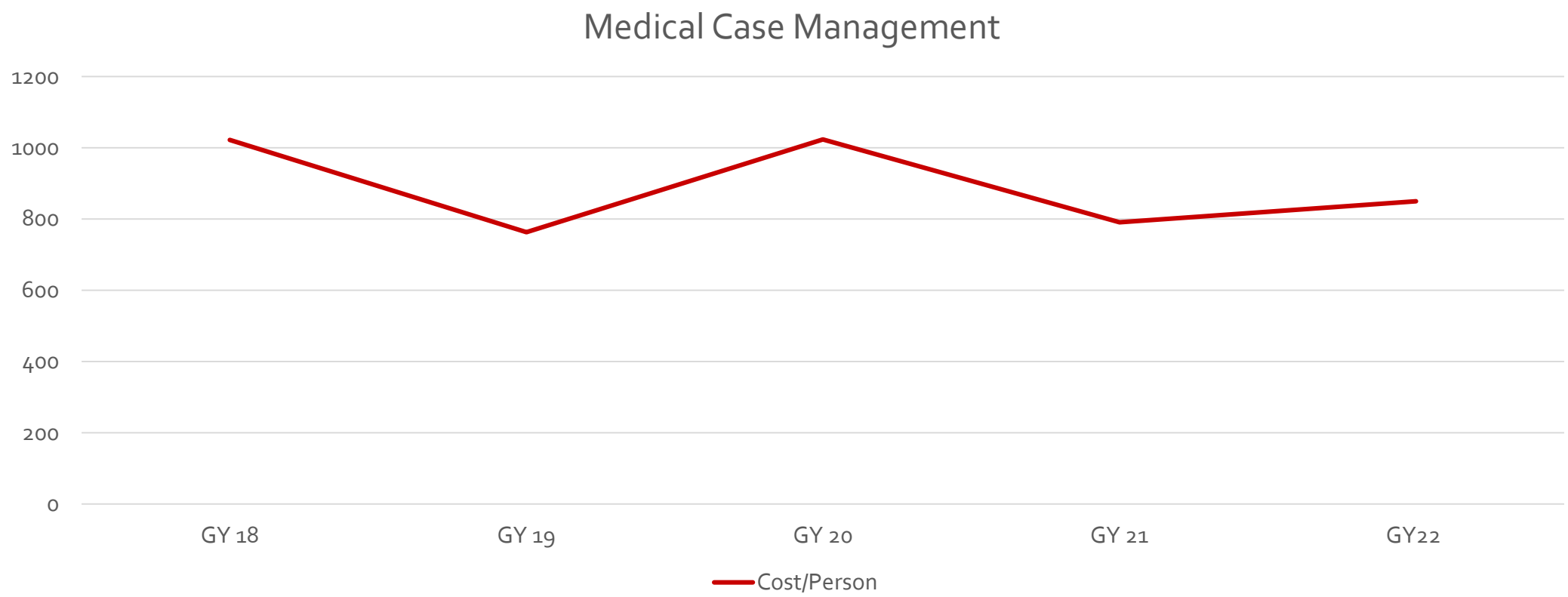
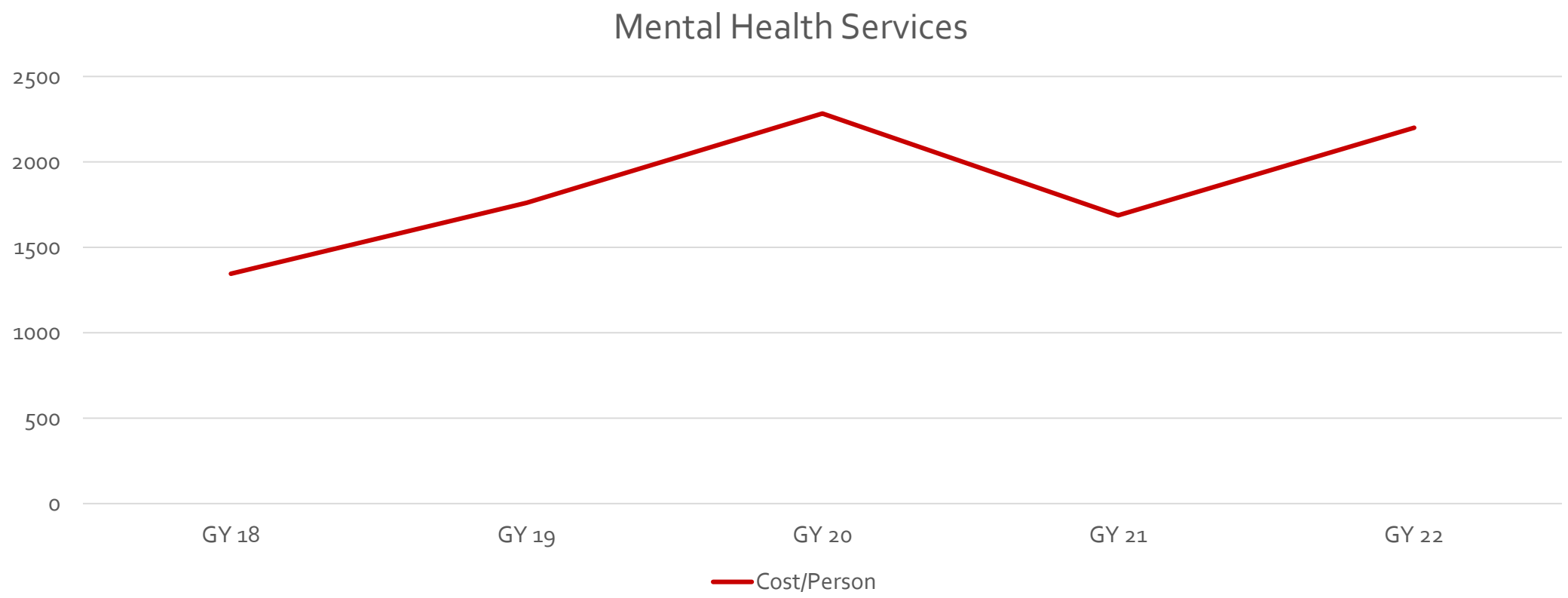


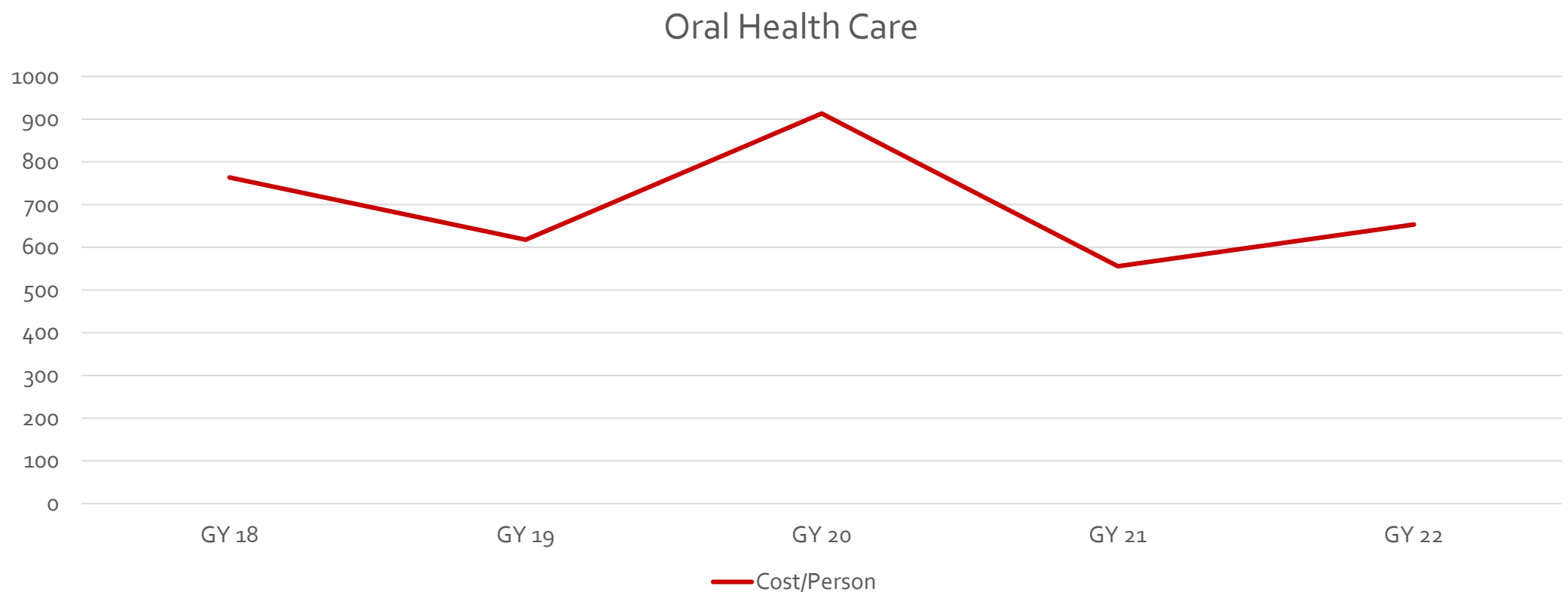
5 Year Trends-Cost/Person by Service Category



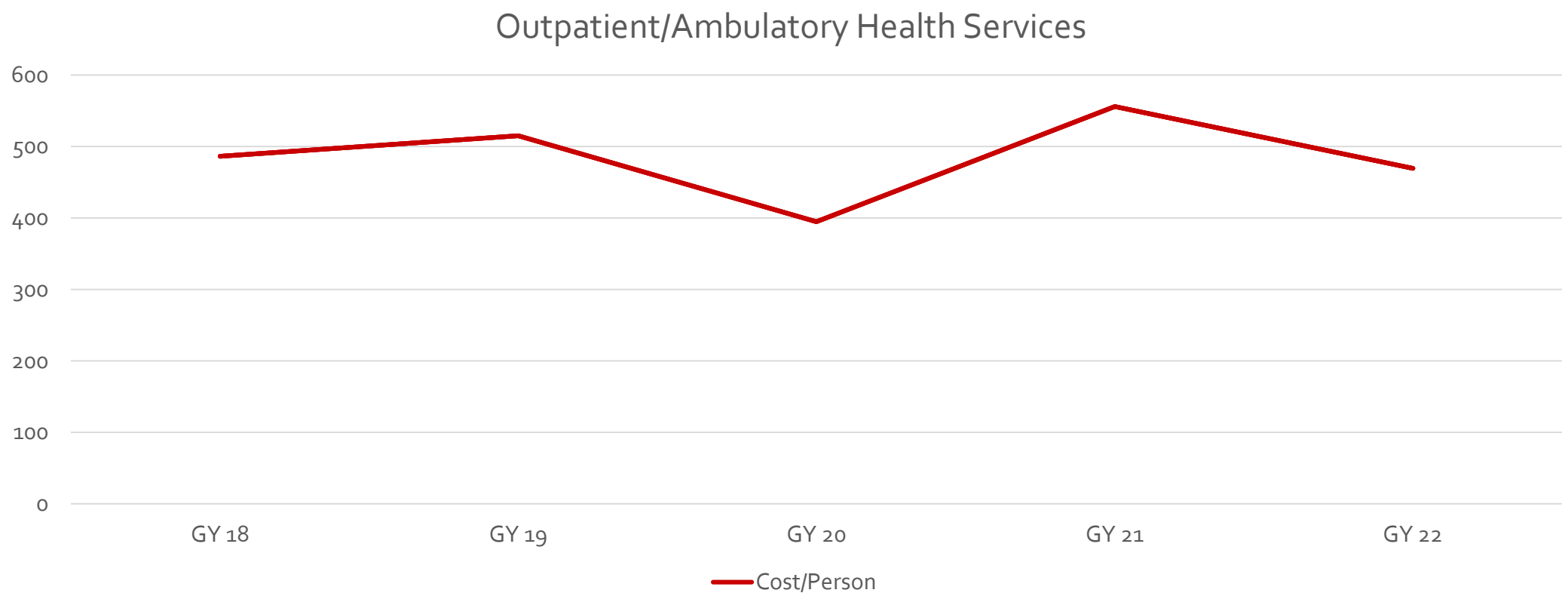
5 Year Trends-Cost/Person by Service Category



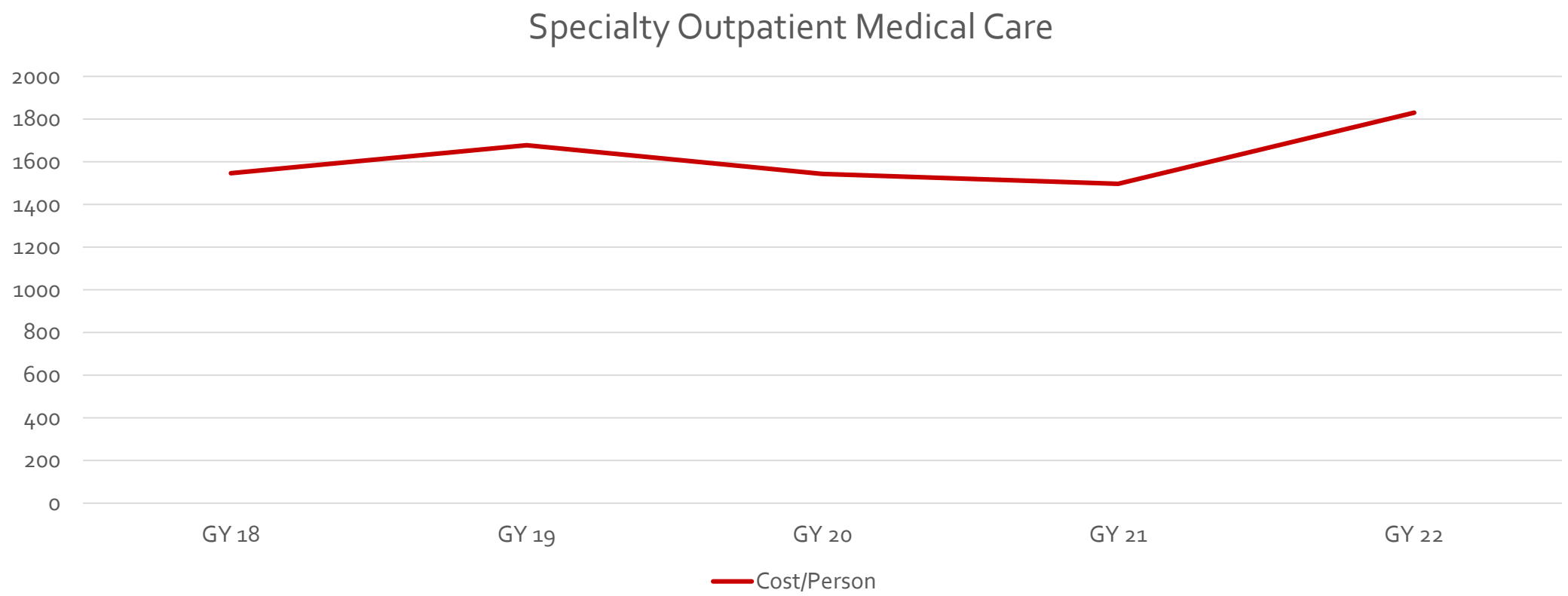
5 Year Trends-Cost/Person by Service Category



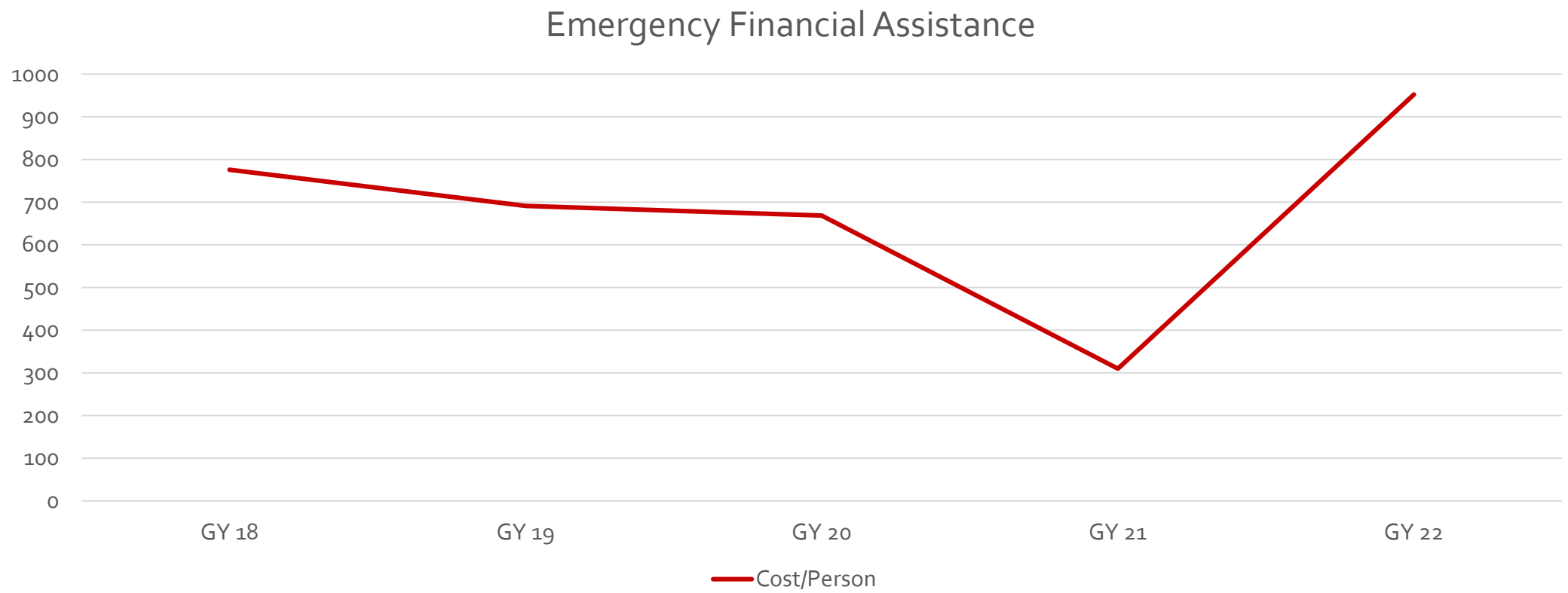
5 Year Trends-Cost/Person by Service Category



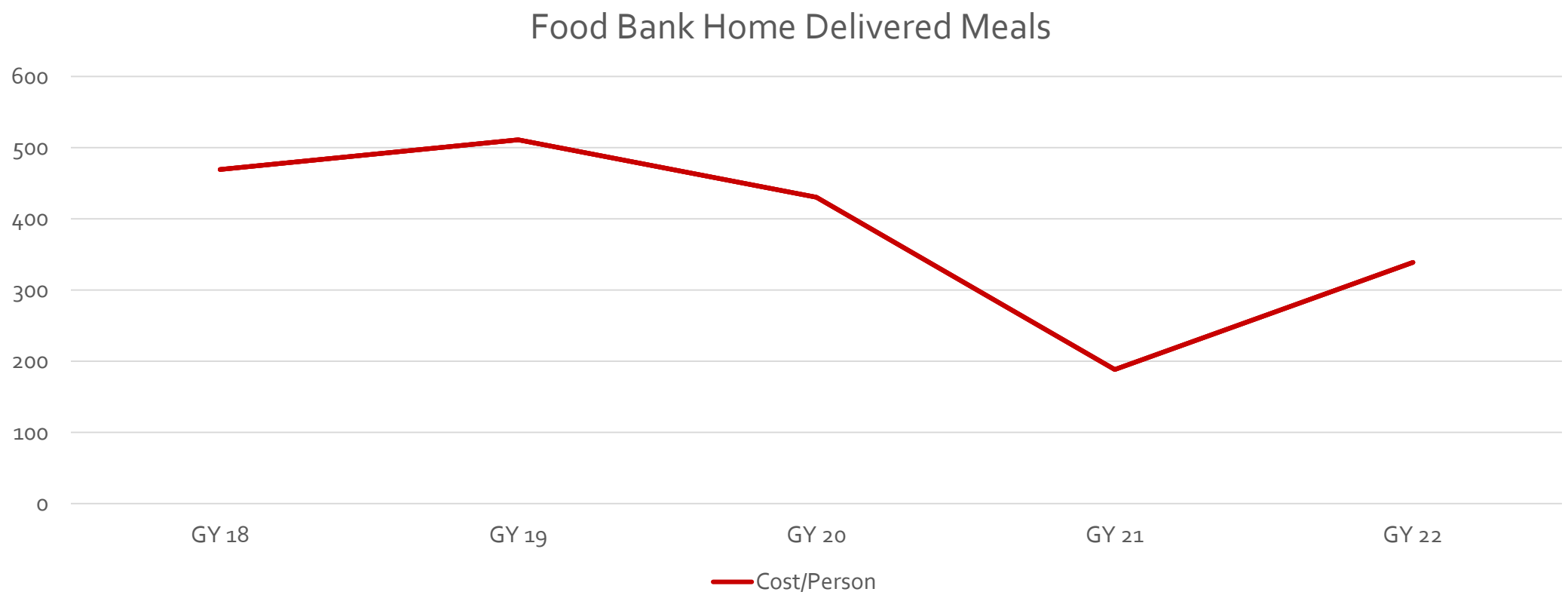
5 Year Trends-Cost/Person by Service Category



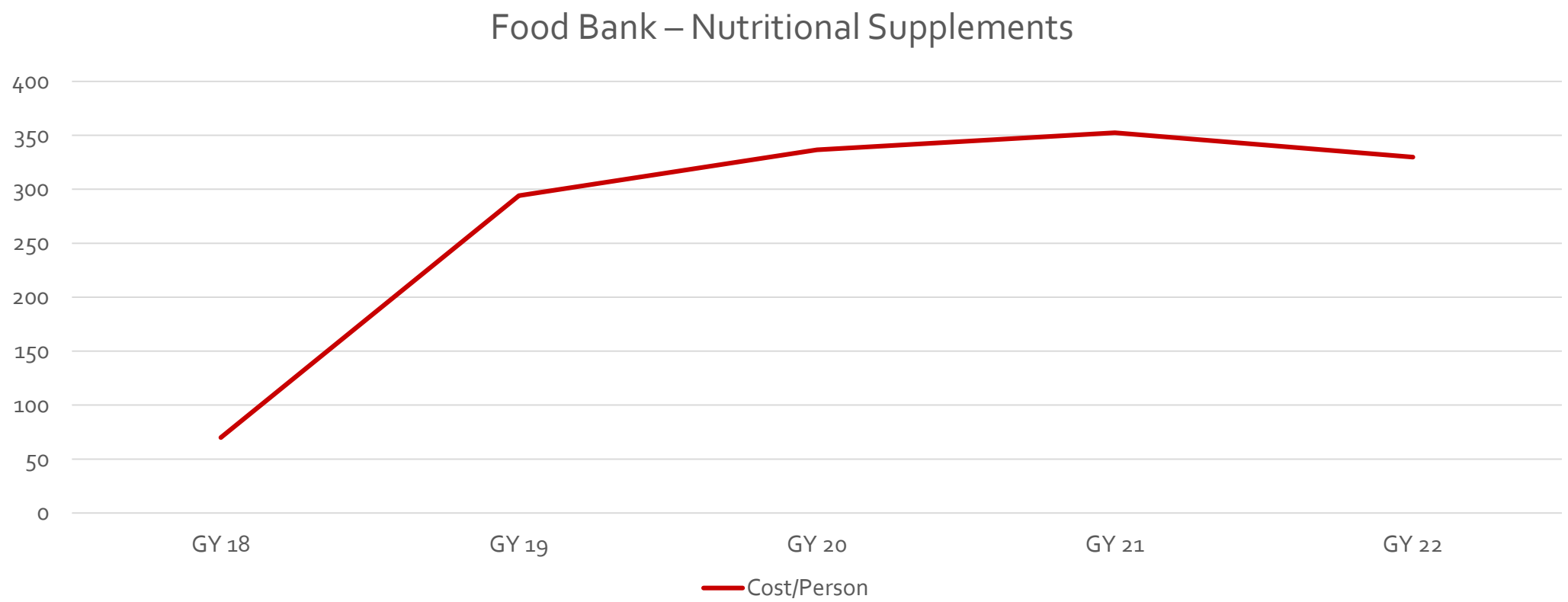
5 Year Trends-Cost/Person by Service Category



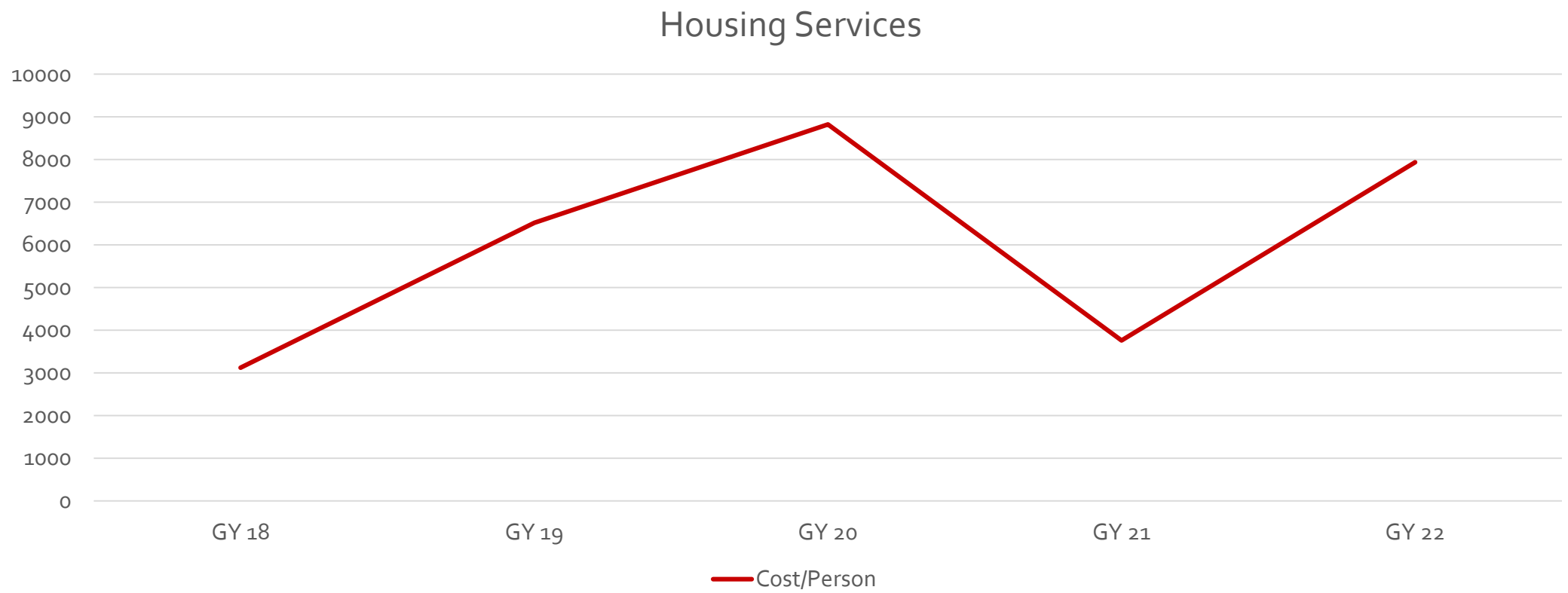
5 Year Trends-Cost/Person by Service Category



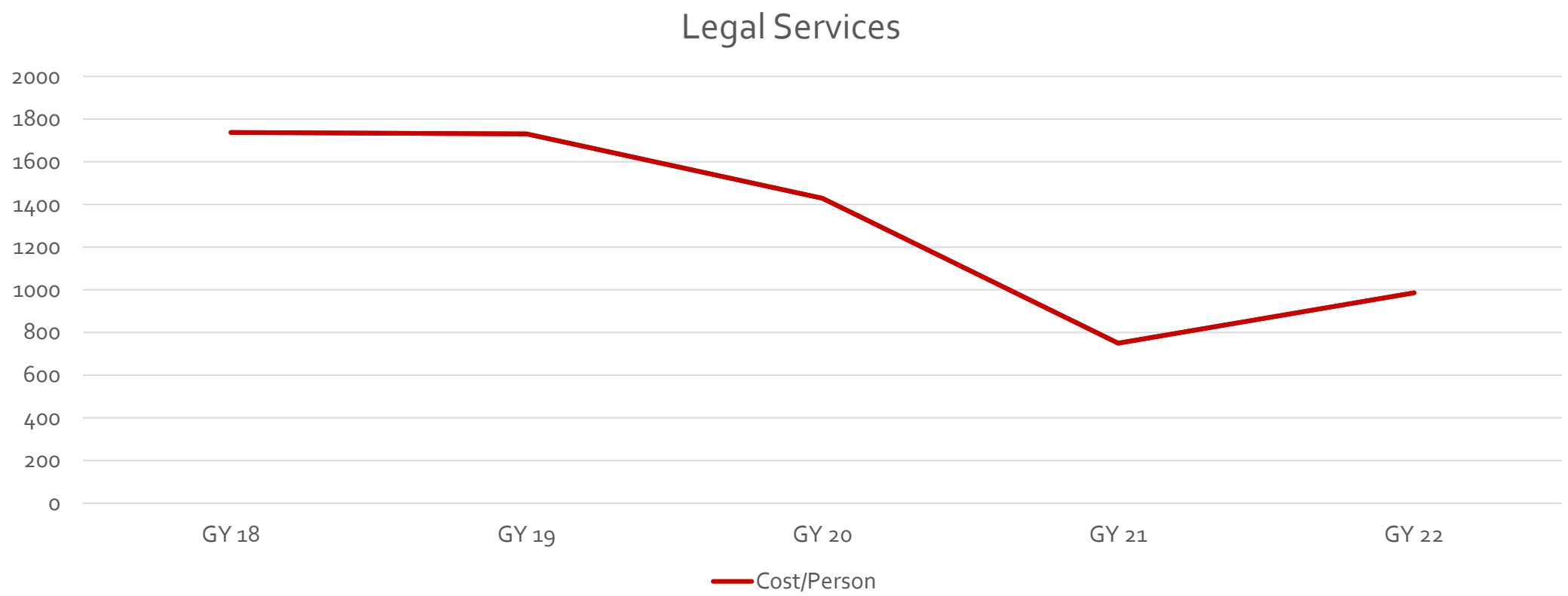
5 Year Trends-Cost/Person by Service Category



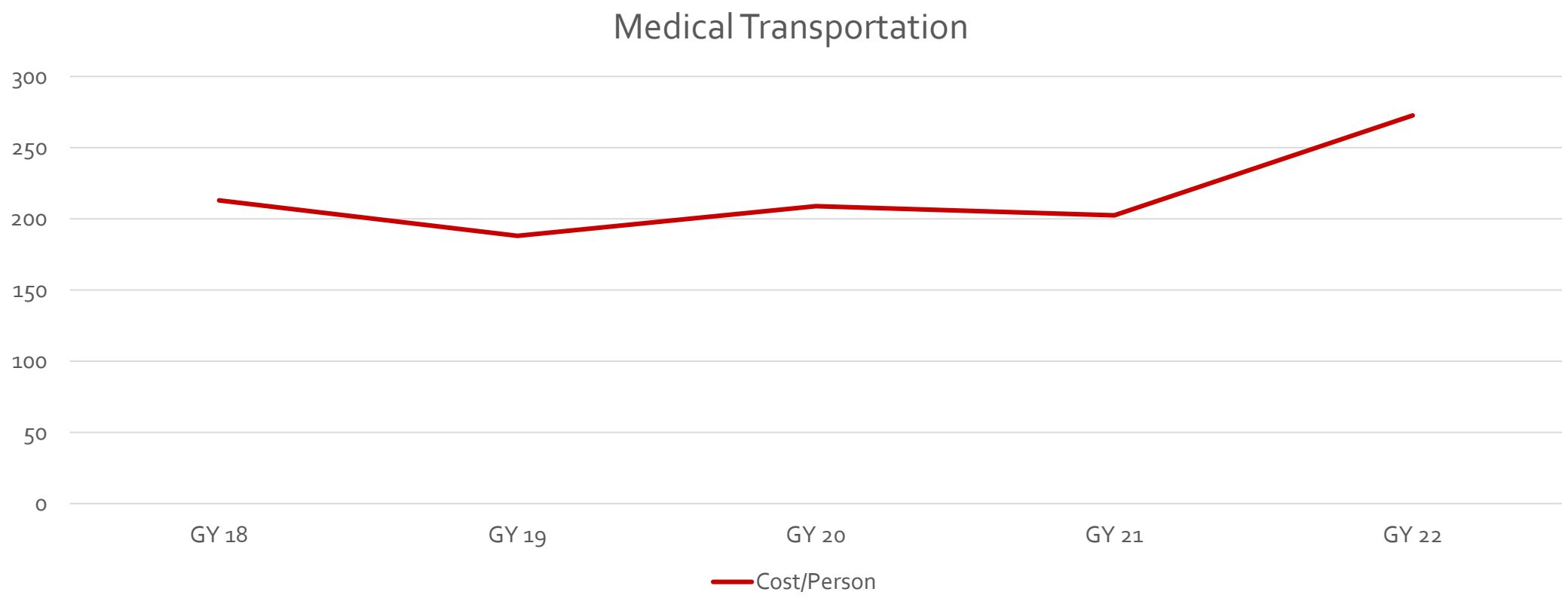
5 Year Trends-Cost/Person by Service Category



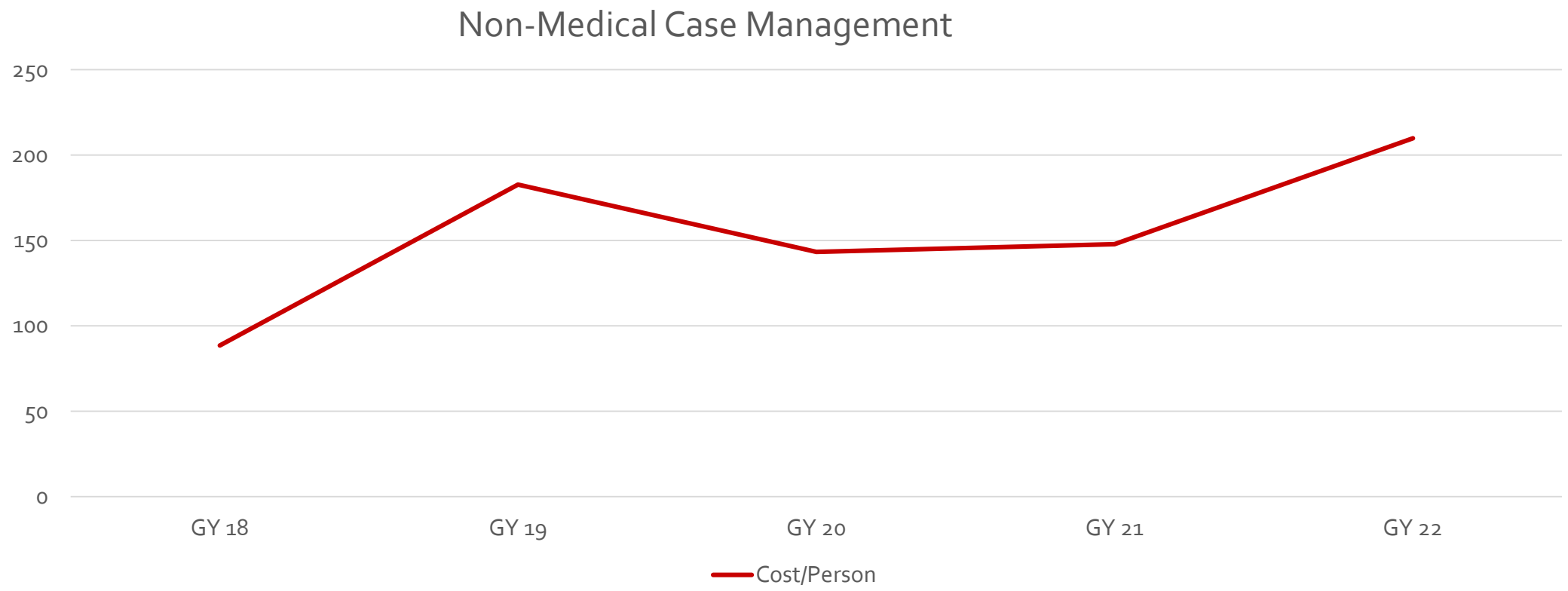
5 Year Trends-Cost/Person by Service Category



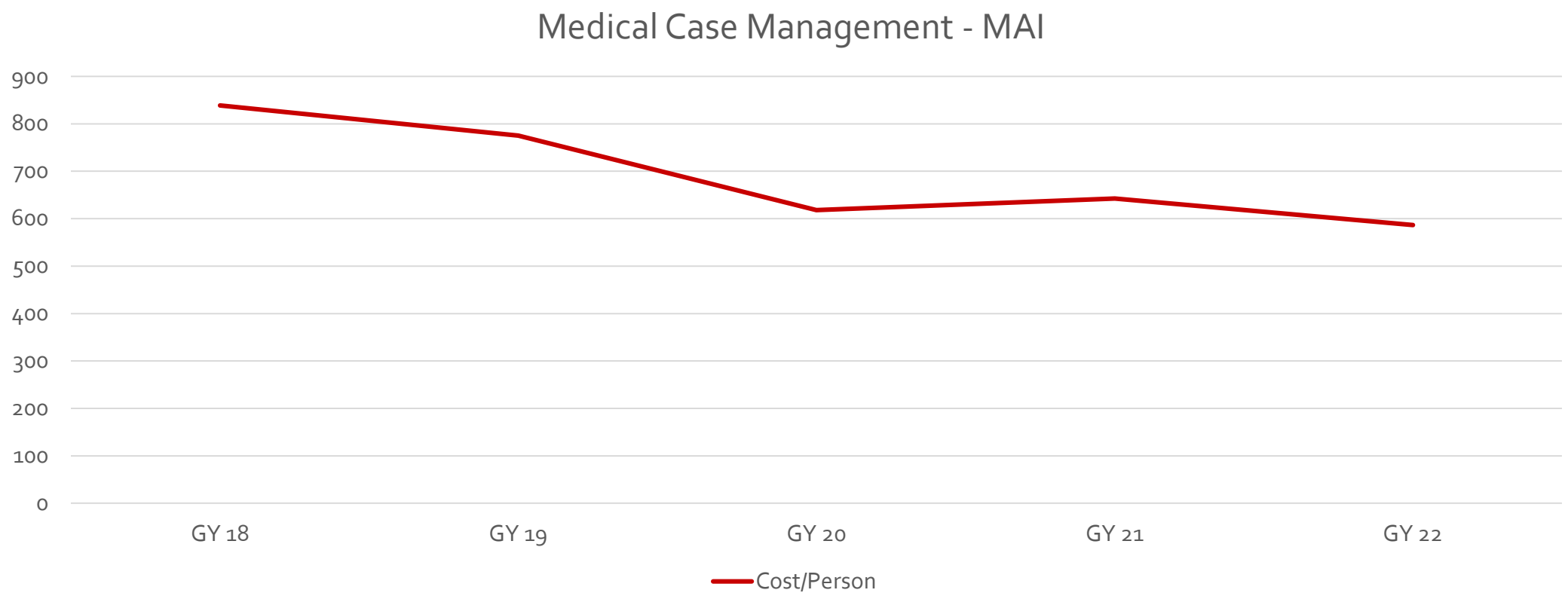
5 Year Trends-Cost/Person by Service Category



5 Year Trends-Cost/Person by Service Category



5 Year Trends-Cost/Person by Service Category



5 Year Trends-Cost/Person by Service Category Summary

Core Medical Service Category	5 Year Trend-Cost/Person
AIDS Pharmaceutical Assistance (LPAP)	-76%
Early Intervention Services	+27%
Health Insurance	+118%
Home and Community-based Health Services	No Longer Funded
Laboratory Diagnostic Testing	-27%
Medical Case Management	-17%

5 Year Trends-Cost/Person by Service Category Summary…cont.

Core Medical Service Category	5 Year Trend-Cost/Person
Medical Nutrition Therapy	No Longer Funded
Mental Health Services	+64%
Oral Health Care	-14%
Outpatient/Ambulatory Health Services	-3%
Specialty Outpatient Medical Care	+18%

5 Year Trends-Cost/Person by Service Category Summary

Support Service Category	5 Year Trend-Cost/Person
Emergency Financial Assistance	+319%
Emergency Financial Assistance-Prior Auth.	No historical data
Food Bank/Home Delivered Meals	-18%
Food Bank-Nutritional Supplements	+393%
Housing	+154%

5 Year Trends-Cost/Person by Service Category Summary…cont.

Support Service Category	5 Year Trend-Cost/Person
Legal Services	-43%
Medical Transportation	+27%
Non-Medical Case Management	-79%
Medical Case Management	-17%

1 Year Trend-Cost/Person by Service Category Ordered by Percent Increase

1	Emergency Financial Assistance	307%	$ 642.14	*
2	EFA-Prior Authorizations	253%	$ 89.50	
3	Emergency Housing Services	211%	$ 4,175.76	*
4	Food Bank/Home Delivered Meals	180%	$ 150.24	
5	Health Insurance	145%	$ 1,541.32	*
6	Non-Medical Case Management	142%	$ 61.91	
7	Medical Transportation	135%	$ 70.18	
8	Legal Services	131%	$ 235.95	
9	Psychosocial Support Services-MAI	131%	$ 38.55	
10	Mental Health Services	130%	$ 512.97	*

Green = Salary-funded Blue = Direct assistance to clients *Largest increase by $$$

Questions?

Florida Department of Health

Ryan White Part B

Service Utilization and Cost Analysis

Robert Scott

HIV/AIDS Program Coordinator

Florida Department of Health in Palm Beach County

Robert.Scott@flhealth.gov

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FDOH in Palm Beach County

- Ryan White Part B services are guided by the needs of Part B clients (Needs Assessment, Consumer Surveys, Grievance Logs, Consumer and Community Feedback)
- Part B services are available to any PWH in Palm Beach County
- Not all services were provided for all 12 months of the GY
- GY timelines:
  - Patient Care Consortia – April 1 – March 31
  - Patient Care Network – July 1 – June 30
  - Patient Care General Revenue – July 1 – June 30

Definition of Services

1. Outpatient Ambulatory Health Services
    1. Lab w/NOE – Viral load/CD4, Comprehensive labs as ordered by provider
    2. Lab no NOE – Viral load/CD4, Comprehensive labs as ordered by provider
    3. Medical – Appointments with provider, NOE required, Medicaid cost-based reimbursement rate
2. Referral For Health Care/Support Services
    1. Care Coordination
    2. No NOE required
3. Medical Nutrition Therapy
    1. Nutritional Assessments performed by licensed Nutritionist
    2. Nutritional Supplements distributed based on assessments
    3. No NOE required

Definition of Services

4. Oral Health
    1. Oral Health Services provided at Northeast Health Center
    2. Reimbursed at Medicaid cost-based reimbursement rate
    3. NOE Required
5. Mental Health Services
    1. Intake and Psychosocial Assessments
    2. Follow-Up Mental Health Sessions
    3. No NOE required
    4. No limit to the number of sessions
6. Treatment Adherence Counseling
    1. Determined necessary by therapist or other clinic/program staff
    2. No NOE required
    3. No limit to the number of sessions

Definition of Services

7. Medical Transportation Services
    1. Transportation provided to patients utilizing oral health services
    2. From Belle Glade and Delray Beach to Northeast Health Center
    3. Bus Passes
8. Food Bank
    1. Food Pantry (up to $90/mo)
    2. Food recommended by nutritionists
    3. No NOE required

GY21 Grant Patient Care Dollars

GY21 Award Information	Annual
Part B Consortia 4/1/2021 – 3/31/2022	$773,137
Patient Care Network 7/1/2021 – 6/30/2022	$616,645
General Revenue 7/1/2021 – 6/30/2022	$770,000
Total	$2,159,782

GY21 Part B Consortia Expenditures – PTC22

Expenditure Categories	Amount Budgeted	Amount Spent	Percent
Core Medical Services	$660,599	$540,996	81%
Support Services	$10,000	$9,940	99%
CQM/P&E	$50,000	$50,000	100%
Administration	$52,538	$39,889	76%
Total	**$773,137**	**$640,825**	**82%**

GY21 Patient Care Network Expenditures – 4BNWK

Expenditure Categories	Amount Budgeted	Amount Spent	Percent
Core Medical Services	$398,149	$386,188	99%
Support Services	$202,894	$135,985	67%
Administration	$15,602	$14,917	96%
Total	**$616,645**	**$537,090**	**87%**

GY21 Patient Care GR Expenditures – 4B000

Expenditure Categories	Amount Budgeted	Amount Spent	Percent
Core Medical Services	$550,917	$443,057	80%
Support Services	$74,471	$65,447	87%
CQM/P&E	$71,000	$67,420	95%
Administration	$73,612	$73,612	100%
Total	**$770,000**	**$649,536**	**84%**

GY21 Award and Expenditure Summary

Funding	Amount Awarded	Amount Spent	Balance
Part B Consortia 4/1/2021 – 3/31/2022	$773,137	$640,825	$132,312
Patient Care Network 7/1/2021 – 6/30/2022	$616,645	$537,090	$79,555*
General Revenue 7/1/2021 – 6/30/2022	$770,000	$649,536	$120,464*
Total	**$2,159,784**	**$1,827,451**	**$332,331**

*10% of award carried over as cash balance to GY22

GY21 Part B Consortia
Core Medical & Support Services expenditures by service category

Core Medical Services Category	Amount Budgeted	Amount Spent	Percent
Outpatient/Ambulatory Health Srvcs (Lab)	$513,414	**$488,316**	95%
Medical Nutrition Therapy	$147,185	**$52,680**	36%

Support Services Category	Amount Budgeted	Amount Spent	Percent
Medical Transportation	$10,000	**$9,940**	99%

GY21 Patient Care Network
Core Medical & Support Services expenditures by service category

Core Medical Services Category	Amount Budgeted	Amount Spent	Percent
Outpatient/Ambulatory Health Srvcs (Clinic)	$389,149	**$386,188**	99%

Support Services Category	Amount Budgeted	Amount Spent	Percent
Referral for Health Care/ Supportive Srvcs	$202,894	**$135,985**	67%

GY21 Patient Care GR

Core Medical & Support Services expenditures by service category

Core Medical Services Category	Amount Budgeted	Amount Spent	Percent
Outpatient/Ambulatory Health Srvcs (Lab no NOE)	$88,000	**$50,167**	57%
Oral Health Care	$276,837	**$229,079**	83%
Mental Health Services	$93,040	**$78,115**	84%
Treatment Adherence	$93,040	**$85,696**	92%

Support Services Category	Amount Budgeted	Amount Spent	Percent
Referral for Health Care/ Supportive Srvcs	$58,847	**$49,823**	85%
Food Bank/ Food Pantry	$15,624	**$15,624**	100%

Service Category Ordered by Expenditure

Services Category	Amount	Percent
Outpatient Ambulatory (Lab)	$ 488,316.03	30.9%
Outpatient Ambulatory (Clinic)	$ 386,188.30	24.4%
Oral Health Care	$ 229,079.09	14.5%
Referral for Healthcare	$ 185,808.11	11.7%
MCM/ Treatment Adherence	$ 85,696.00	5.4%
Mental Health Services	$ 78,115.00	4.9%
Medical Nutrition Therapy	$ 52,679.60	3.3%
Outpatient Ambulatory (Lab no NOE)	$ 50,166.62	3.2%
Food Bank	$ 15,624.00	1.0%
Medical Transportation Serv	$ 9,940.00	0.6%

Service Category cost per person/ per unit Ordered by Persons Served

Core Medical/ Support Service Category	Amount	Persons Served	Units of Service	Cost/ Person	Cost/ Unit
Outpatient Ambulatory (Clinic)	$386,188.30	**1,962**	2,125	$196.83	$181.74
Referral for Healthcare	$185,808.11	**1,795**	2,512	$103.51	$ 73.97
Oral Health Care	$229,079.09	**1,225**	1,957	$187.00	$117.06
Mental Health Services	$ 78,115.00	**1,206**	1,957	$ 64.77	$ 39.92
Outpatient Ambulatory (Lab)	$488,316.03	**1,093**	7,542	$446.77	$ 64.75
MCM/ Treatment Adherence	$ 85,696.00	**842**	1,038	$101.78	$ 82.56
Food Bank	$ 15,624.00	**819**	871	$ 19.08	$ 17.94
Medical Nutrition Therapy	$ 52,679.60	**590**	599	$ 89.29	$ 87.95
Outpatient Ambulatory (Lab no NOE)	$ 50,166.62	**416**	2,326	$120.59	$ 21.57
Medical Transportation Serv	$ 9,940.00	**209**	209	$ 47.56	$ 47.56

*Oral Health: Number of Visits, Cost per Visit

Service Category cost per person/ per unit
Ordered by Cost/Person

Core Medical/ Support Service Category	Amount	Persons Served	Units of Service	Cost/ Person	Cost/ Unit
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Questions?

PBC Housing Opportunities for People with HIV/AIDS (HOPWA) 2021-2022

Andres Correa

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PBC Ryan White HIV/AIDS Program

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Palm Beach County
Ryan White HIV/AIDS Program

INTRODUCTION

- The Housing Opportunities for Persons with HIV/AIDS (HOPWA) Program is the Federal Government's primary targeted response to the pressing housing needs of persons with HIV (PWH) and their families. The program, which is administered by the U.S. Department of Housing and Urban Development's Office of HIV/AIDS Housing, is authorized by statute "to provide States and localities with the resources and incentive to devise long-term, comprehensive strategies for meeting the housing needs of persons with acquired immunodeficiency syndrome and families of such persons."

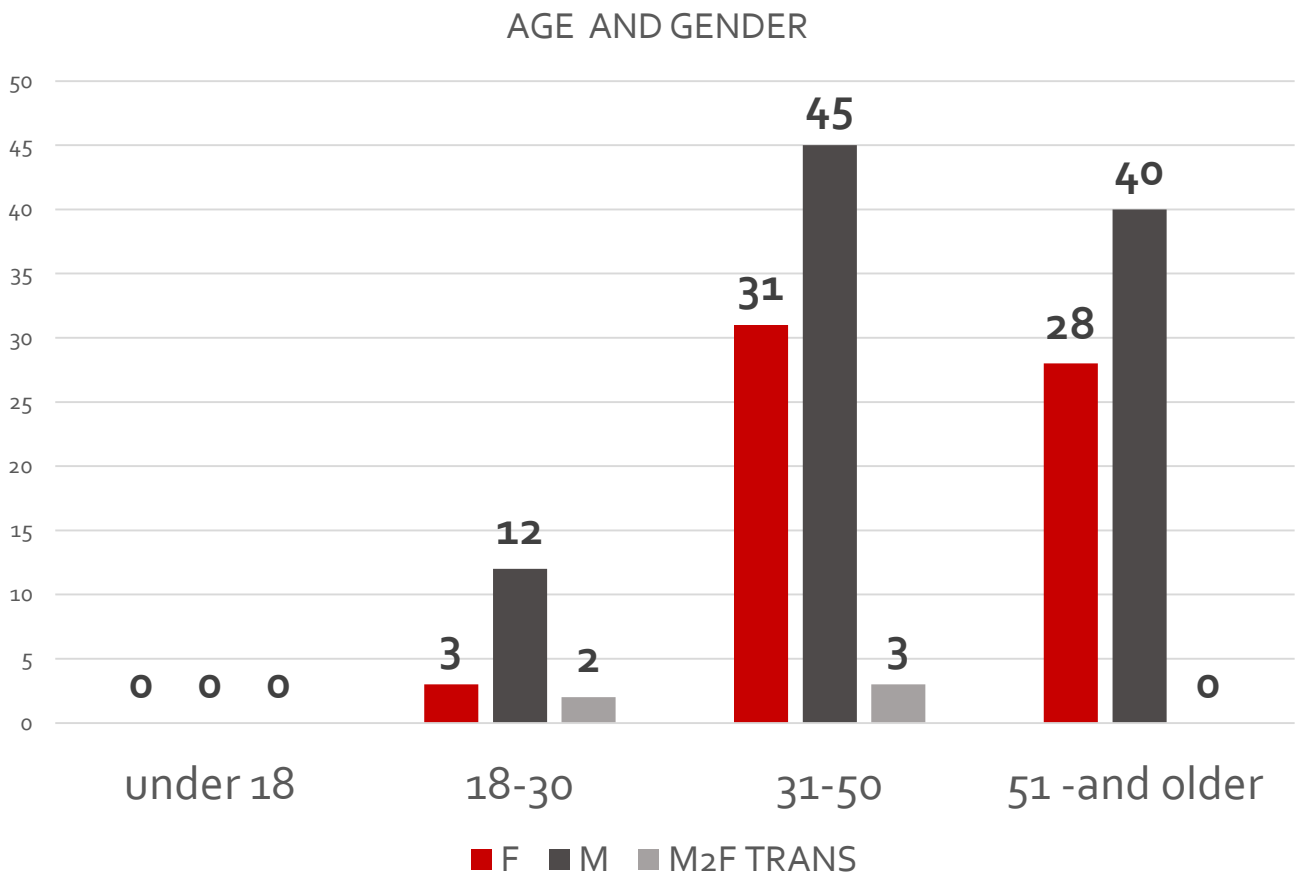
HOPWA Goals

The HOPWA Program has 3 primary goals.

- ***Increase Housing Stability***
- ***Reduce Risk of Homelessness***
- ***Increase Access to Care and Support***

GY 21-22 HOPWA Client Demographics

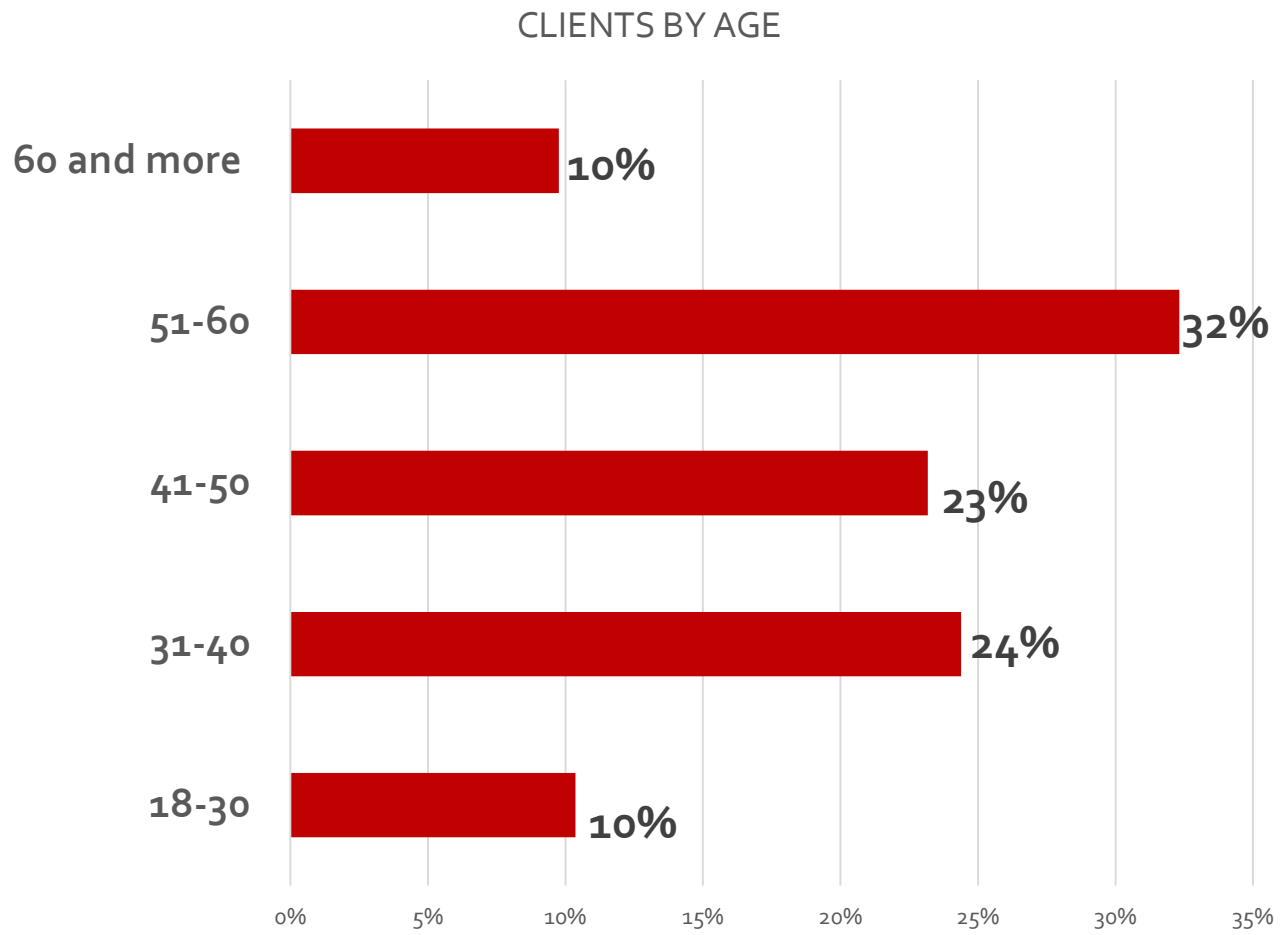
Age	F	M	M2F TRANS	total by age
under 18	0	0	0	0
18-30	3	12	2	17
31-50	31	45	3	79
51 -and older	28	40	0	68
Total	62	97	5	164



Palm Beach County
Ryan White HIV/AIDS Program

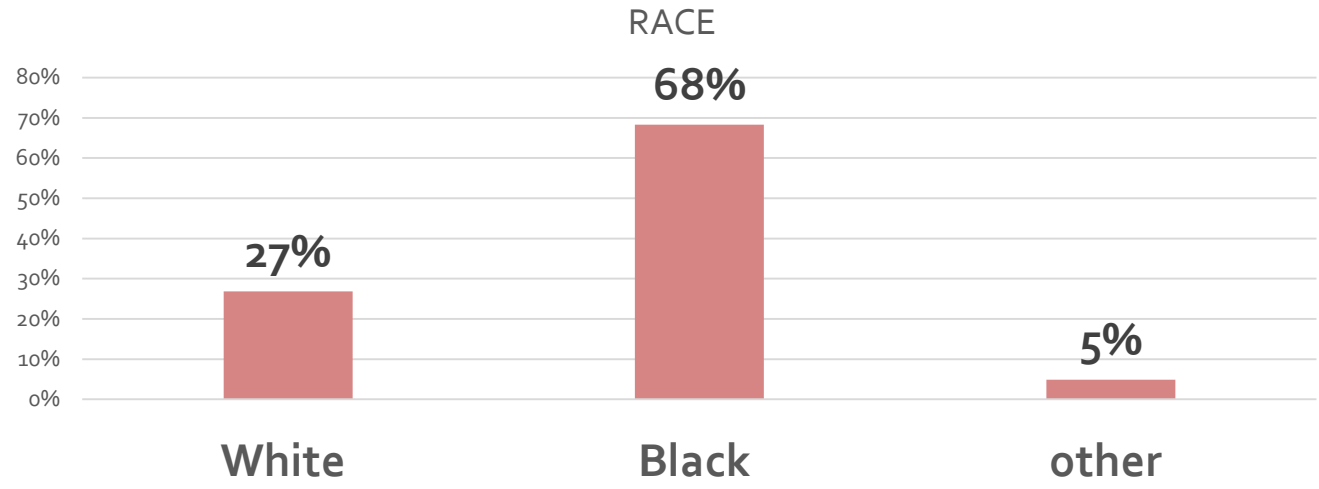
GY 21-22 HOPWA Client Demographics

Age	Frequency	%
18-30	17	10%
31-40	40	24%
41-50	38	23%
51-60	53	32%
60 and more	16	10%
Total	164	100

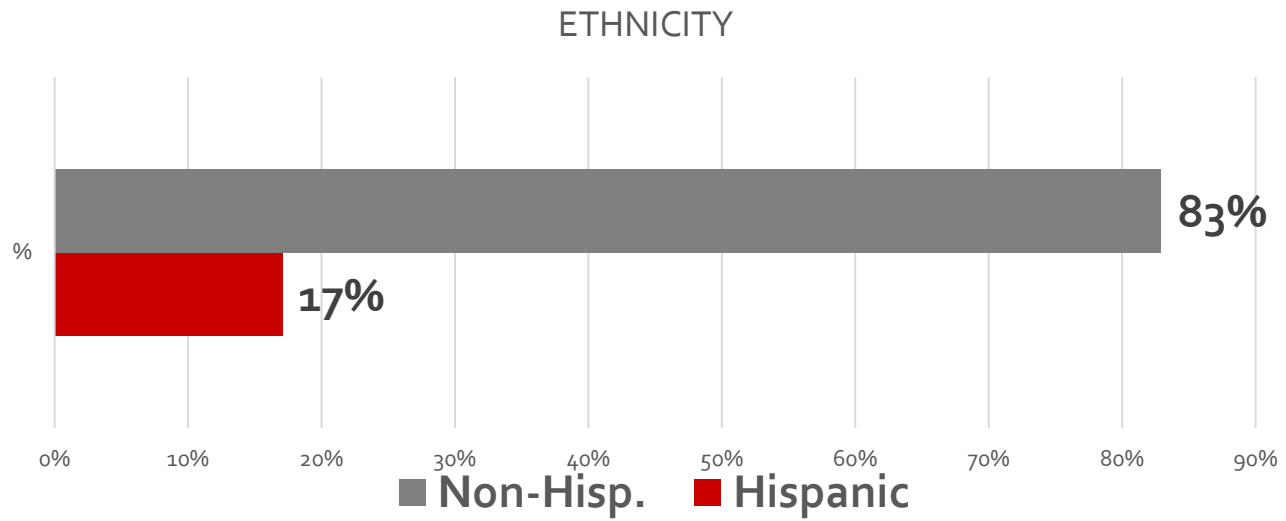


GY 21-22 HOPWA Client Demographics

Race	frequency	%
White	44	27%
Black	112	68%
other	8	5%
Total	164	100



Ethnicity	frequency	%
Hispanic	28	17%
Non-Hisp.	136	83%
Total	164	100



Palm Beach County
Ryan White HIV/AIDS Program

Category		HOPWA Eligible Individuals		All Other Beneficiaries	
		[A] Race	[B] Ethnicity	[C] Race	[D] Ethnicity
		[all individuals reported in Section 2,	[Also identified as Hispanic or Latino]	[total of individuals reported in Section 2, Chart a., Rows	[Also identified as Hispanic or Latino]
1	American Indian/Alaskan Native	0	1	0	0
2	Asian	0	0	0	0
3	Black/African American	112	0	37	0
4	Native Hawaiian/Other Pacific Islander	0	0	0	0
5	White	44	28	10	10
6	American Indian/Alaskan Native & White	0	0	0	0
7	Asian & White	0	0	0	0
8	Black/African American & White	0	0	0	0
9	American Indian/Alaskan Native & Black/African American	0	0	0	0
10	Other Multi-Racial	8	0	0	0
11	**Column Totals (Sum of Rows 1-10)**	**164**	**29**	**47**	**10**

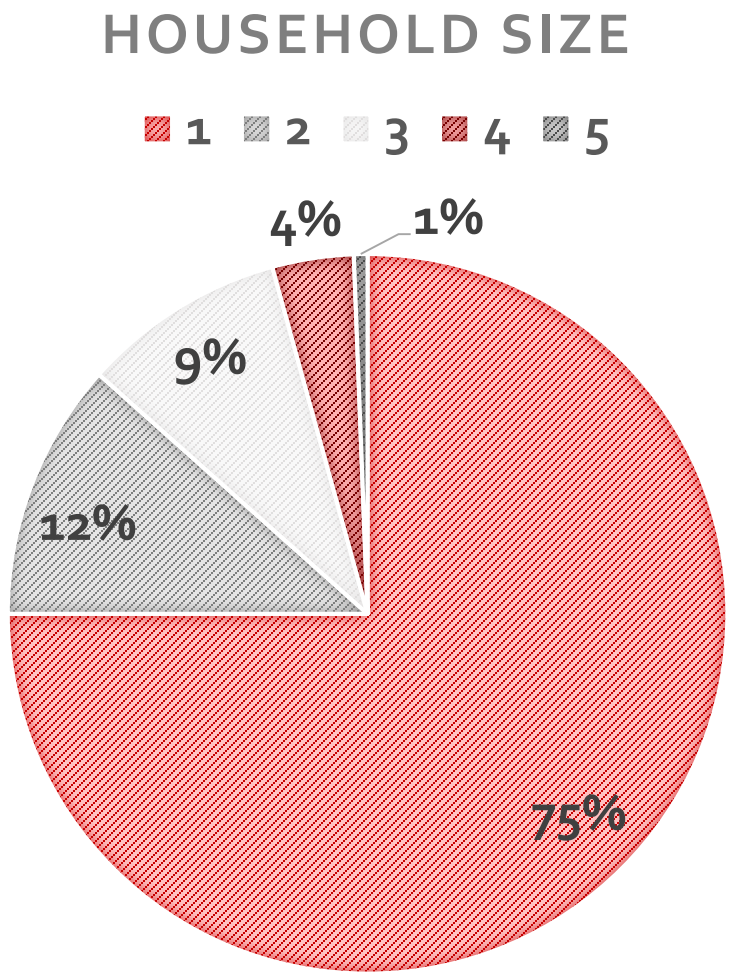
Data Check: Sum of Row 11 Column A and Row 11 Column C equals the total number HOPWA Beneficiaries reported in Part 3A, Section 2, Chart a., Row 4.

**Reference (data requested consistent with Form HUD-27061 Race and Ethnic Data Reporting Form)*

211

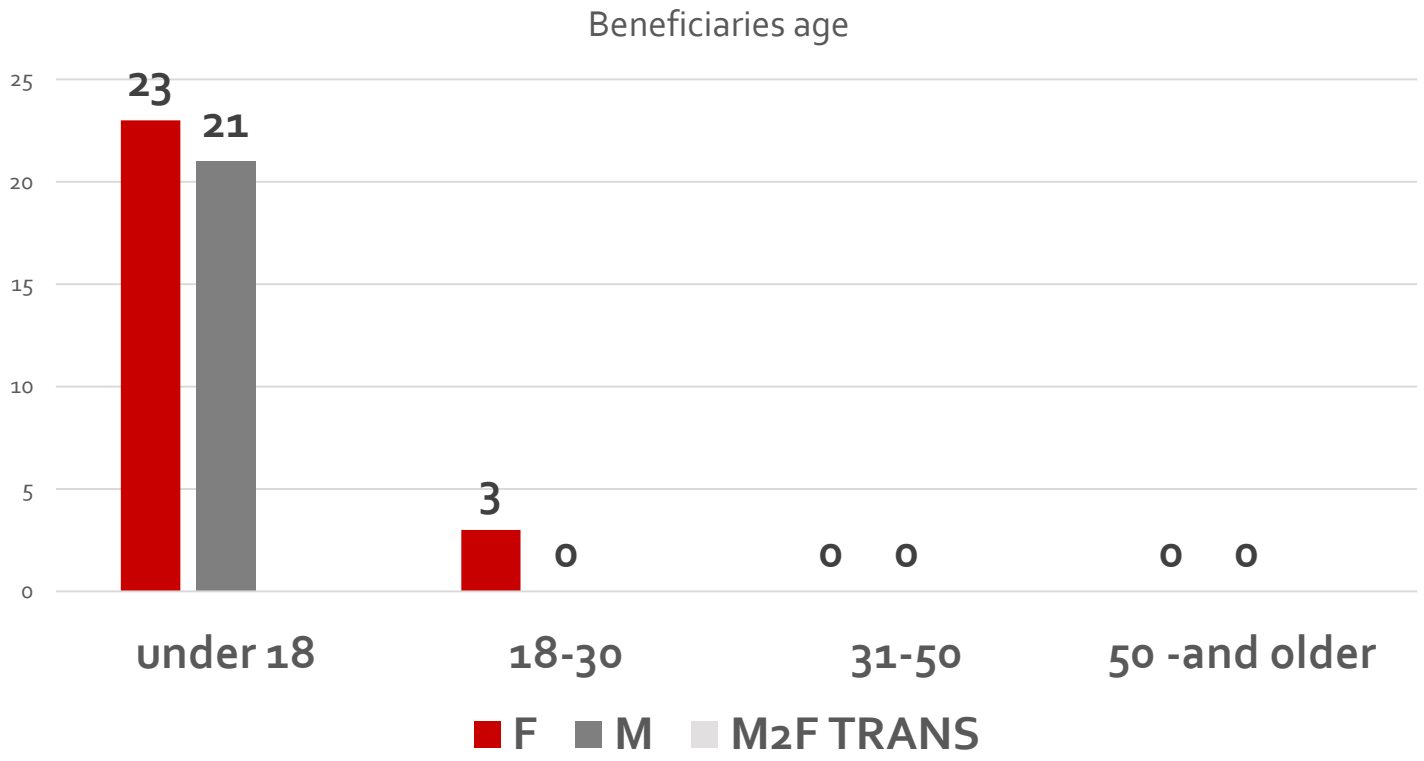
GY 21-22 HOPWA Client Demographics

Household Size	Frequency	%
1 person	123	75%
2 people	19	12%
3 people	15	9%
4 people	6	4%
5 people	1	1%
Total	164	100



GY 21-22 HOPWA Client Demographics

Age	F	M	M2F TRANS	total by age
under 18	23	21	0	44
18-30	3	0	0	3
31-50	0	0	0	0
50 -and older	0	0	0	0
TOTAL	26	21		47



Palm Beach County
Ryan White HIV/AIDS Program

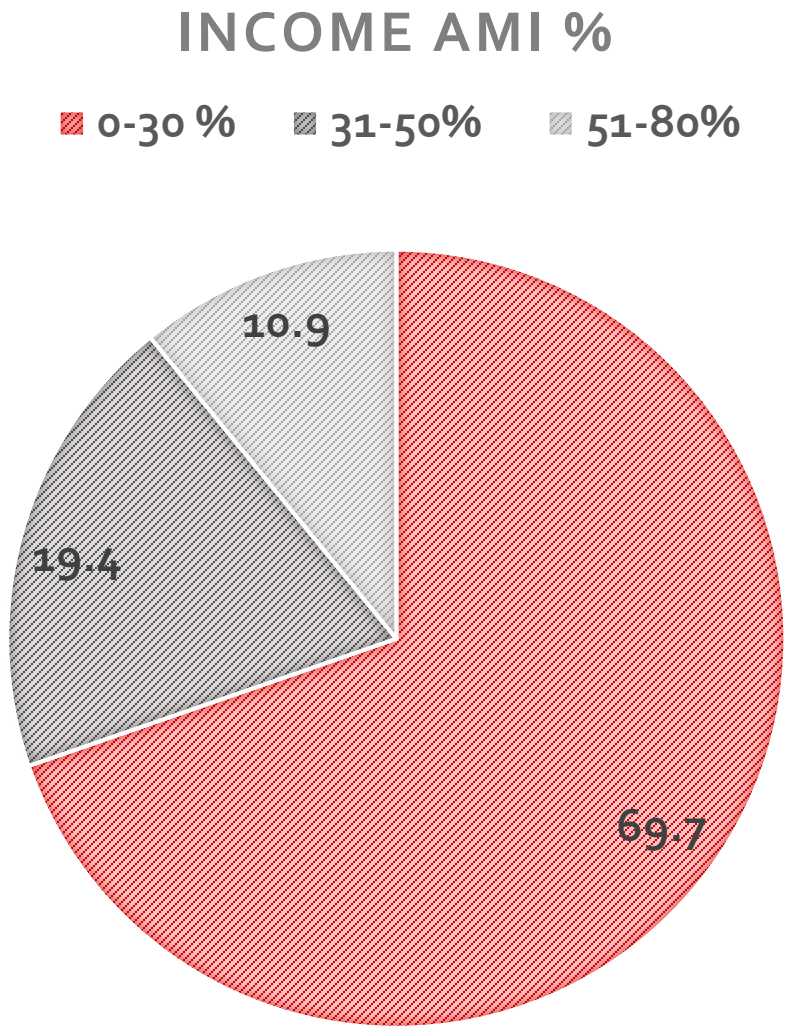
		A.	B.	C.	D.	E.
		Male	Female	Transgender M to F	Transgender F to M	TOTAL (Sum of Columns A-D)
1	Under 18	0	0	0	0	0
2	18 to 30 years	12	3	2	0	17
3	31 to 50 years	45	31	3	0	79
4	51 years and Older	40	28	0	0	68
5	Subtotal (Sum of Rows 1-4)	97	62	5	0	164

All Other Beneficiaries (Chart a, Rows 2 and 3)						
		A.	B.	C.	D	E.
		Male	Female	Transgender M to F	Transgender F to M	TOTAL (Sum of Columns A-D)
6	Under 18	21	23	0	0	44
7	18 to 30 years	0	3	0	0	3
8	31 to 50 years	0	0	0	0	0
9	51 years and Older	0	0	0	0	0
10	Subtotal (Sum of Rows 6-9)	21	26	0	0	47
Total Beneficiaries (Chart a, Row 4)						
11	TOTAL (Sum of Rows 5 & 10)	118	88	5	0	211

GY 21-22 HOPWA Client Demographics

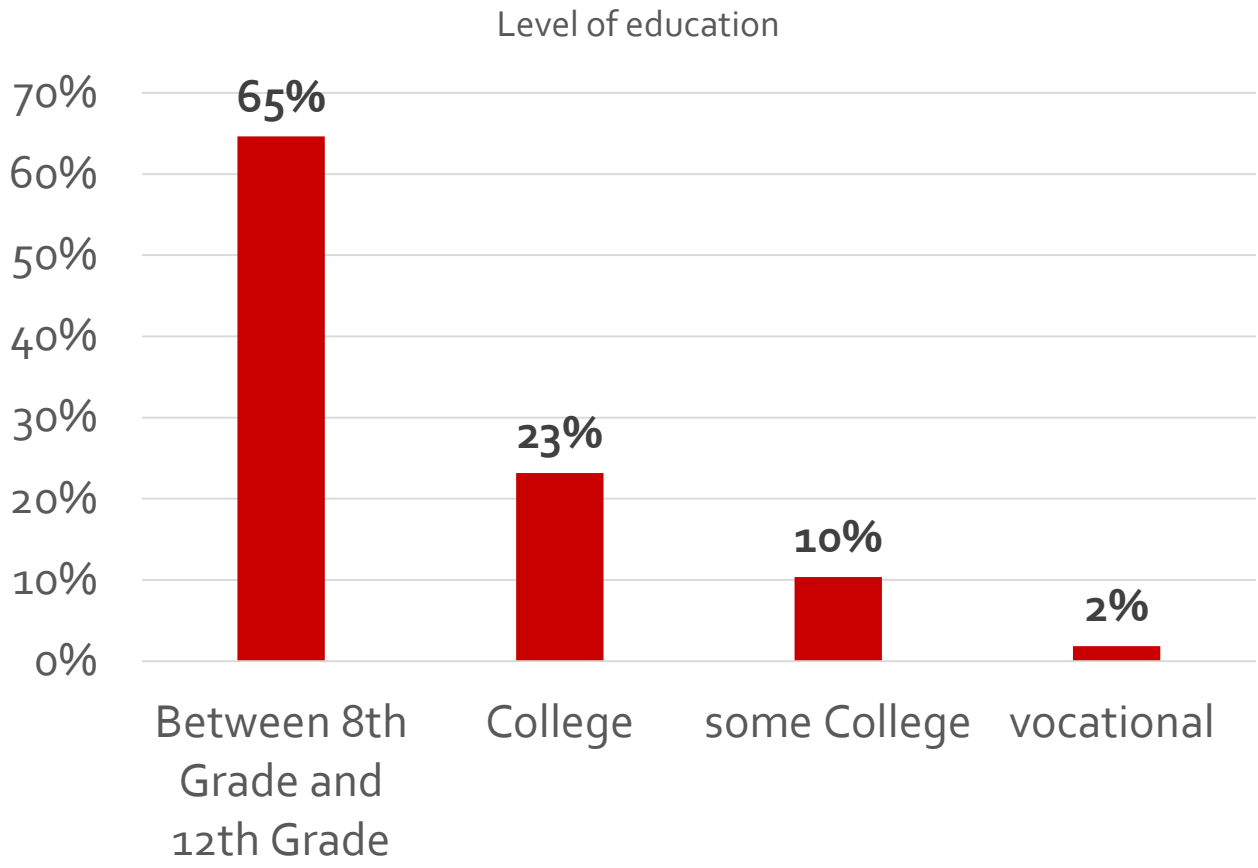
Income AMI %	Frequency	%
0-30 %	114	69.7
31-50%	32	19.4
51-80%	18	10.9
Total	164	100

	Percentage of Area Median Income	Households Served with HOPWA Housing Subsidy Assistance
1	0-30% of area median income (extremely low)	114
2	31-50% of area median income (very low)	32
3	51-80% of area median income (low)	18
4	Total (Sum of Rows 1-3)	164



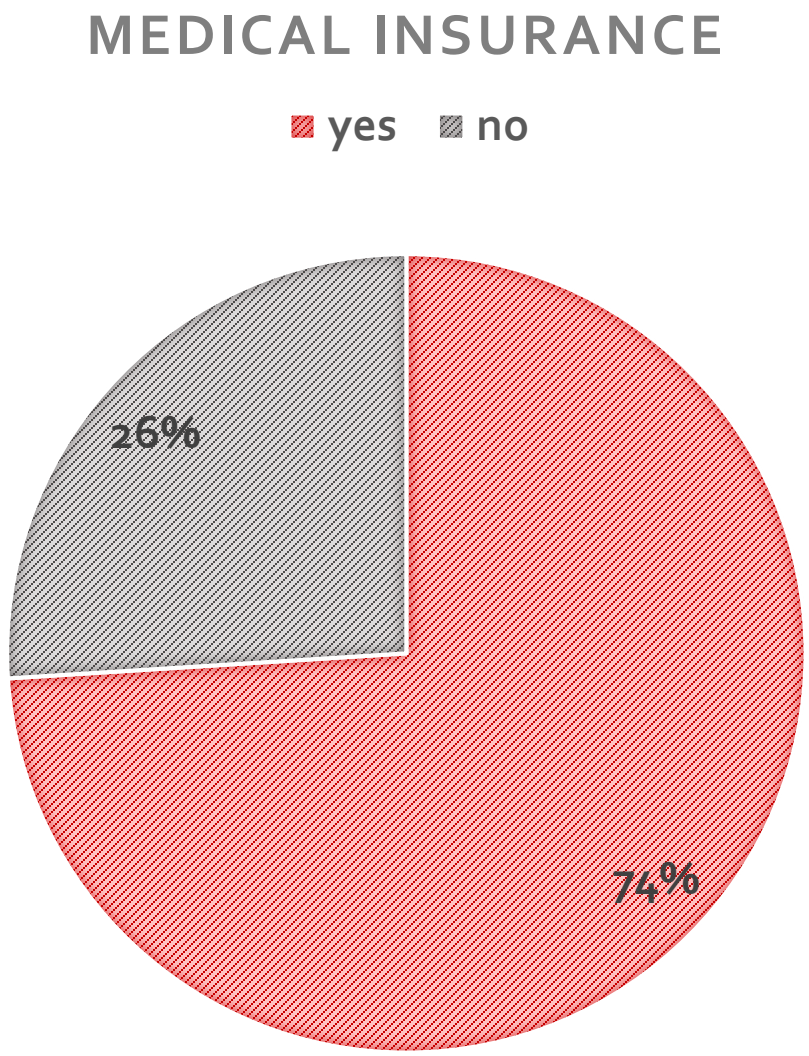
GY 21-22 HOPWA Client Demographics

Level of education	Freq	%
Between 8th Grade and 12th Grade	106	65%
College	38	23%
some College	17	10%
vocational	3	2%
Total	164	100



GY 21-22 HOPWA Client Demographics

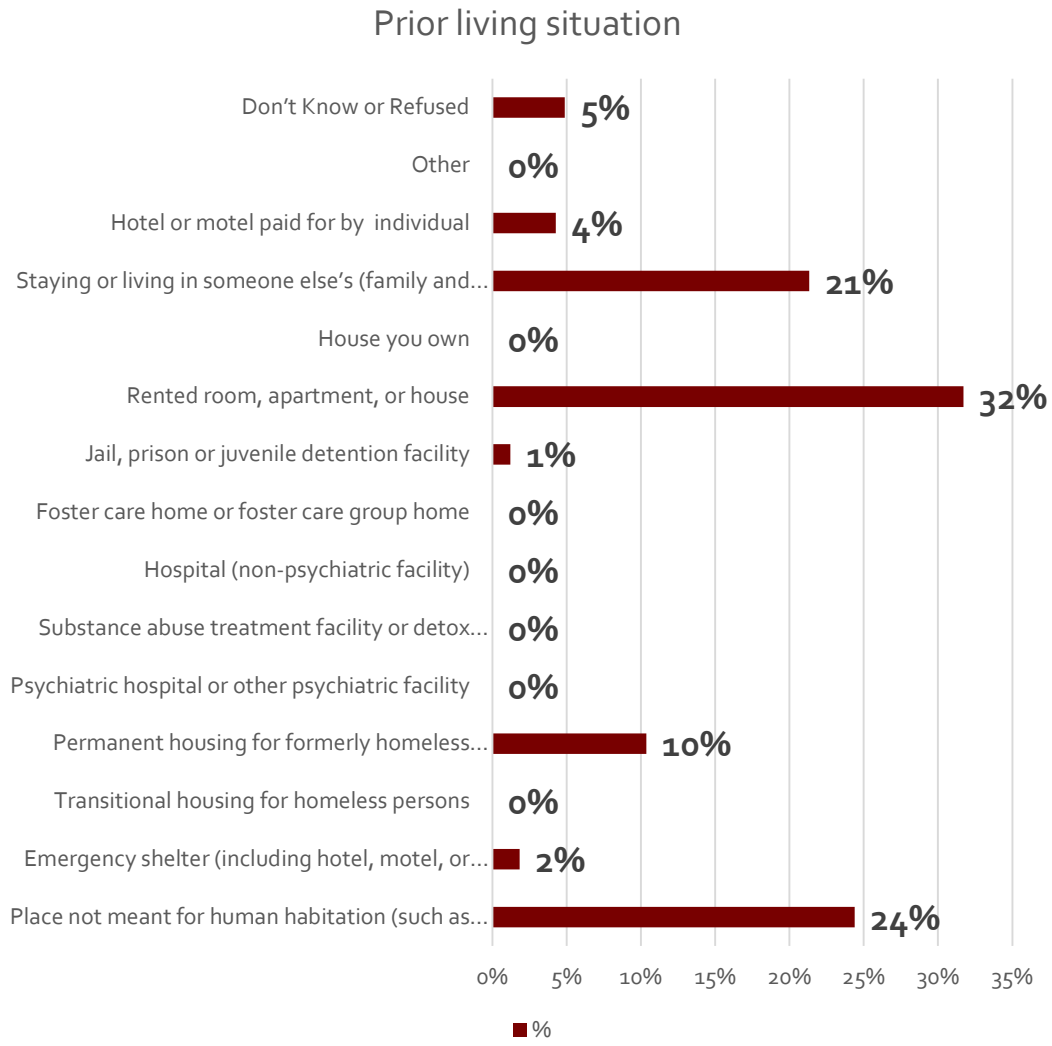
INSURANCE	Freq	%
yes	121	74%
no	43	26%
Total	164	100%



Palm Beach County
Ryan White HIV/AIDS Program

GY 21-22 HOPWA Client Demographics

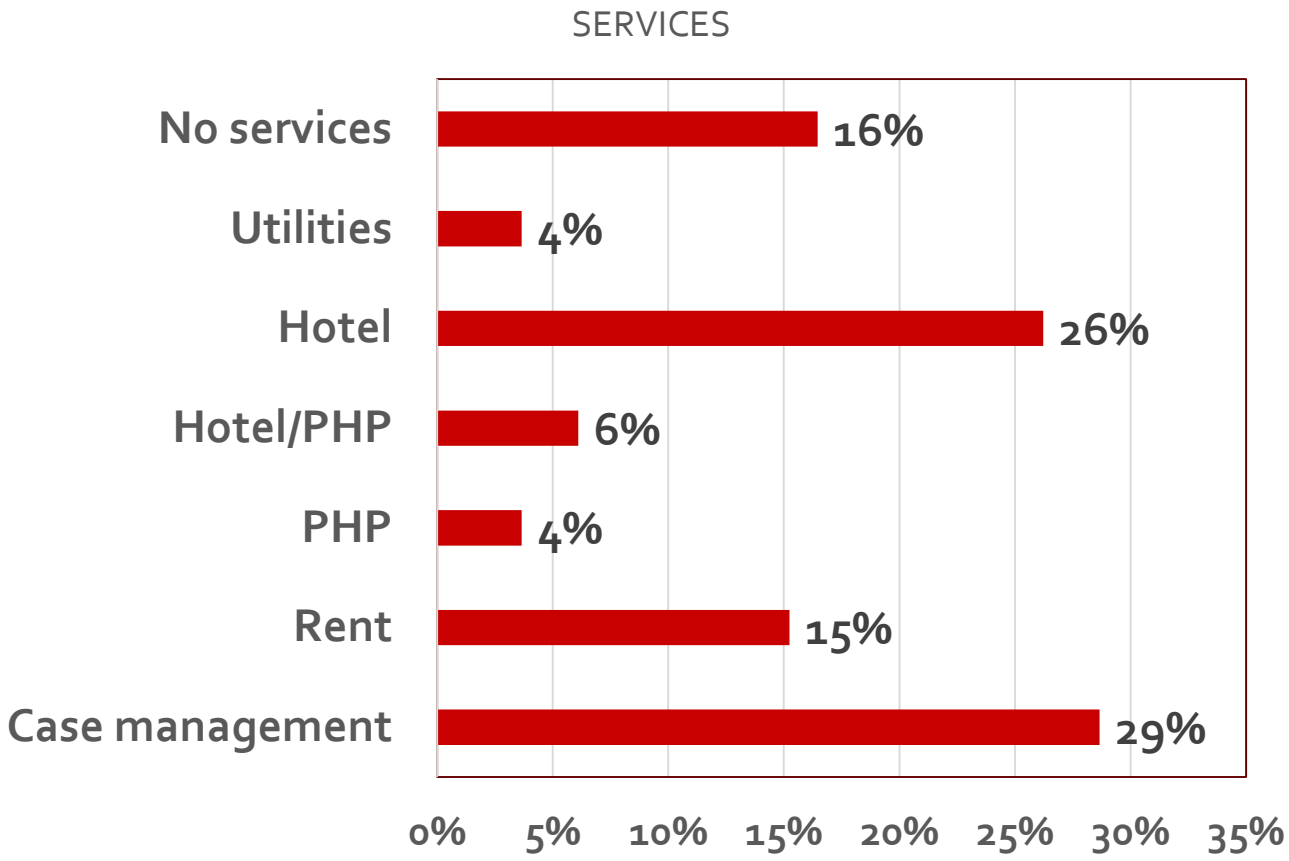
PRIOR LIVING SITUATION	freq	%
Place not meant for human habitation (such as a vehicle, abandoned building, bus/train/subway station/airport, or outside)	40	24%
Emergency shelter (including hotel, motel, or campground paid for with emergency shelter voucher)	3	2%
Transitional housing for homeless persons	0	0%
Permanent housing for formerly homeless persons (such as Shelter Plus Care, SHP, or SRO Mod Rehab)	17	10%
Psychiatric hospital or other psychiatric facility	0	0%
Substance abuse treatment facility or detox center	0	0%
Hospital (non-psychiatric facility)	0	0%
Foster care home or foster care group home	0	0%
Jail, prison or juvenile detention facility	2	1%
Rented room, apartment, or house	52	32%
House you own	0	0%
Staying or living in someone else's (family and friends) room, apartment, or house	35	21%
Hotel or motel paid for by individual	7	4%
Other	0	0%
Don't Know or Refused	8	5%
Total	164	100



Palm Beach County
Ryan White HIV/AIDS Program

GY 21-22 HOPWA Client Demographics

Services	Freq	%
Case management	47	29%
Rent	25	15%
PHP	6	4%
Hotel/PHP	10	6%
Hotel	43	26%
Utilities	6	4%
No services	27	16%
Total	164	100%



HOPWA Program Activities

Permanent Housing Placement (PHP):

To help establish permanent residence when continued occupancy is expected. Allows Application Fees, Security and Utility Deposit, First Month Rent.

HOPWA Housing Subsidy Assistance Category: Permanent Housing Placement Assistance		[1] Output: Number of Households Served	[2] Output: Total HOPWA Funds Expended during Operating Year by Project Sponsor
a.	Permanent Housing Placement Services	16	$0
b.	Direct program delivery costs (e.g., program staff time)		$0
c.	**TOTAL Permanent Housing Placement Services (sum of Rows a. and b.)**	**16**	**$0**

HOPWA Program Activities

Transitional Housing:

Provisional housing used to provide temporary shelter for any individual for no more than 60 calendar days in any six month period.

B. Transitional Housing Assistance

[1] Total Number of Households Receiving Housing Assistance		[2] Of the Total Number of Households Receiving Housing Assistance this Operating Year		[3] Assessment: Number of Exited Households and Housing Status	
Transitional/Short-Term Supportive Facilities/Units	57	Total number of households that will continue in residences:	1 Emergency Shelter/Streets	3	3
			2 Temporary Housing	53	53
			3 Private Housing		
			4 Other HOPWA		
		Total number of households whose tenure exceeded 24 months:	5 Other Subsidy		
			6 Institution		0
			7 Jail/Prison		
			8 Disconnected/unknown		3
			9 Death	1	-1

HOPWA Program Activities

Short-Term Rent and Utility (STRU):

A time limited housing subsidy assistance, designed to prevent homelessness and increase housing stability. STRU assistance may be provided for up to 21 weeks in any 52-week period and the amount of assistance varies per client depending on funds available, tenant need, and program guidelines.

Housing Subsidy Assistance Categories (STRMU)		[1] Output: Number of Households Served	Expended on STRMU during Operating Year
a.	Total Short-term mortgage, rent and/or utility (STRMU) assistance	34	$0
b.	Of the total STRMU reported on Row a, total who received assistance with mortgage costs ONLY.	0	$0
c.	Of the total STRMU reported on Row a, total who received assistance with mortgage and utility costs.	0	$0
d.	Of the total STRMU reported on Row a, total who received assistance with rental costs ONLY.	25	$0
e.	Of the total STRMU reported on Row a, total who received assistance with rental and utility costs.	3	$0
f.	Of the total STRMU reported on Row a, total who received assistance with utility costs ONLY.	6	$0
g.	Direct program delivery costs (e.g., program operations staff time)		$0

Questions?

PBC Ryan White Part A/MAI Needs Assessment & Integrated Plan

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Palm Beach County
Ryan White HIV/AIDS Program

Outline

- Needs Assessment Methodology and Sampling Plan
- Needs Assessment Analysis
  - Demographic
  - Treatment and Care
  - Service Utilization
  - Quality of Life
  - Follow Up Analysis
- Integrated Prevention and Care Plan
  - Overview
  - Baseline Data

Palm Beach County Needs Assessment Consumer Survey 2020-2021

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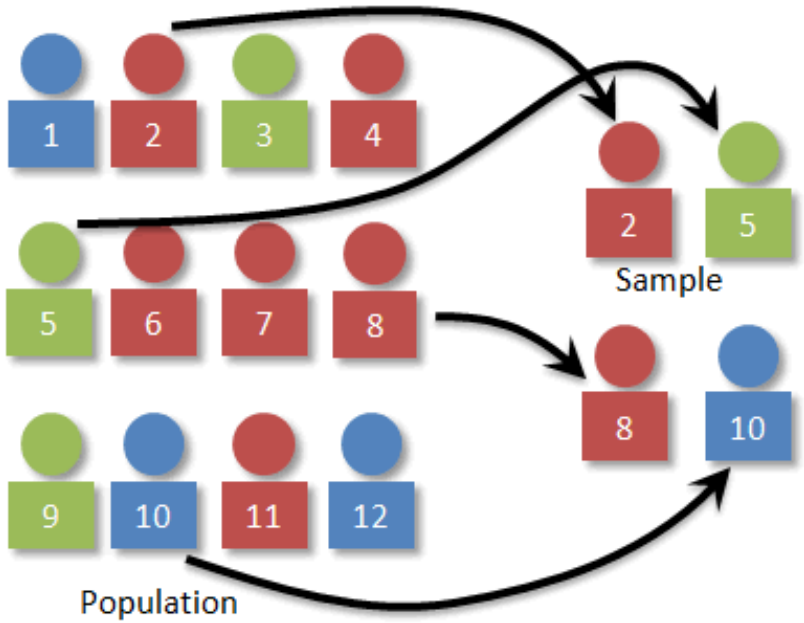
Palm Beach County
Ryan White HIV/AIDS Program

Methodology

- Created by the HIV Care Council members
  - Reviewed questions from other jurisdictions
  - Reviewed past Palm Beach County surveys
  - Developed new questions and revisions
- A random stratified sampling method was utilized
- Temporary staff were hired to conduct and implement the surveys with clients mostly via phone and by paper
- Awarded participants

Sampling Plan

- PWH Population:
  - Ryan White
  - HIV Care Outside of Ryan White
  - PWH Out of Care
- Ryan White: randomly selected clients using a stratified sampling plan with data pulled from Provide Enterprise Databases
- HIV Care Outside of Ryan White: Outside providers contacted to provide masked lists of client IDs which were randomly selected. However, outside RW providers gave the surveys to their clients to complete on paper
- PWH Out of Care: All individuals out of care were asked to complete the survey upon re-entry into care through EIS



Sampling Plan

- Stratification of the sampling began with the Haitian-born sub-population using 2018 FDOH PBC Epi Profile
- Stratification continued with the other sub-populations including Black/African American, Hispanic and Other race/ethnicities

Ryan White Part A Palm Beach County
HIV Care Council Planning Committee
Sample Size for Needs Assessment in 2020

	% or #	Explanation
Margin of Error	5%	*The margin of error is the amount of error that you can tolerate. 5% is the commonly accepted standard.*
Confidence Level	95%	*The confidence level is the amount of uncertainty you can tolerate. 95% is the commonly accepted standard.*
Population Size	**8547**	*This is the total number of people living with HIV (diagnosed) in Palm Beach County in 2018.*
Response Distribution	50%	*For each question, what do you expect the results will be? If you don't know, use 50%.*

		Past Sample (2016)
Sample Size	**368**	357

Stratified by Proportion*	#	#
Out of Care (30%)	110	57
In Care (70%)	258	300
In Care with Ryan White (59%)	*151*	-
In Care with Other Providers (41%)	*107*	-

PHASE 1 of Needs Assessment	
Stratified by Haitian-born individual	# or %
Total PLWH Haitian-born	**1629**
Proportion Haitian-born	18.9%
Sample Size for Needs Assessment	**70**
Out of Care (38%)	27
In Care (62%)	43
In Care with Ryan White (45%)	*31*
In Care with Other Providers (17%)	*12*

Sampling Plan

	Sample Size	Completed	Needed
Sample Size	368	**398**	-30
Stratified by Race/Ethnicity			
Haitian-born	70	**72**	-2
African-American (not Haitian-born)	146	**157**	-11
White/Caucasian	74	**113**	-39
Hispanic/Latinx	55	**55**	**0**
Other Race/Ethnicity	7	**13**	-6

Needs Assessment Logistics Highlights

- There were a total of 398 survey responses
- The survey was conducted online, over the phone and on-paper. Among those who opened the survey link, there is an estimated 68% completion rate
- 53 total questions, with an estimate of 21 minutes to complete online
- Bilingual temporary staff conducted the surveys in Spanish and Haitian Creole for respondents who required translation services
- The survey responses were completed from August 2020 to October 2021

Needs Assessment Analysis

Palm Beach County
Ryan White HIV/AIDS Program

Demographic Analysis

Palm Beach County
Ryan White HIV/AIDS Program

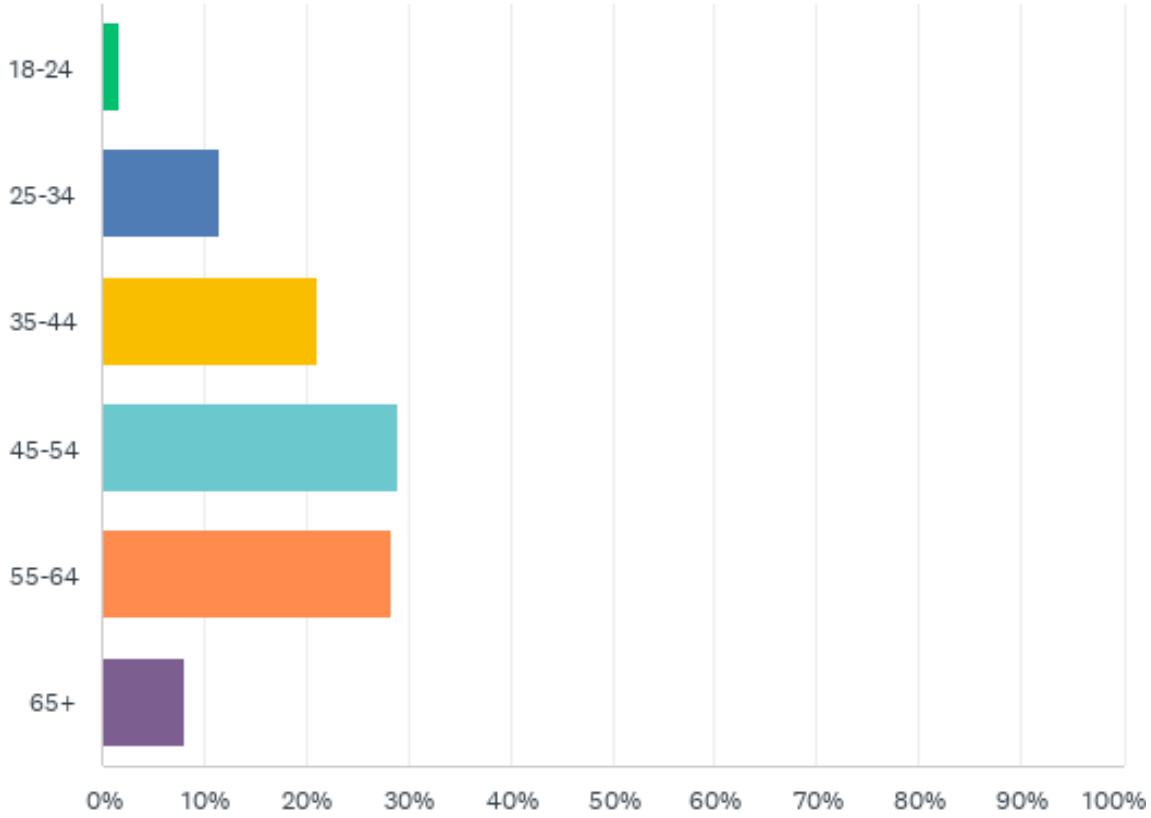
Demographic Questions

- Questions 1- 13 focus on demographic data such as:
  - Age, Zip code, Gender
  - Race, Ethnicity, Income, Housing etc.

Age
How old are you?

Of the 397 respondents,

- 29.0% (115/397) are between the ages of **45-54**
- 28.5% (113/397) are between the ages of **55-64.**
- 21.2% (84/397) are between the ages of **35-44.**



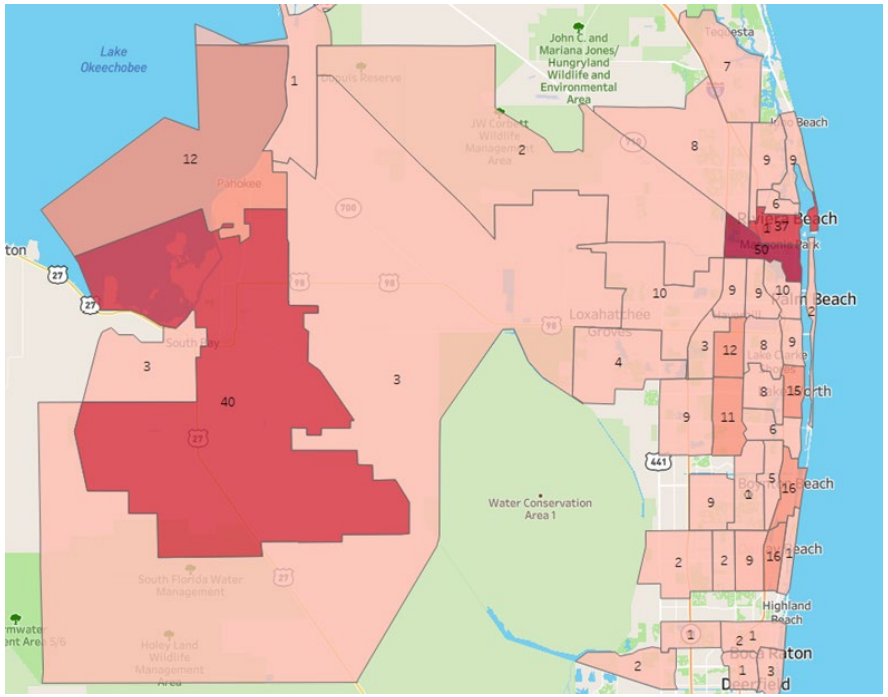
Answered: 397, Skipped: 1

Location
Which zip code do you live in?

Of the 392 respondents,

- **12.8% (50/392)** are located in the **33407 West Palm Beach**
- **10.2% (40/392)** are located in the **33430 Belle Glade**
- **9.4% (37/392)** are located in the **33404 Riviera Beach**

Answered: 392, Skipped: 6

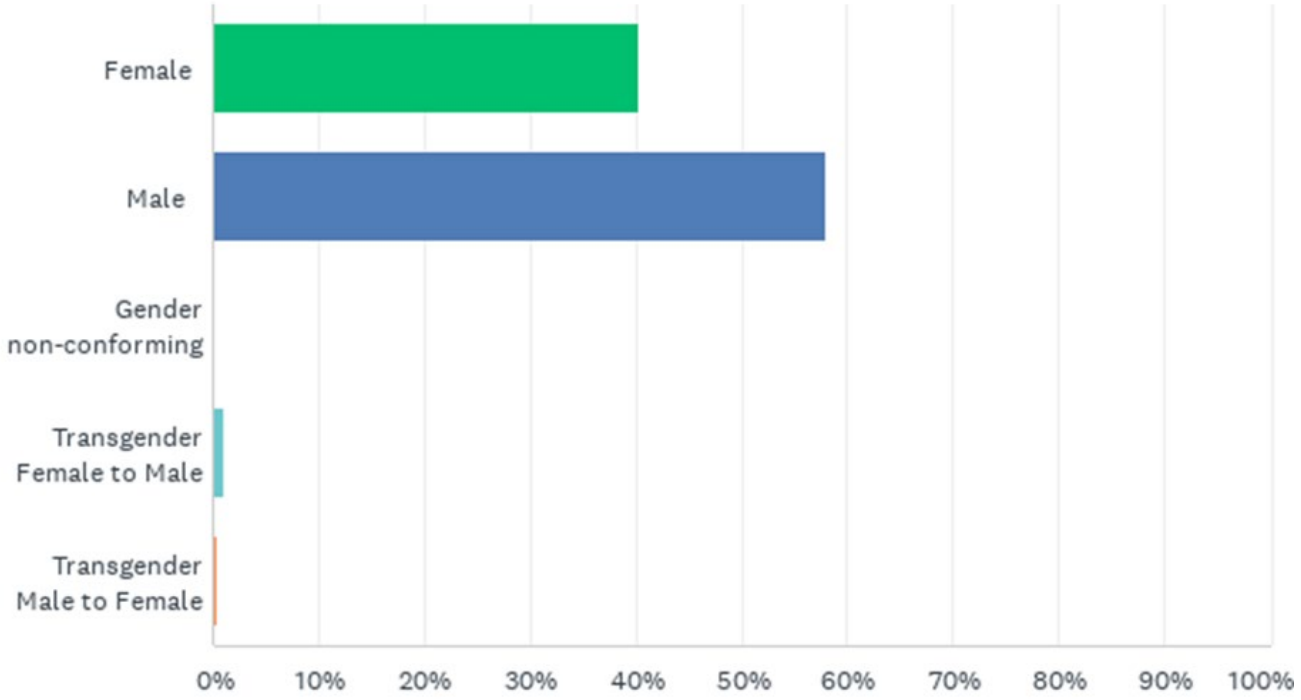


Palm Beach County
Ryan White HIV/AIDS Program

Gender
Which one of these do you identify with?

Of the 396 respondents,

- **40.4% (160/396)** identify as **Female**
- **58.1% (230/396)** identify as **Male**
- **1.0% (4/396)** identify as **Transgender Female to Male**
- **0.5% (2/396)** identify as **Transgender Male to Female**.

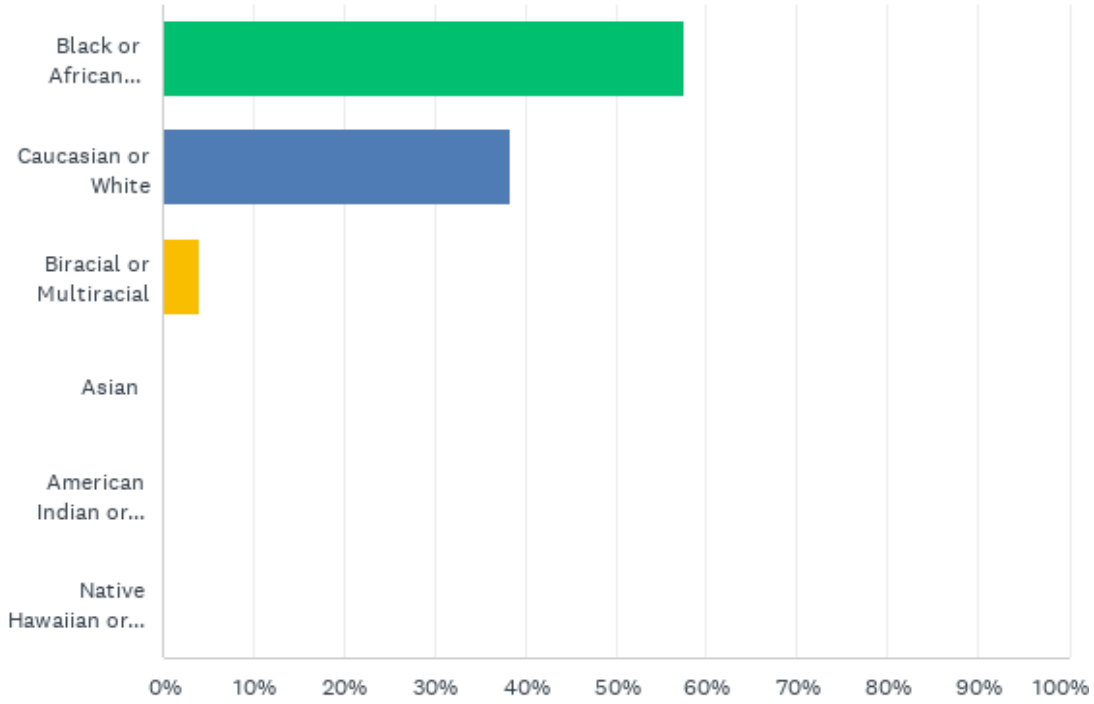


Answered: 396, Skipped: 2

Race
What is your race?

Of the 325 respondents,

- 57.5% (187/325) are **Black or African American**
- 38.5% (125/325) are **Caucasian or White**
- 4.0% (13/325) are **Biracial or Multiracial**

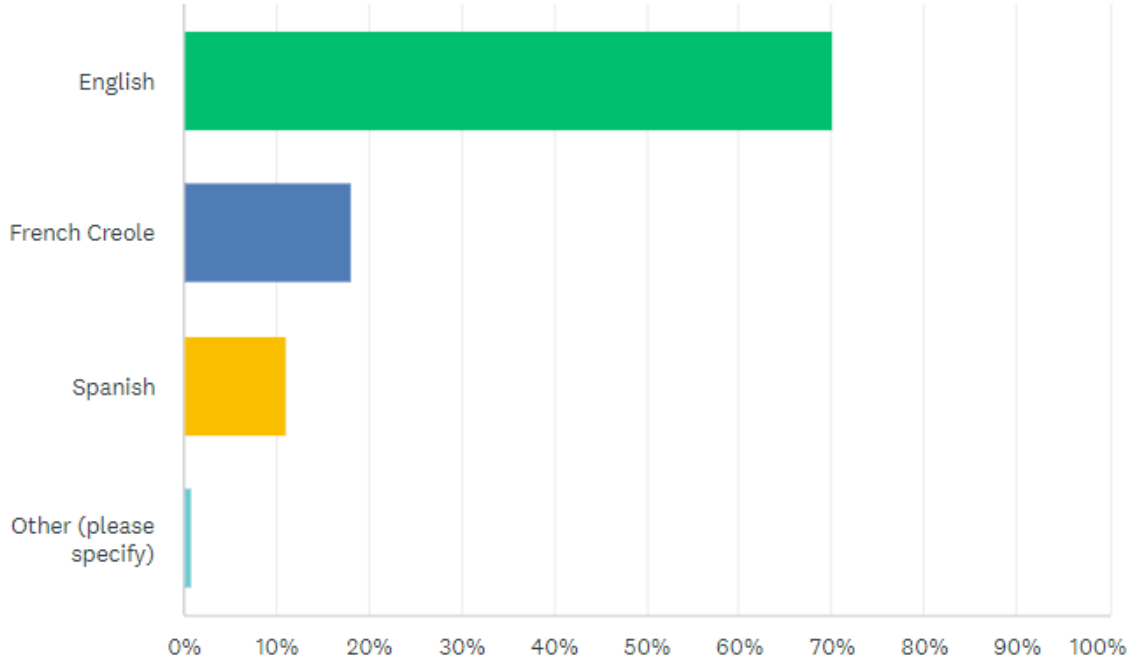


Answered: 325, Skipped: 73

Language
In what language do you speak most fluently?

Of the 398 respondents,

- **70.1% (279/398)** speak **English** fluently
- **18.1% (72/398)** speak **French/Haitian Creole** fluently
- **11.1% (44/398)** speak **Spanish** fluently.

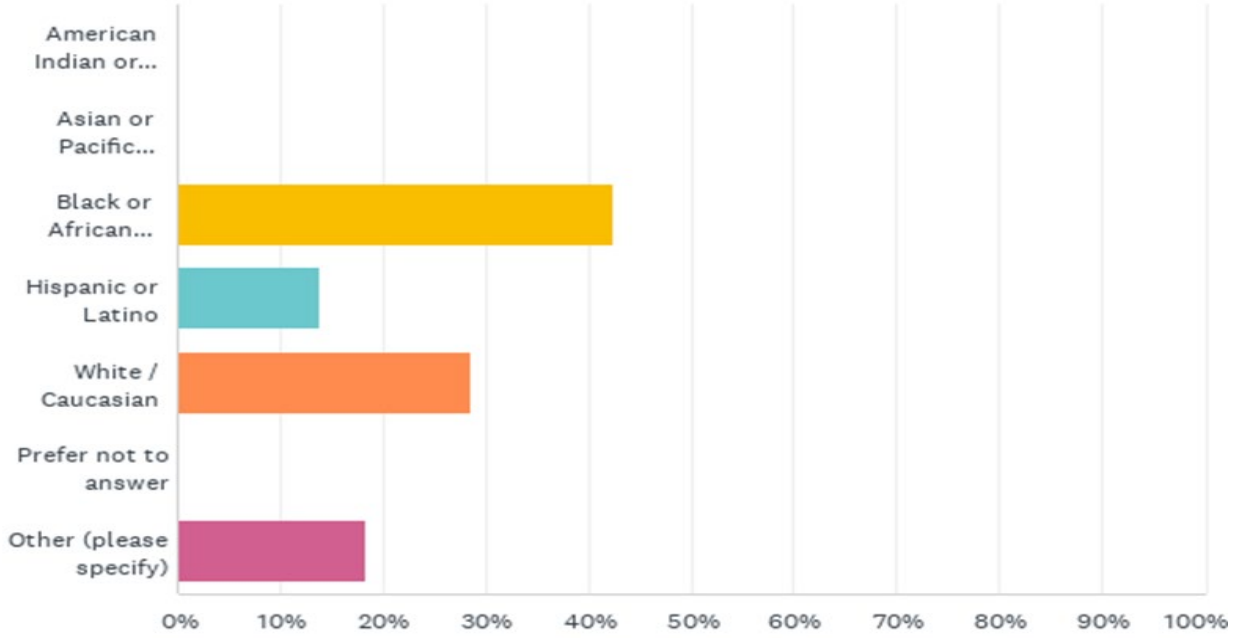


Answered: 398, Skipped: 0

Ethnicity
What is your ethnicity?

Of the 396 respondents,

- 42.4% (168/396) are **Black or African American**
- 28.5% (113/396) are **White/Caucasian**
- 13.9% (55/396) are **Hispanic or Latino**
- 18.4% (73/396) reported **Other**.

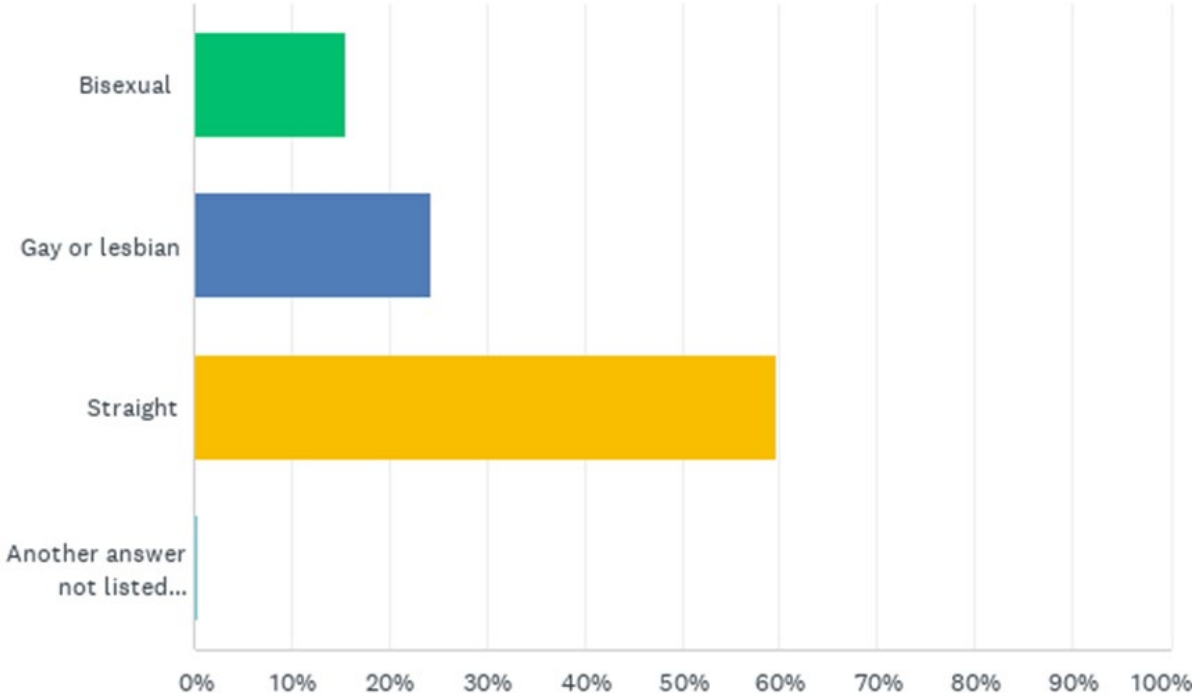


Answered: 396, Skipped: 2

Sexual Orientation
What is your sexual orientation?

Of the 392 respondents,

- 59.7% (234/392) are **Straight**
- 24.2% (95/392) are **Gay or Lesbian**
- 15.6% (61/392) are **Bisexual**



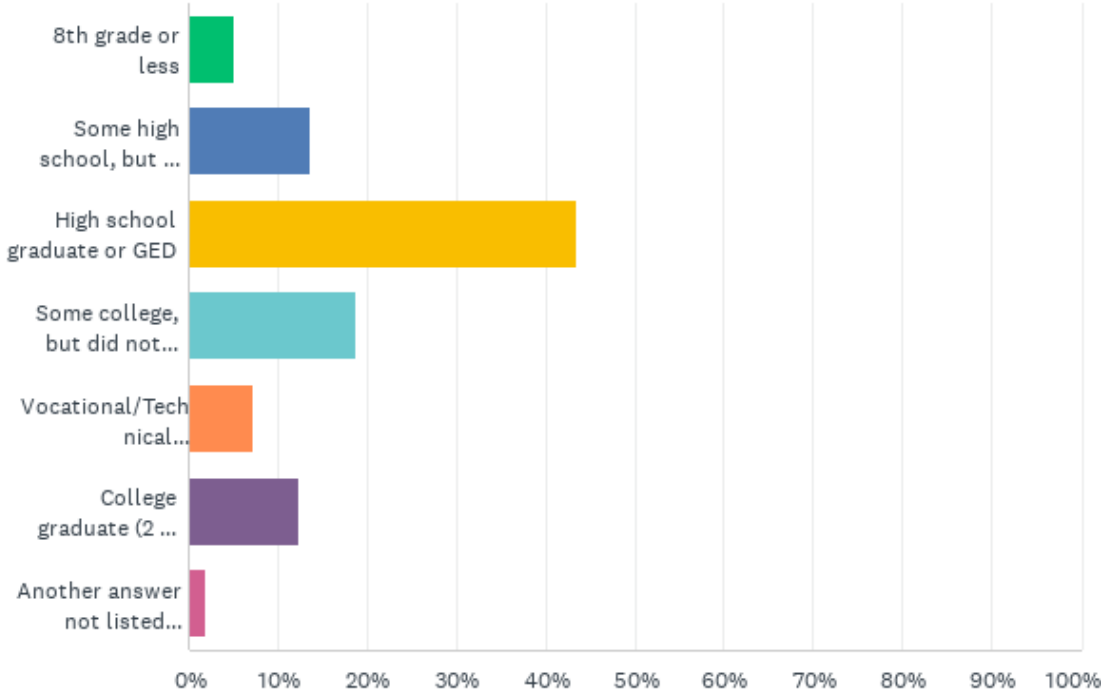
Answered: 392, Skipped: 6

Education

What is the highest degree or level of school you completed? (check one)

Of the 396 respondents,

- 43.4% (172/396) completed a **high school graduate diploma or GED**
- 18.7% (74/396) completed **some college but did not finish**
- 13.6% (54/396) **completed some high school, but did not graduate**

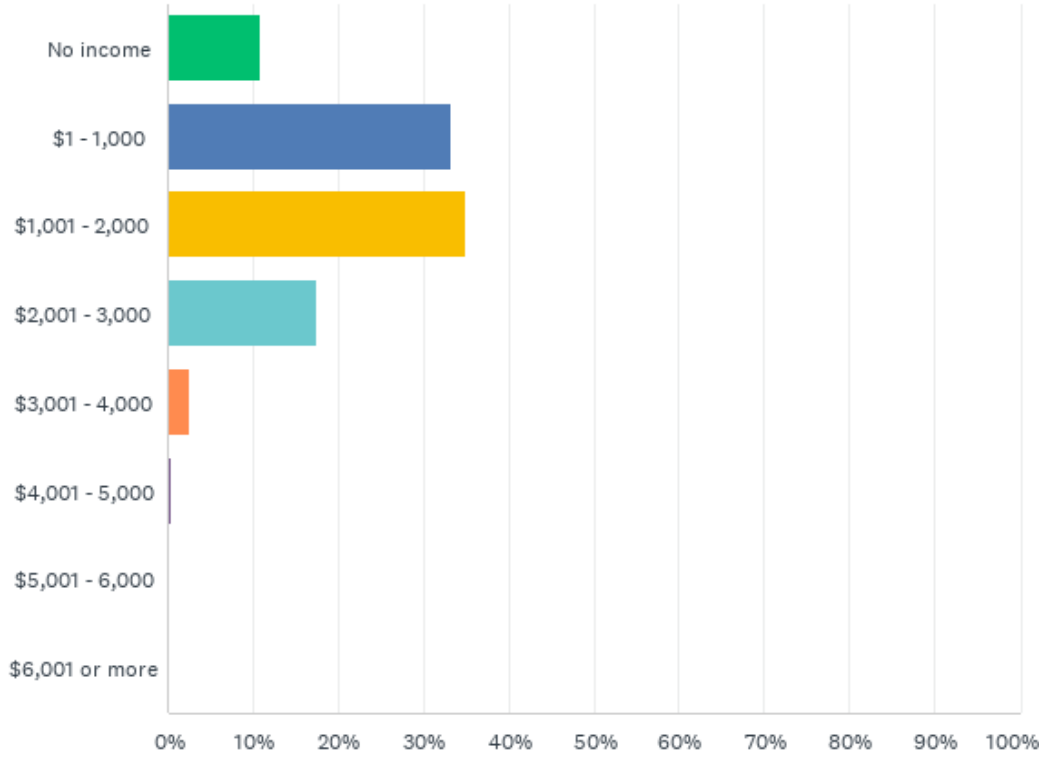


Answered: 396, Skipped: 2

Income
What is your monthly income?

Of the 398 respondents,

- 34.9% (139/398) earned monthly income is **between $1,001-2000**
- 33.2% (132/398) earned monthly income is **between $1-$1,000**
- 17.6% (70/398) earned monthly income is **between $2,001-3,000**



Answered: 398, Skipped: 0

Demographics Key Takeaways

- More than half, **57.4% (228/397)** of respondents are between the ages of 45-64
- **32.4% (127/392)** of respondents live in Hotspot areas of West Palm, Riviera, and Belle Glade
- More than half, **58.1% (230/396)** of respondents are Male
- More than half,**57.5% (187/325)** of respondents are of Black/African American race
- More than half,**59.7% (234/392)** of respondents identify as straight

Questions?

Treatment and Care Analysis

Palm Beach County
Ryan White HIV/AIDS Program

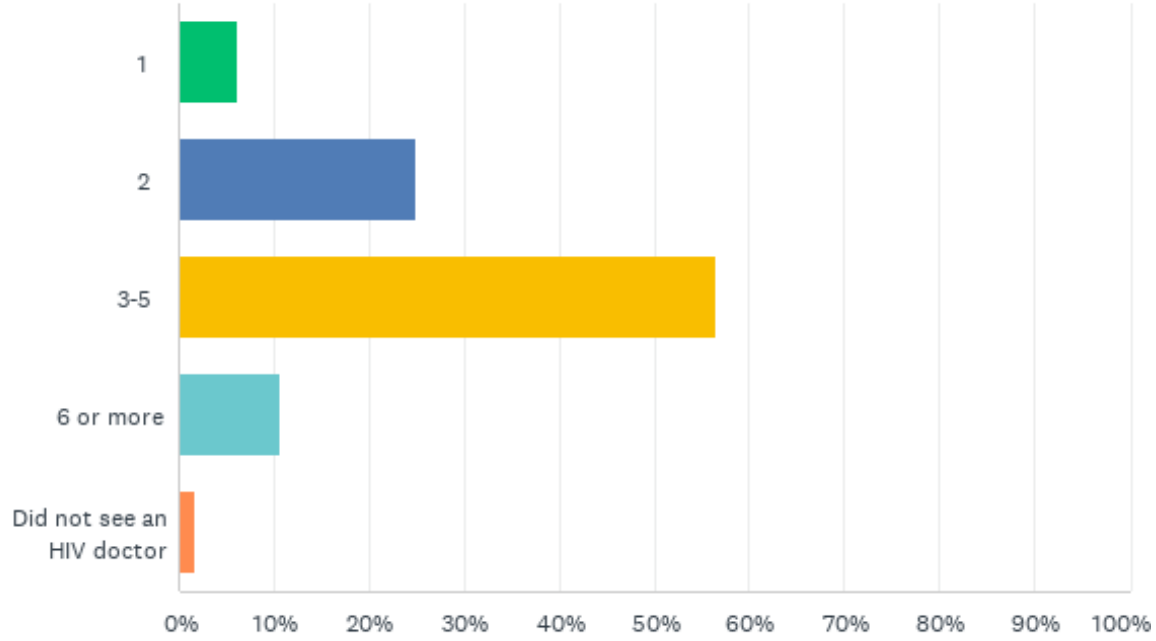
Treatment and Care Questions

- Questions 14- 23 focus on care and treatment such as:
  - Most recent HIV test, access to medical care and case management, PrEP usage, etc.

Medical Appointments
In the past 12 months, how many times did you see your HIV medical provider? (check one)

Of the 394 respondents,

- 56.6% (223/394) saw their HIV medical provider **3-5 times**
- 24.9% (98/394) saw their HIV medical provider **2 times**
- 10.7% (42/394) saw their HIV medical provider **6 times or more**

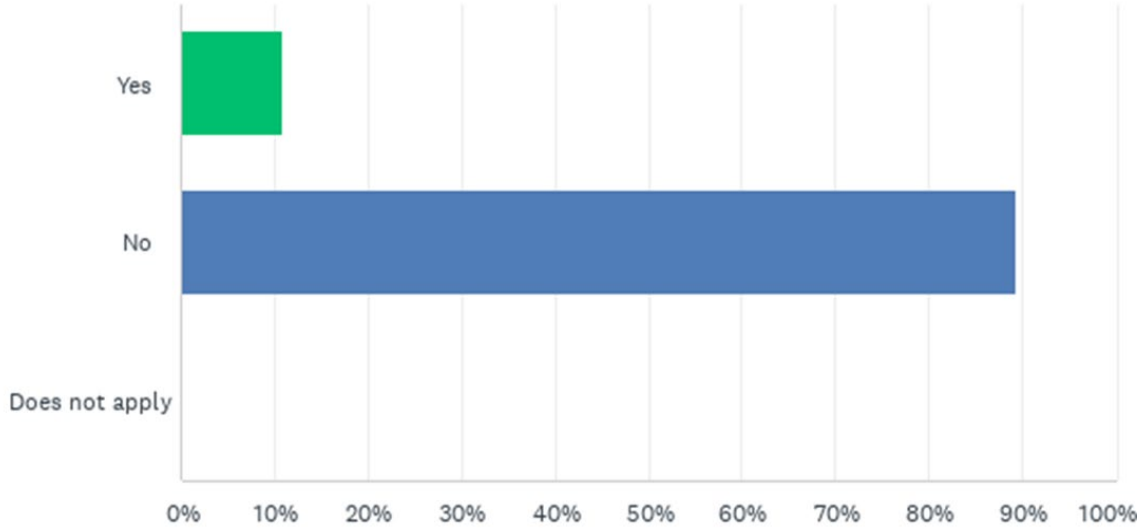


Answered: 394, Skipped: 4

Access to medical care
In the past 12 months, did you ever need HIV medical care but could not get it? (check one)

Of the 393 respondents,

- **10.9% (43/393) were not able to** receive medical care when they needed it.
- **89.3% (351/393) were able to** receive medical care when they needed it.

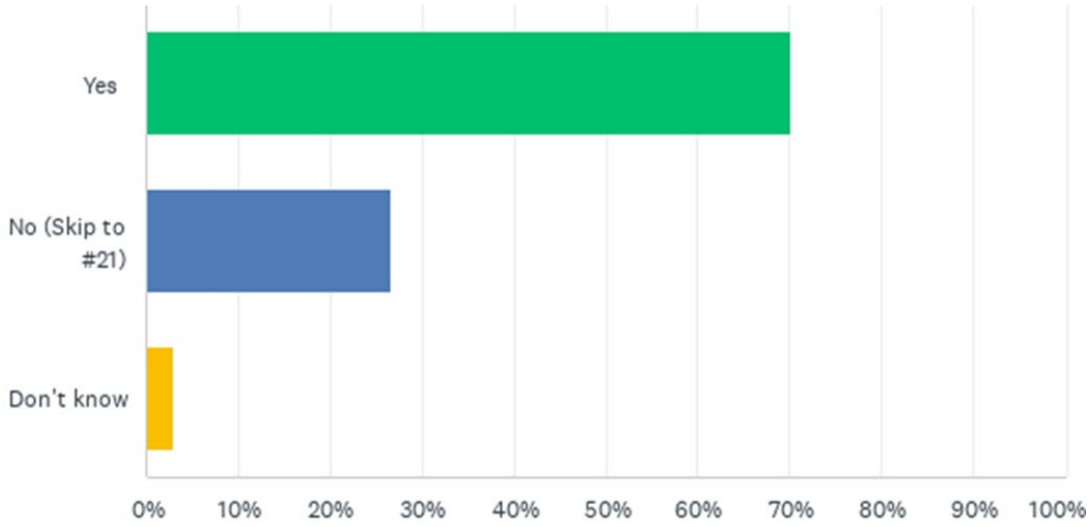


Answered: 393, Skipped: 5

Case Management
Do you have an HIV case manager? (check one)

Of the 393 respondents,

- 70.2% (276/393) **have** an HIV case manager
- 26.7% (105/393) **do not have** an HIV case manager

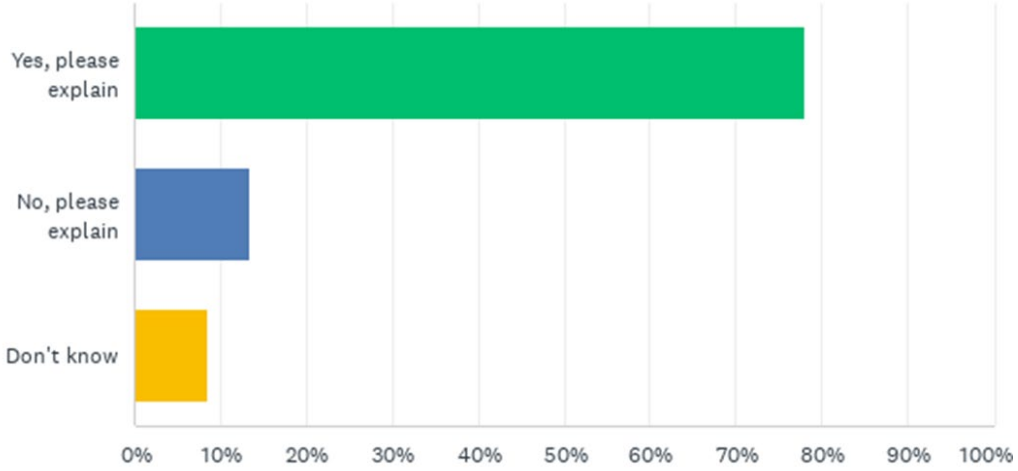


Answered: 393, Skipped: 5

Case Management Satisfaction
Are you satisfied with the HIV case management services? (check one)

Of the 329 respondents,

- 78.1% (257/329) reported that they **are satisfied** with their HIV case management services
- 13.4% (44/329) reported that they **are not satisfied** with the HIV case management services

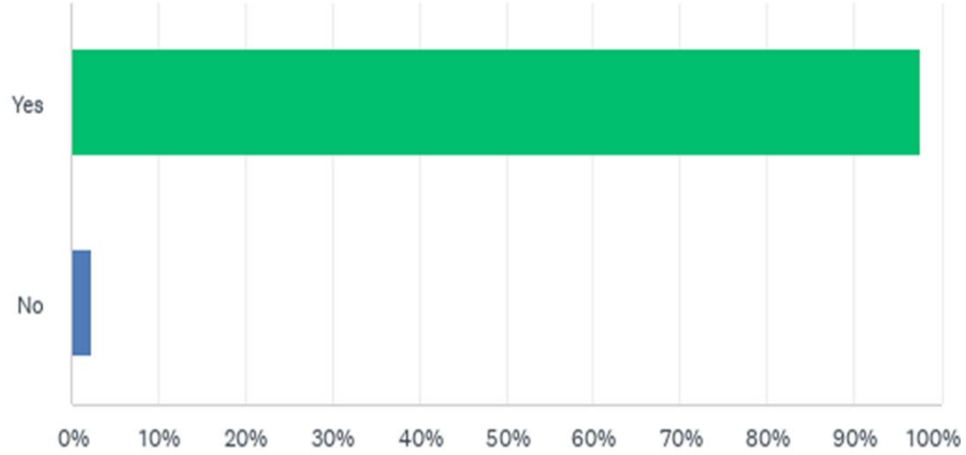


Answered: 329, Skipped: 69

Antiretroviral Medicine Usage
Are you currently taking any antiretroviral medicines to treat your HIV? (check one)

Of the 385 respondents,

- 97.7% (376/385) are **currently taking** antiretroviral medicines to treat their HIV
- 2.3% (9/385) are **not currently** taking antiretroviral medicines to treat their HIV



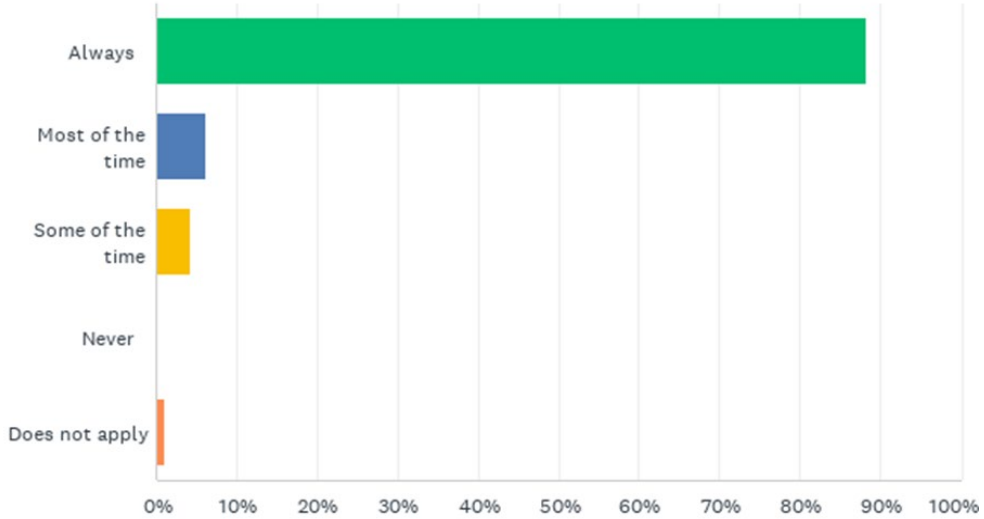
Answered: 385, Skipped: 13

Medical Care Explanation

Over the last 12 months, has your HIV medical provider taken the time to explain your lab results, diagnoses, treatment plans and answer all of your questions? (check one)

Of the 394 respondents,

- **88.3% (348/394)** reported that their HIV medical provider **always** provided explanations about their care for them
- **6.1% (24/394)** reported that their HIV medical provider provided explanations about their care **most of the time**
- **4.3% (17/394)** reported that their HIV medical provider provided explanations about their care **some of the time**



Answered: 394, Skipped: 4

Treatment and Care Key Takeaways

- More than half of respondents **56.6% (223/394)** saw their HIV medical provider **3-5** times in the 12 months prior to taking the survey **24.9% (98/394)** saw their HIV medical provider **2 times 10.7% (42/394)** saw their HIV medical provider **6 times or more**
- A majority of respondents **89.3% (351/393)** indicated that in the 12 months prior to taking the survey, they **were able to receive** medical care when they needed it
- A majority of respondents **88.3% (348/394)** reported that in the 12 months prior to taking the survey, their HIV medical providers explained their lab results, diagnoses, and treatment plans and answered their questions all the time
- A majority of **97.7% (376/385)** of respondents indicated that they **are currently** taking antiretroviral medicines to treat their HIV

Questions?

Service Utilization Analysis

Palm Beach County
Ryan White HIV/AIDS Program

Service Utilization Analysis:

Participants were asked to check all the services used in the last 12 months and the services they needed but did not receive for any reason.

For each service category, the participants were asked to select from the following options:

- I have used this service in the last 12 months
- I needed this service but did not get it
- I did not use this service or I did not need this service

Service Utilization Analysis:
I have used this service in the last 12 months

Highlights:

- **69.7% (258/370)** of respondents used Laboratory Diagnostic Services services
- **69.8% (257/368)** of respondents used AIDS Pharmaceutical services
- **66.1% (244/369)** of respondents used Medical Case management services

	I HAVE USED THIS SERVICE IN THE LAST 12 MONTHS
Laboratory Diagnostic Testing	69.73% 258
AIDS Pharmaceutical Assistance	69.84% 257
Medical Case Management	66.12% 244
Health Insurance (Financial Assistance for Premiums and Copays)	59.19% 219
SNAP Benefits	37.84% 140
Early Intervention Services (Services to help you get HIV medical care or get back into care after a time away)	31.89% 118
Specialty Medical Care (Oncology, dermatology, cardiology, etc.)	29.19% 108
Oral Health Care (Dental Services)	24.32% 90
Social Security Income (SSI) Benefits	23.72% 88
Food Bank/Home Delivered Meals	21.74% 80
Food Bank/Nutritional Supplements	21.08% 78
Medical Transportation Services	14.32% 53
Outpatient/Ambulatory (Medical Care)	13.35% 49
Medical Nutrition Therapy (Nutritional Supplements, Nutritionist)	11.89% 44
Mental Health Therapy/Counseling	8.65% 32
Housing Services	7.61% 28
Substance Use Treatment (Residential)	6.22% 23
Home Health and Community Based Health Services (professional nurse provides medical care in your home)	6.22% 23
Emergency Financial Assistance	5.41% 20
Legal Services	4.10% 15
EFA-Prior Authorization (Received Emergency Pharmacy)	3.55% 13

Service Utilization Analysis: I needed this service but did not get it

Highlights:

- **45.4% (168/370)** of respondents need Oral Health Care (Dental Services) but did not get it
- **12.8% (47/368)** of respondents needed housing services but did not get it

	I NEEDED THIS SERVICES BUT DID NOT GET IT
Oral Health Care (Dental Services)	45.41% 168
Housing Services	12.77% 47
SNAP Benefits	11.62% 43
Emergency Financial Assistance	11.35% 42
Specialty Medical Care (Oncology, dermatology, cardiology, etc.)	10.27% 38
Medical Case Management	8.94% 33
Food Bank/Nutritional Supplements	8.92% 33
Food Bank/Home Delivered Meals	8.42% 31
Social Security Income (SSI) Benefits	7.82% 29
Medical Transportation Services	7.57% 28
Mental Health Therapy/Counseling	7.57% 28
Medical Nutrition Therapy (Nutritional Supplements, Nutritionist)	7.03% 26
Legal Services	6.56% 24
Home Health and Community Based Health Services (professional nurse provides medical care in your home)	5.95% 22
Health Insurance (Financial Assistance for Premiums and Copays)	5.68% 21
EFA-Prior Authorization (Received Emergency Pharmacy)	5.74% 21
Outpatient/Ambulatory (Medical Care)	5.45% 20
Substance Use Treatment (Residential)	5.41% 20
Laboratory Diagnostic Testing	5.14% 19
AIDS Pharmaceutical Assistance	4.35% 16
Early Intervention Services (Services to help you get HIV medical care or get back into care after a time away)	2.70% 10

Service Utilization Analysis:
I did not need this service or I did not use this service

Highlights:

- **90.7% (332/366)** of respondents did not need or use EFA- Prior Authorization Emergency Pharmacy
- **89.3% (327/366)** of respondents did not need or use Legal Services

	I DID NOT USE THIS SERVICE OR I DID NOT NEED THIS SERVICE
EFA-Prior Authorization (Received Emergency Pharmacy)	90.71% 332
Legal Services	89.34% 327
Substance Use Treatment (Residential)	88.38% 327
Home Health and Community Based Health Services (professional nurse provides medical care in your home)	87.84% 325
Mental Health Therapy/Counseling	83.78% 310
Emergency Financial Assistance	83.24% 308
Medical Nutrition Therapy (Nutritional Supplements, Nutritionist)	81.08% 300
Outpatient/Ambulatory (Medical Care)	81.20% 298
Housing Services	79.62% 293
Medical Transportation Services	78.11% 289
Food Bank/Nutritional Supplements	70.00% 259
Food Bank/Home Delivered Meals	69.84% 257
Social Security Income (SSI) Benefits	68.46% 254
Early Intervention Services (Services to help you get HIV medical care or get back into care after a time away)	65.41% 242
Specialty Medical Care (Oncology, dermatology, cardiology, etc.)	60.54% 224
SNAP Benefits	50.54% 187
Health Insurance (Financial Assistance for Premiums and Copays)	35.14% 130
Oral Health Care (Dental Services)	30.27% 112
AIDS Pharmaceutical Assistance	25.82% 95
Laboratory Diagnostic Testing	25.14% 93
Medical Case Management	24.93% 92

Questions?

Quality of Life Analysis

Palm Beach County
Ryan White HIV/AIDS Program

Quality of Life Analysis:

Participants were asked to rank their quality of life satisfaction, health, relationship, and wellbeing.

Participants were asked to use a scale from 1- not at all to a 5- extremely.

The full scale is as follows:

- 1-Not at all
- 2- Slightly
- 3- Moderately
- 4- Very
- 5-Extremely

Quality of Life Analysis:

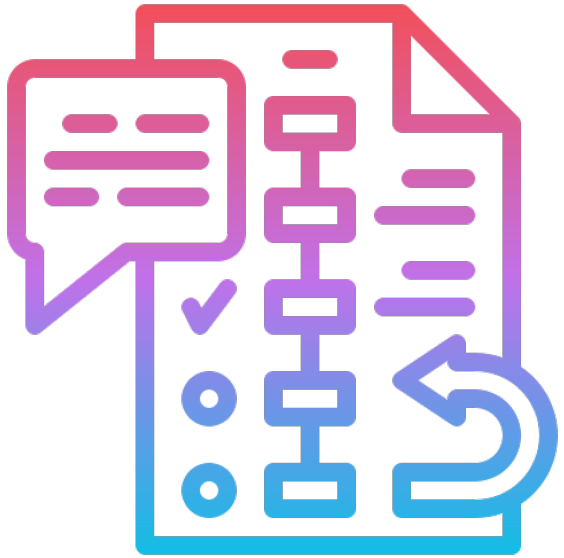
Highlights:

- **88.2% (322/365)** of respondents are moderately,very, or extremely optimistic about the future
- **50.8% (186/365)** of respondents are moderately,very, or extremely afraid that people may reject them when they learn they have HIV
- **71.2% (259/364)** of respondents are moderately,very, or extremely fearful of the health effect of HIV as they get older

	MODERATELY	VERY	EXTREMELY
I lack a sense of belonging with people around me	32.79% 120	10.38% 38	4.64% 17
Having HIV limits my opportunities in life	27.05% 99	12.30% 45	6.56% 24
I feel that HIV prevents me from doing as much as I would like	28.61% 105	11.99% 44	7.36% 27
I am afraid that people may reject me when they learn I have HIV	31.51% 115	10.41% 38	9.04% 33
Managing HIV wears me out	24.04% 88	14.75% 54	6.83% 25
I feel that HIV limits my personal relationships	32.70% 120	15.53% 57	8.17% 30
I fear the health effects of HIV as I get older	27.20% 99	33.24% 121	10.71% 39
I worry about the impact of HIV on my health	27.32% 100	33.61% 123	10.38% 38
I worry about my health	32.60% 119	30.96% 113	13.70% 50
I feel in control of my life	30.96% 113	42.19% 154	14.52% 53
I feel good about myself as a person	28.14% 103	40.98% 150	18.58% 68
I am enjoying life	32.97% 121	40.87% 150	14.99% 55
I am optimistic about my future	33.42% 122	40.27% 147	14.52% 53

Questions?

Service Utilization, Treatment and Care Follow Up Analysis



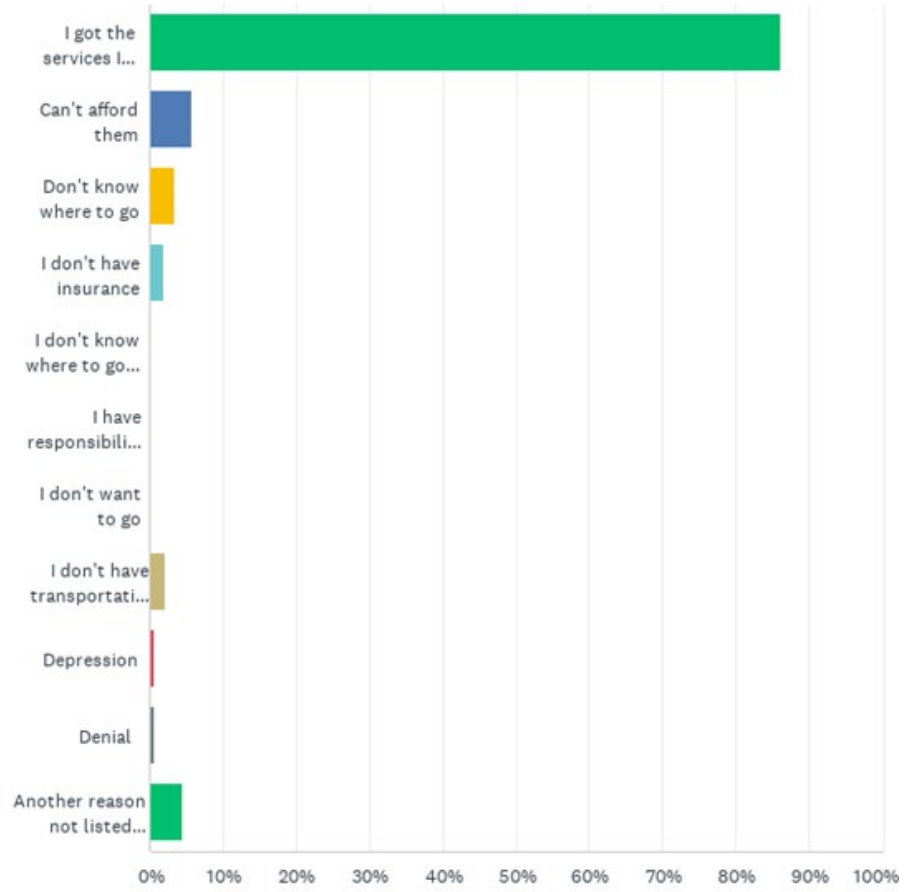
Palm Beach County
Ryan White HIV/AIDS Program

Access to Health and Medical Services

In the past 12 months, if you could not get health or medical services you needed, what are the reasons? (please check all that apply)

Of the 360 respondents,

- 86.1% (310/360) **received** the services that they needed
- 5.8% (21/360) **did not** receive services because they **could not afford it**
- 3.3% (12/394) **did not** receive services because they **did not know where to go**

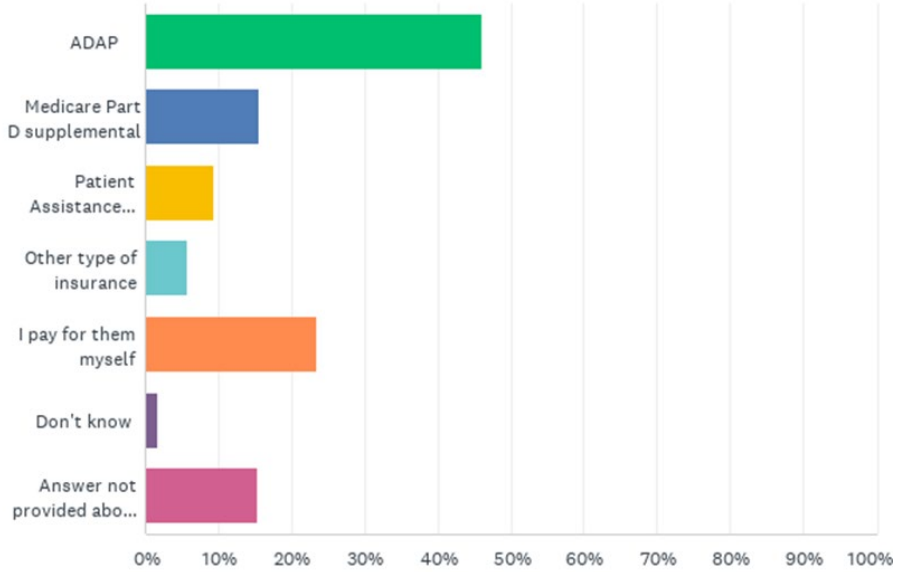


Answered: 360, Skipped: 38

Payment for Medication
How do you pay for medications?

Of the 364 respondents,

- 46.2% (168/364) of respondents use **ADAP** to pay for their medication
- 23.4% (85/364) of respondents **pay for their own medication themselves**
- 15.7% (57/364) of respondents use **Medicare Part D** supplemental to pay for their medication

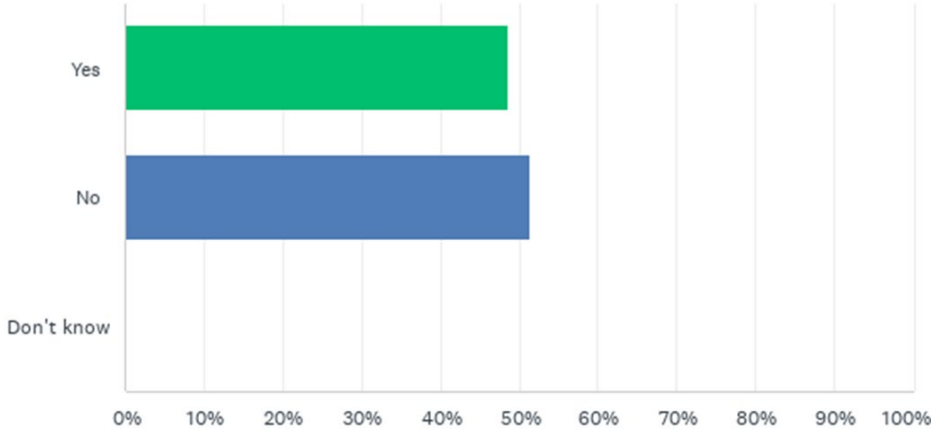


Answered: 364, Skipped: 34

Dental Insurance
Do you have dental insurance? (check one)

Of the 362 respondents,

- **48.6% (176/362)** of respondents **have** dental insurance
- **51.4% (186/362)** of respondents **do not have** dental insurance



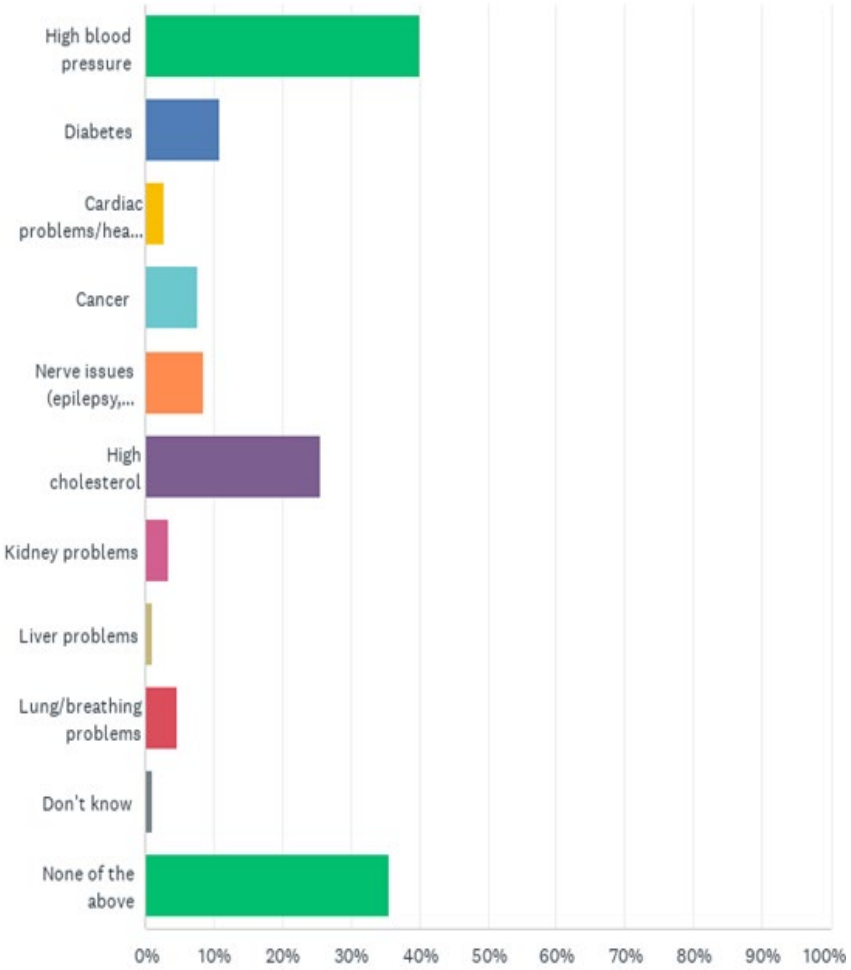
Answered: 362, Skipped: 36

Other Health Conditions

Has a doctor ever told you that you have any of the following conditions? (check all that apply)

Of the 362 respondents,

- 40.1% (145/362) of respondents also have **high blood pressure**
- 25.7% (93/362) of respondents also have **high cholesterol**
- 35.6% (129/362) of respondents **did not report any co-occurring conditions**

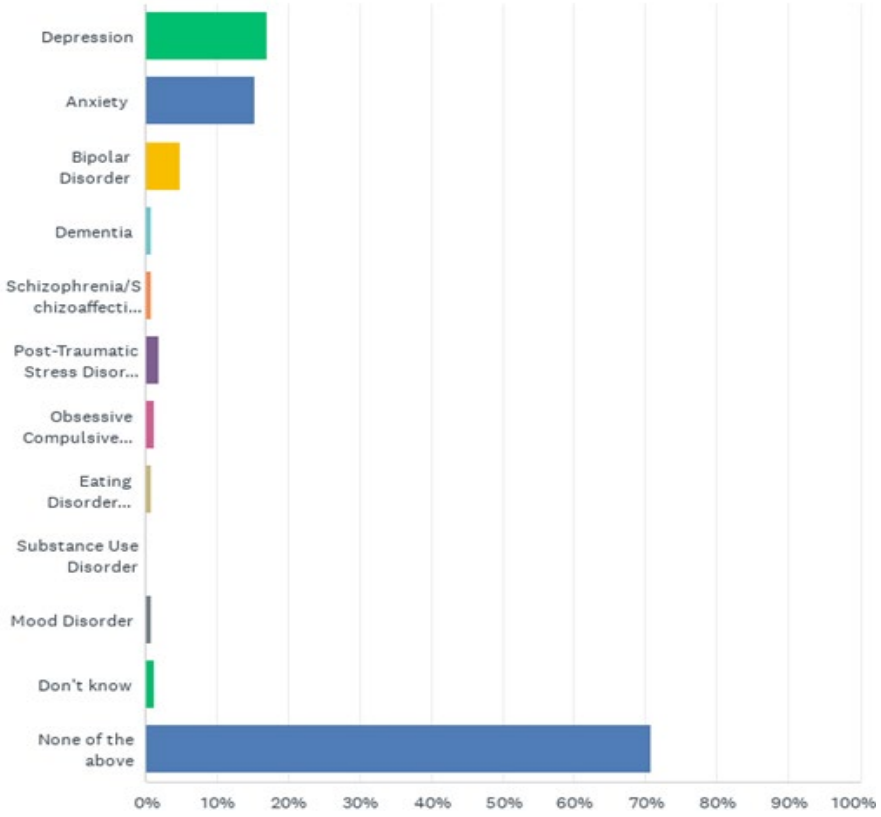


Answered: 362, Skipped: 36

Mental Health Disorders
Has a doctor ever told you that you have any of the following? (check all that apply)

Of the 363 respondents,

- 70.8% (257/363) were informed by their doctors that they **did not** have a mental health disorder
- 17.1% (62/363) were informed by their doctor that they **have depression**
- 15.4% (56/363) were informed by their doctor that they **have anxiety**

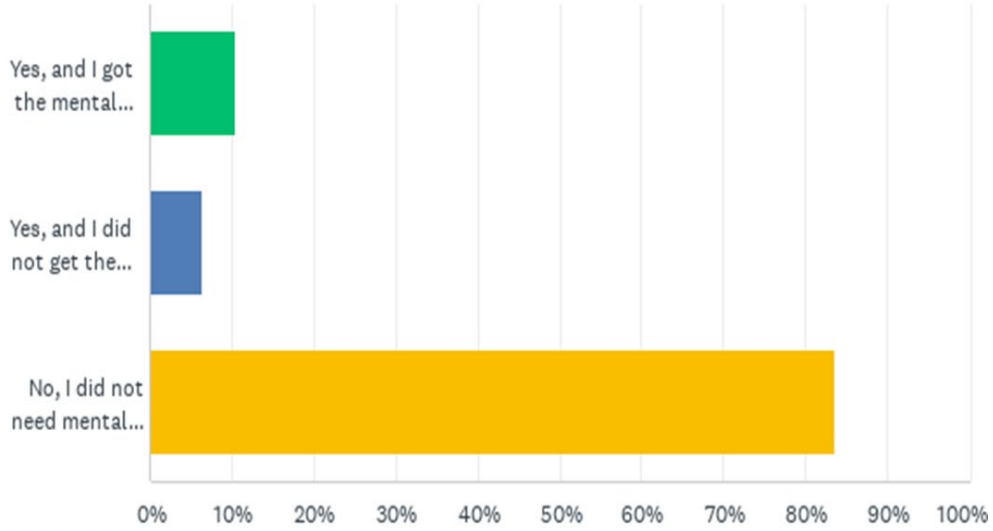


- Answered: 363, Skipped: 35

Mental Health Care
In the last 12 months, did you need mental health care or counseling services?

Of the 364 respondents,

- 83.5% (304/364) **did not need** mental health care or counseling
- 10.4% (38/364) **needed** mental health care or counseling and **received** the mental health care they needed
- 6.3% (23/364) **needed** mental health care but **did not get** the mental health care they needed



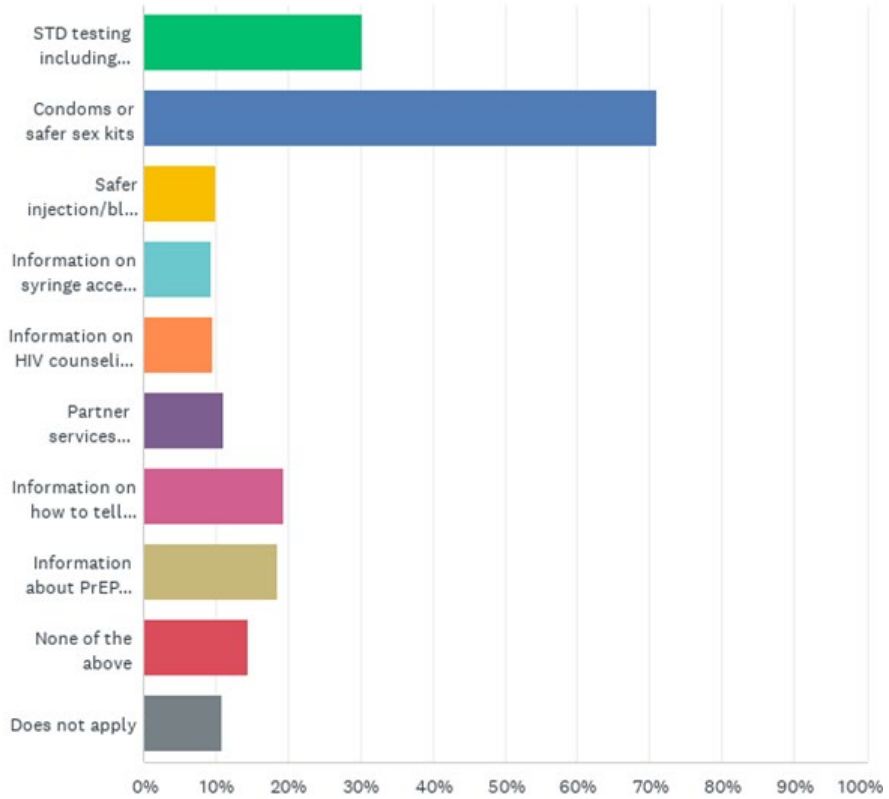
Answered: 364, Skipped: 34

Additional Medical Services

In the last 12 months, has your medical provider offered any of the following services to you? (check all that apply)

Out of the 361 respondents,

- 70.9% (256/361) of respondents were given **condoms and safer sex kits**
- 30.2%(109/361) of respondents were **STD tested including hepatitis C**
- 19.4% (70/361) of respondents were **given information on how to tell someone about your HIV status (disclosure)**
- 18.6% (67/361) of respondents were **given information about PrEP for themselves or their partners**

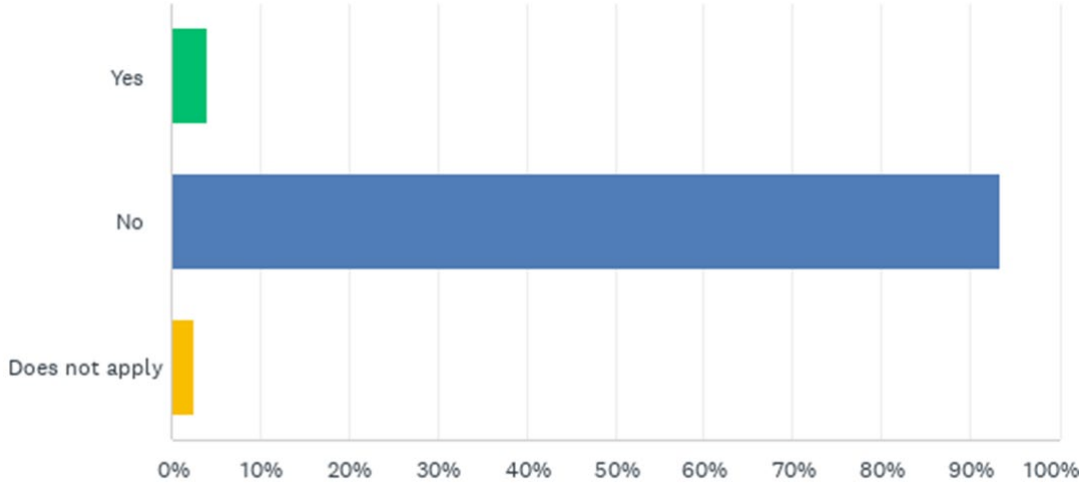


Answered: 361, Skipped: 37

Access to Services and Language Barriers
In the last 12 months, have you had problems getting medical care or other services because of the language/s you speak? (check one)

Of the 362 respondents,

- 93.4% (338/362) **did not have** problems getting medical care or other services because of the language/s they speak
- 4.1% (38/362) **had problems** getting medical care or other services because of the language/s they speak

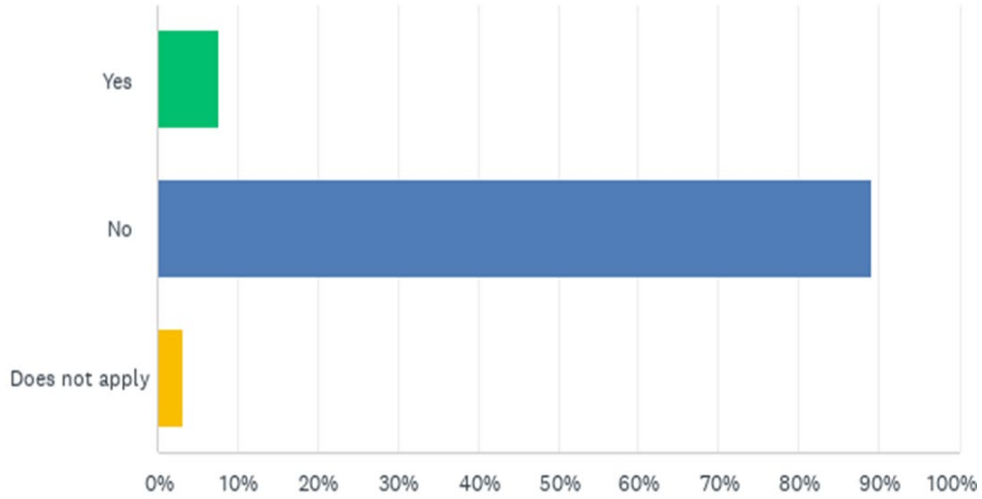


Answered: 362, Skipped: 36

Access to Medical Care and Affordability
In the last 12 months, have you not gotten medical care because you could not afford a co-pay or deductible? (check one)

Of the 362 respondents,

- 89.1% (325/365) **have** gotten medical care
- 7.7% (28/365) **did not** receive medical care because they could not afford a co-pay or deductible

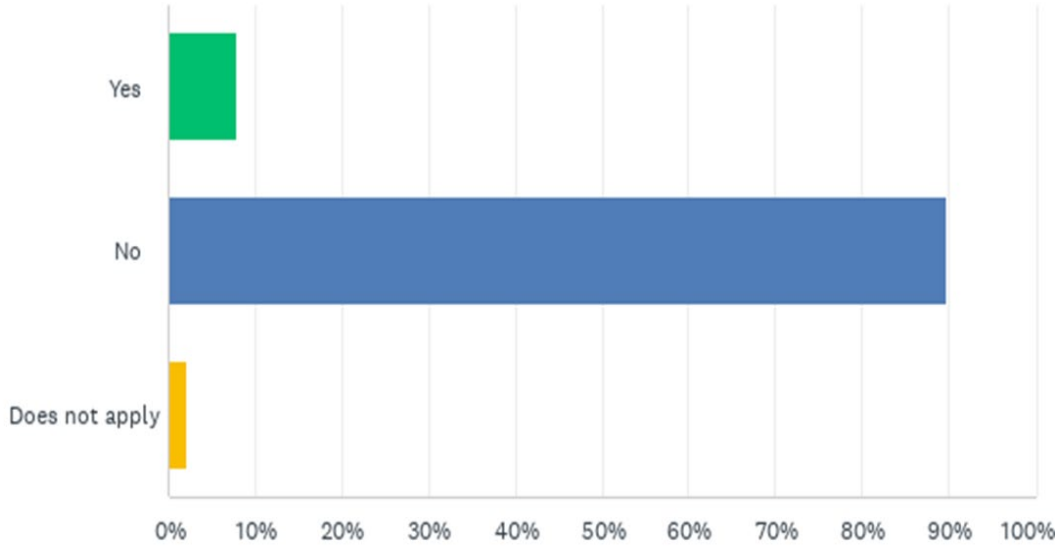


Answered: 362, Skipped: 33

Medical Appointments and Transportation
In the last 12 months, have you missed a medical appointment because you had problems with transportation and you could not get there on time? (check one)

Of the 363 respondents,

- 89.8% (338/363) of respondents reported that they **did not miss** a medical appointment because they had problems with transportation
- 8.0% (29/363) of respondents reported that they **had missed** a medical appointment because they had problems with transportation and could not get there on time



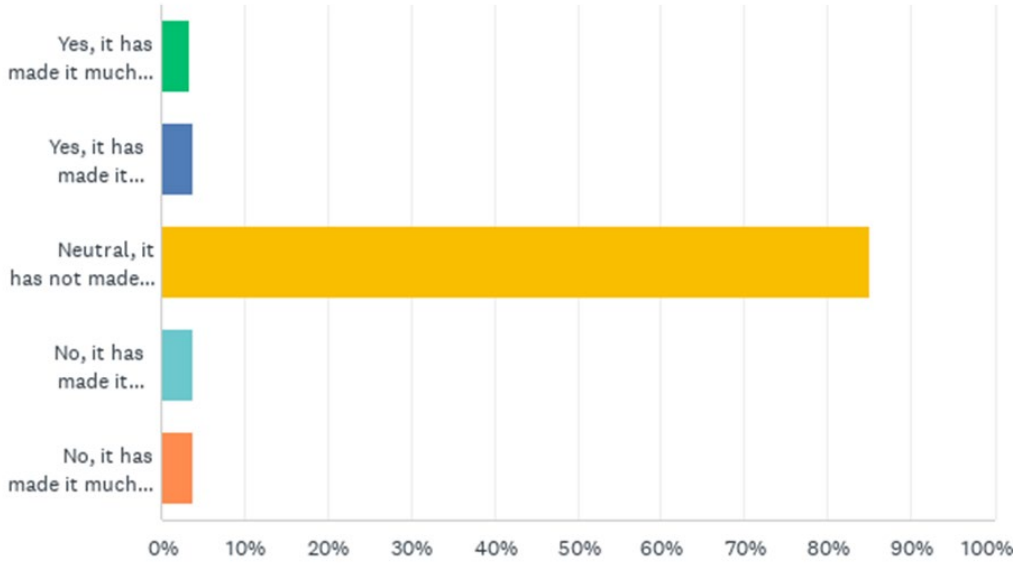
Answered: 363, Skipped: 35

COVID Impact

Has a change in Ryan White services provided due to COVID-19 (i.e. telehealth and having to do things remotely) adversely affected your ability to receive services?

Out of the 262 respondents,

- 85.1% (223/262) respondents reported that COVID-19 had a n**eutral impact** not making it harder or easier to access services



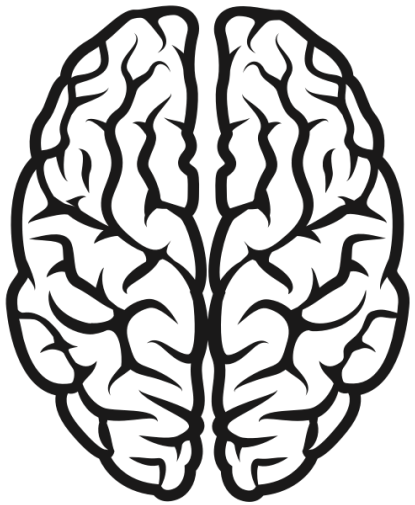
Answered: 262, Skipped: 136

Follow Up Key Takeaways

- A little more than half **51.4% (186/362)** of respondents do not have dental insurance
- **40.1% (145/362)** of respondents also have high blood pressure followed by **25.7% (93/362)** of respondents who also have high cholesterol
- While a little less than half **46.2% (168/364)** of respondents indicated that they use ADAP to pay for their medication, **23.4% (85/364)** of respondents pay for their own medication themselves, followed by **15.7% (57/364)** of respondents use Medicare Part D supplemental to pay for their medication
- A majority of respondents **85.1% (223/262)** reported that COVID-19 had a neutral impact not making it harder or easier to access services

Needs Assessment Key Takeaways

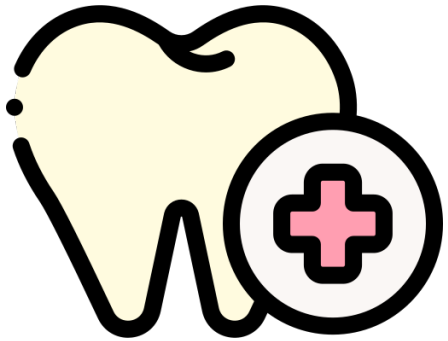
- The data indicates that majority of the respondents' needs are being met
  - **89.3%** of participants reported that they were able to receive care when needed
  - **93.4%** of participants reported that the language/s they speak were not a problem in receiving care
- While a majority of respondents indicated that they were not informed that they have a mental health disorder **(70.8%), 17.1%** reported that they were informed of having depression, and **15.4%** were informed that they have anxiety
- Majority of the respondents indicate that they are satisfied with their HIV case management services **(78.1%)**
- However, while majority of participants report that they are satisfied with their care, only **70.2%** of respondents indicated that they have a case manager



Palm Beach County
Ryan White HIV/AIDS Program

Needs Assessment Key Takeaways

- More than half of respondents **(56.6%)** have seen their HIV medical provider 3-5 times in the past 12 months
- A little less than half of respondents **(45.4%)** indicated that they need Oral Health Care Dental Services but were not able to receive it.
  - The COVID-19 Pandemic could be a factor to the decreases access to Dental care
- Based on the service utilization analysis, the 3 most used services are as follows:
  - **69.8%**- AIDS Pharmaceutical Assistance
  - **69.7%** - Laboratory Diagnostic Testing
  - **66.1%**- Medical Case Management
- **77.3%** of respondents feel at least moderately worried about their health
- **87.7%** of respondents feel at least moderately in control of their life



Questions?

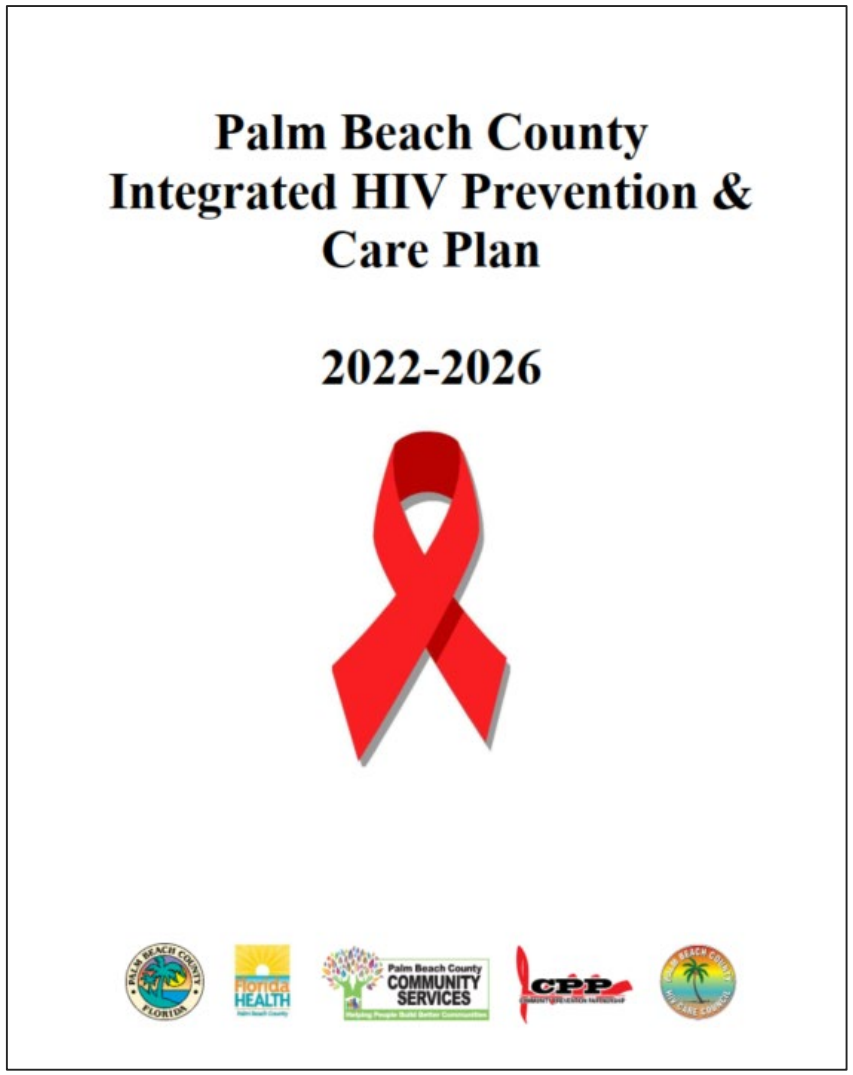
Integrated Prevention and Care Plan

2022-2026

Palm Beach County
Ryan White HIV/AIDS Program

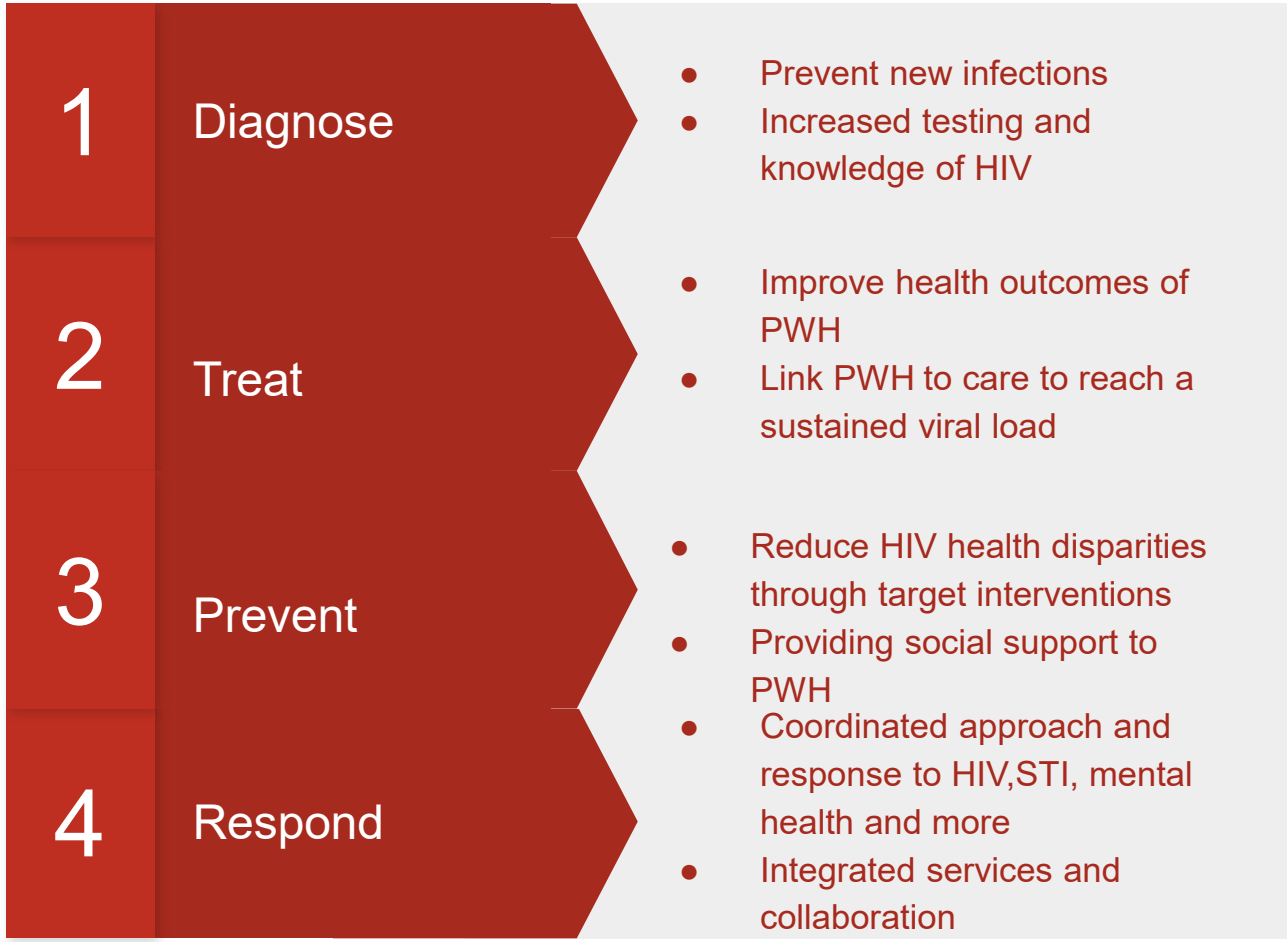
Overview

- The Integrated Prevention and Care Plan is a 5 year strategic, jurisdictional plan
- Submitted to HRSA on January 9th, 2023. Feedback was received at the end of May 2023
- The Integrated Plan consists of specific goals and objectives focused on testing, linkage to care, prevention, research and training initiatives, etc.
- Living Document
- Integrated Planning Workgroup:
  - Key Community Stakeholder representation: Care Council, RW Part B, CPP, PLWH, Behavioral Health and more
  - Assist with monitoring and implementation of plan



Pillars

- The Integrated Prevention and Care Plan consists of 4 pillars
  - NHAS Goals
  - Ending the HIV Epidemic Initiative
- Consists of 160+ activities ranging from training and HIV education, testing, linkage to care,treatment services, research initiatives,etc.
- Assessing Integrated Plan baseline data from subrecipients



Integrated Plan Activities

Strategies	Activities	Target Population
T3.1 d	Focus on Test and Treat programs, increasing rapid entry to care	Persons at risk for HIV, Newly diagnosed PWH
T3.1 h	Adopt a virtual/telehealth approach to help clients whenever possible	PWH
T1.1 c	Expand/maintain number of Providers with same day appointment and walk-ins	People at risk for HIV, Newly diagnosed PWH, PWH out of care
P1.1 g	Provide Outreach and HIV and STI Testing and education in zipcodes of priority populations	PWH, persons at risk for HIV
P 4.1 d	Implement comprehensive prevention and care services in mobile health units	PWH

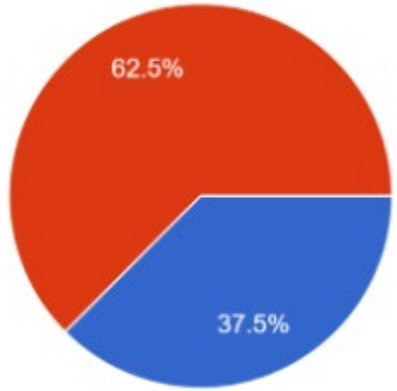
Baseline Data

Do you currently have a mobile unit?

Of the 8 subrecipients who responded,

62.5% (⅝) do not have a mobile unit

37.5% (⅜) reported that they do have a mobile unit

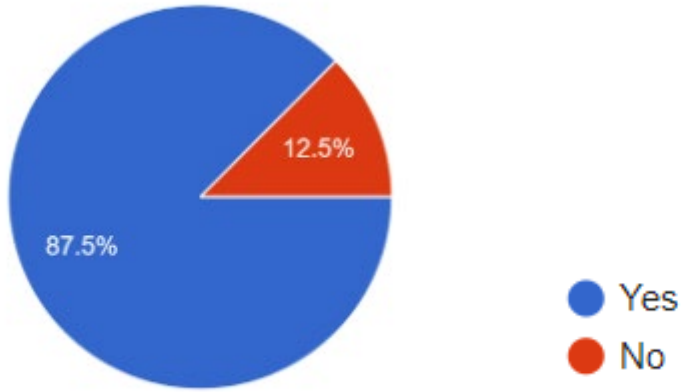


Do you currently provide telehealth services for RW patients?

Of the 8 subrecipients who responded,

87.5% (⅞) provide telehealth services for RW patients

12.5% (⅛) do not provide telehealth services for RW patients



Do you currently have the capacity to take in same day/walk-in appointments?

Of the 9 respondents **100%** reported that they have the capacity to take in same day/walk-in appointments

Baseline Data

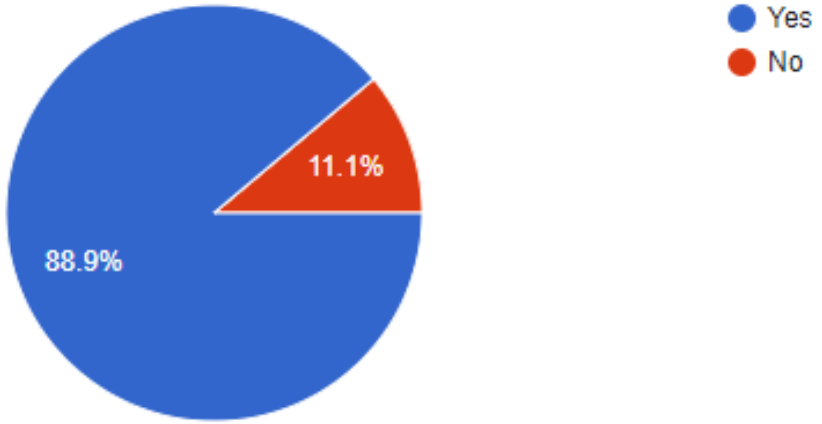
How many test and treat site do you currently have?

Between our 9 subrecipient agencies, we currently have **20-22 test and treat sites**

Which services are provided via telehealth?

Of our 8/9 (**88.9%**) subrecipients that provide telehealth services, there is a monthly **average of 61 patients using telehealth services**

- **37.5% (3/8)** only provide telehealth casement management services
- **37.5% (3/8)** provide a variety of telehealth services
- **25% (2/8)** only provide telehealth medical appointments



Baseline Data

Which geographical area do you target for outreach and testing events?

- Between 7 of our funded agencies, outreach and testing events are covered throughout all of Palm Beach County
- There have specialized testing and outreach focus in the following areas:
  - West Palm Beach
  - Riviera Beach

Questions?

Palm Beach County
Ryan White Part B HIV Needs Assessment
2022 - 2023

Tiffany B. Canate, MPH
Health Planner & Programs Manager

July 11th, 2023

HEALTH COUNCIL OF SOUTHEAST FLORIDA

Health Council of Southeast Florida

Who we are:

- Defined in Florida State Statute 408.033
- HCSEF is one of 11 local health planning council
- We cover a 5-county service area:
  - Palm Beach
  - Martin
  - St. Lucie
  - Okeechobee
  - Indian River

What we do:

- Forecast healthcare and social needs in the community
- Assist in community-based healthcare and social service planning
- Create and disseminate materials to inform communities about healthcare and social service issues
- Provide a repository of health and social determinant of health data
- Collect, analyze, and interpret population data to improve effective service delivery

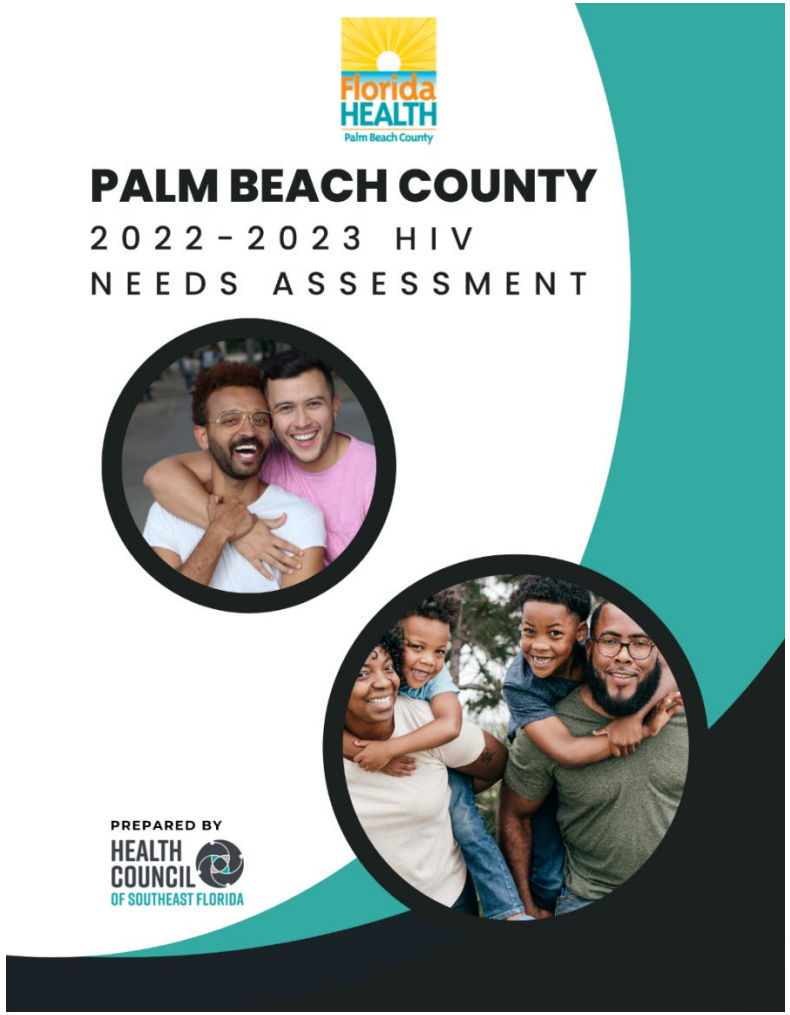
HEALTH COUNCIL OF SOUTHEAST FLORIDA

Palm Beach County
Ryan White Part B HIV Needs Assessment

- **Identify the needs** of individuals living with HIV, as well as **trends and current progress towards ending the HIV epidemic** and outcomes across the HIV care continuum in Palm Beach County.

- Is used to identify service gaps and pinpoint where prevention and mitigation efforts may be most impactful to **address unmet needs.**

- Indicators reviewed:
  - **Diagnosis** of HIV
  - **Treatment** (viral suppression)
  - **Prevention** (PrEP)
  - **Response** to infection



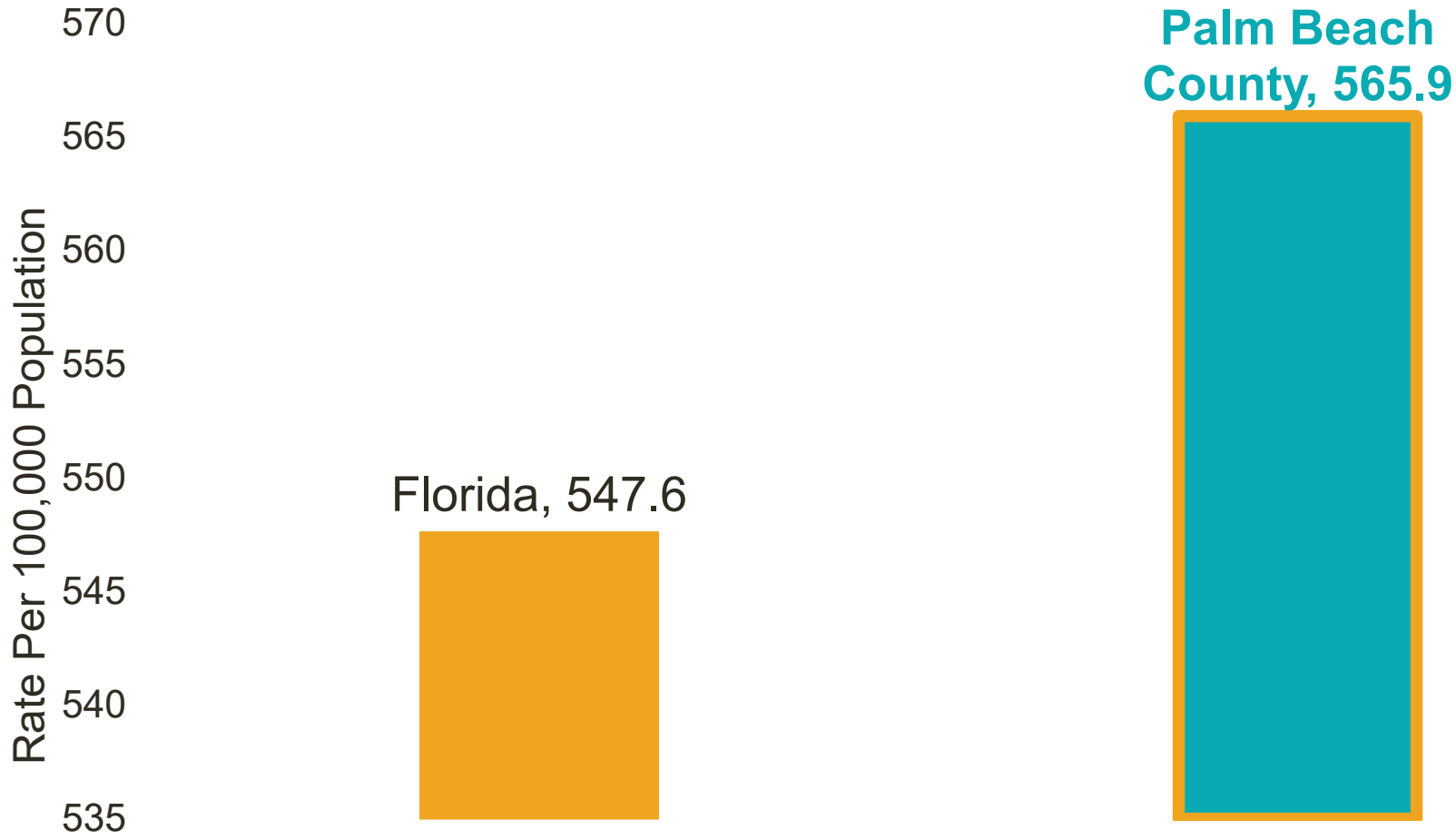
Local Epidemiology

2022-2023 Palm Beach County
Ryan White Part B HIV Needs Assessment

Persons Living with HIV (PWH)

Palm Beach County vs. Florida

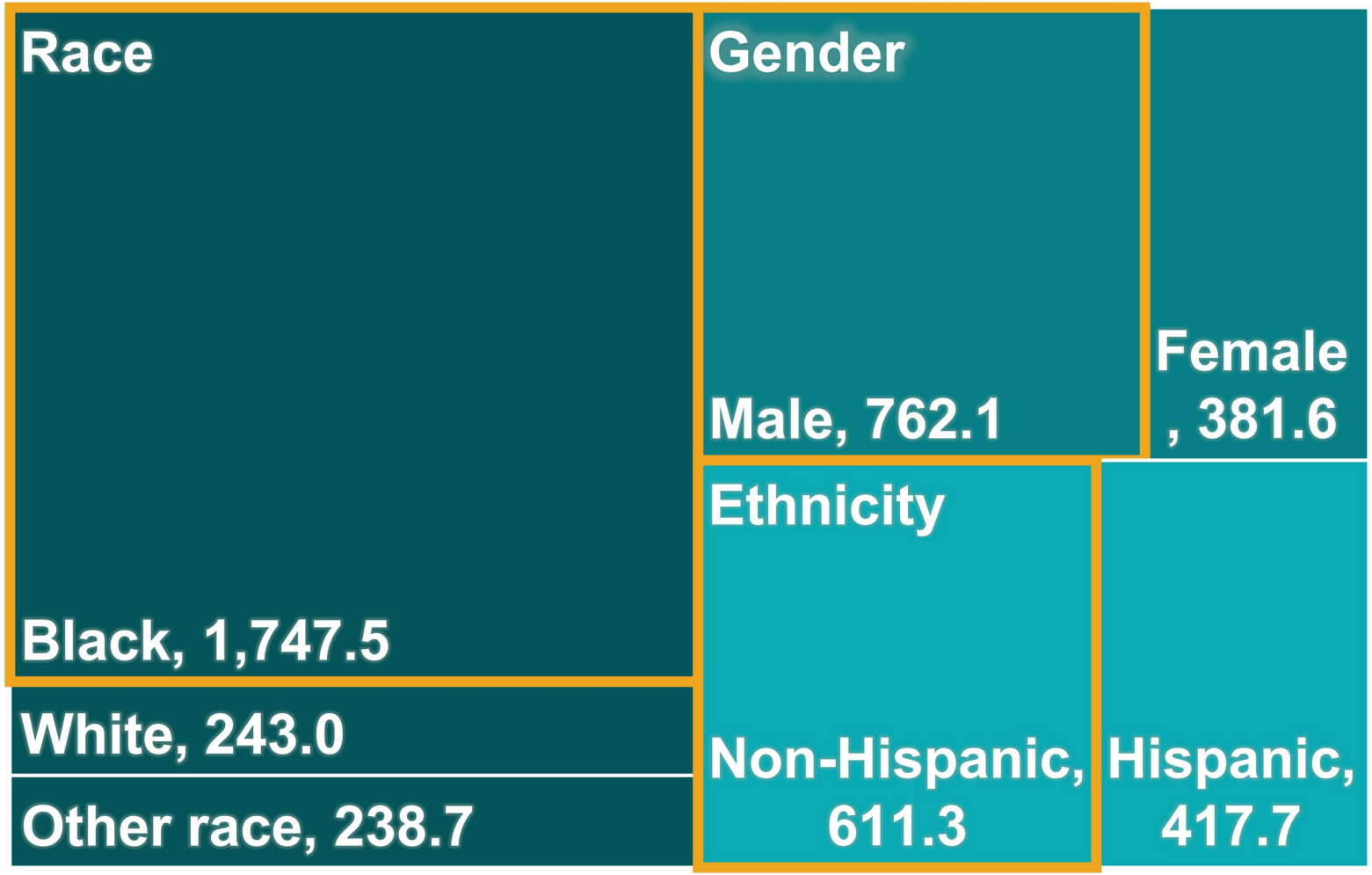
In 2021, the rate per 100,000 population of Persons with HIV (PWH) was **greater in Palm Beach County** compared to Florida.



FLHealth Charts, Bureau of Communicable Diseases, 2022

Persons Living with HIV (PWH)

By Race, Ethnicity, Sex

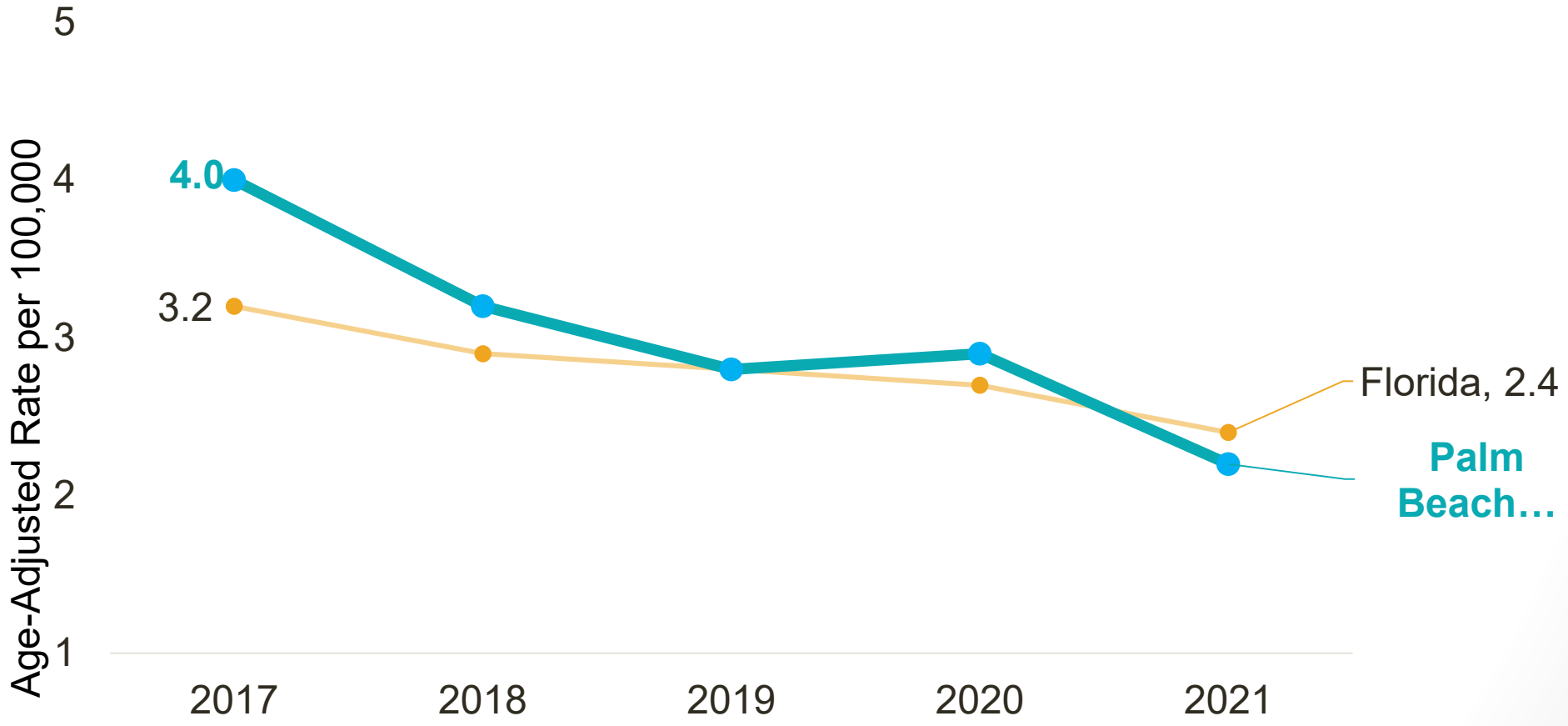


FLHealth Charts, Bureau of Communicable Diseases, 2022

Age-Adjusted Deaths Due to HIV/AIDS

Palm Beach County vs. Florida

In 2021, the age-adjusted death rate due to HIV/AIDS in **Palm Beach County was slightly less than in Florida** for the first time in the past five years.



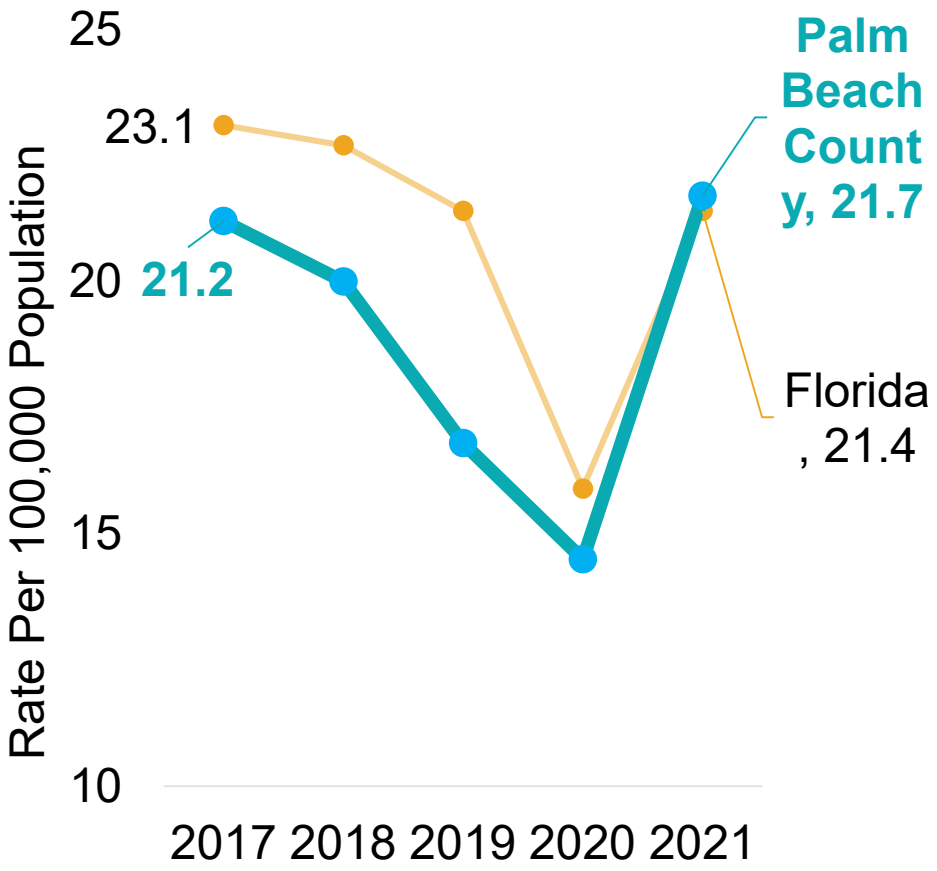
FLHealth Charts, Bureau of Communicable Diseases, 2022

Ending the HIV Epidemic in the U.S. (EHE) Initiative

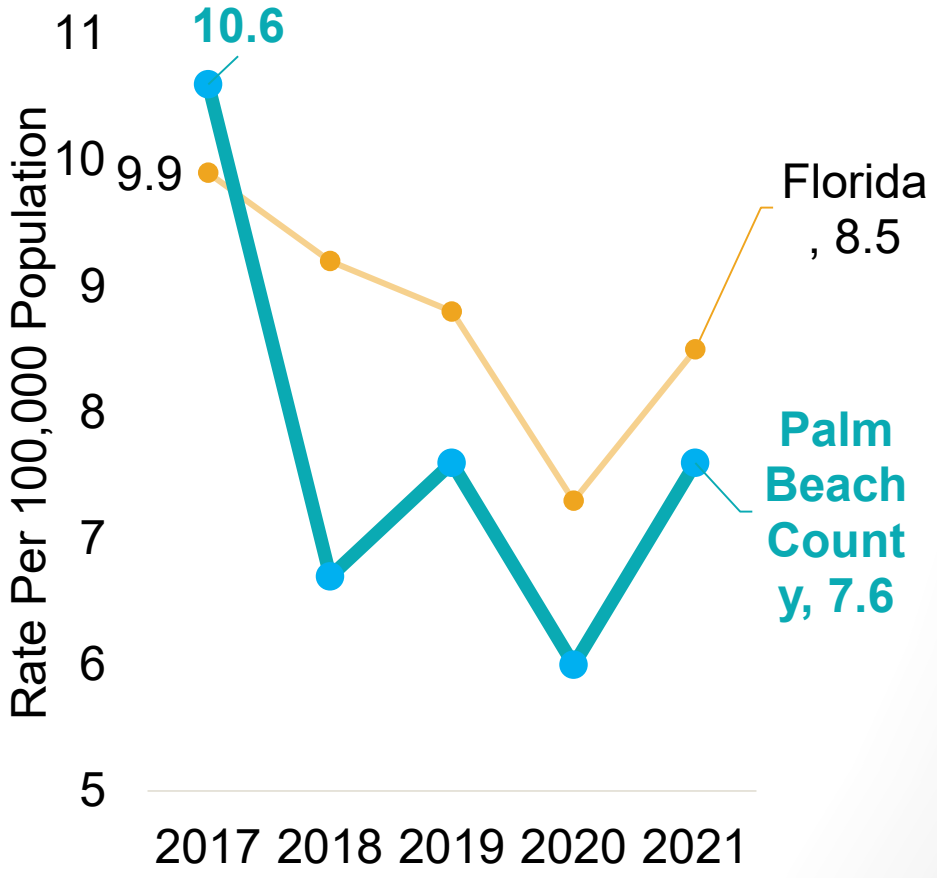
1) **Diagnose**
2) Treat
3) Prevent
4) Respond

New Diagnoses (HIV & AIDS)

In 2021, the rate of new HIV diagnoses in **Palm Beach County was slightly more than in Florida**.



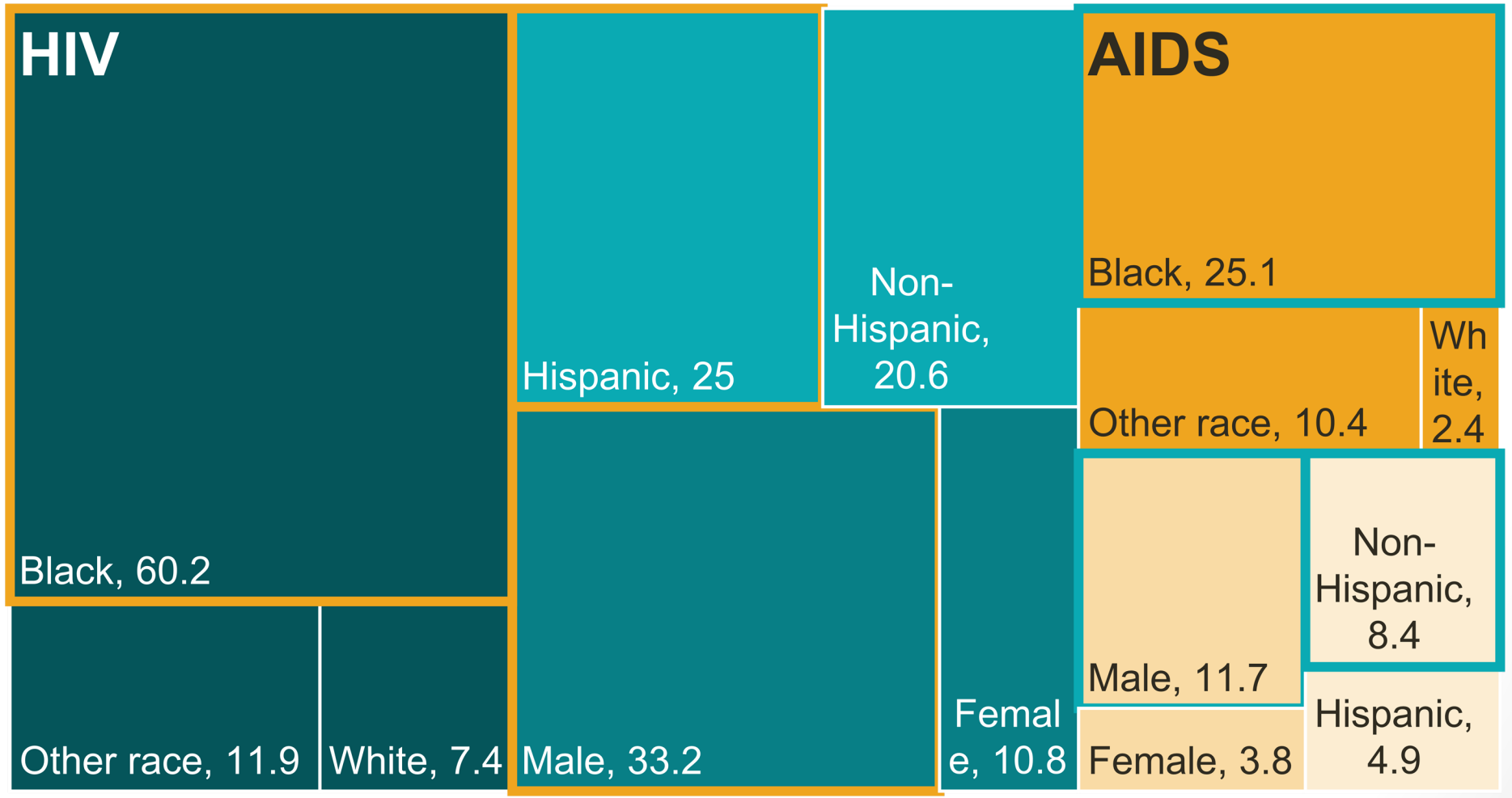
In 2021, the rate of new AIDS diagnoses in **Palm Beach County was lower than in Florida**.



FLHealth Charts, Bureau of Communicable Diseases, 2022

New Diagnoses (HIV & AIDS)

By Race, Ethnicity, and Sex

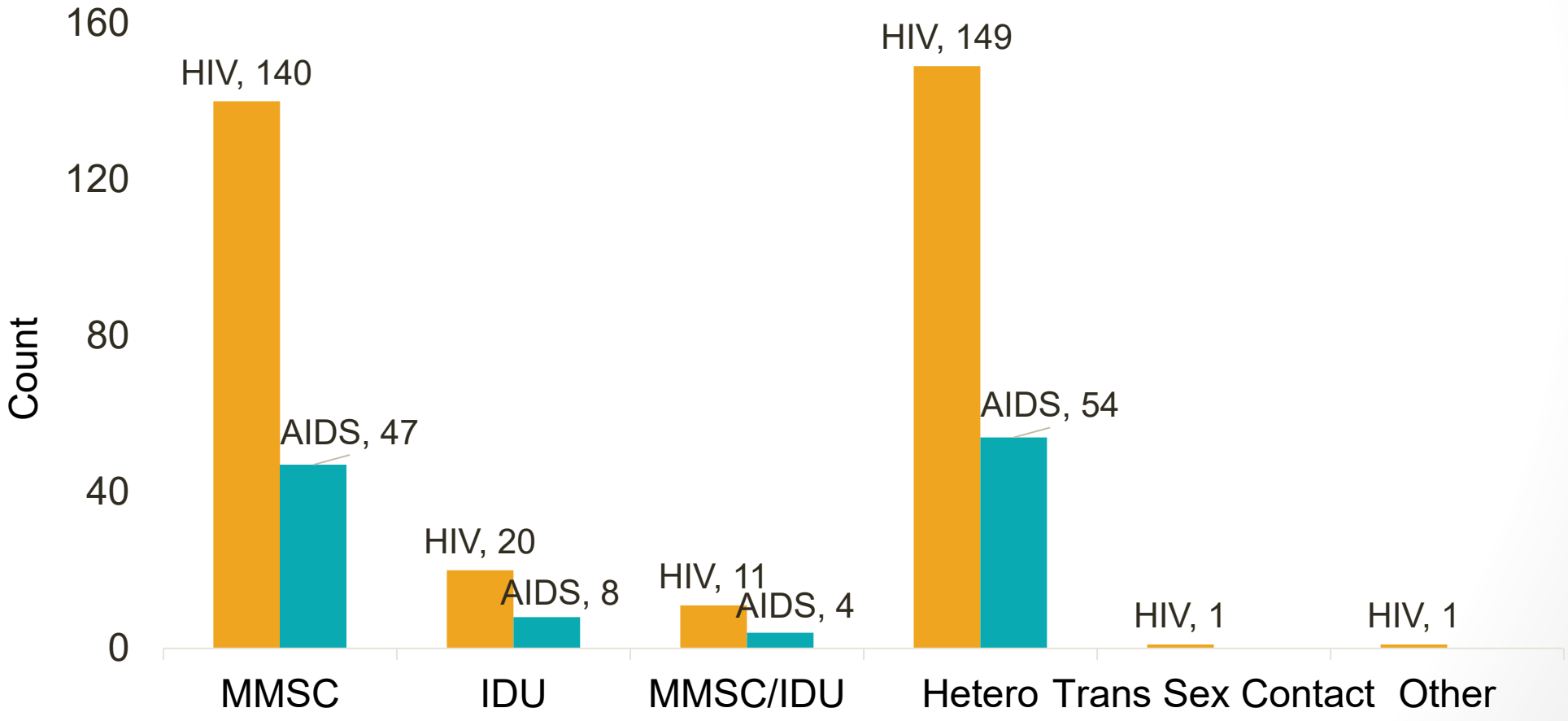


FLHealth Charts, Bureau of Communicable Diseases, 2022

New Diagnoses (HIV & AIDS)

By Mode of Exposure

Among those newly diagnosed in Palm Beach County, **heterosexual contact** was the predominant mode of exposure reported in 2021, although it was closely followed by **male-male sexual contact for both HIV and AIDS.**



FLHealth Charts, Bureau of Communicable Diseases, 2022

Ending the HIV Epidemic in the U.S. (EHE) Initiative

1) Diagnose
2) **Treat**
3) Prevent
4) Respond

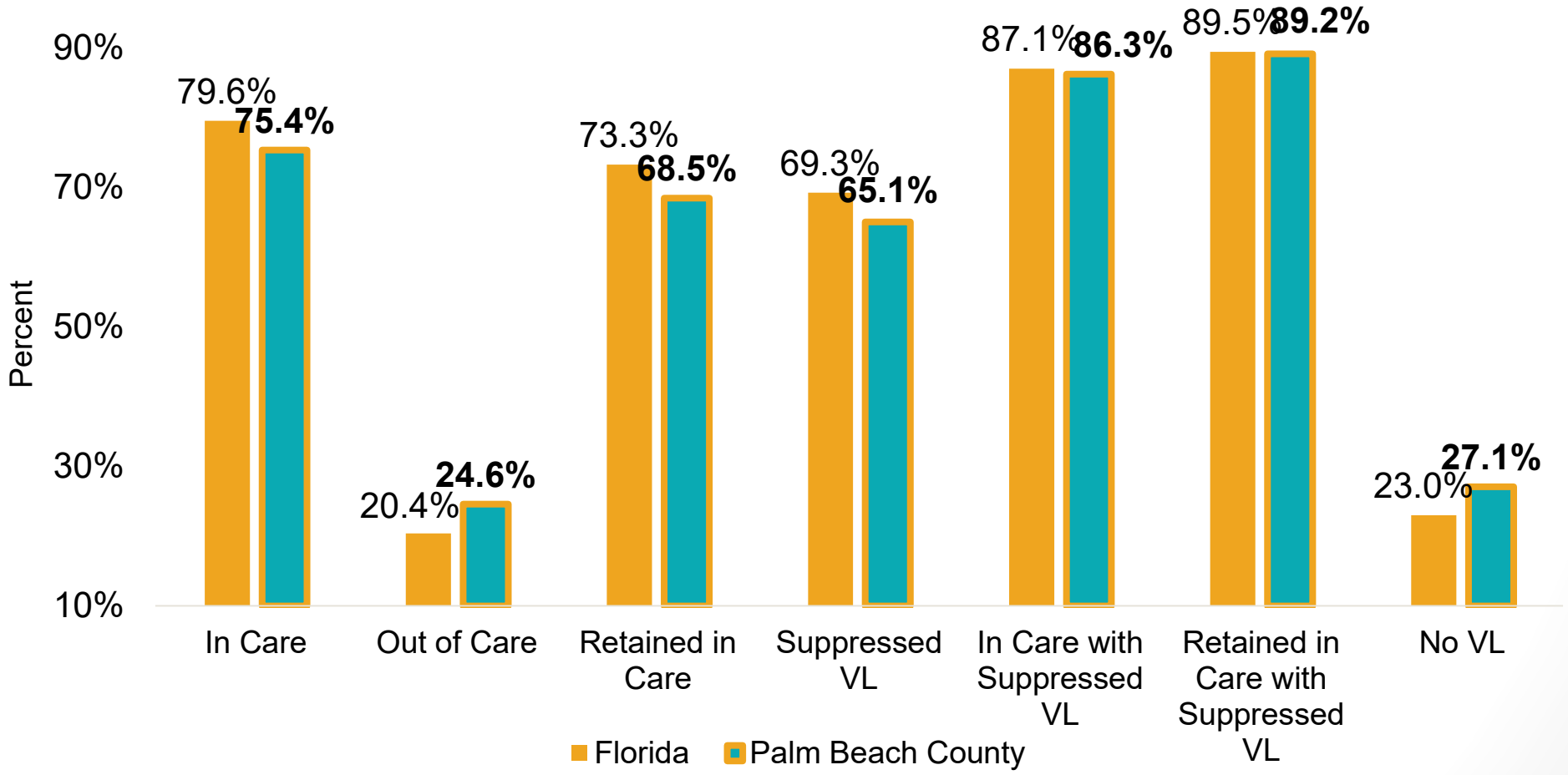
HIV Care Continuum

Adapted from: Florida Department of Health, HIV/AIDS Surveillance Program

HIV Care Continuum

Palm Beach County vs. Florida

In 2021, **Palm Beach County mirrored state trends** for various HIV Care Continuum indicators.



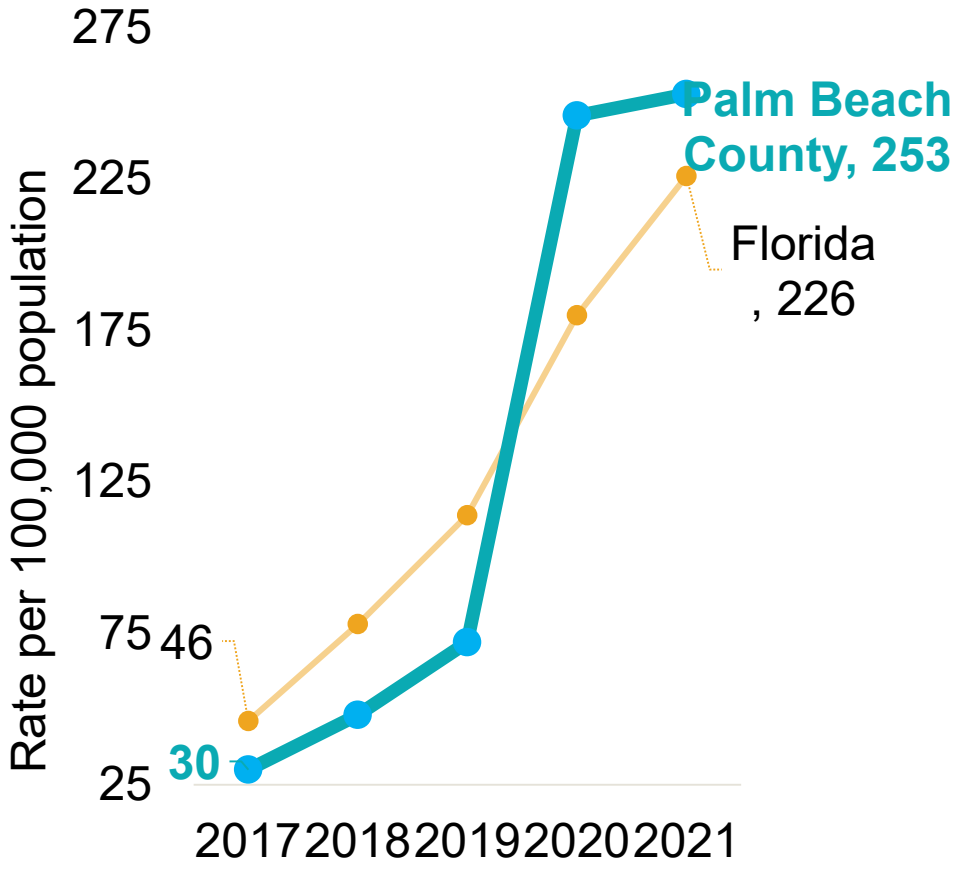
Florida Department of Health, enhanced HIV/AIDS Reporting System (eHARS), 2022

Ending the HIV Epidemic in the U.S. (EHE) Initiative

1) Diagnose
2) Treat
3) **Prevent**
4) Respond

PrEP Coverage

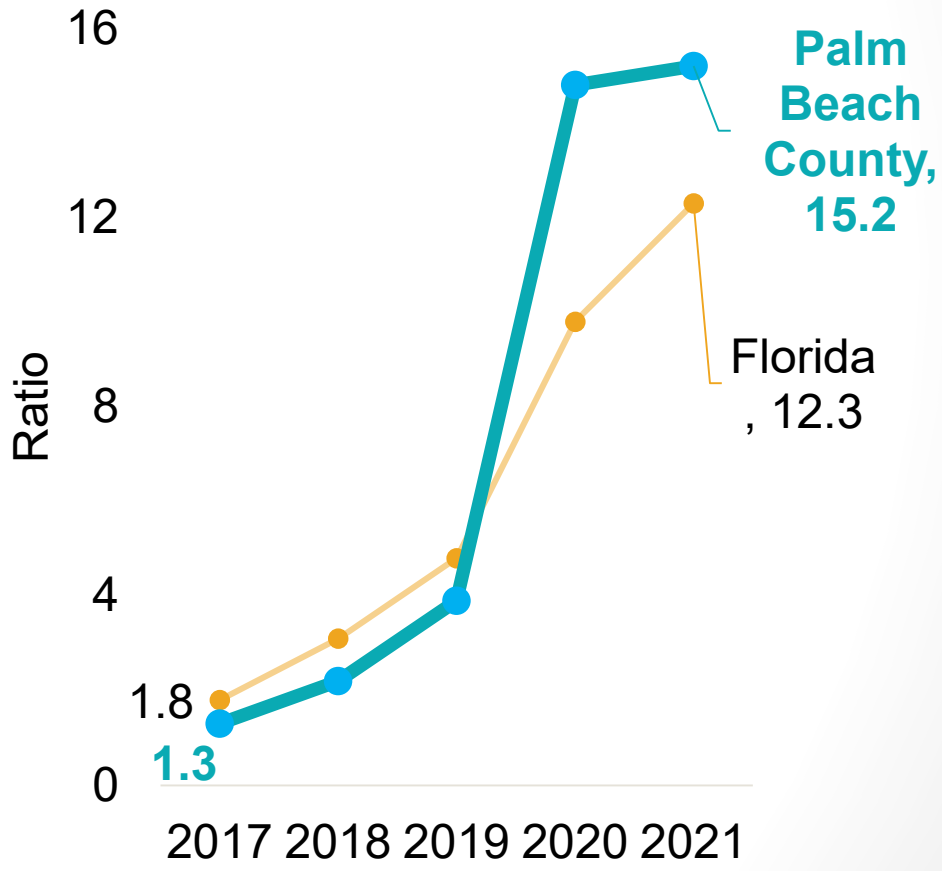
In 2021, the rate of PrEP coverage in **Palm Beach County was higher than Florida**.



PrEP to Need

In 2021, the PNR in **Palm Beach County was higher than in Florida**.

(Lower PNR= higher unmet needs)



FLHealth Charts, Bureau of Communicable Diseases, 2022

Ending the HIV Epidemic in the U.S. (EHE) Initiative

1) Diagnose
2) Treat
3) Prevent
4) **Respond**

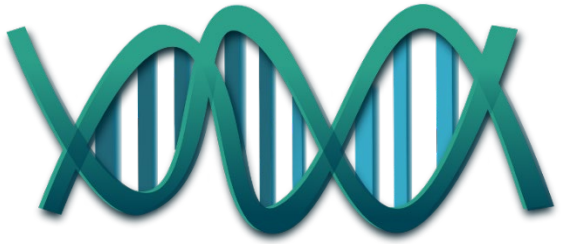
Tracking Molecular Clusters

Molecular Cluster includes persons living with HIV identified with genetically similar strains.

Transmission Network includes persons with HIV (diagnosed and undiagnosed) who share a transmission connection but are *not genetically sequenced*.

Risk Network includes *persons at risk for HIV infection* due to behaviors or contacts.

41%



18 residents

11

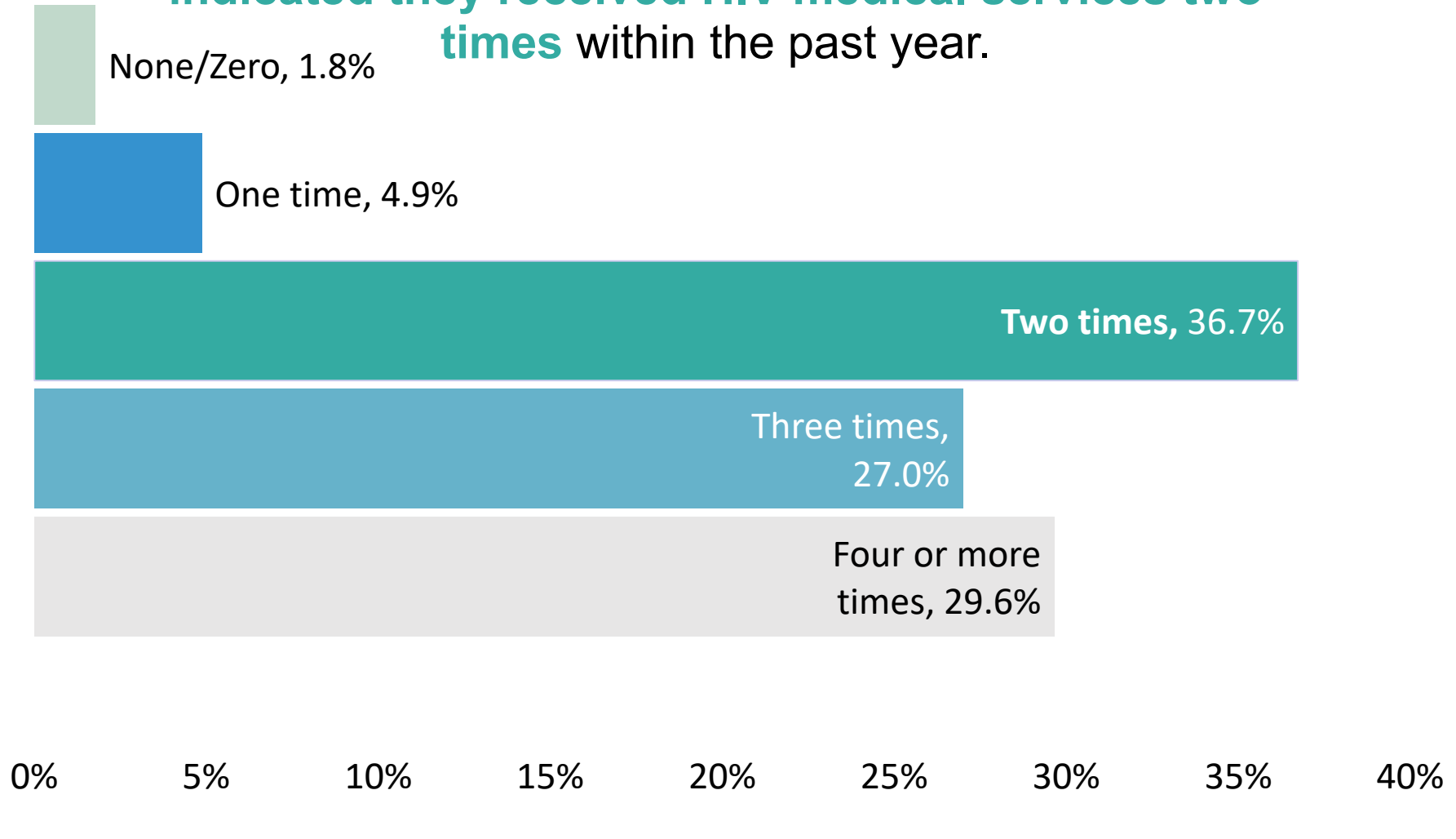
Adapted from: CDC (2017) Detecting, Investigating and Responding to HIV Transmission Clusters

Community Perspectives

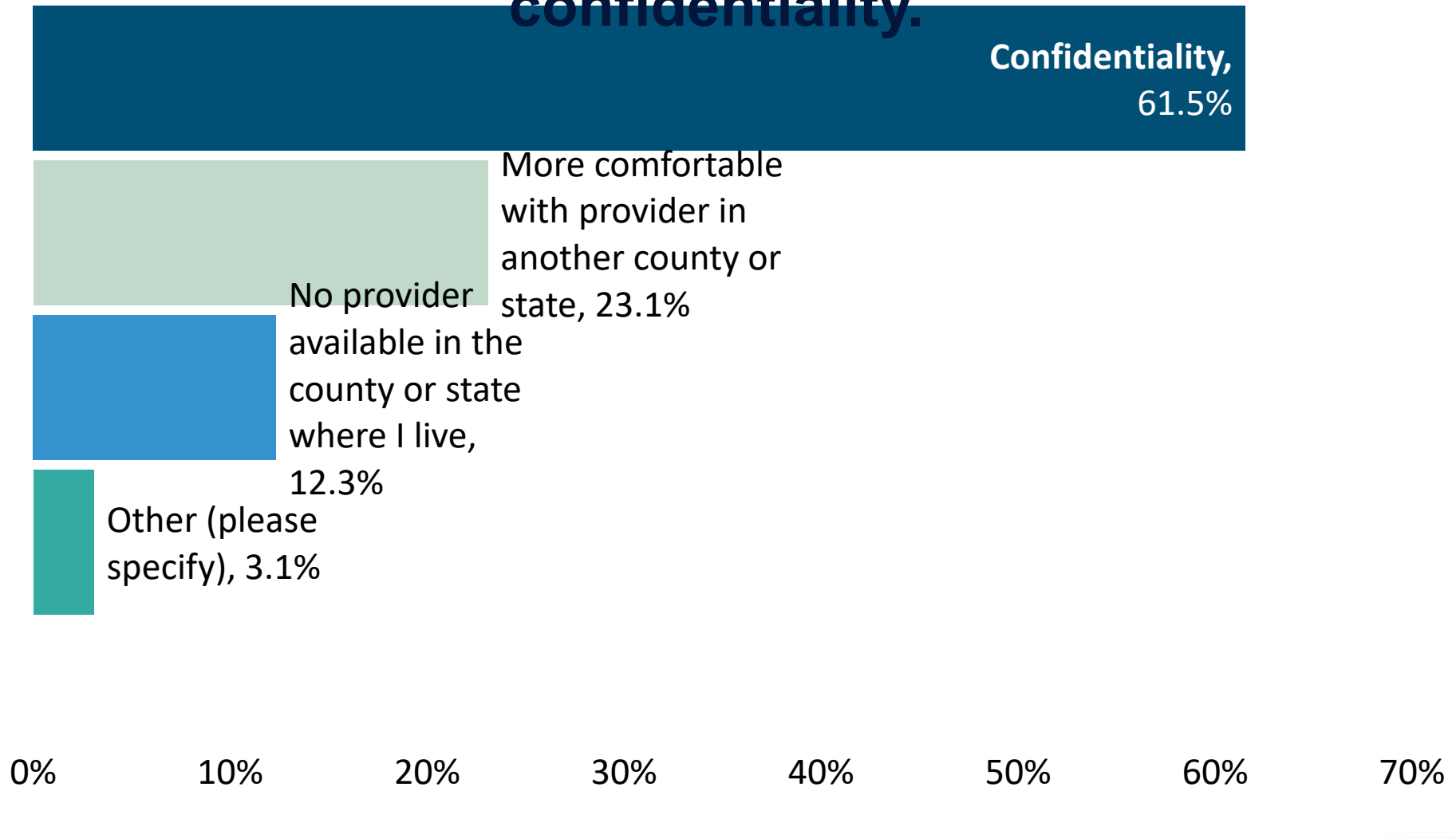
2022-2023 Palm Beach County
Ryan White Part B HIV Needs Assessment

Survey Highlights

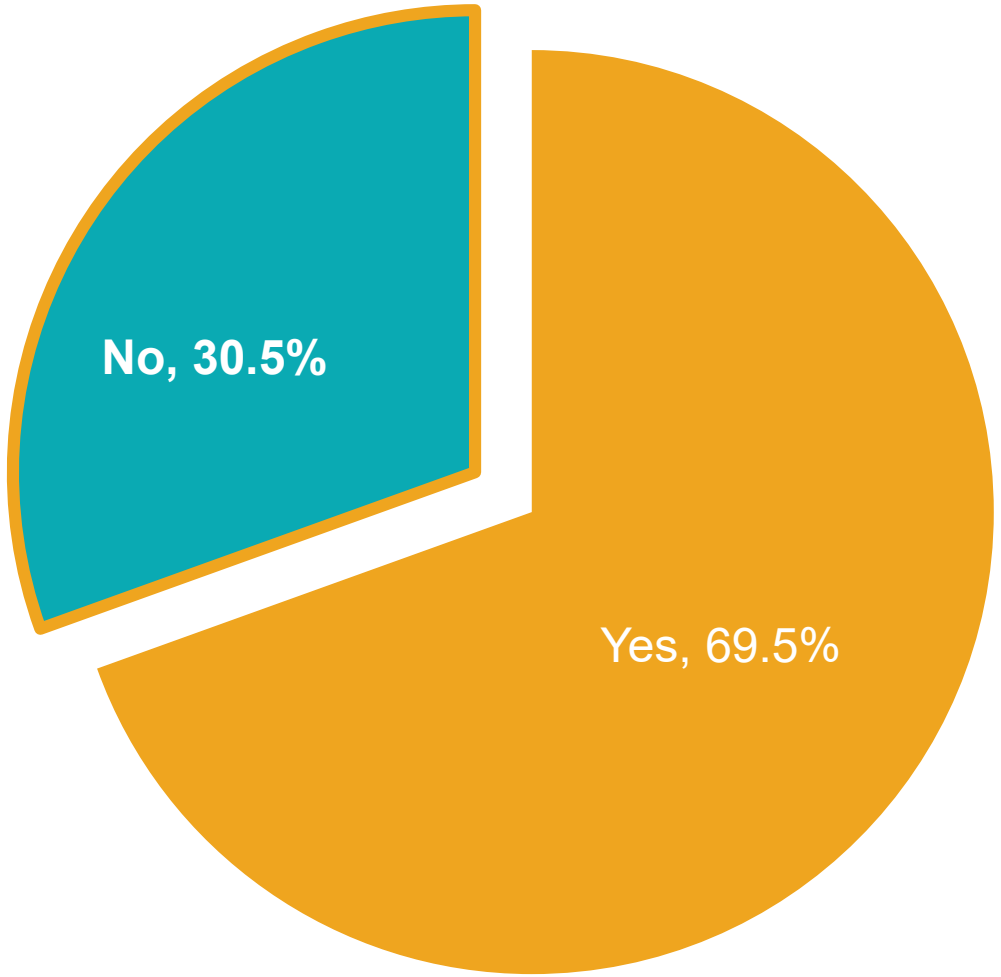
When asked “How often did you receive HIV-related medical care during the past 12 months?”, **36.7% indicated they received HIV medical services two times** within the past year.



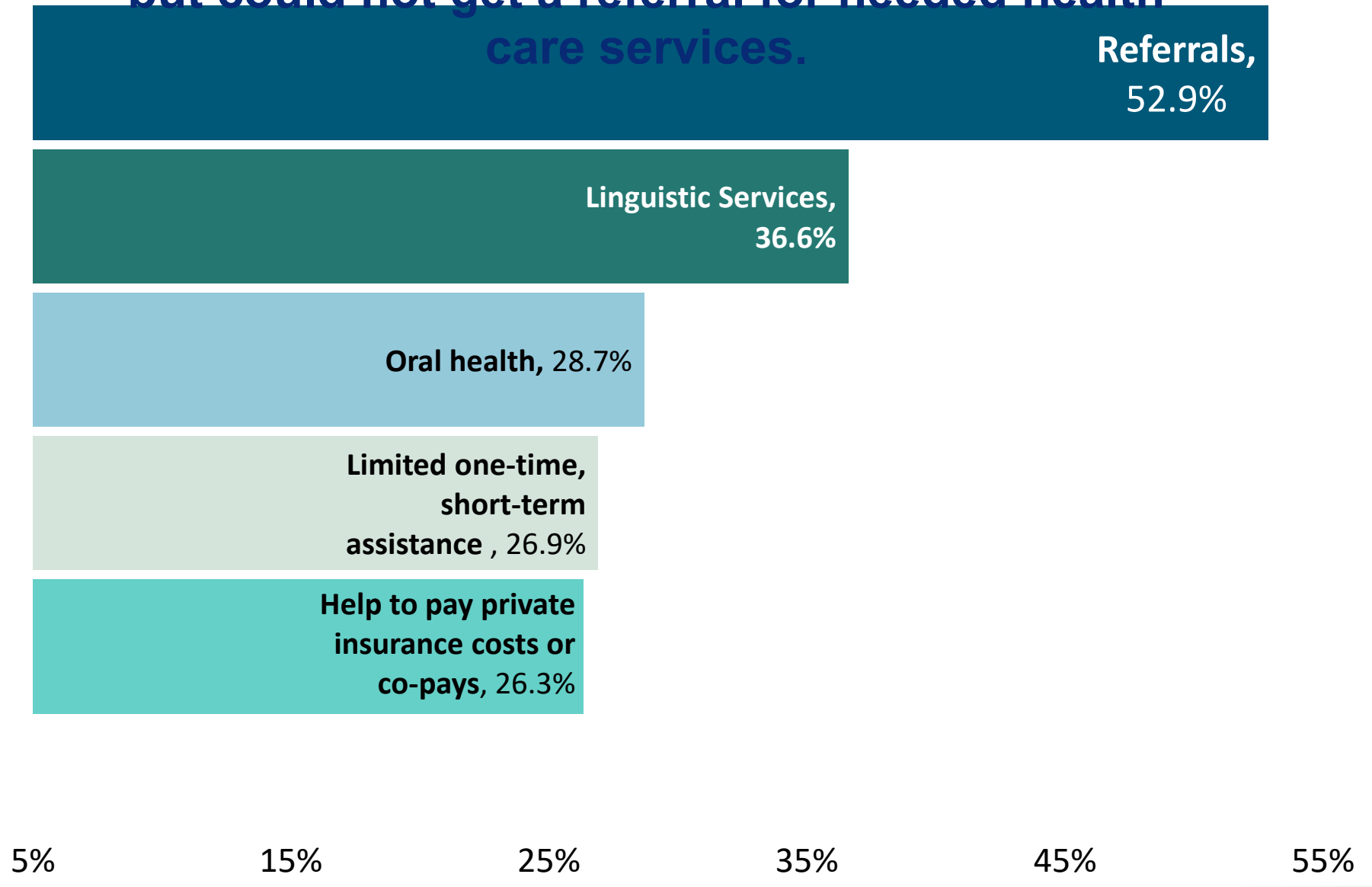
Most survey respondents received HIV Care outside the county that they live in due to **confidentiality.**



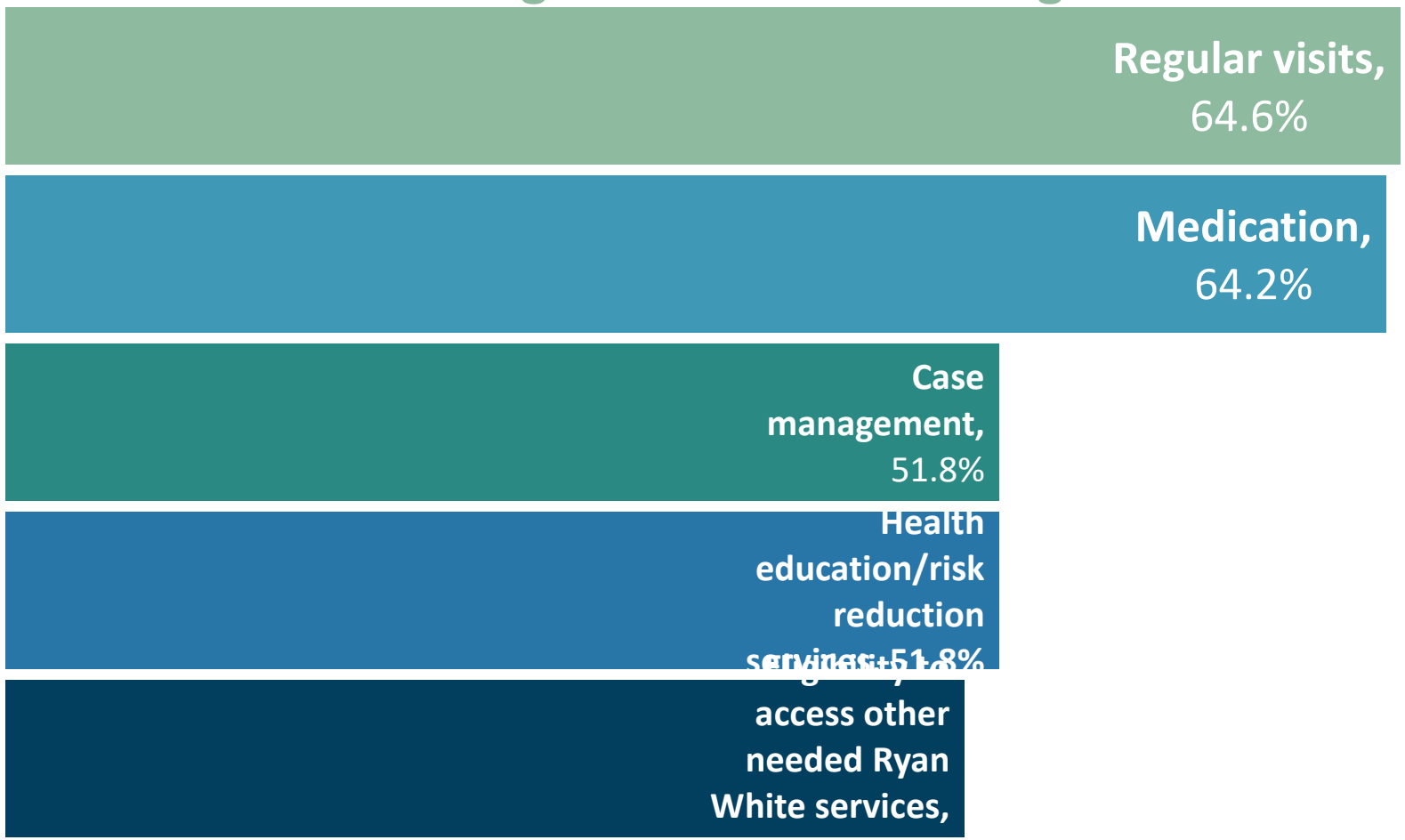
Among all survey respondents, **one-third (30.5%) were not aware of the principals behind U=U**.



When asked to identify services they needed but could not get, **over half of participants needed but could not get a referral for needed health care services.**



When asked to identify services they needed and were able to receive, most respondents were able to **see a doctor or go to the clinic for regular visits.**



Focus Group Highlights

Focus Group Highlights

- Participants felt that HIV in Palm Beach County is **frequently stigmatized** and **misconstrued**. Participants also highlighted that **engagement or conversations** related to HIV **are limited** within the community.
- Medication Management and Care Adherence:

- **Participants indicated that once connected to care, they have adhered to their treatments and have not faltered in their care.**
  - Managing side-effects when trying to find the right medication
  - Entering care can be “overwhelming at the beginning”

Focus Group Highlights *(Continued)*

- **Positive Experiences** with Providers:
  - Staff treats them with kindness
  - makes them ‘feel human again.” …often felt “invisible” or “lesser” but a simple compliment fosters joy

- **Neutral:** Difficulty finding a new PCP that will also take care of their HIV needs.
  - “Dual doctor” → limits the number of different providers they have to see.

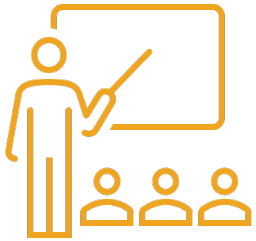
Focus Group Highlights *(Continued)*

- **Concerns**
  - Medication pick-up at Pharmacy → Fears of being 'outed'
  - Home- Delivered Medications → Fears of losing housing
  - Barriers accessing HOPWA



- **Navigating romantic and sexual relationships**

- **Increasing Community Education**



Key Informant Interview Highlights

Program Successes

- **Test and Treat Program**
- **Early Intervention Services (EIS) program**
- **AIDS Drug Assistance Program (ADAP)**
  - Provide medications to clients on-site
  - If clients come in or call with medication issues, the staff are able to “trouble shoot right away… as they see medication as a priority.”

Key Informant Interview Highlights

- **Health literacy**
  - Clients may not understand why they are being referred to a specialist → results in Participants becoming agitated and disengaging with the system.
  - Challenges clients face when they switch insurance and, usually unknowingly, lose their Ryan White eligibility.
- **Increasing staff capacity**
  - Hire staff who speak other languages, such as Spanish and Haitian-Creole.
  - Increasing knowledge of services amongst new staff hires.
- **Addressing Social and Economic Conditions that impact health**
  - The system will “save [clients] from HIV and AIDS, but they’re going to die of hunger.”
  - With proper support and training, Participants can be “world builders and [poverty] cycle-breakers.”

Questions?

Thank you!

For more information, reach out to us at planning@hcsef.org or visit our website at www.HCSEF.org.

HEALTH COUNCIL OF SOUTHEAST FLORIDA

DAY 2 – JULY 12, 2023

HIV Dashboards Overview

Casey Messer, DHSc, PA-C, AAHIVS

Program Manager

PBC Ryan White HIV/AIDS Program

cmesser@pbcgov.org

561-355-4730

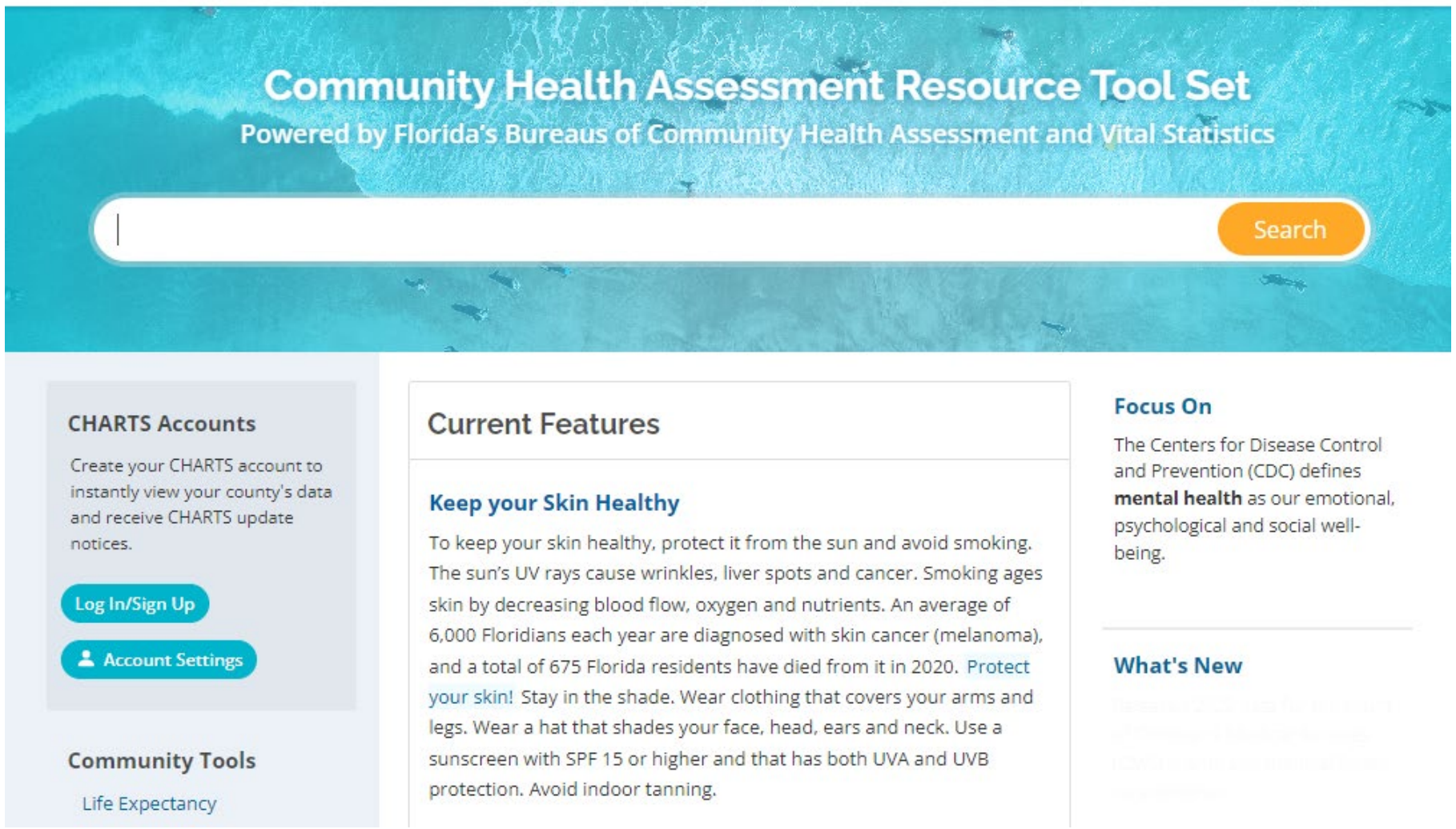
Palm Beach County
Ryan White HIV/AIDS Program

HIV Dashboards Overview

- Ryan White HIV/AIDS Program Compass Dashboard
- Americas HIV Epidemic Analysis Dashboard (AHEAD)
- AIDSVu
- FDOH Ending the HIV Epidemic Dashboard

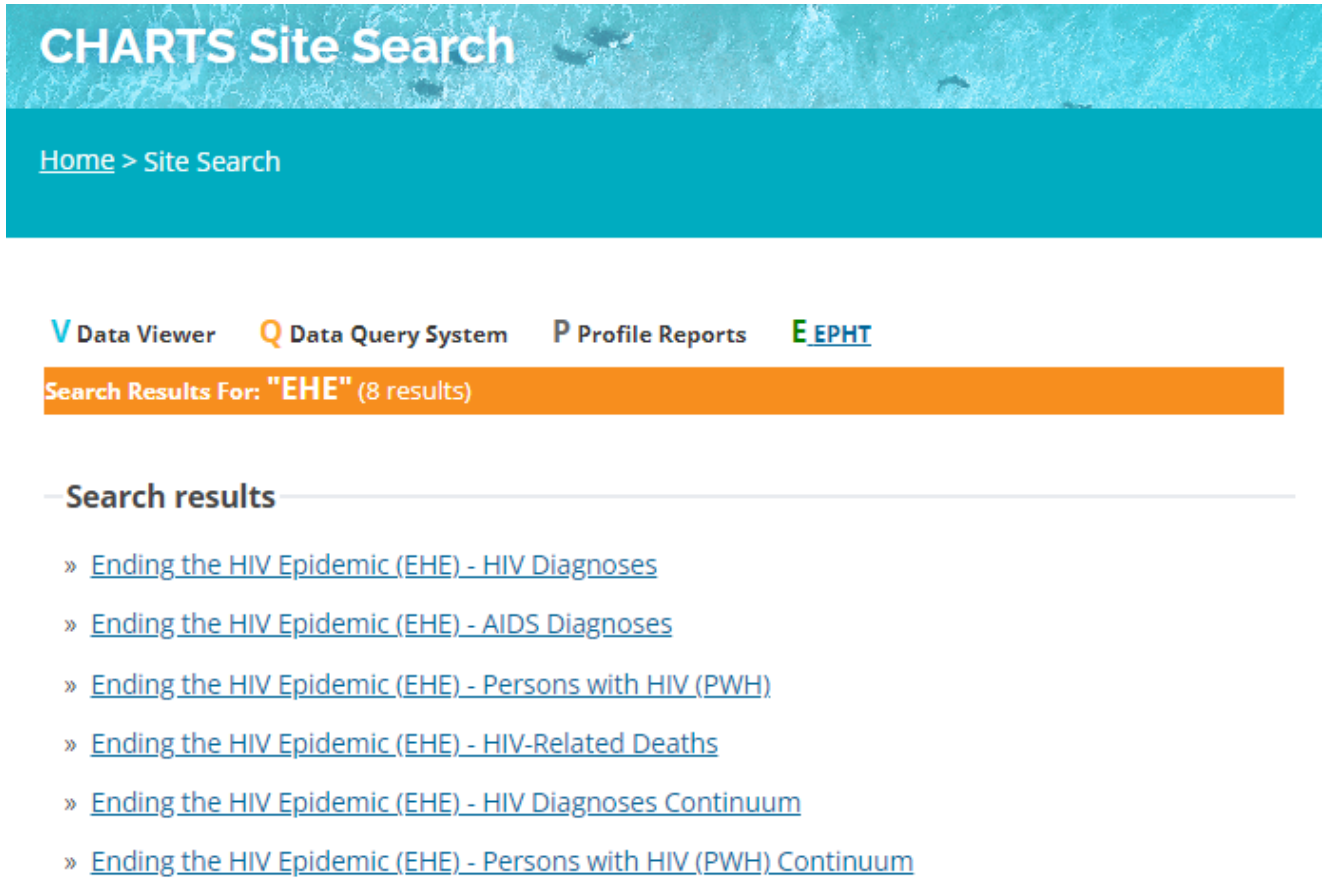
Florida Department of Health

FLHealthCHARTS
EHE Dashboard

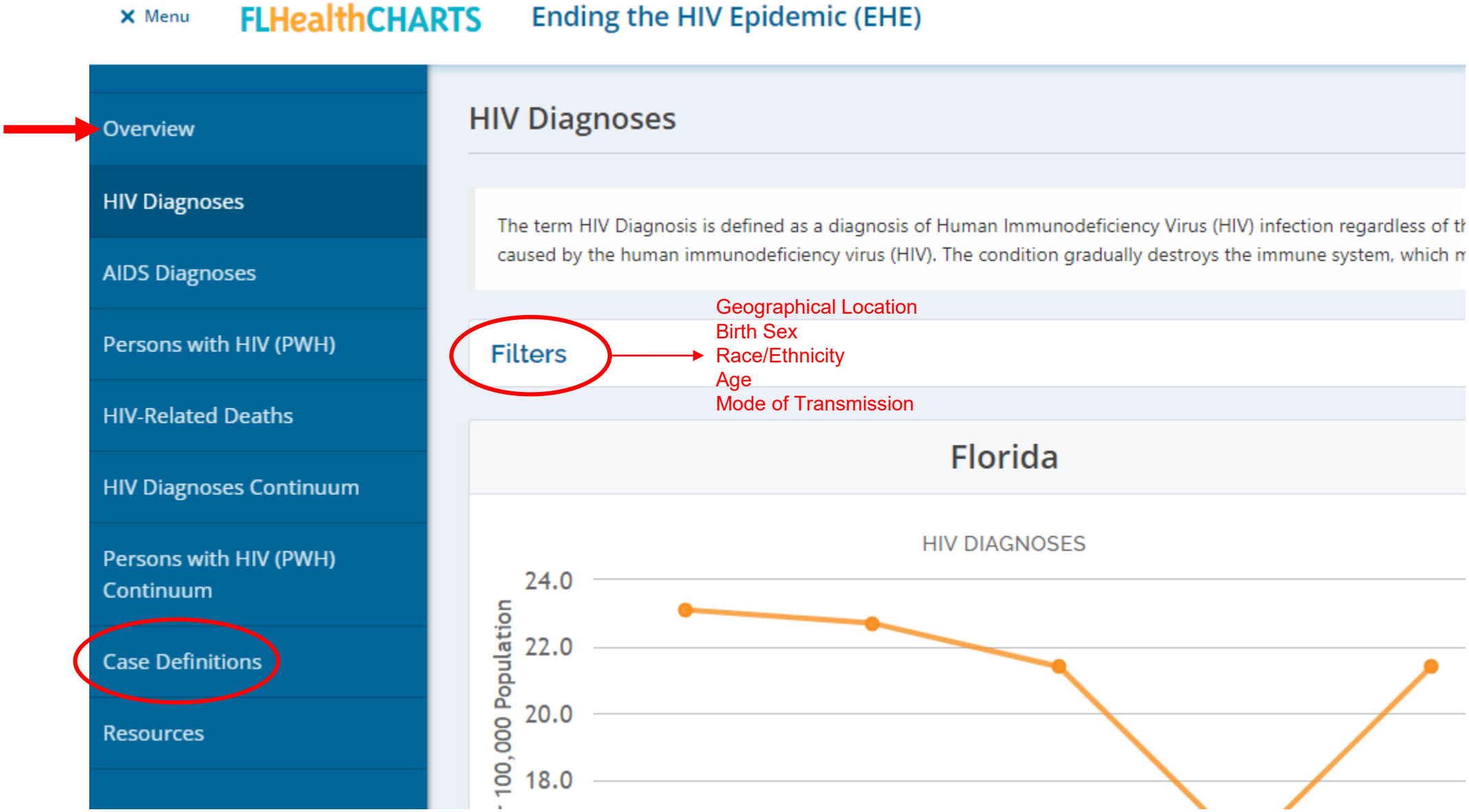


https://www.flhealthcharts.gov/charts/

Search “EHE” or “Ending the HIV Epidemic”

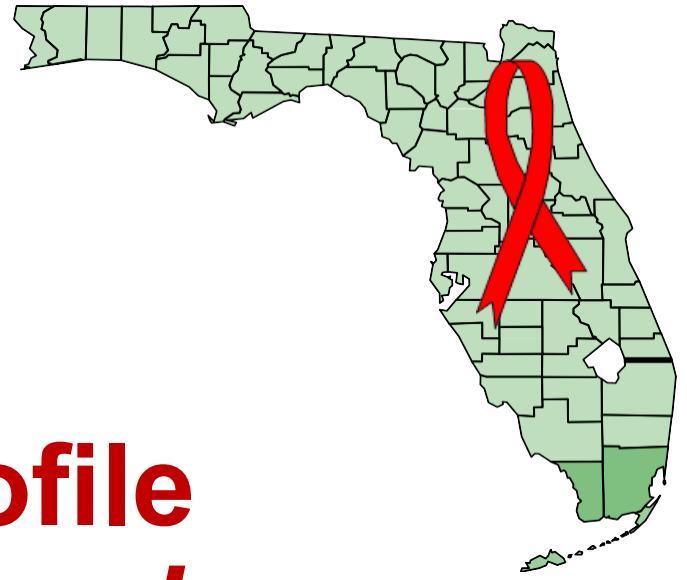


https://www.flhealthcharts.gov/EHE/rdPage.aspx?rdReport=Overview


× Menu
FLHealthCHARTS
Ending the HIV Epidemic (EHE)
Overview
HIV Diagnoses
AIDS Diagnoses
Persons with HIV (PWH)
HIV-Related Deaths
HIV Diagnoses Continuum
Persons with HIV (PWH) Continuum
Case Definitions
Resources
HIV Diagnoses
The term HIV Diagnosis is defined as a diagnosis of Human Immunodeficiency Virus (HIV) infection regardless of th
caused by the human immunodeficiency virus (HIV). The condition gradually destroys the immune system, which m
Filters
Geographical Location
Birth Sex
Race/Ethnicity
Age
Mode of Transmission
Florida
HIV DIAGNOSES
24.0
22.0
20.0
18.0
100,000 Population

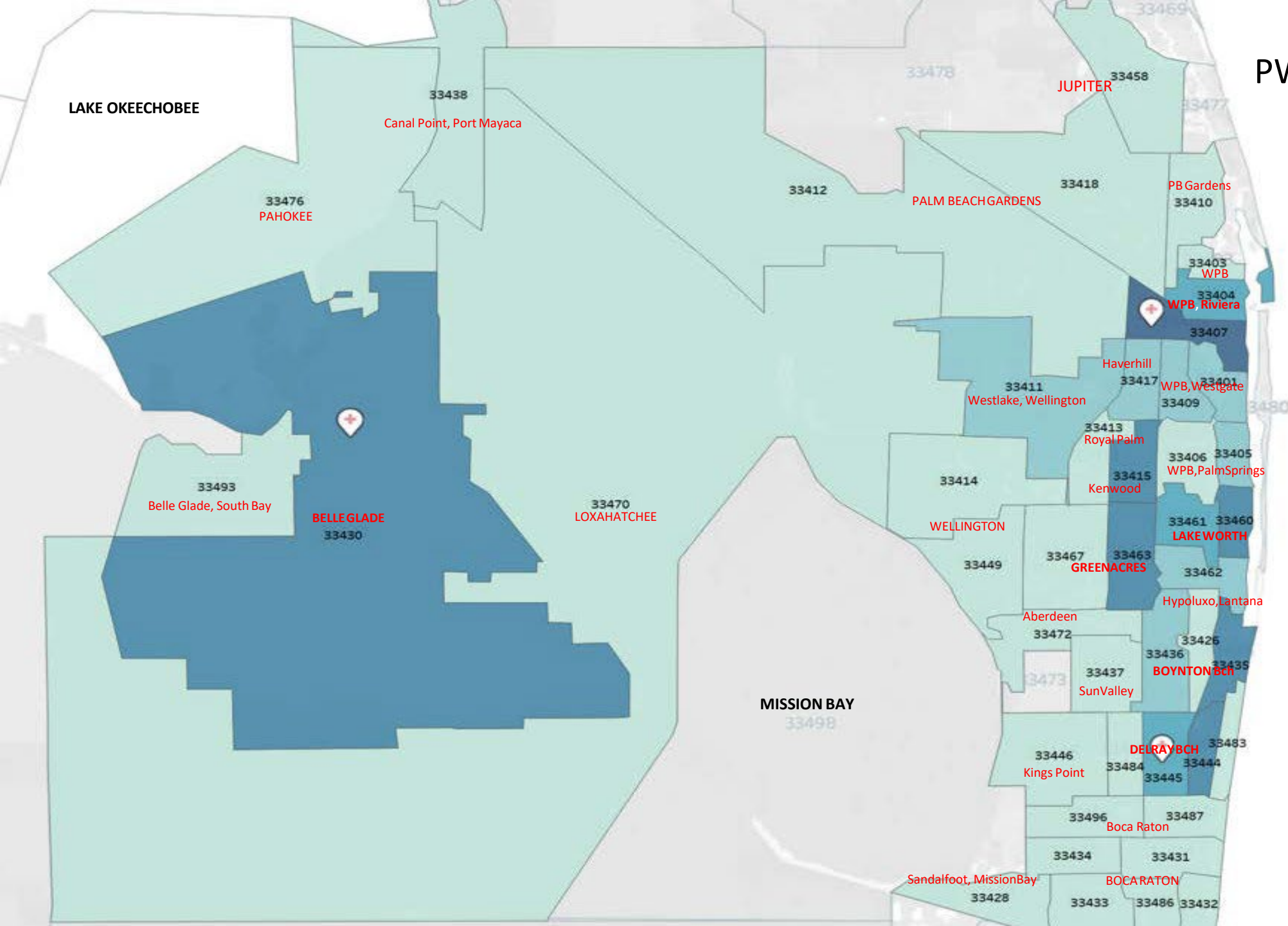
Contact Information

Maricruz Jurado
EHE Coordinator
Maria.Jurado@flhealth.gov
561-946-8910



2021 HIV Epidemiologic Profile & Care Continuum--*Palm Beach*

PWH by Zip Codes- ***2021***
Palm Beach County

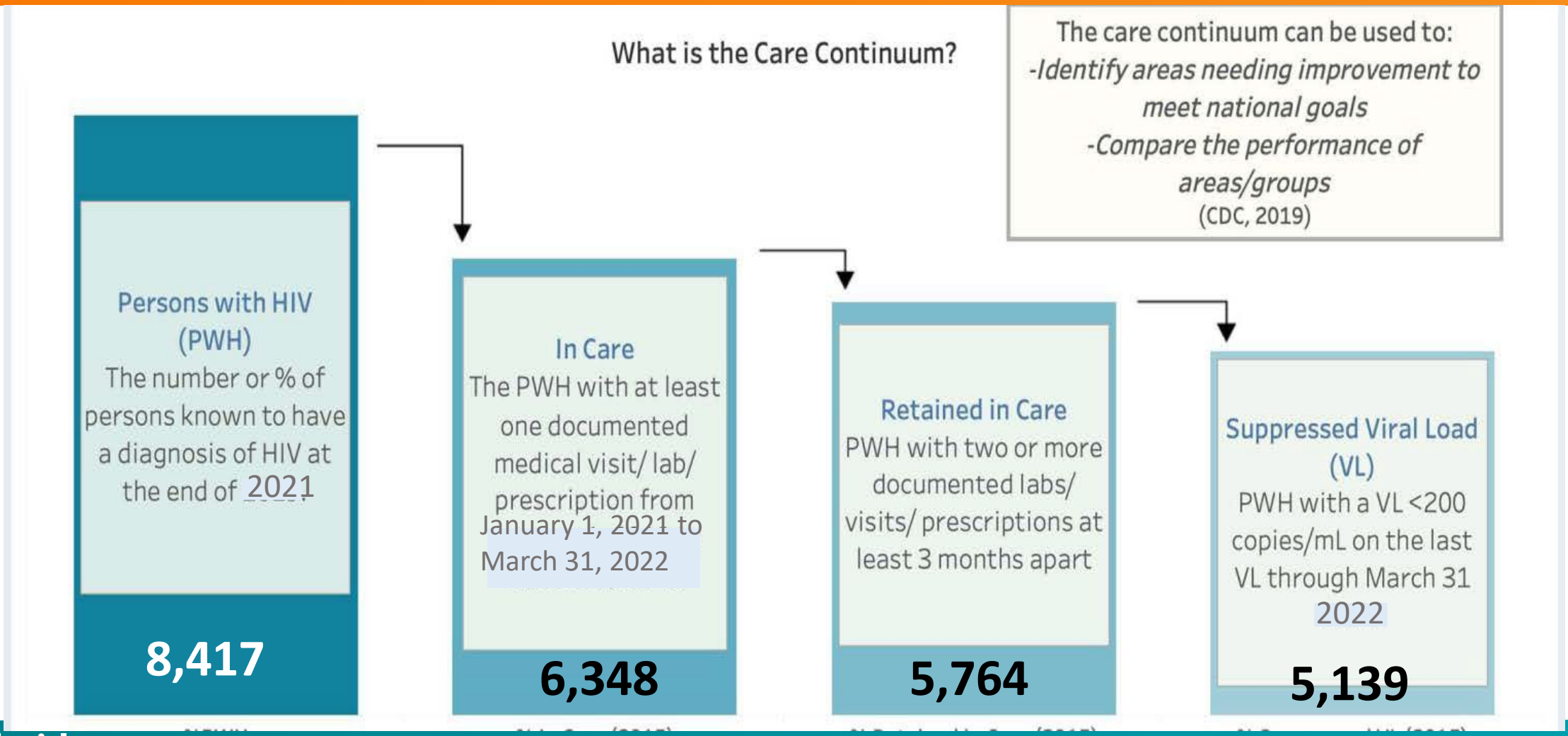


PWH 2021 – by Zip Codes --Palm Beach	(N)
33401 West Palm Beach	433
33403 Riviera Beach	126
33404 Riviera Bch / Lake Park/ North Palm Beach	543
33405 West Palm Beach	146
33406 CloudLake/ GlenRidge/ PalmSprings/ Pine Air	188
33407 Riviera Bch / Mangonia Park / Wes tPalm Bch	676
33409 WestGate / West Palm Beach	274
33411 Westlake/Royal Palm Beach/Golden Lakes	274
33414 Wellington / Royal Palm Beach	128
33415 RoyalPalm/ AcaciaVillas/ Haverhill /Kenwood	270
33417 Haverhill / Lakeside Green / Cypresss Lake	214
33426 Boynton Beach	164
33428 Sandalfoot Cove / Mission Bay	107
33430 Belle Glade	446
33431 33432 33434 Boca Raton	169
33433 Boca Pointe / Boca Del Mar / Sandalfoot	96
33435 Briny Breezes / Boynton Bch /Ocean Ridge	480
33436 Dunes Road / Boynton Beach / Golf	196
33437 Sun Valley	116
33444 Delray Beach	479
33445 Delray Beach	238
33458 Limestone Creek / Jupiter	88
33460 Lake Worth	441
33461 Lake Worth / Palm Springs	296
33462 Hypoluxo/ San Castle/ Lantana / Manalapan	229
33463 Greenacres	328
33467 Greenacres	136
33476 Pahokee	92

Palm Beach HIV Epidemiology = 2021 vs. 2020

PALM BEACH Epidemiology	2021 = Palm Beach (2021 Pop'n= 1,487,272)	2020 = Palm Beach (2020 Pop'n= 1,469,904)
Incidence (New) = HIV	322	222
(New) = AIDS	113	89
Total New (H + A)	435	311
Incidence Rate = HIV	21.7 / 100,000	15 /100,000
= AIDS	7.6 / 100,000	6 /100,000
Diagnosis Rate (IR) = H + A	29 / 100,000	21 / 100,000
Prevalence (PWH: ongoing cases)	8,417	8,280
PREVALENCE Rate (PWH ongoing)	566/ 100,000	563/100,000
HIV Deaths	39	48
HIV Death Rate	3.0 / 100,000	3.9/100,000
HIV Case Fatality Rate	4.6 / 1,000 HIV's	5.7/1000 HIV's

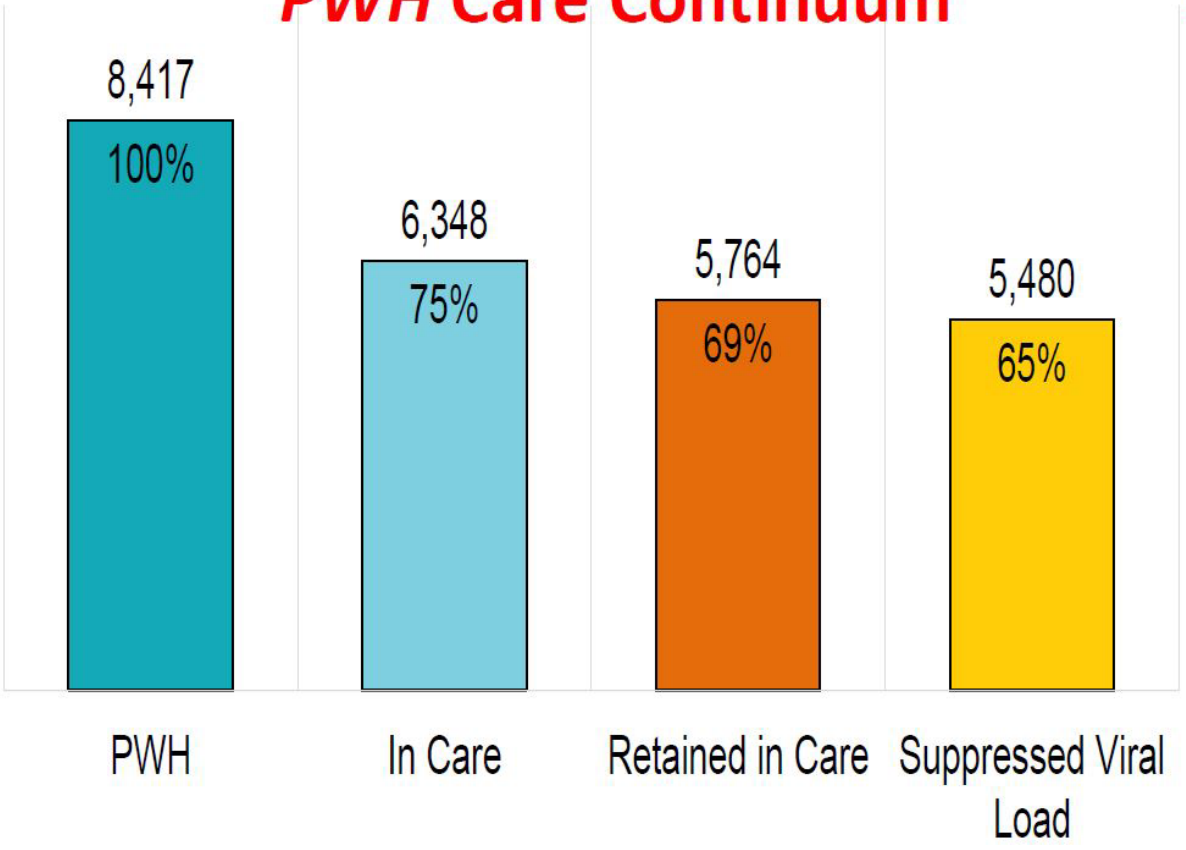
Definitions: HIV *Care Continuum* stages –Palm Beach 2021



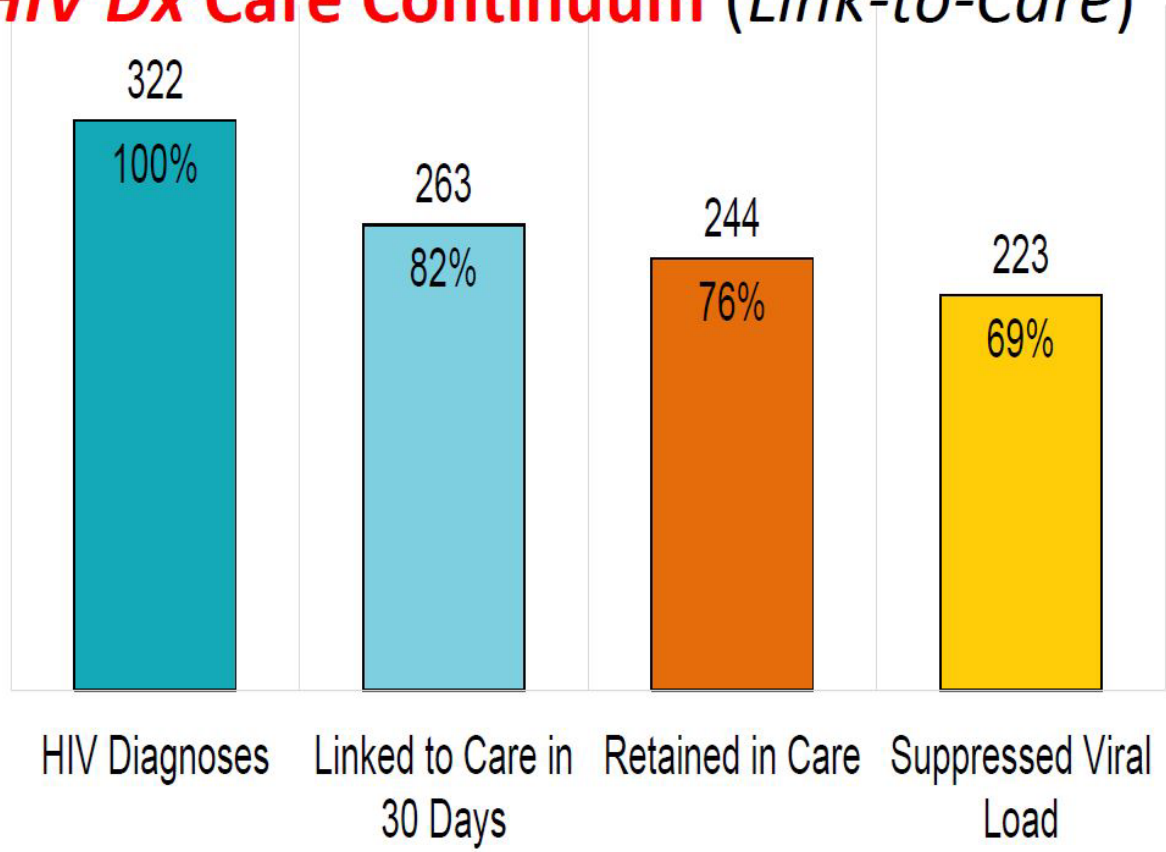
NOT in CARE - 2,068 *(25%)*

Care Continuum: *PWH* vs. *New HIV Dx* --2021 Palm Beach

PWH Care Continuum



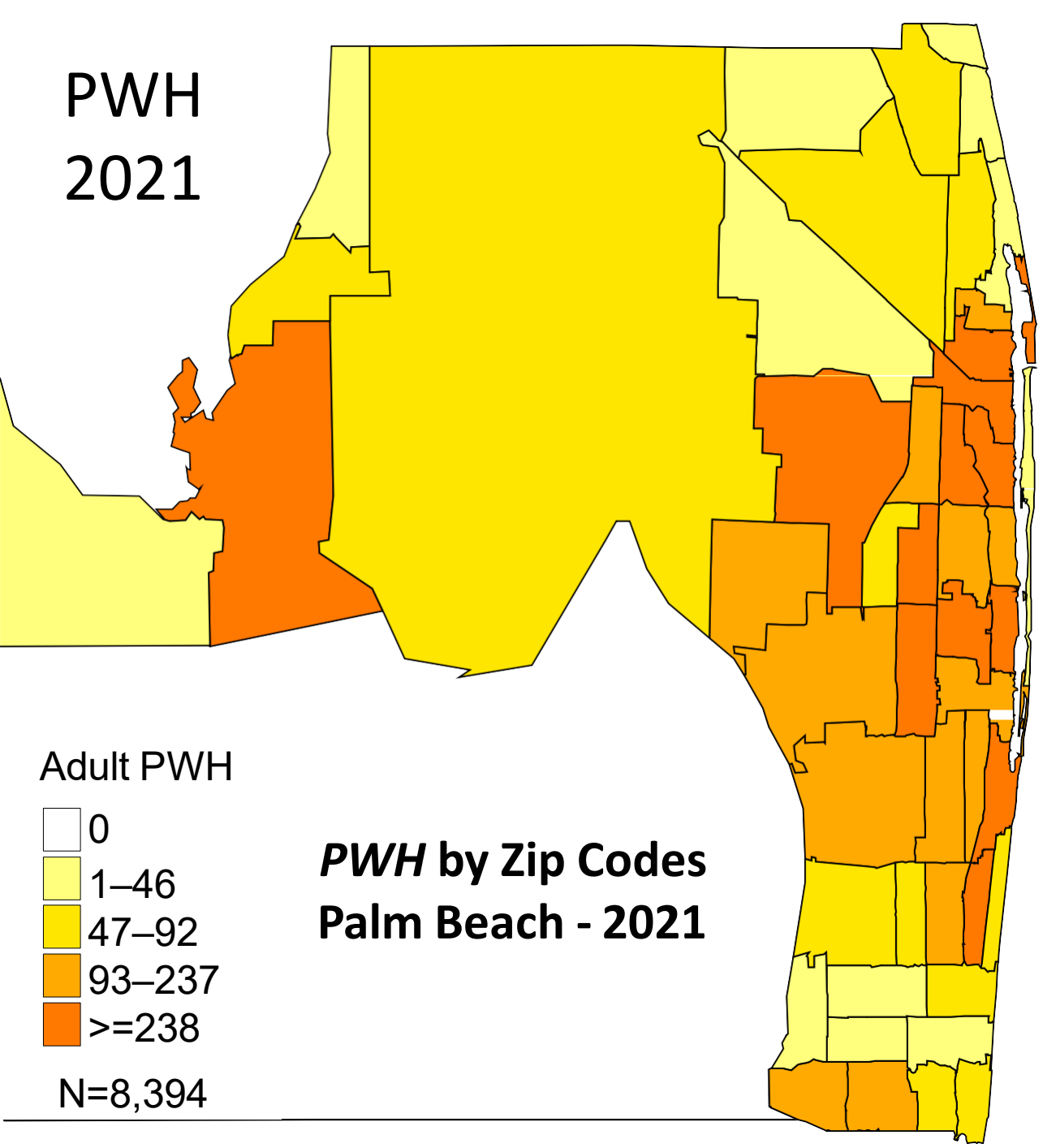
New HIV Dx Care Continuum (*Link-to-Care*)



Florida HEALTH

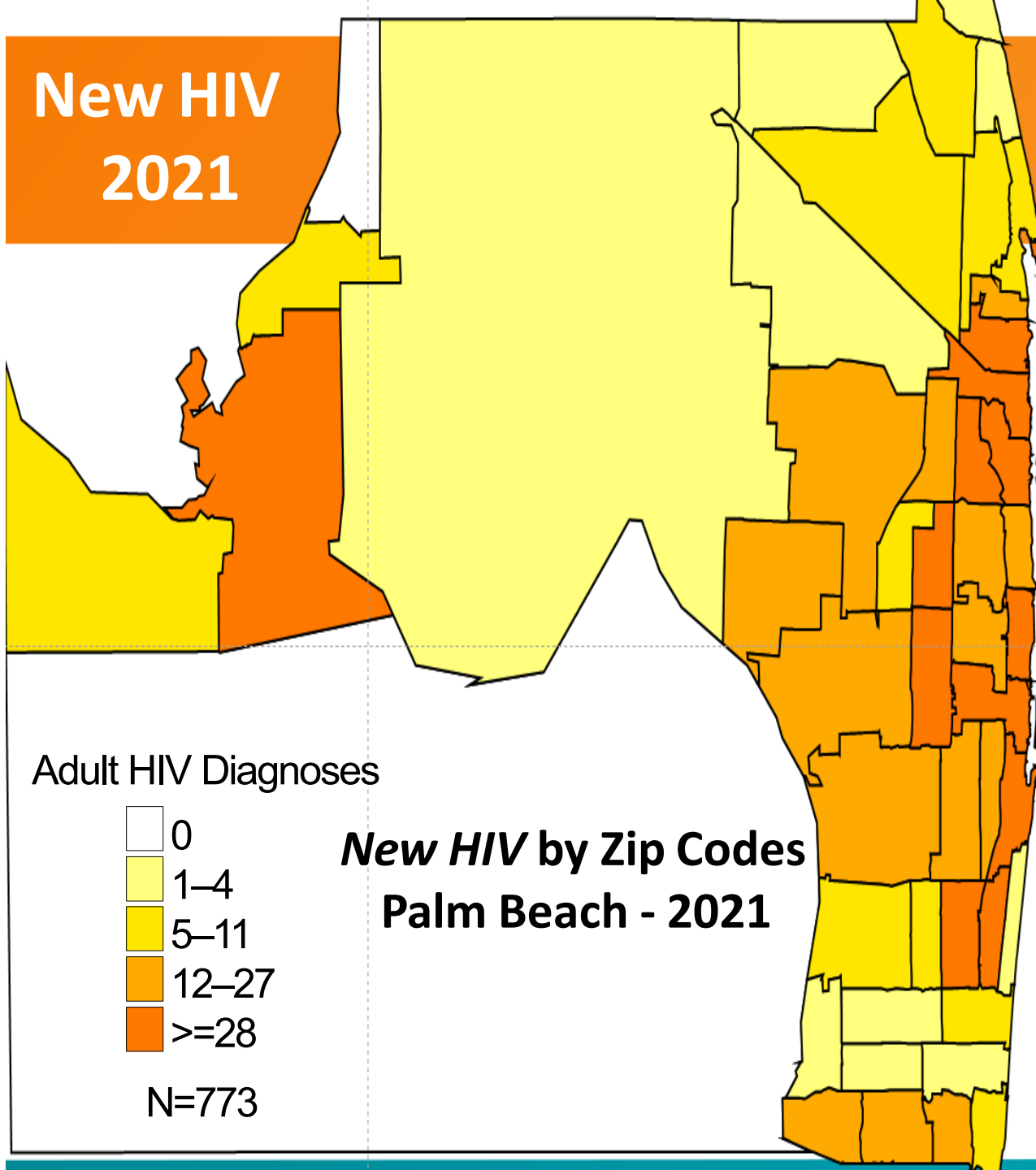
Note: 89% of persons retained in care had a suppressed viral load.

PWH
2021

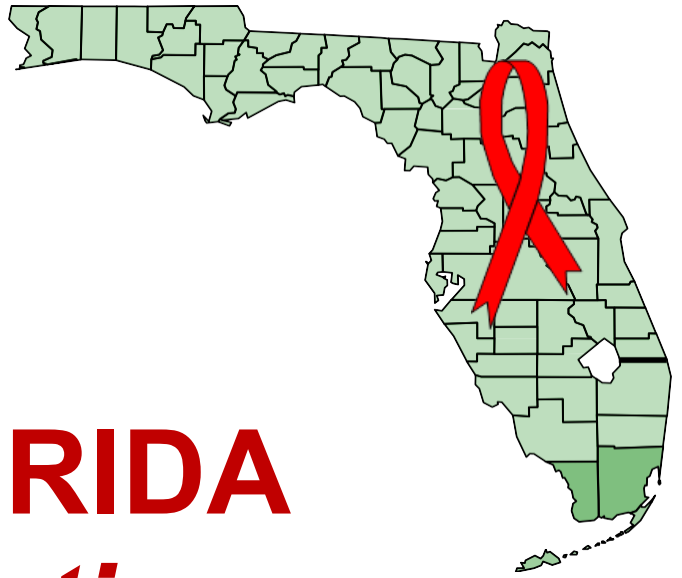


***PWH* by Zip Codes**
Palm Beach - 2021

New HIV
2021



***New HIV* by Zip Codes**
Palm Beach - 2021

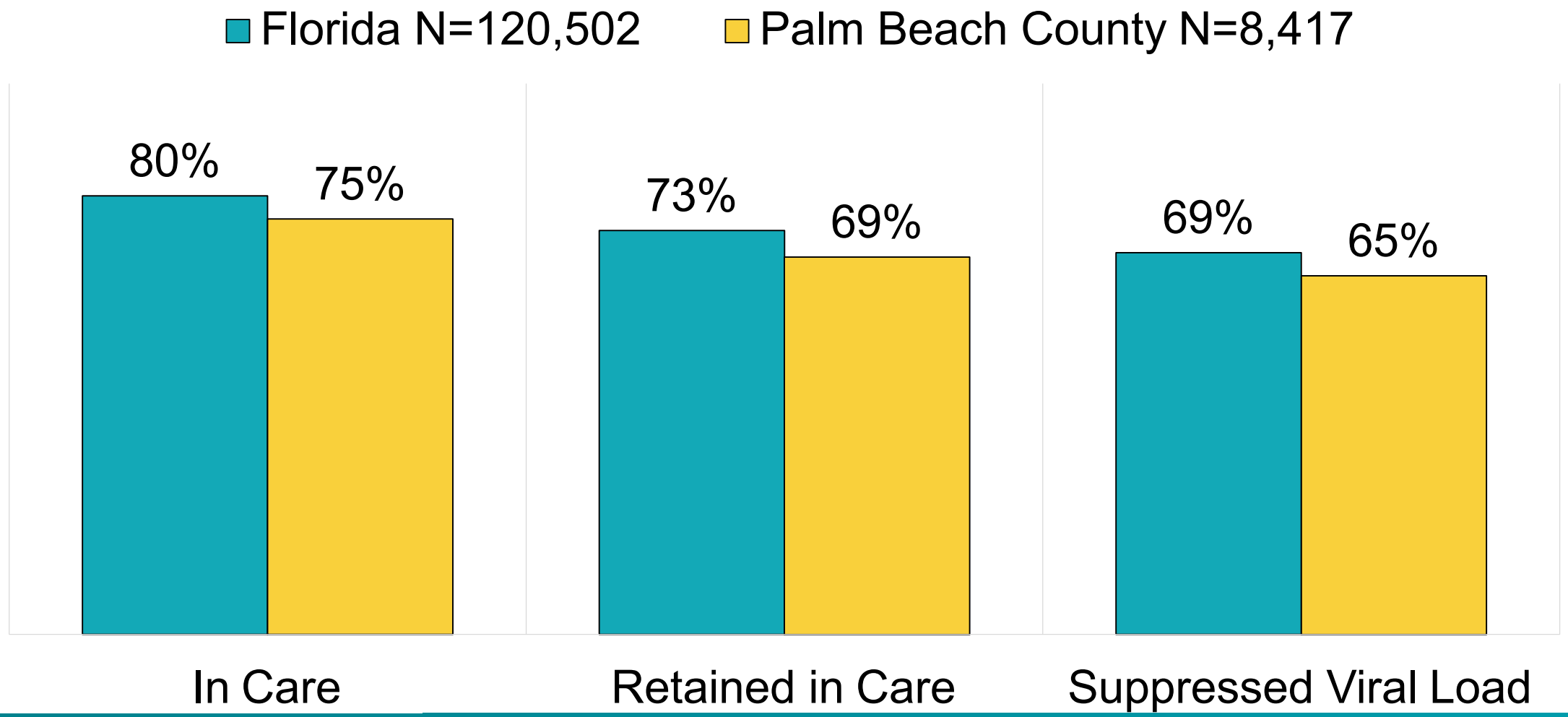


2021 Palm Beach vs. FLORIDA

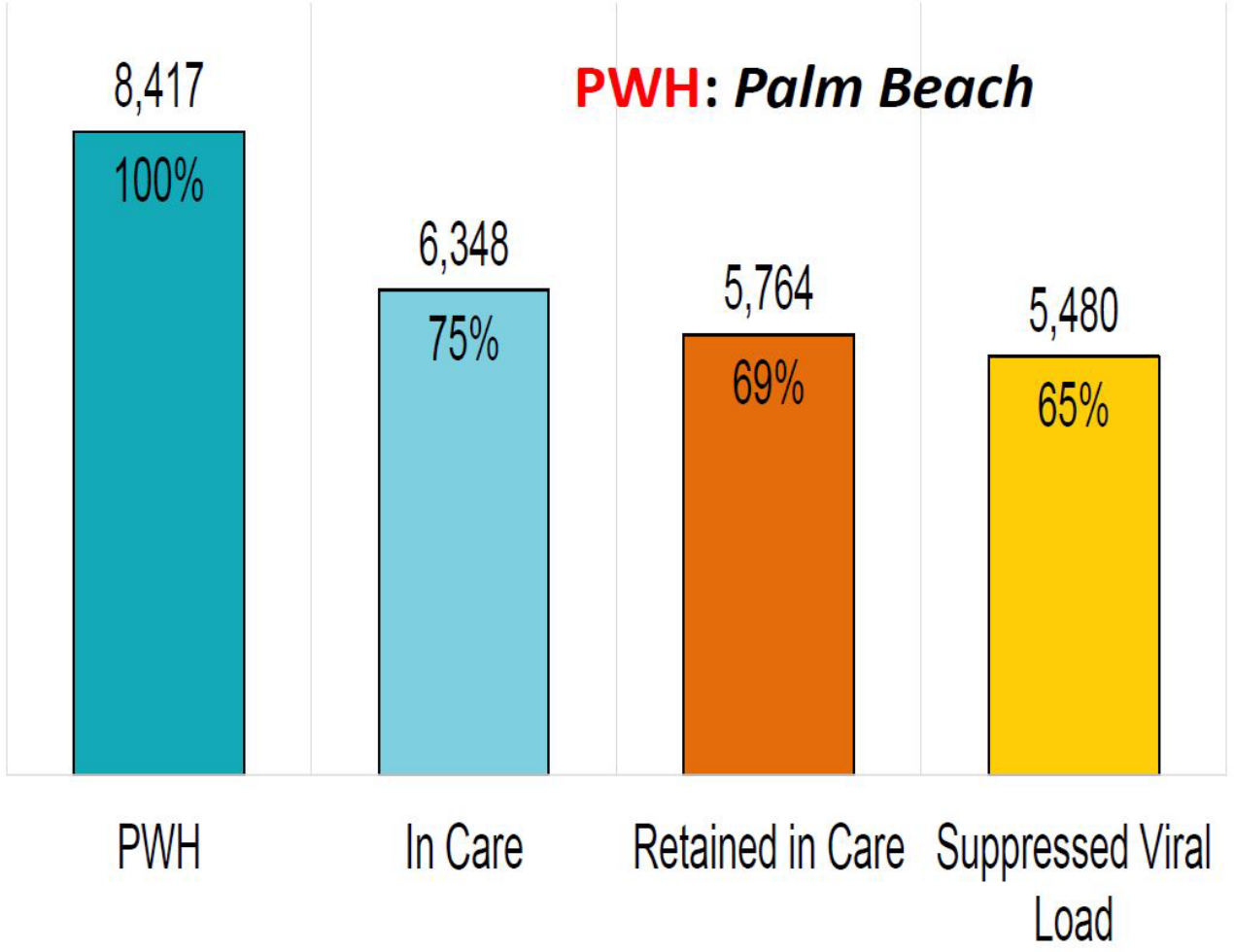
PWH Epi Profile & Care Continuum

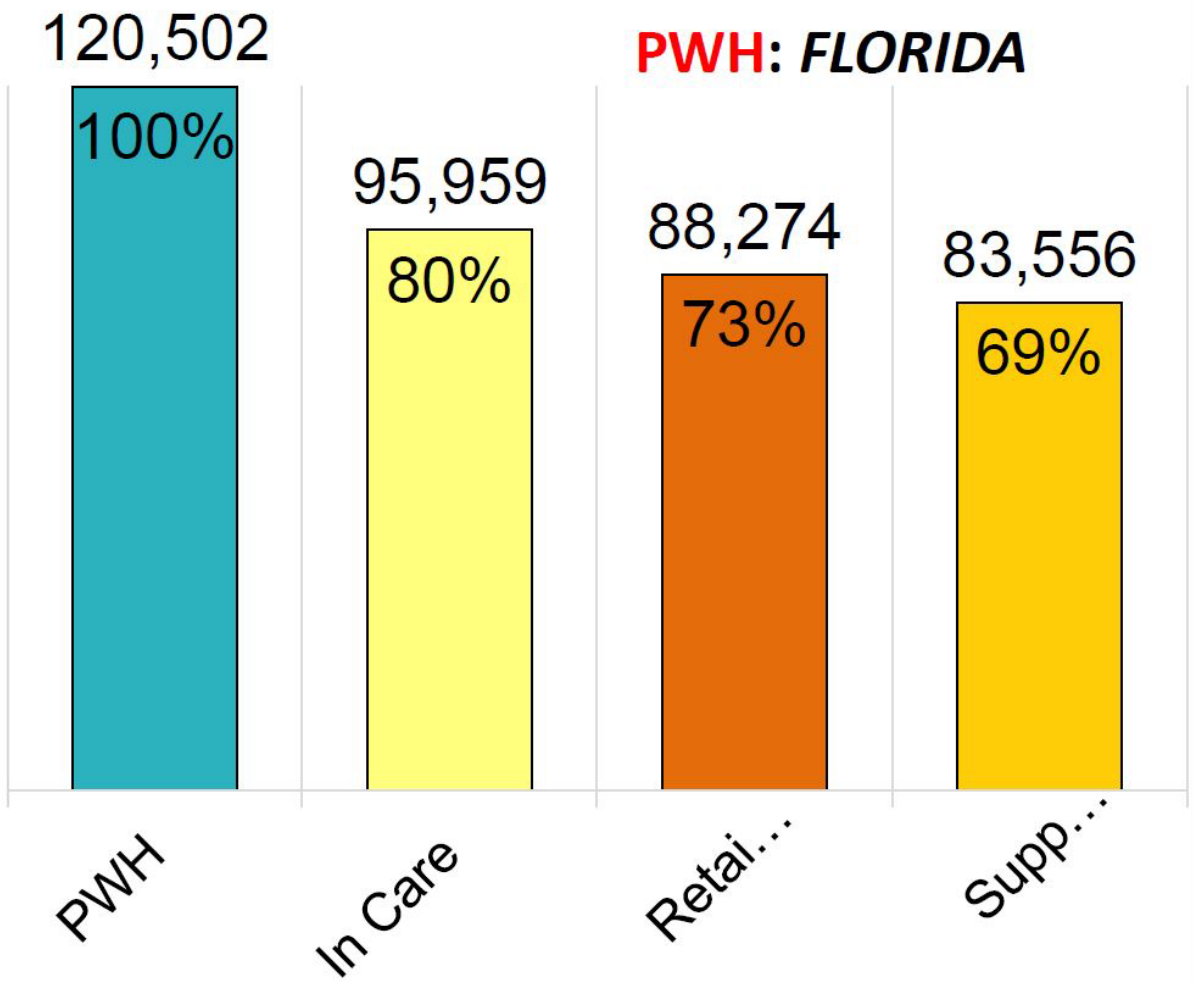
2021 HIV Epidemiology	AREA 9 = Palm Beach (2021 Pop'n= 1,487,272)	FLORIDA (2021 Pop'n = 22,005,587)
Incidence (New) = HIV	322	4,708
(New) = AIDS	113	1,860
Total New (H + A)	435	6,568
INCIDENCE Rate = HIV	21.7 /100,000	21.4 /100,000
= AIDS	7.6 /100,000	8.5 /100,000
DIAGNOSIS RATE = HIV + AIDS	29 /100,000	30 /100,000
Prevalence (PWH = H+A) (new + ongoing)	8,417	120,502
PREVALENCE Rate (PWH)	566/100,000	548/100,000
HIV Deaths	39	629

PWH in *Care Continuum* – FLORIDA vs. Palm Beach --2021



PWH in HIV *Care Continuum* – Palm Beach vs. Florida 2021



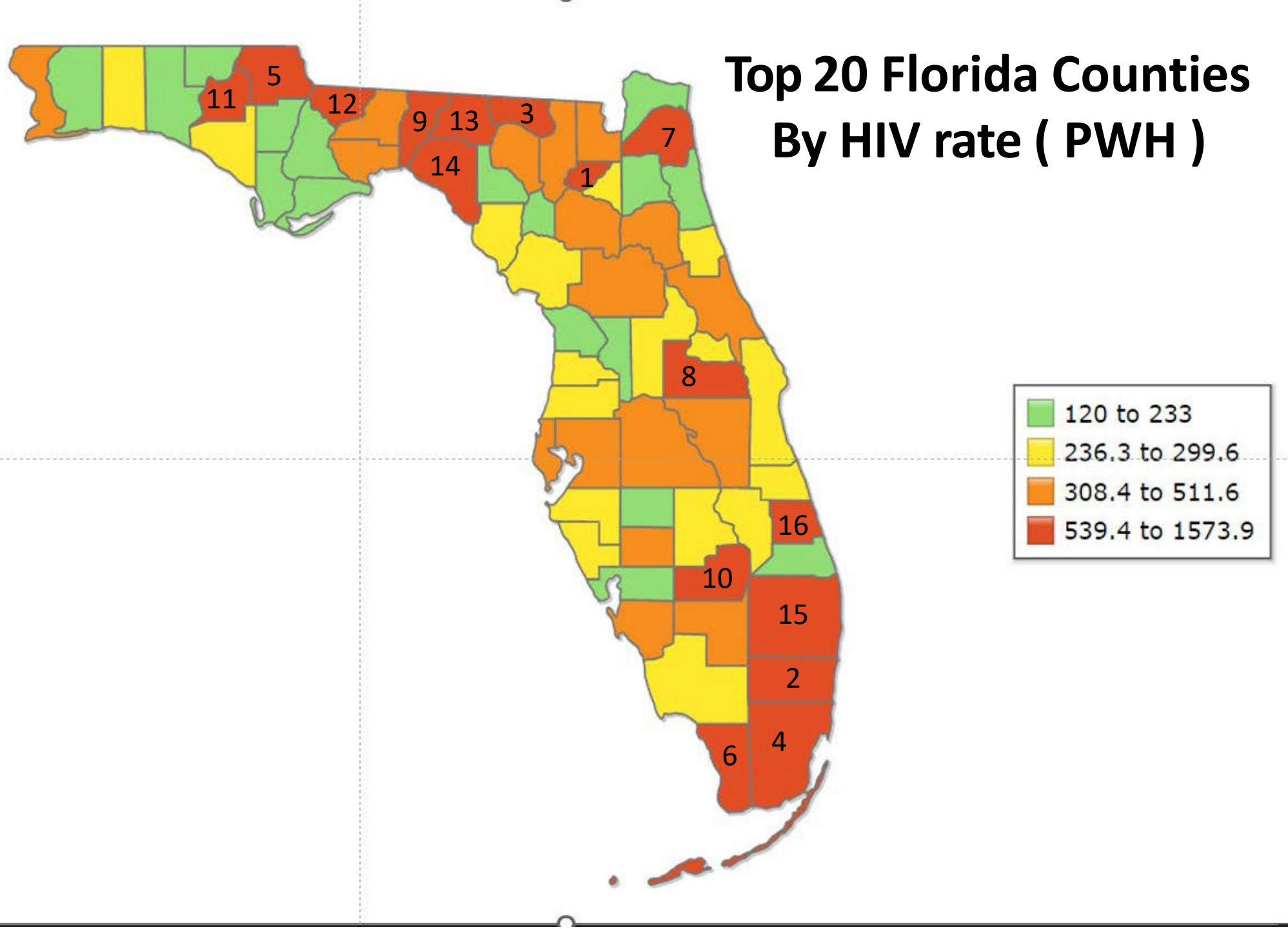


Florida HEALTH

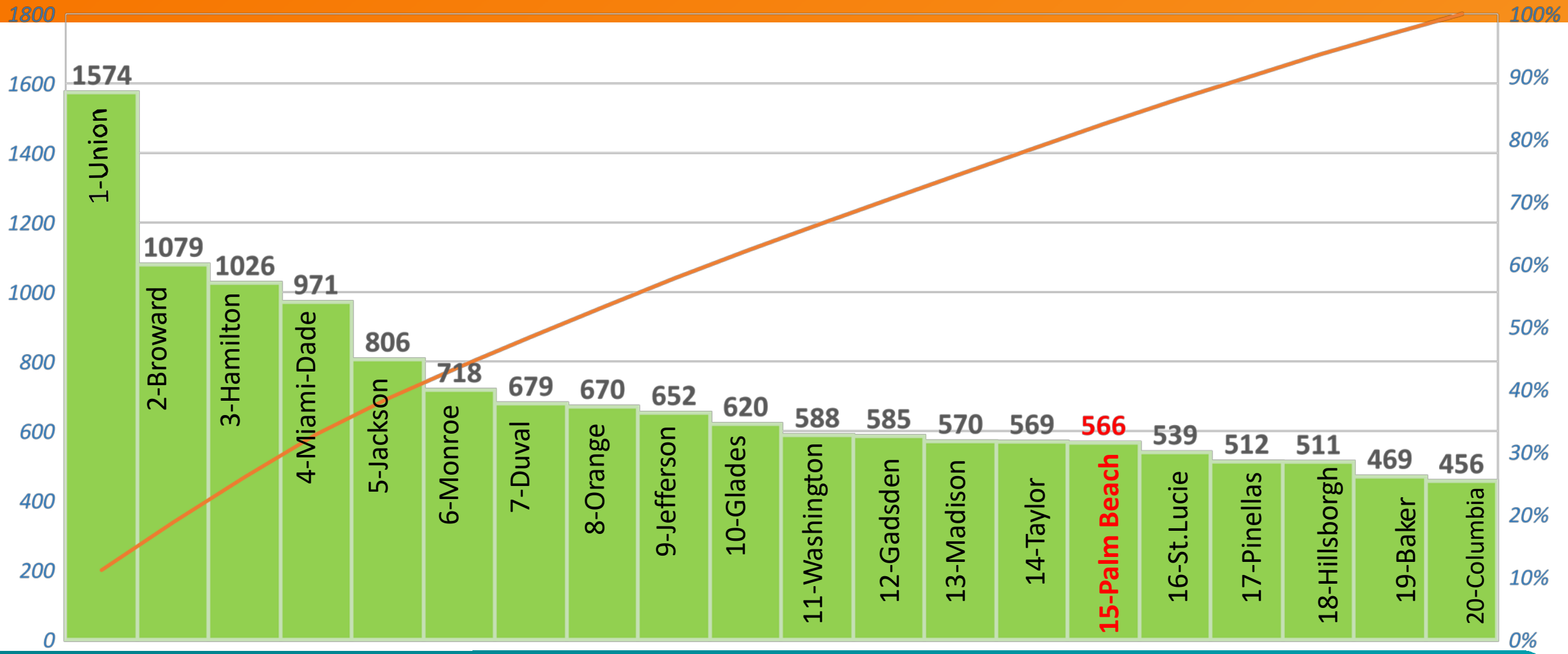
Note: 90% of persons retained in care had a suppressed viral load.

PWH by County - Rate /100,000 Popn. - 2021

1-Union
2-Broward
3-Hamilton
4-Miami-Dade
5-Jackson
6-Monroe
7-Duval
8-Orange
9-Jefferson
10-Glades
11-Washington
12-Gadsden
13-Madison
14-Taylor
15-Palm Beach
16-St. Lucie
17-Pinellas
18-Hillsborough
19-Baker
20-Columbia



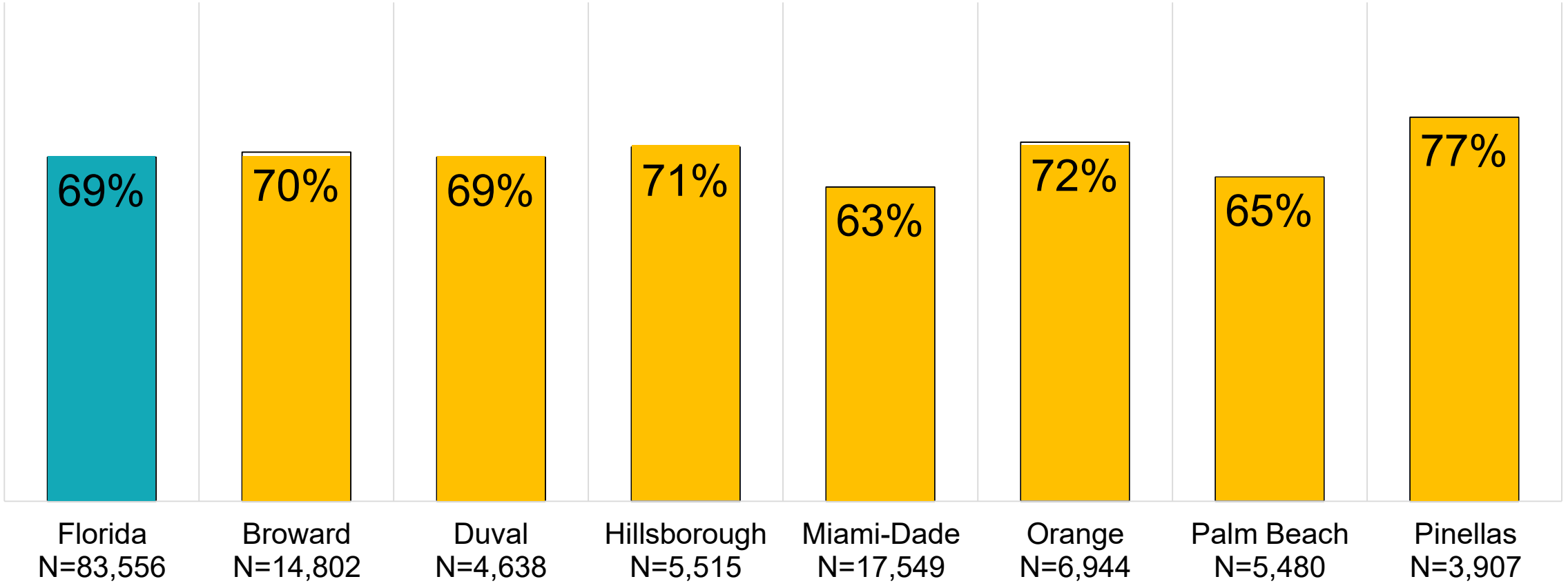
PWH: Top 20 Counties- *PWH Rates/100,000 popn.*-2021



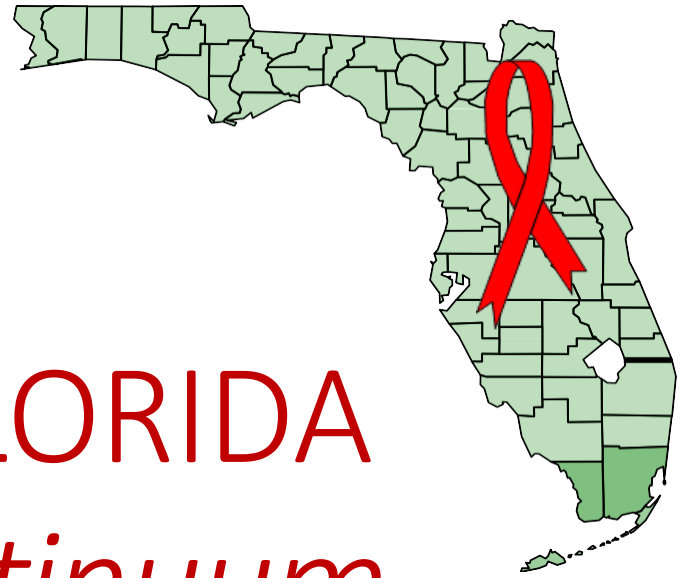
PWH: Top 20 Counties w. highest *PWH Rates* - 2021

County	Count	Denominator	Rate
FLORIDA	120,502	22,005,587	548
Baker	135	28,790	469
Broward	21,014	1,946,733	1,079
Columbia	323	70,869	456
Miami-Dade	27,782	2,860,584	971
Duval	6,754	994,778	679
Gadsden	272	46,520	585
Glades	87	14,040	620
Hamilto n	150	14,616	1,026
Hillsborough	7,742	1,515,107	511
Jackson	376	46,657	806
Jefferso n	94	14,417	652
Madison	108	18,952	570
Monroe	560	77,972	718
Orange	9,703	1,448,933	670
Palm Beach	**8,417**	**1,487,272**	**566**
Pinellas	5,065	990,077	512
St. Lucie	1,808	335,202	539
Taylor	128	22,491	569
Unio n	243	15,439	1,574
Washington	150	25,514	588

PWH : Top 8 Counties *Suppressed Viral Load* -- 2021 FLORIDA



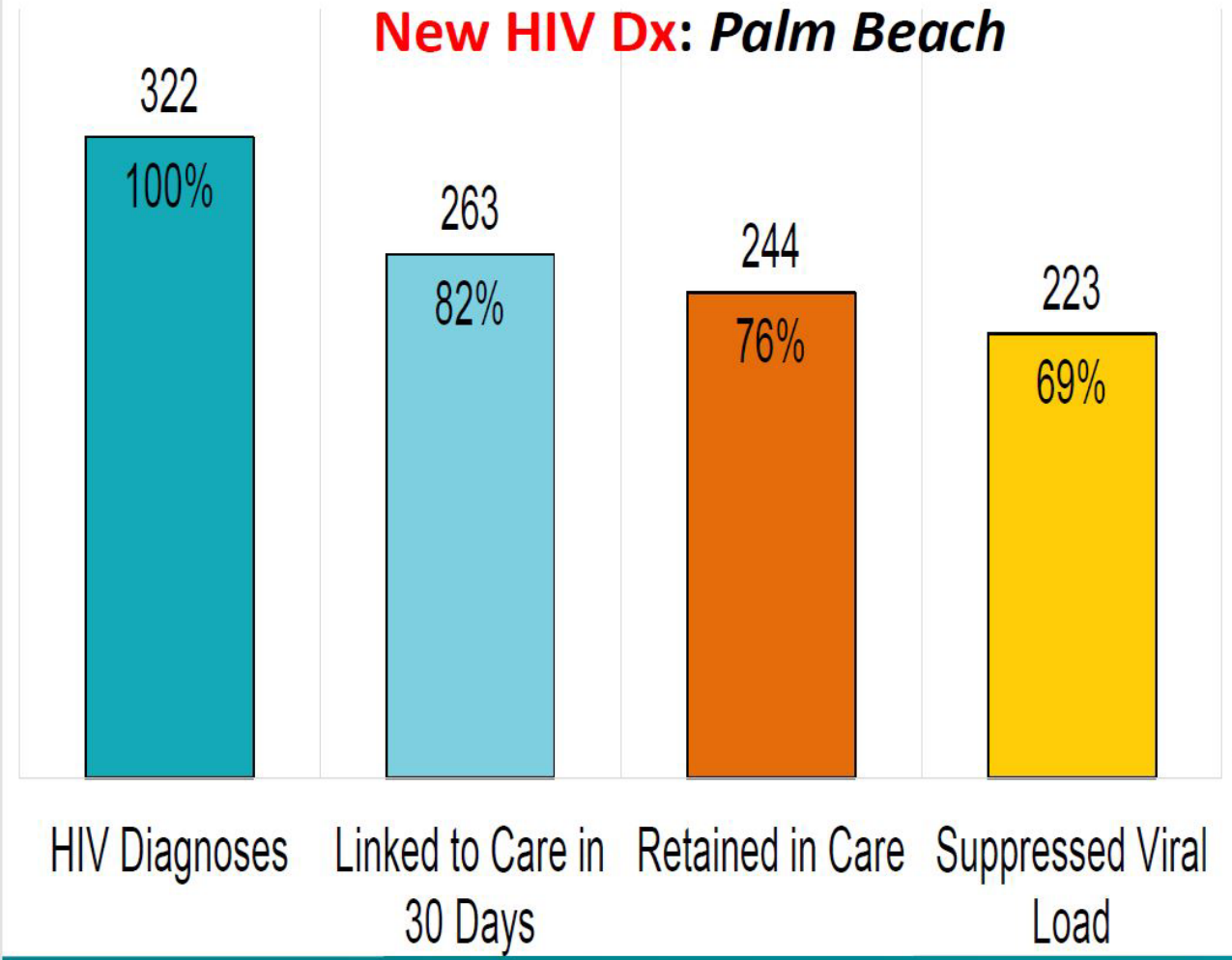
Suppressed Viral Load: PWH with a suppressed VL (<200 copies/mL) on the last VL

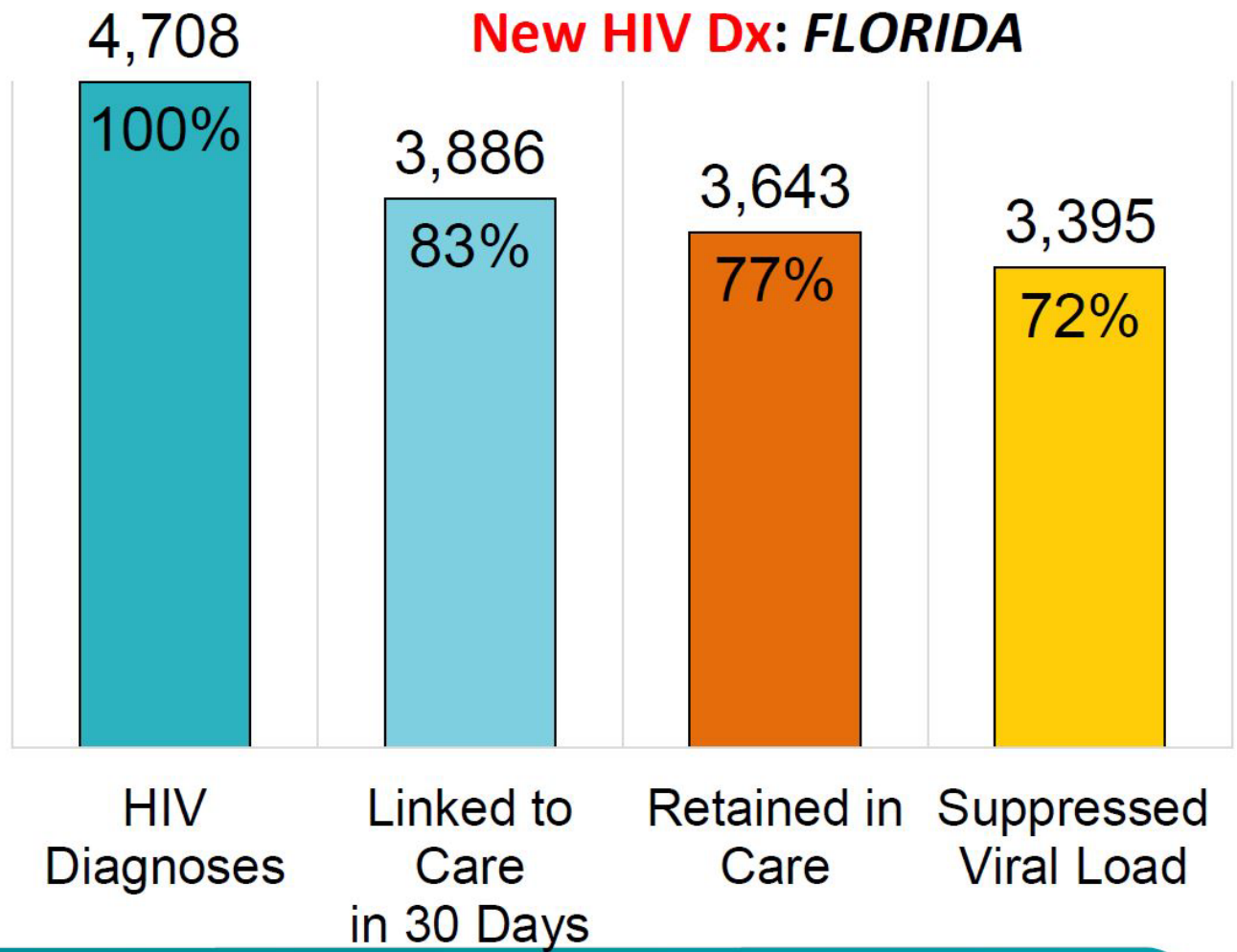


2021 Palm Beach vs. FLORIDA

New HIV Dx & Care Continuum

New HIV Dx in HIV *Care Continuum* – Palm Beach vs. Florida 2021

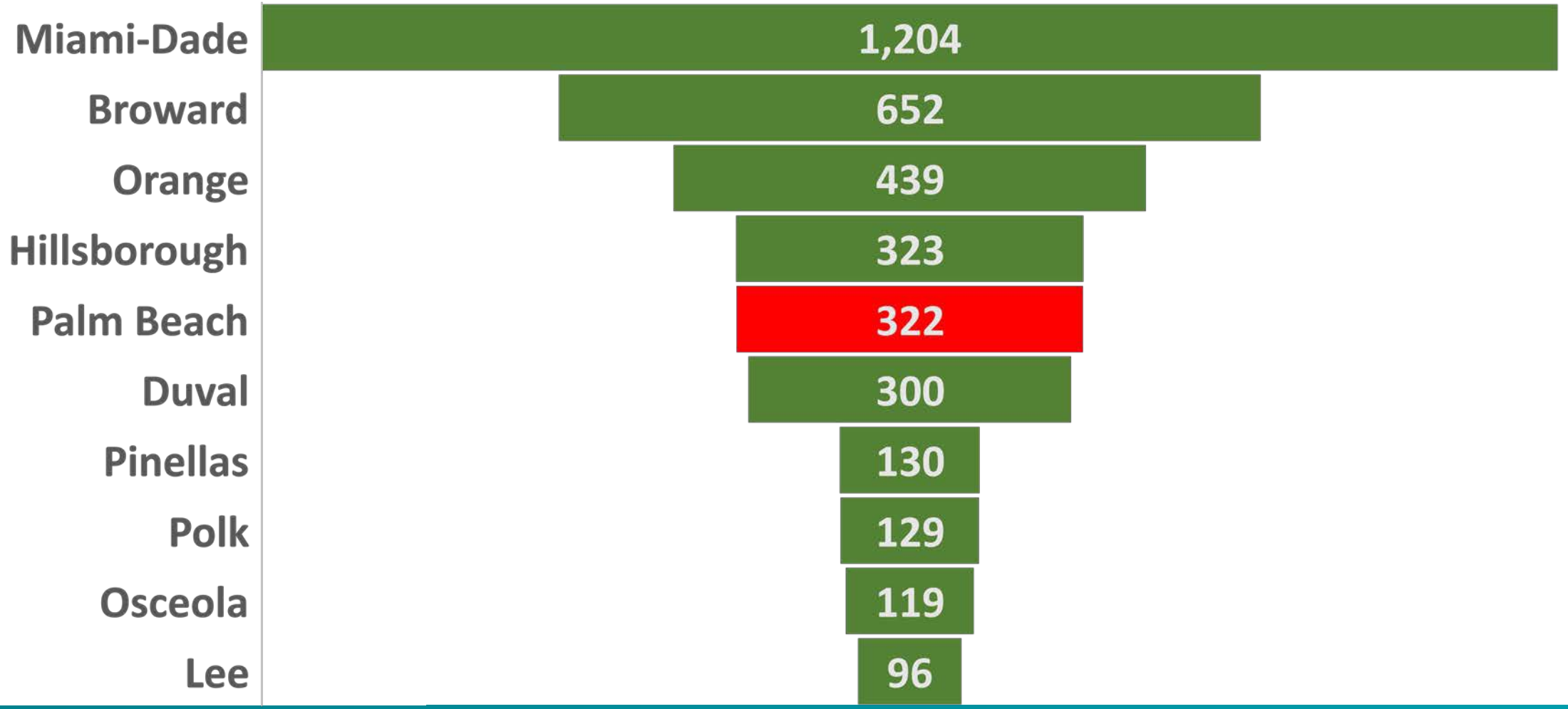




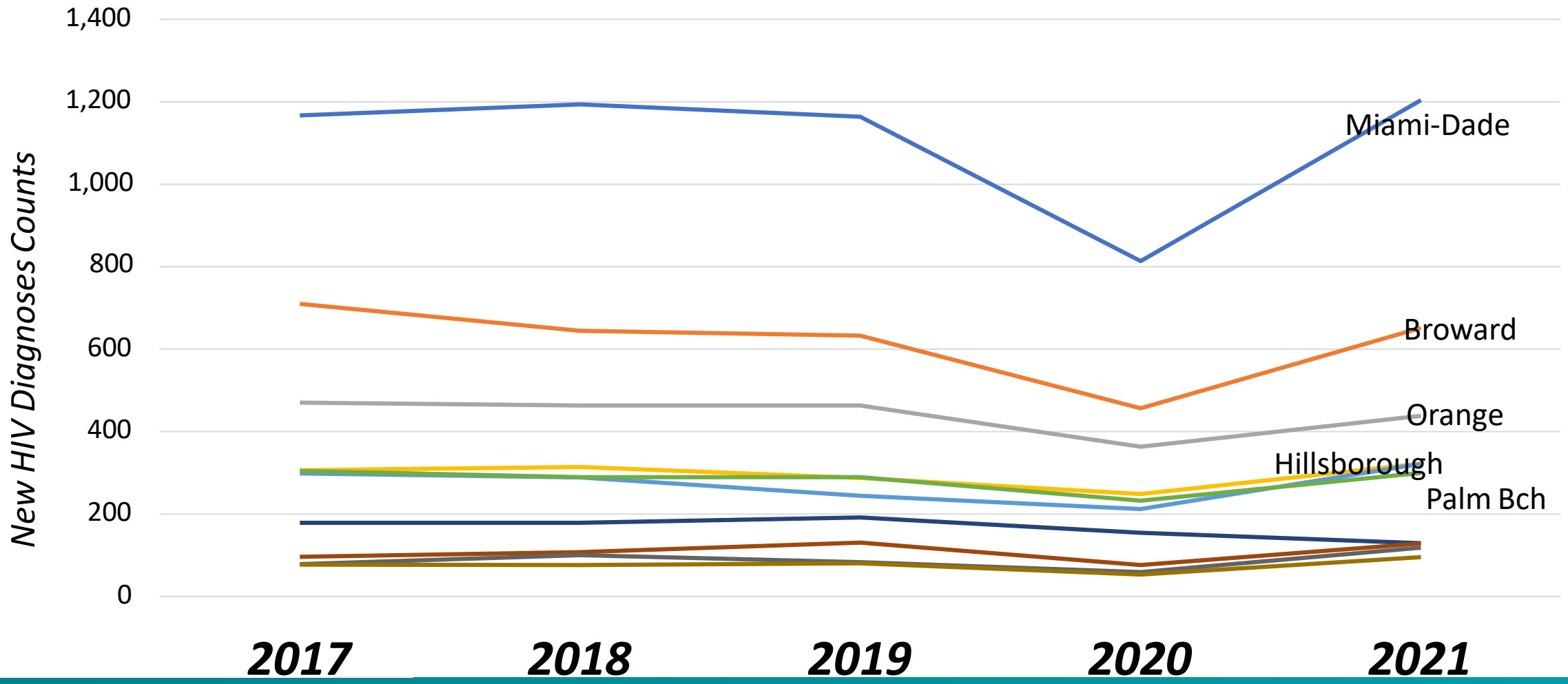
New HIV Dx :Top 10 FL Counties-- *Trend* 2017–2021

	New HIV Diagnosis Year					
County	2017	2018	2019	2020	2021	2020–2021 Relative (%) Change
Miami-Dade	1,167	1,194	1,164	814	1,204	48%
Broward	710	645	633	457	652	43%
Orange	471	464	464	364	439	21%
Hillsborough	307	315	288	249	323	30%
Palm Beach	299	289	245	213	322	51%
Duval	305	290	290	233	300	29%
Pinellas	179	179	192	155	130	-16%
Polk	97	108	131	77	129	68%
Osceola	79	101	84	60	119	98%
Lee	78	77	81	54	96	78%
FLORIDA	4,750	4,749	4,556	3,441	4,708	37%

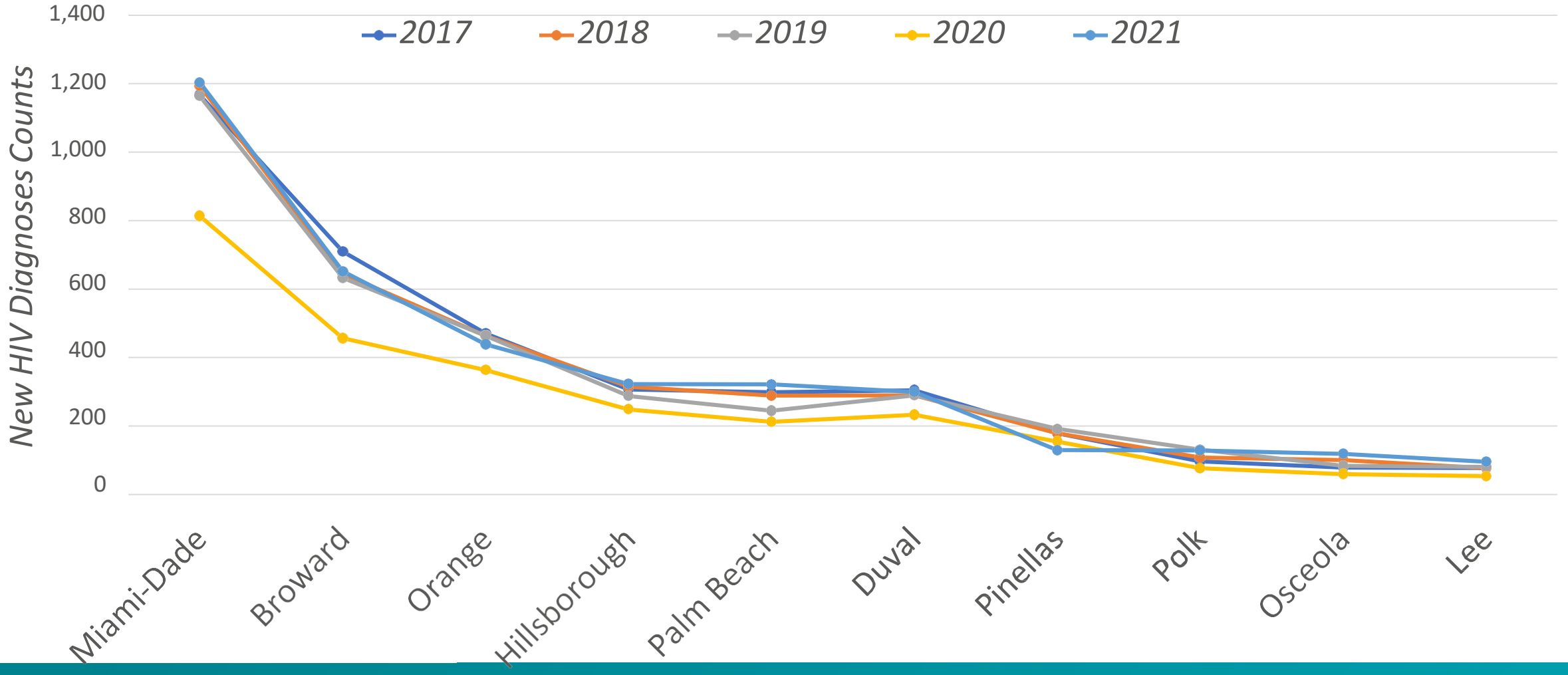
New HIV Dx : Top 10 FL Counties -- 2021

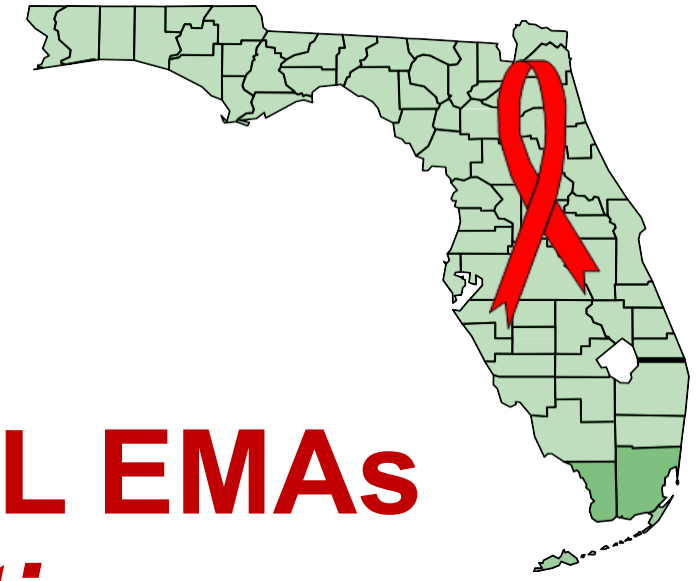


2021 *New HIV Dx*: 5-Yr. Trends in Top 10 FL counties



New HIV Dx : 5-Yr. Trends in Top 10 FL counties





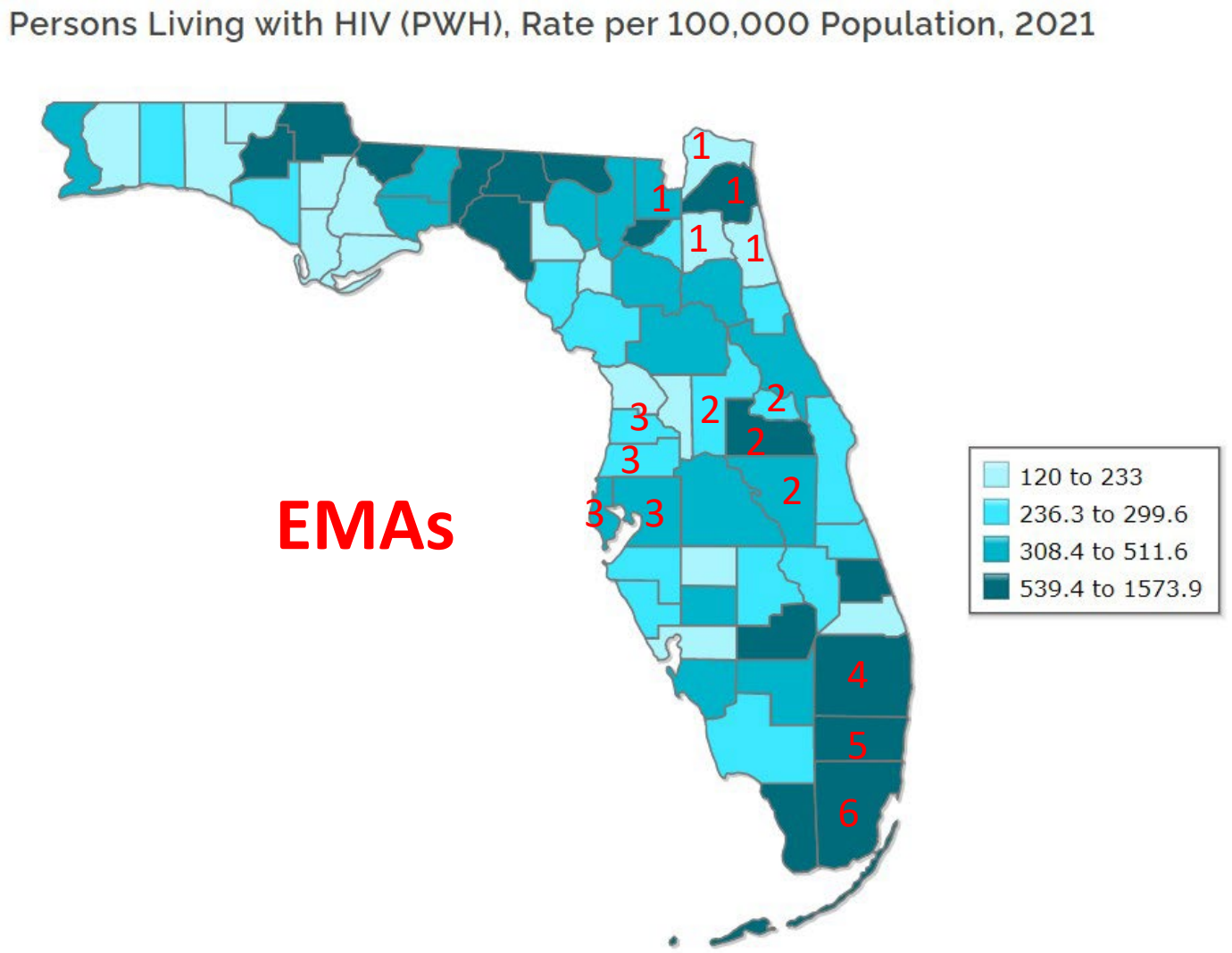
2021 Palm Beach vs. 6 FL EMAs

New HIV Dx & Care Continuum

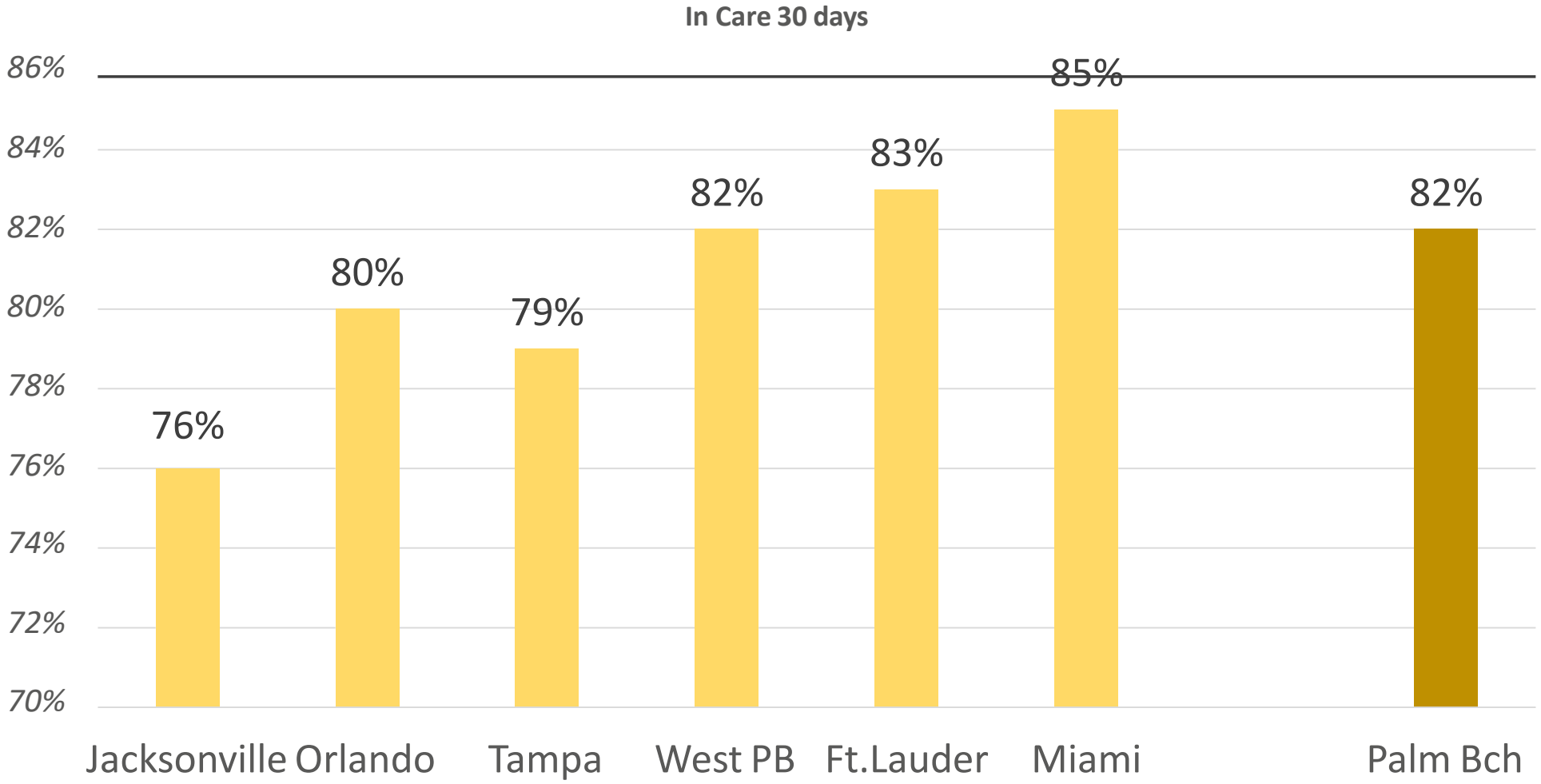
6 Florida EMAs – Eligible Metropolitan Areas

Eligible Metropolitan Areas (EMA)

- *Jacksonville* = **1**
  - Baker, Clay, Duval, Nassau, St. Johns
- *Orlando* = **2**
  - Lake, Orange, Osceola, Seminole
- *Tampa /St. Petersburg* = **3**
  - Hernando, Hillsborough, Pasco, Pinellas
- *West Palm Beach* = **4**
  - Palm Beach
- *Ft. Lauderdale* = **5**
  - Broward
- *Miami* = **6**
  - Miami-Dade



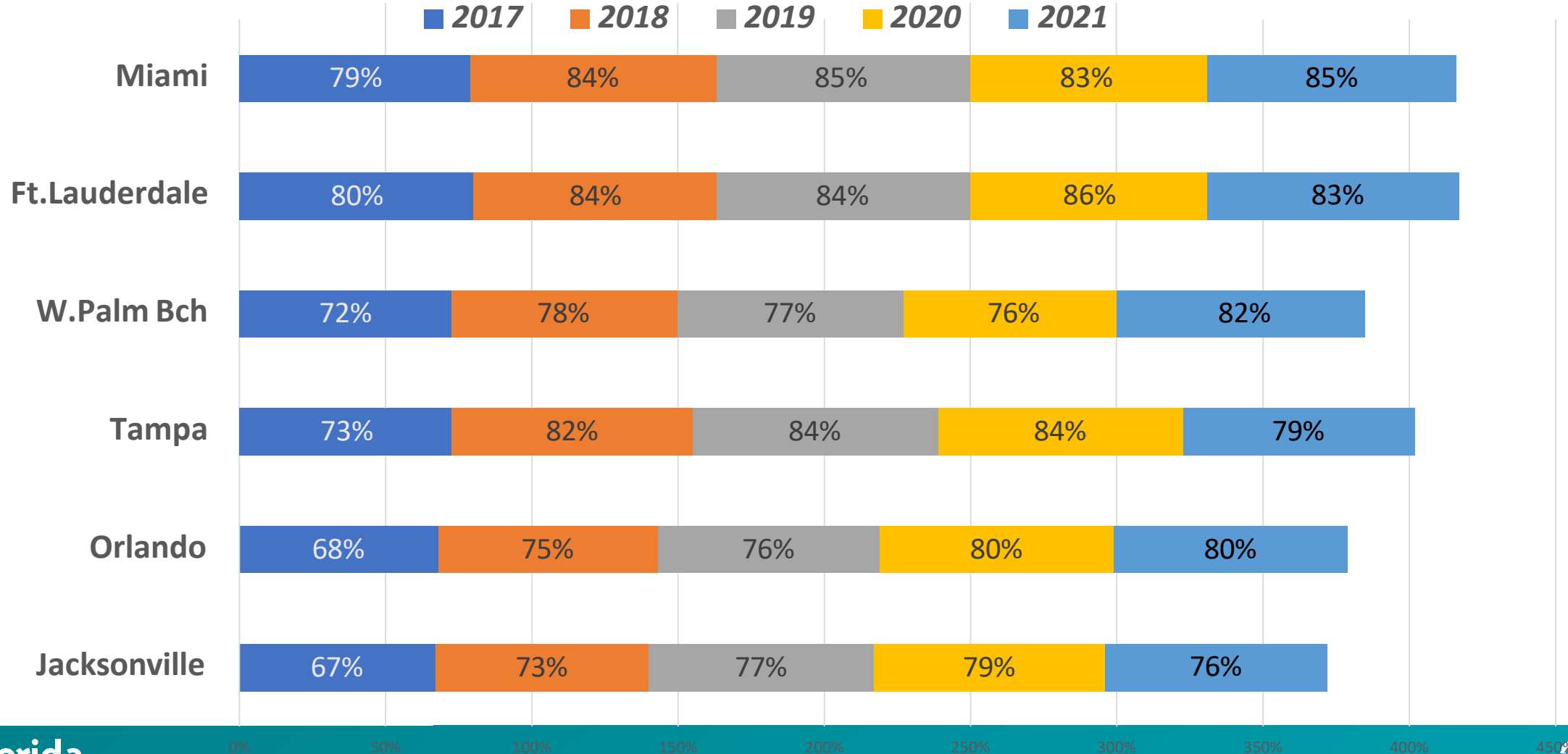
New HIV Dx: *In Care 30 d* = 6 FL EMA's vs. Palm Beach--2021



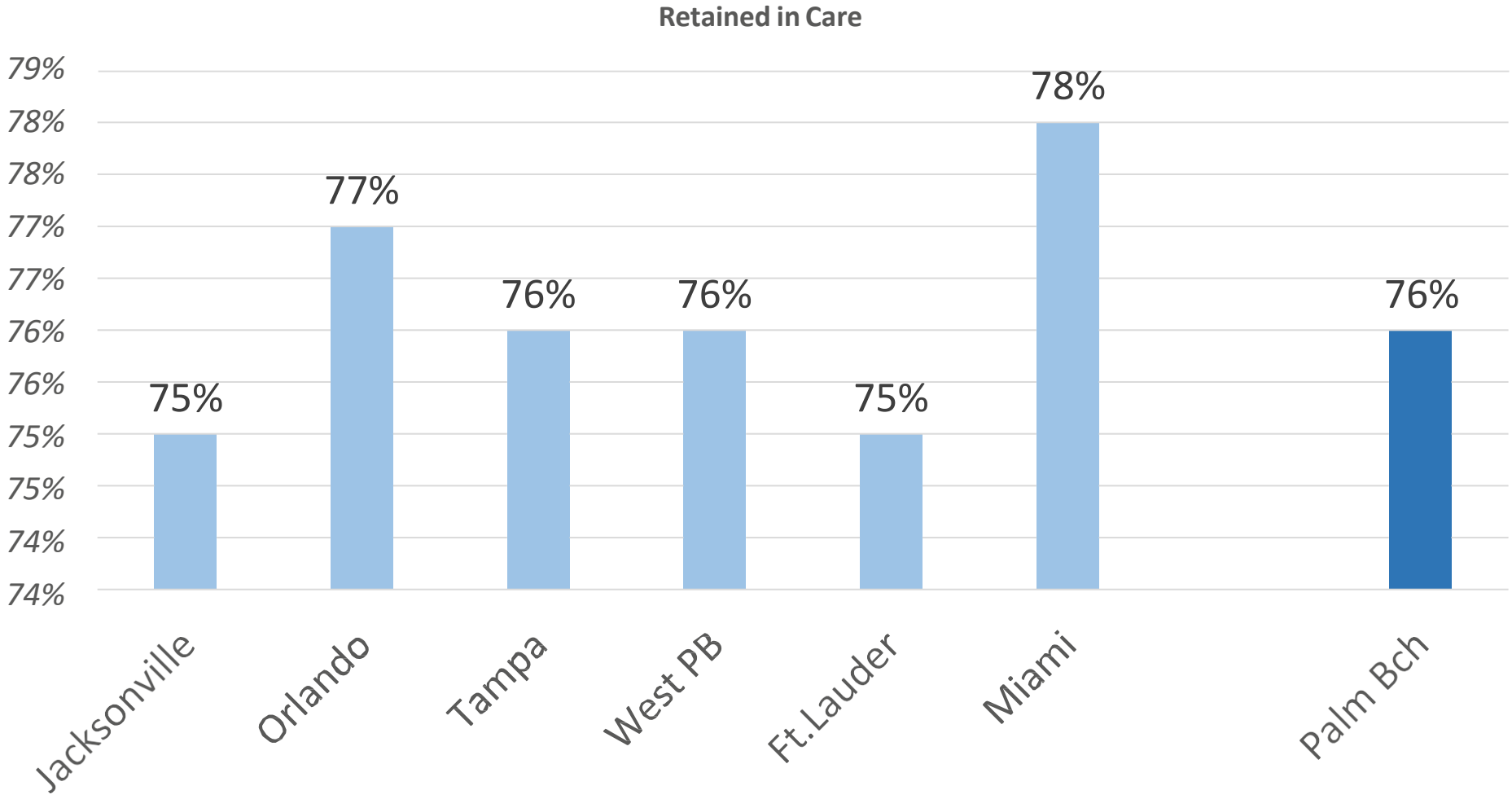
New HIV 5-Yr Trends: *In Care 30 days* (6 EMAs) -2017-2021

Years	Jacksonville	Orlando	Tampa	West Palm Bch	Ft.Lauderdale	Miami
2017	67%	68%	73%	**72%**	80%	79%
2018	73%	75%	82%	**78%**	84%	84%
2019	77%	76%	84%	**77%**	84%	85%
2020	79%	80%	84%	**76%**	86%	83%
2021	76%	80%	79%	**82%**	83%	85%

New HIV Dx 5-Yr Trends: *In Care 30 days* (6 EMAs) - 2017-2021



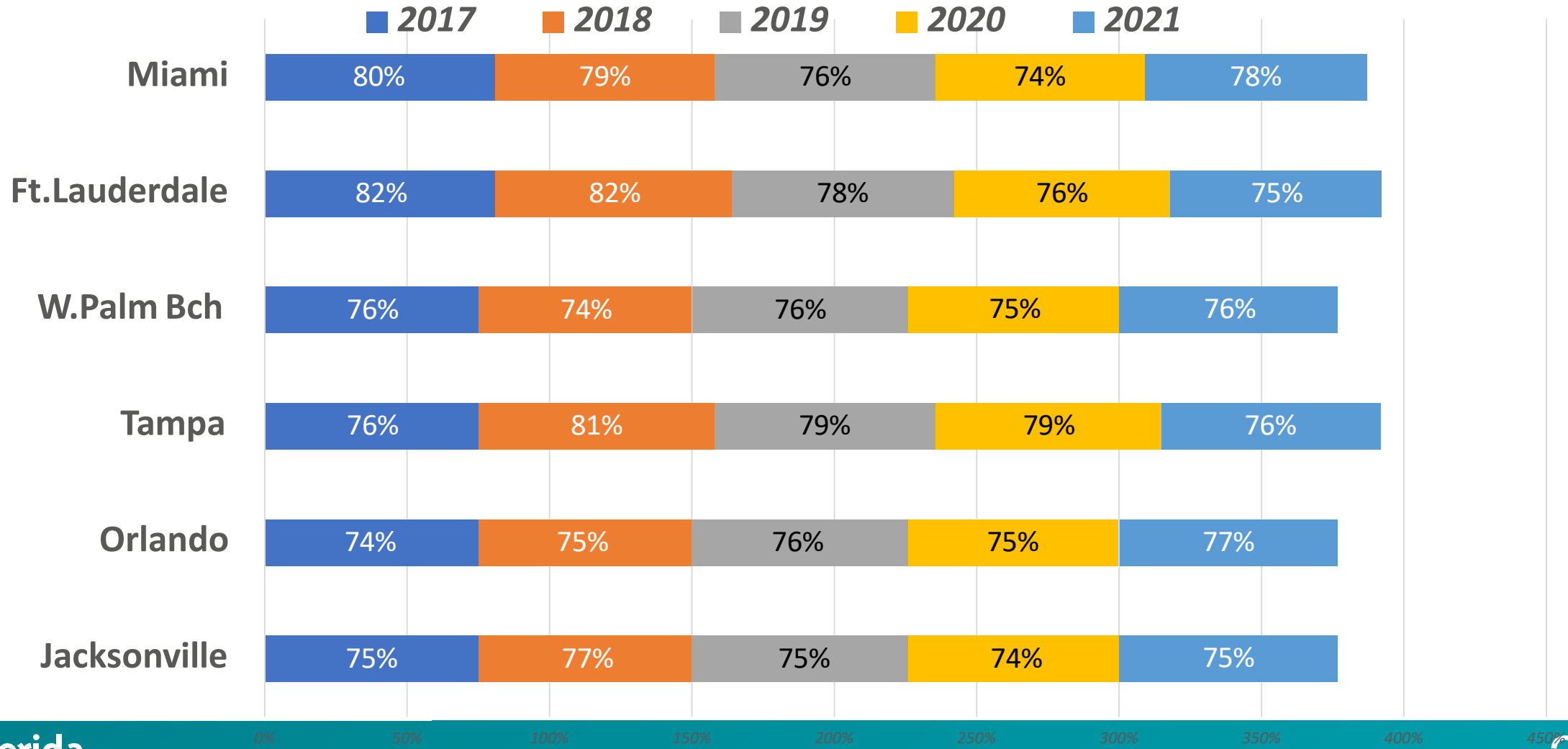
New HIV Dx: *Retained in Care*=6 FL EMA's vs. Palm Bch-2021



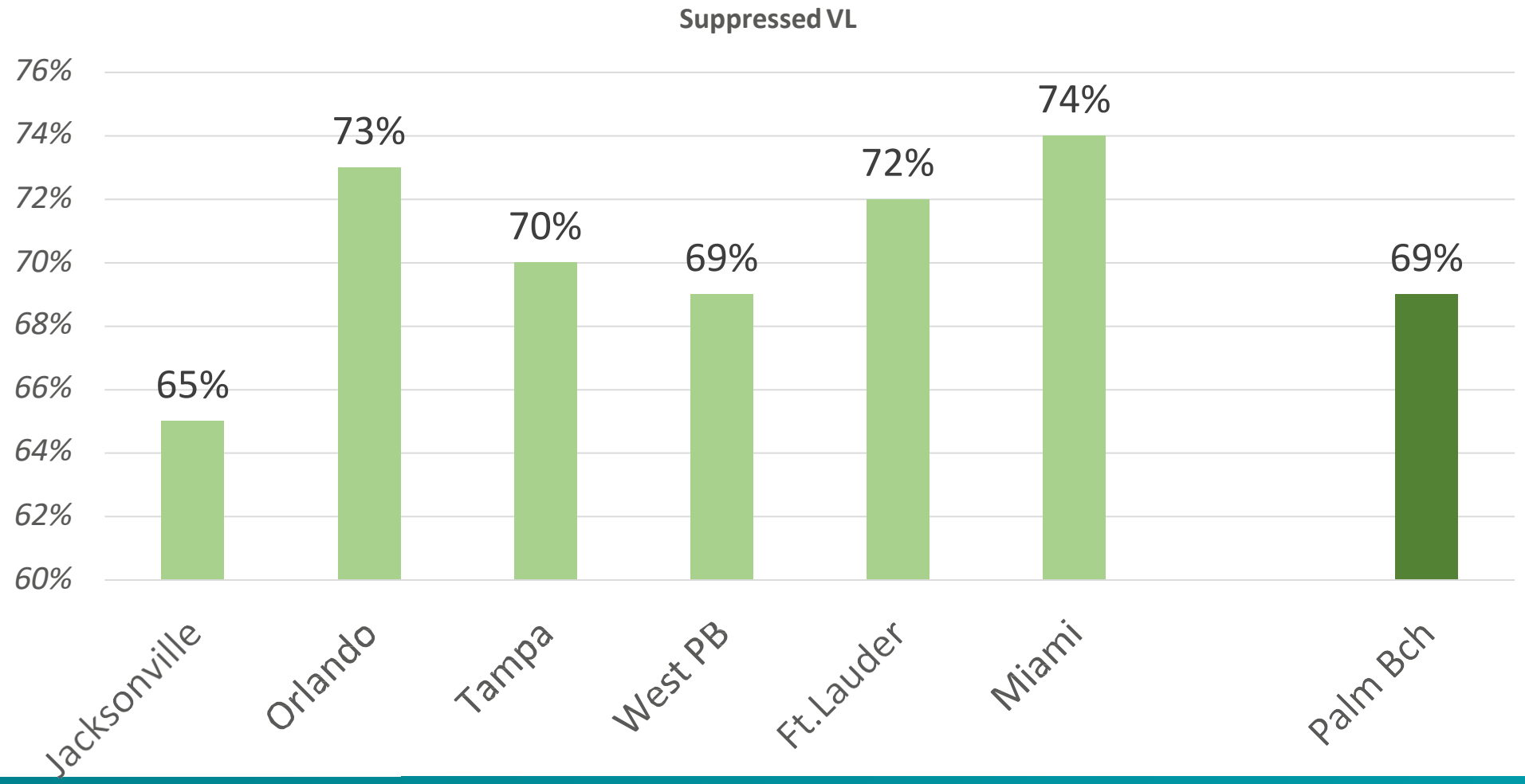
New HIV Dx 5-Yr Trends: *Retained in Care* (6 EMAs) -2017-2021

Years	Jacksonville	Orlando	Tampa	West Palm Bch	Ft.Lauderdale	Miami
2017	75%	74%	76%	**76%**	82%	80%
2018	77%	75%	81%	**74%**	82%	79%
2019	75%	76%	79%	**76%**	78%	76%
2020	74%	75%	79%	**75%**	76%	74%
2021	75%	77%	76%	**76%**	75%	78%

New HIV Dx 5-Yr Trends: *Retained in Care* (6 EMAs) -2017-2021



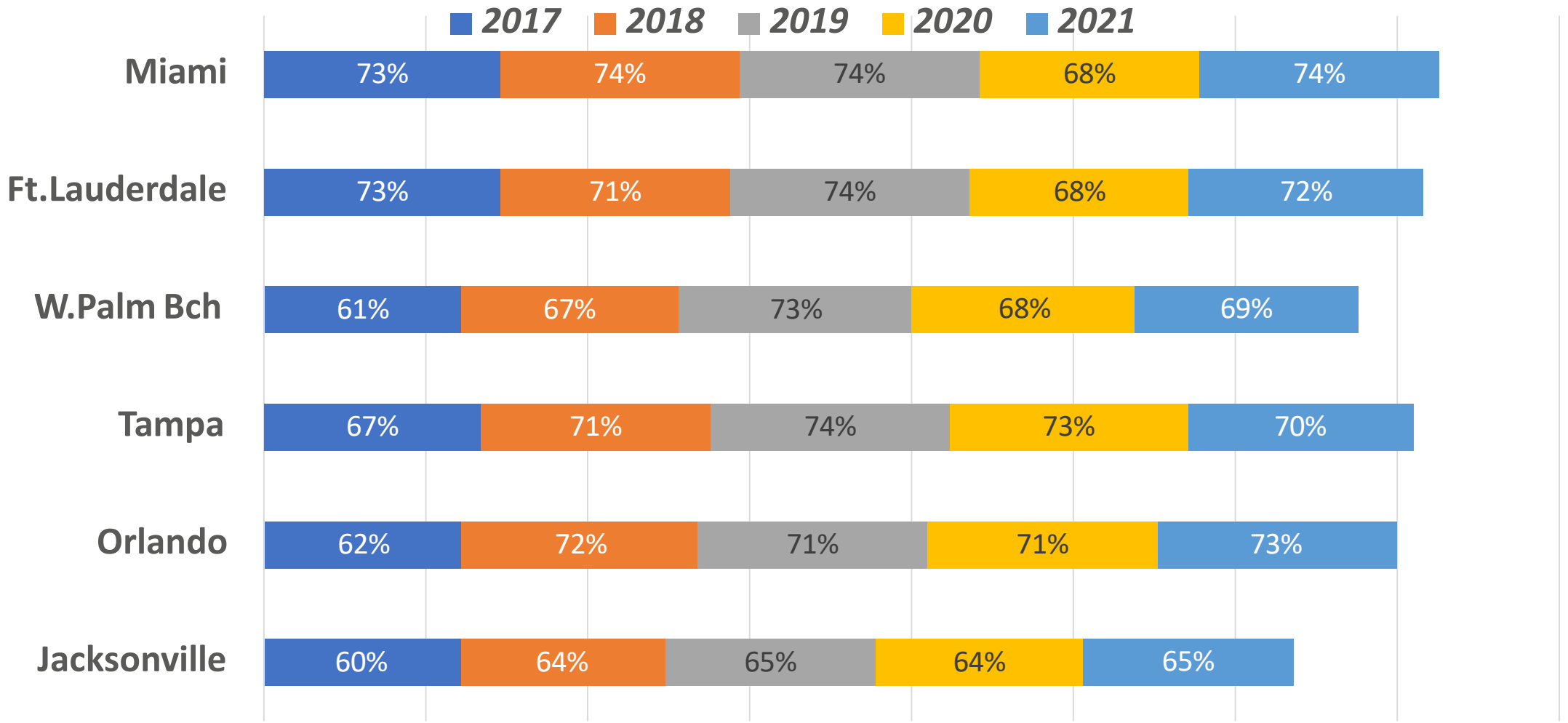
New HIV Dx: *Suppressed VL* = 6 FL EMA's vs. Palm Bch-2021



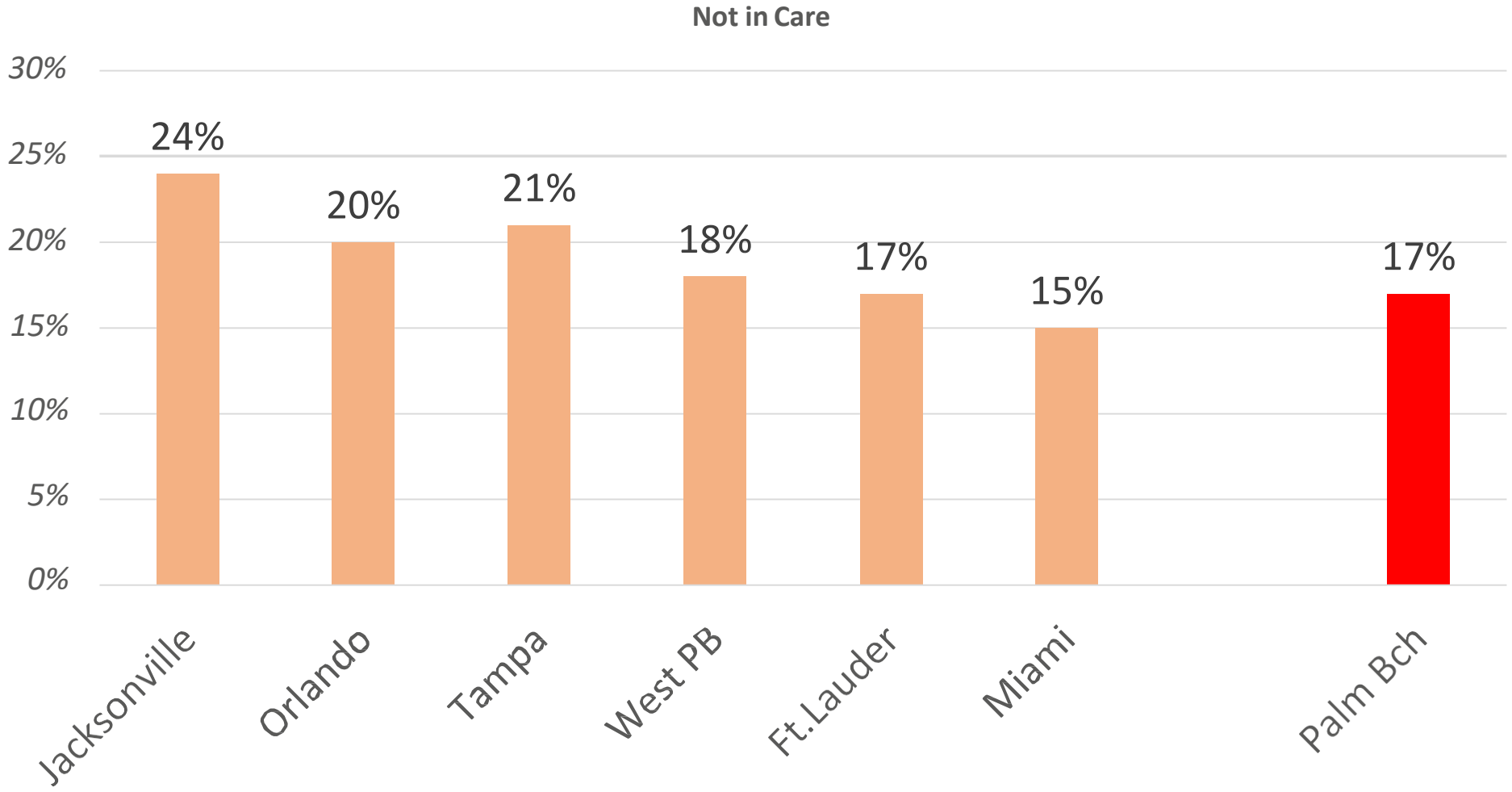
New HIV Dx 5-Yr Trends: *Suppressed VL* (6 EMAs) -2017-2021

Years	Jacksonville	Orlando	Tampa	West Palm Bch	Ft.Lauderdale	Miami
2017	60%	62%	67%	**61%**	73%	73%
2018	64%	72%	71%	**67%**	71%	74%
2019	65%	71%	74%	**73%**	74%	74%
2020	64%	71%	73%	**68%**	68%	68%
2021	65%	73%	70%	**69%**	72%	74%

New HIV Dx 5-Yr Trends: *Suppressed VL* (6 EMAs) - 2017-2021



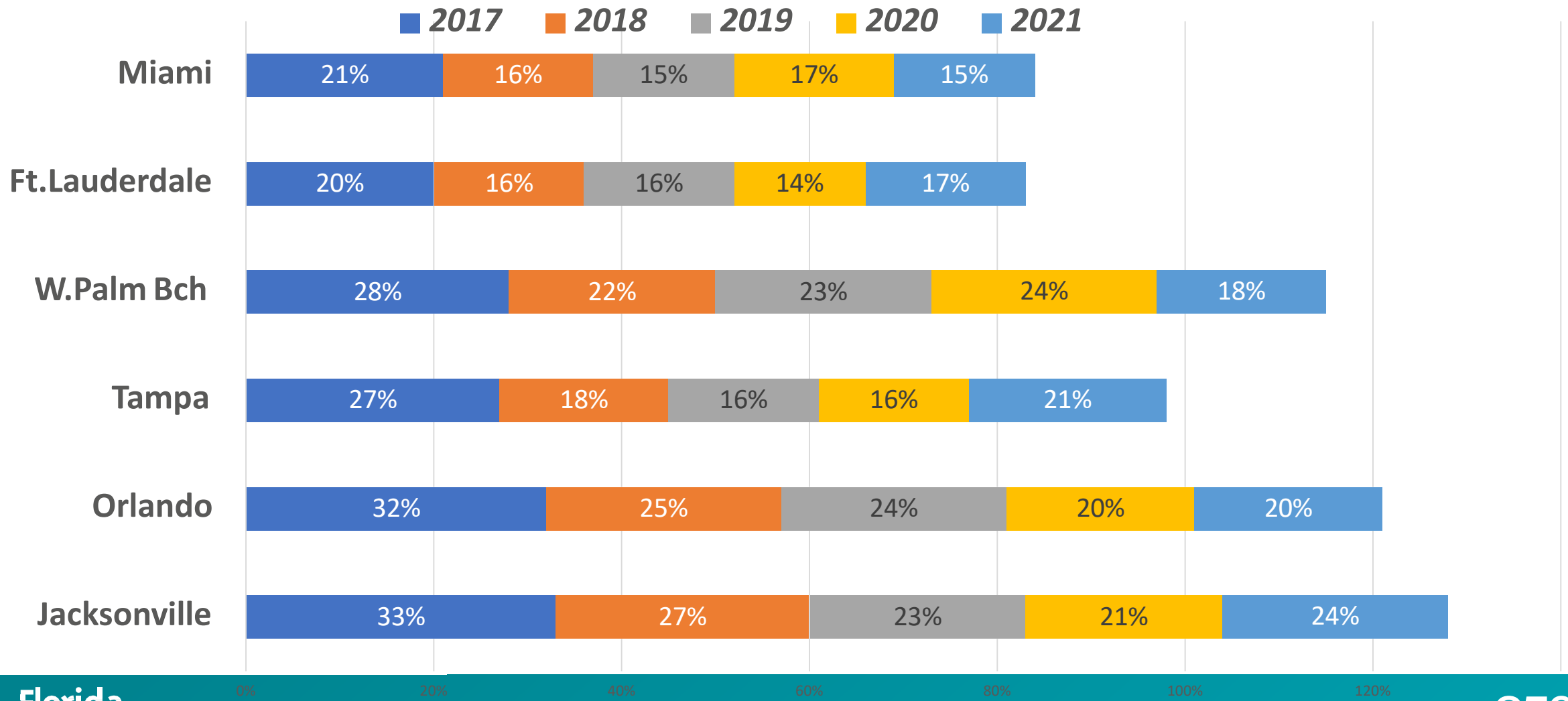
New HIV Dx: NOT *in Care* = 6 FL EMA's vs. Palm Bch-2021



New HIV Dx 5-Yr Trends: *NOT in Care* (6 EMAs) -2017-2021

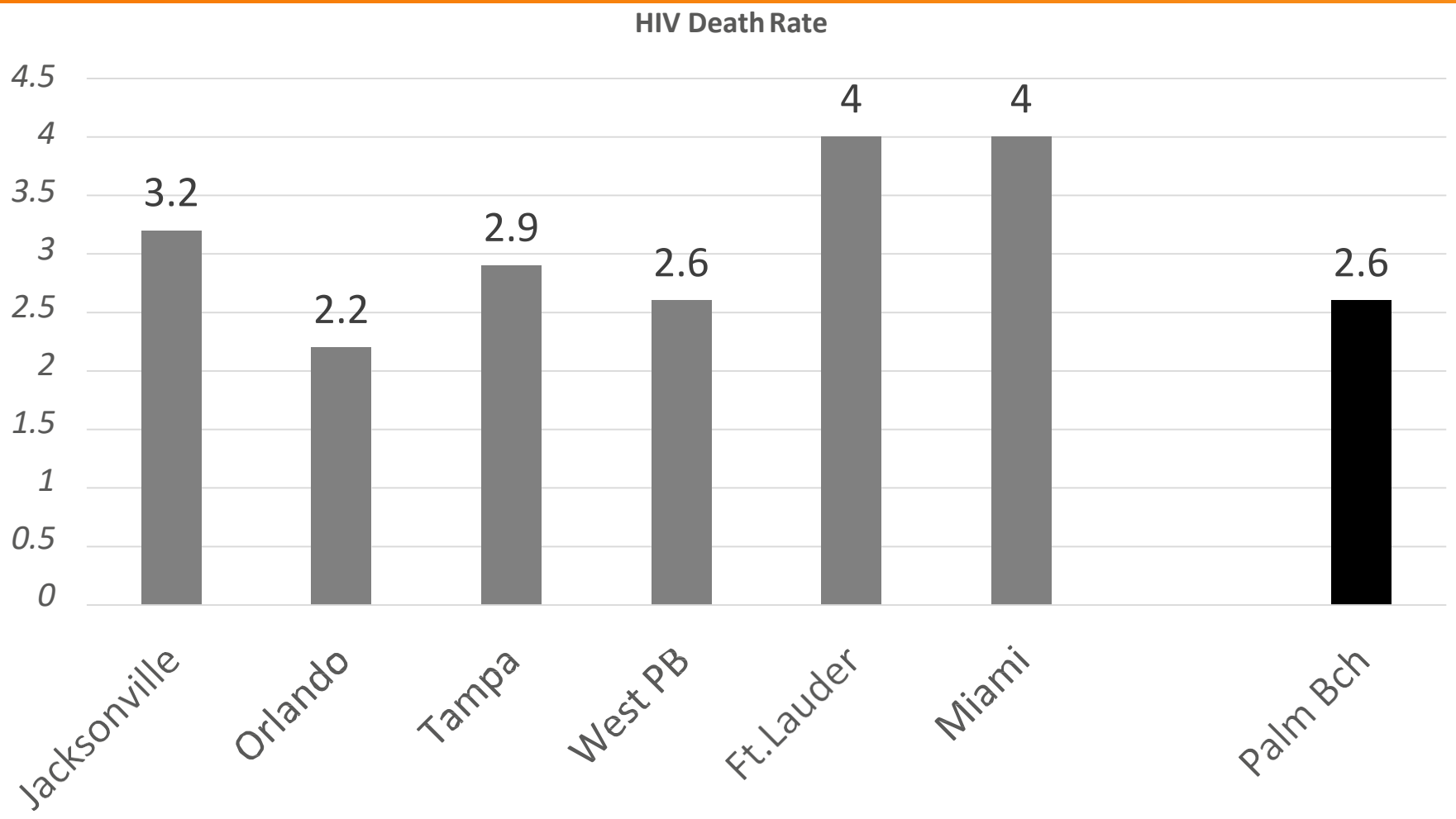
Years	Jacksonville	Orlando	Tampa	West Palm Bch	Ft.Lauderdale	Miami
2017	33%	32%	27%	**28%**	20%	21%
2018	27%	25%	18%	**22%**	16%	16%
2019	23%	24%	16%	**23%**	16%	15%
2020	21%	20%	16%	**24%**	14%	17%
2021	24%	20%	21%	**18%**	17%	15%

New HIV Dx 5-Yr Trends: *NOT in Care* (6 EMAs) -2017-2021



HIV Death rate = 6 FL EMA's vs. Palm Beach --2021

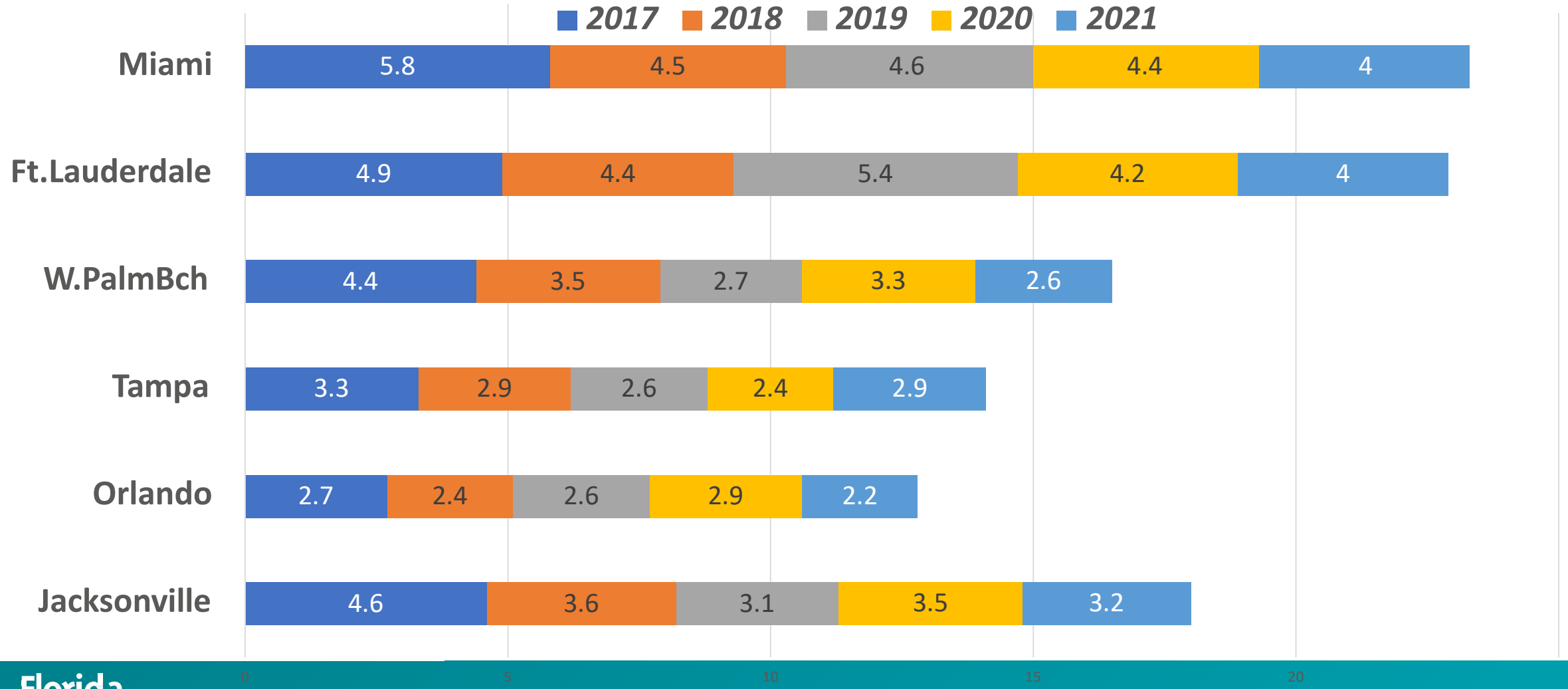
EMA	*HIV Death Rate*
Jacksonville	3.2
Orlando	2.2
Tampa	2.9
West PB	2.6
Ft.Lauder	4.0
Miami	4.0
Palm Bch	2.6

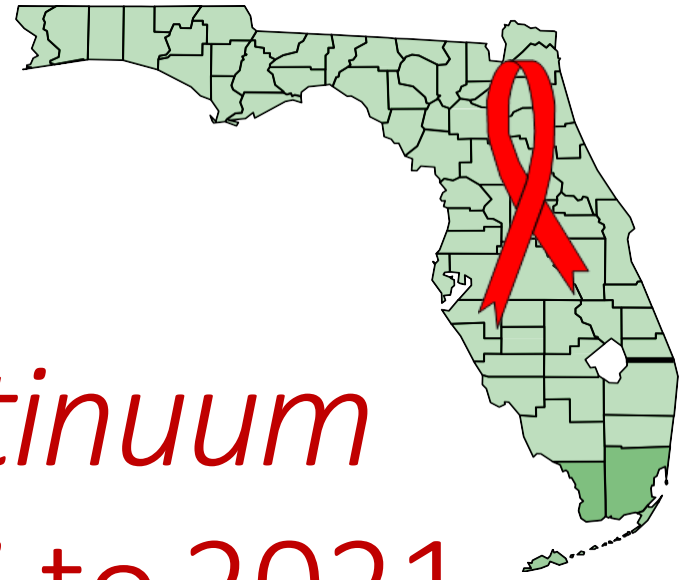


5-Yr Trends: *HIV Death rate* (6 EMAs) -2017-2021

Years	Jacksonville	Orlando	Tampa	West PalmBch	Ft.Lauderdale	Miami
2017	4.6	2.7	3.3	**4.4**	4.9	5.8
2018	3.6	2.4	2.9	**3.5**	4.4	4.5
2019	3.1	2.6	2.6	**2.7**	5.4	4.6
2020	3.5	2.9	2.4	**3.3**	4.2	4.4
2021	3.2	2.2	2.9	**2.6**	4.0	4.0

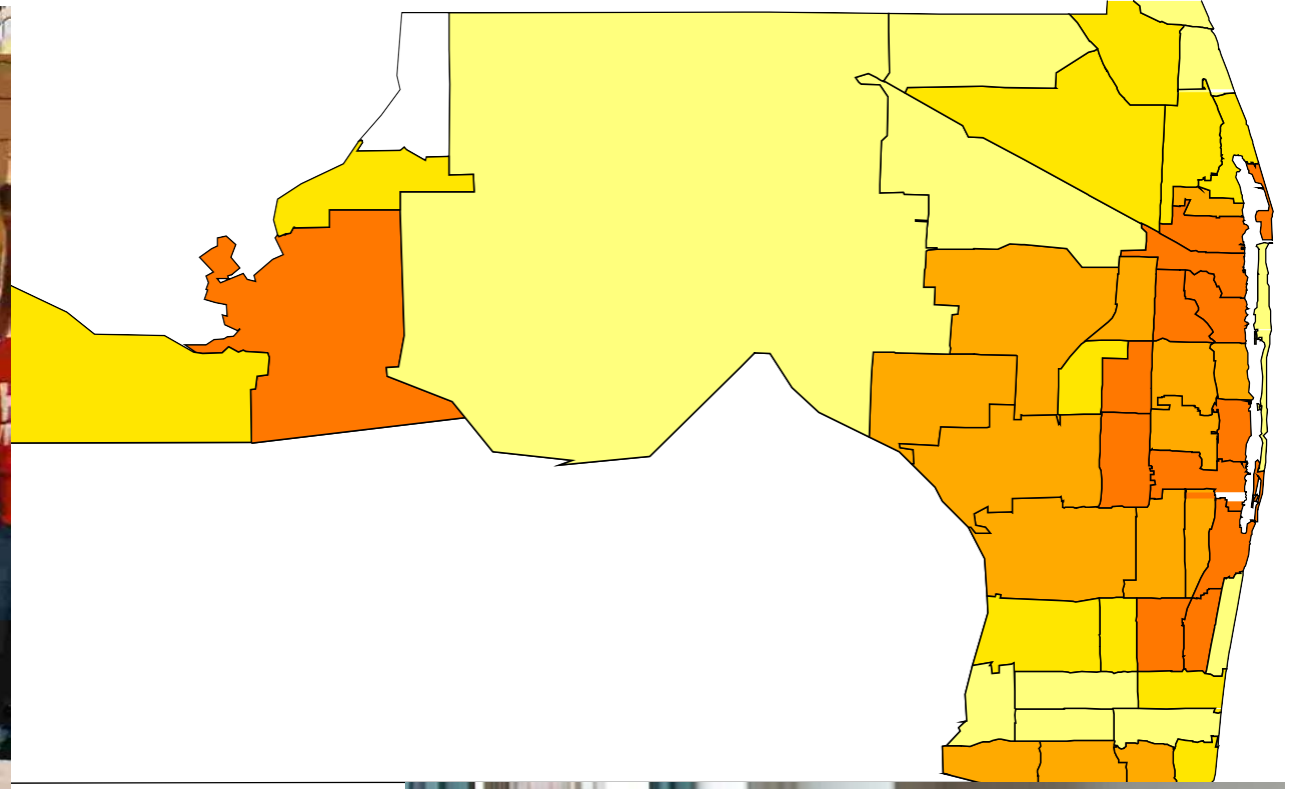
5-Yr Trends: *HIV Death rate* (6 EMAs) -2017-2021

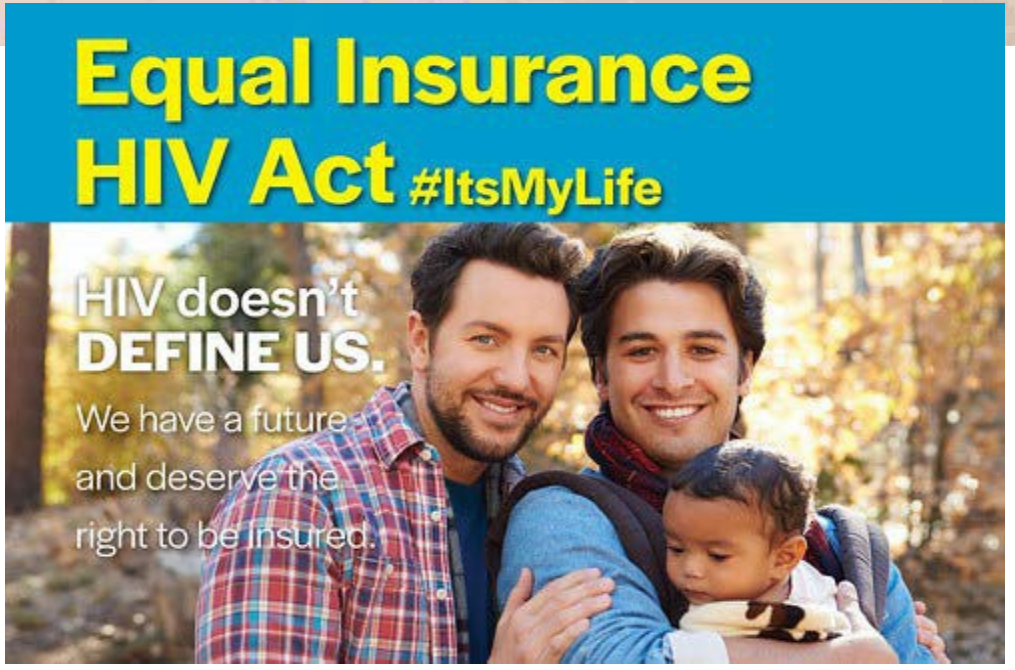




TRENDS in *HIV Care Continuum* --Palm Beach County 2017 to 2021


TREAT THE PEOPLE AIDS DRUGS NOW!
PLEASE CARE FOR US
HIV POSITIVE



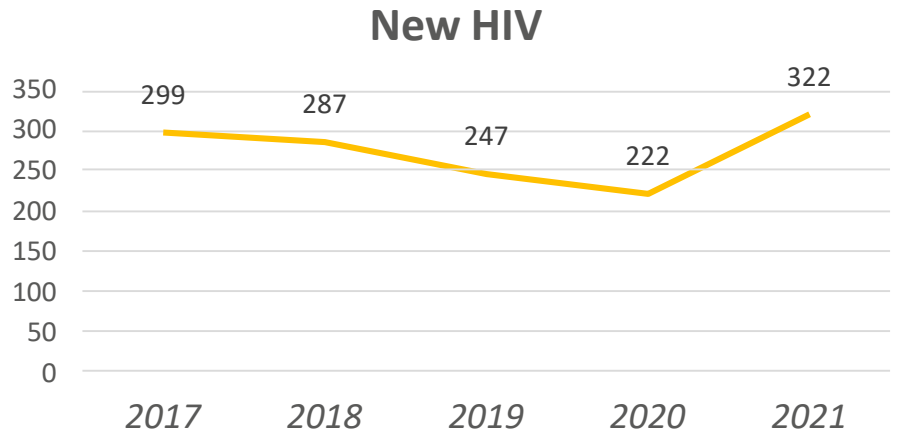

Equal Insurance
HIV Act #ItsMyLife
HIV doesn't
DEFINE US.
We have a future
and deserve the
right to be insured.

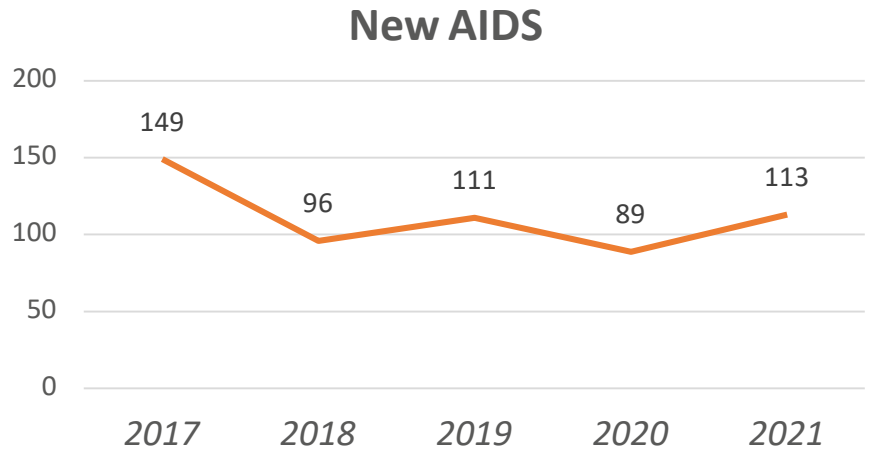

A CONDOM and A PILL AT A TIME...
I am
Facing AIDS
because people I
are infected

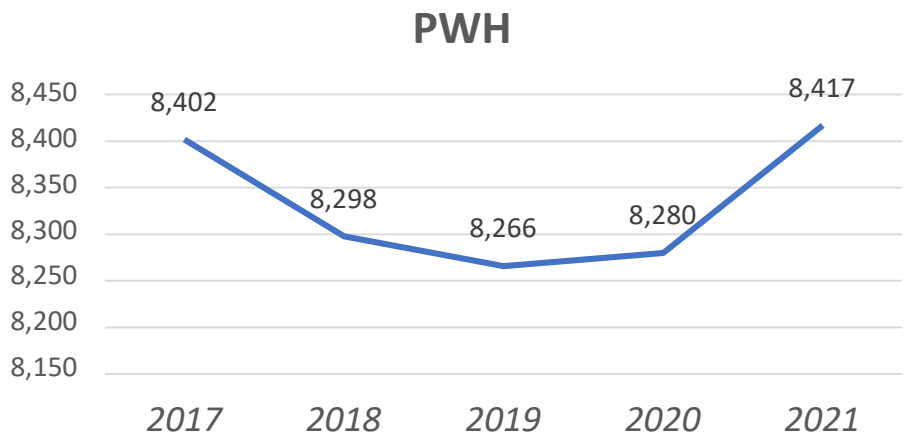
Trend: HIV Incidence, Prevalence--2018-2021 Palm Beach

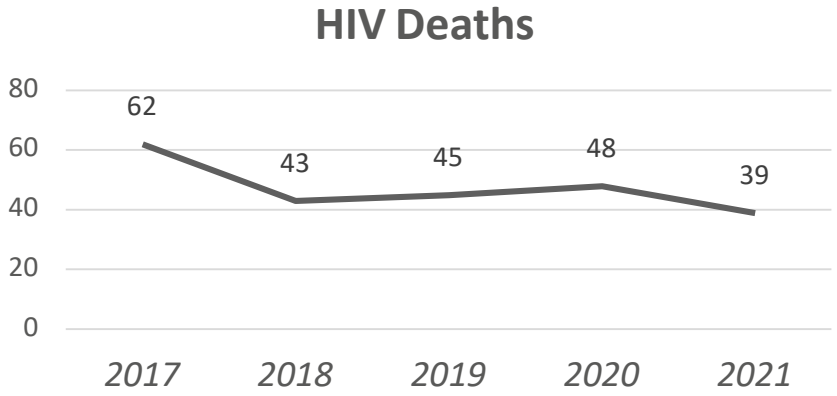
PALM BEACH	INCIDENCE (*New* HIV+AIDS)	*DIAGNOSIS Rate* (100,000 PBC ppl) (H+A New)	PREVALENCE (PWH) [ongoing cases]	HIV DEATHS Death Rates (per 100,000 PBC ppl.)
2021	**435** (322-H ; 113-A)	**30** (22 -H ; 8 -A)	**8,417**	**39** // 3.0 per 100,000
2020	**311** (222-H ; 89-A)	**21** (15 -H ; 6 -A)	**8,280**	**48** // 3.9 per 100,000
2019	**358** (247-H ; 111-A)	**25** (17 -H ; 8 -A)	**8,266**	**45** // 3.1 per 100,000
2018	**383** (287-H ; 96-A)	**27** (20 -H ; 7 -A)	**8,298**	**53** // 4.1 per 100,000

5 yr-*Trends*: New HIV/AIDS, PWH, HIV Deaths-2021 PBC

- 



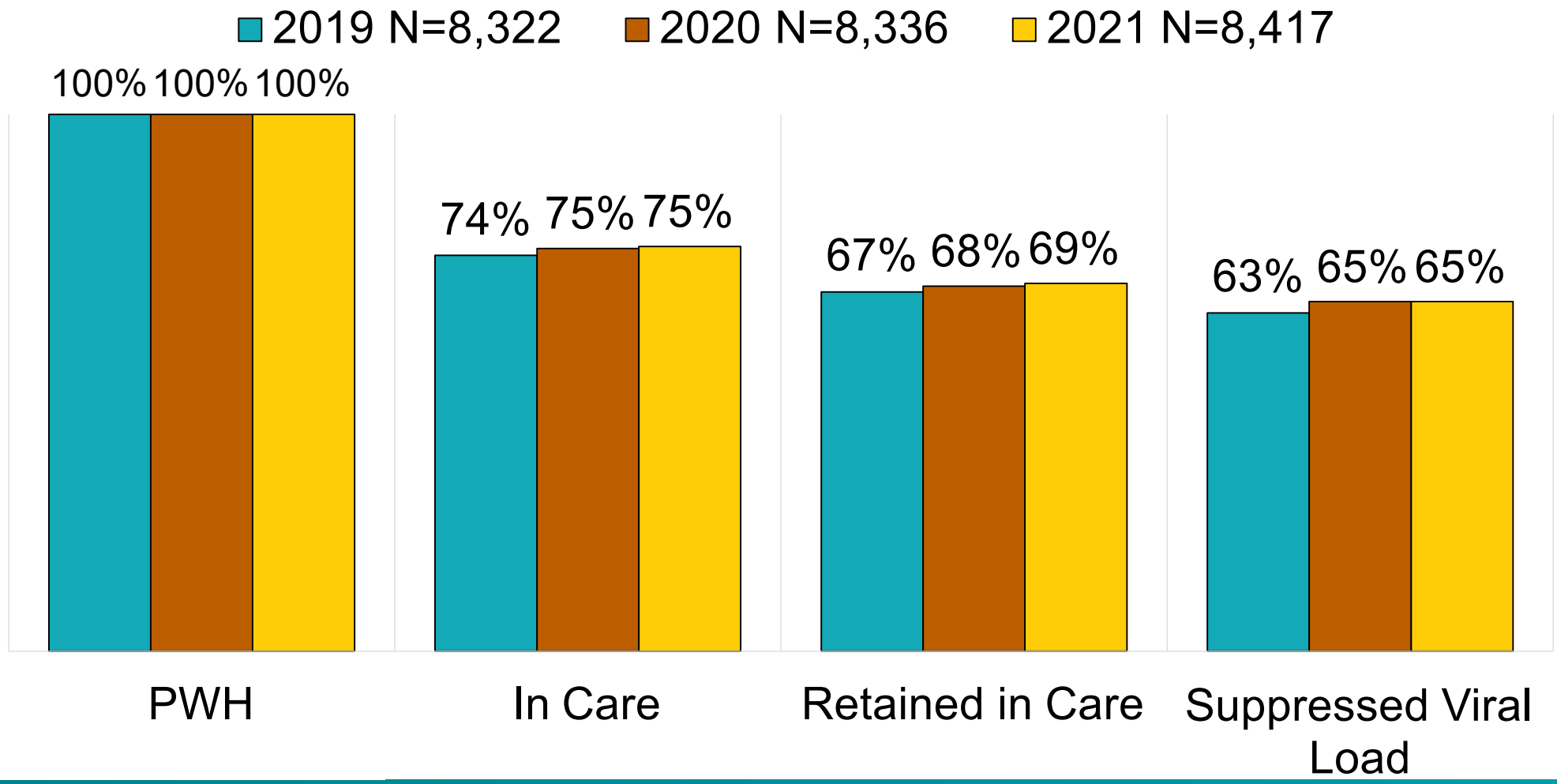




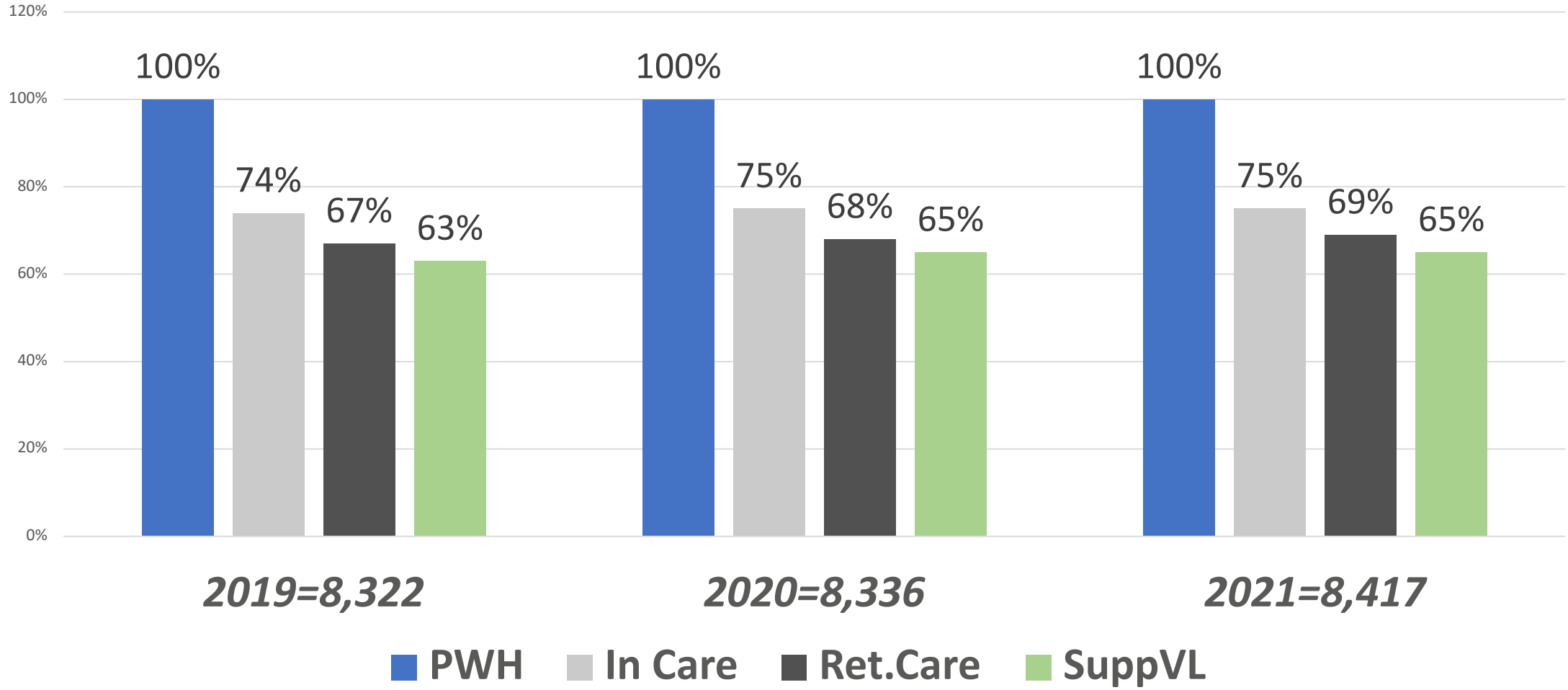
5-yr. Trend: PWH *Care Continuum* --2017-2021 Palm Beach

	PWH *Care Continuum* trends - PBC					Relative point Change 2020–2021
PWH	***2017***	***2018***	***2019***	***2020***	***2021***	
% In Care	71%	73%	74%	75%	75%	0
% Not in Care (OOC)	29%	27%	26%	25%	**25%**	0
% Retained in care	64%	66%	67%	68%	69%	+1
% Supp. Viral Load	58%	61%	63%	65%	65%	0

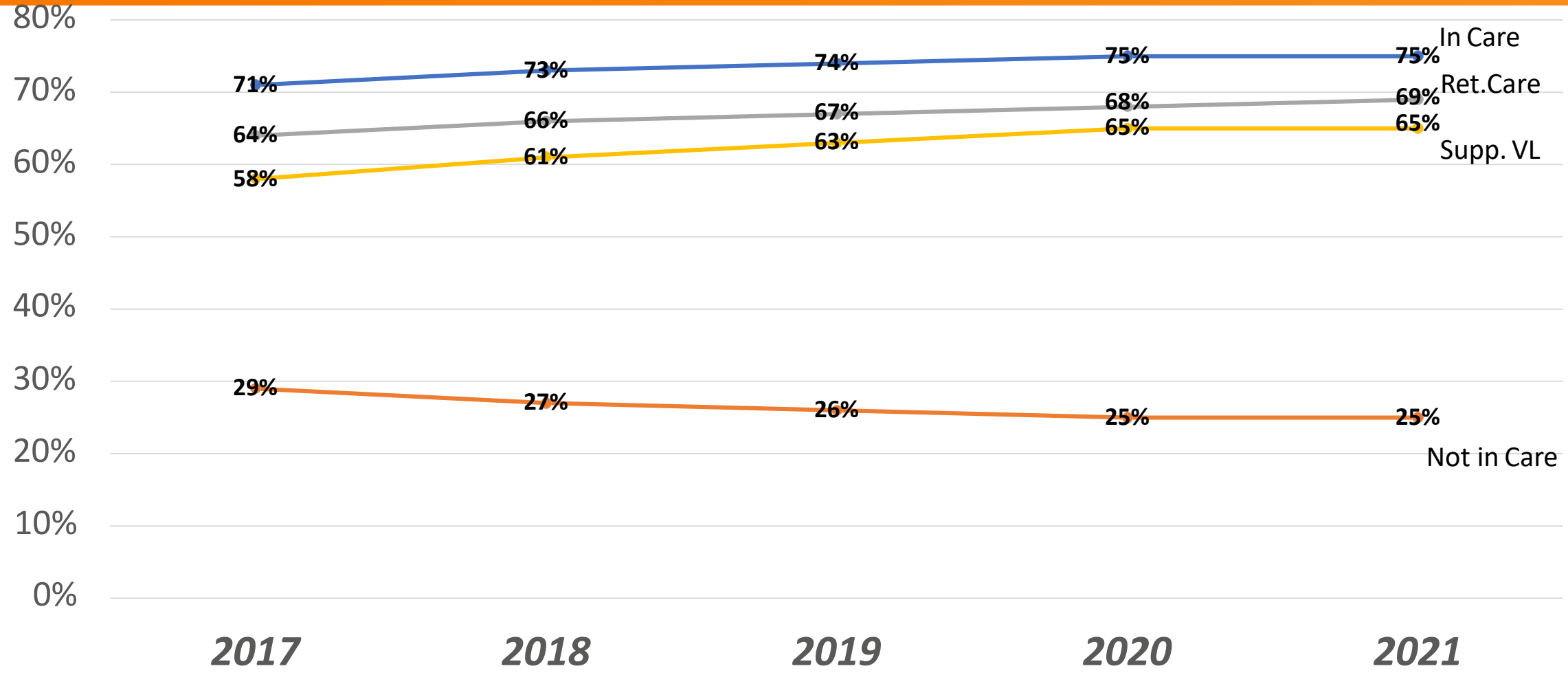
3-yr. Trend: PWH *Care Continuum* --2019-2021 Palm Beach

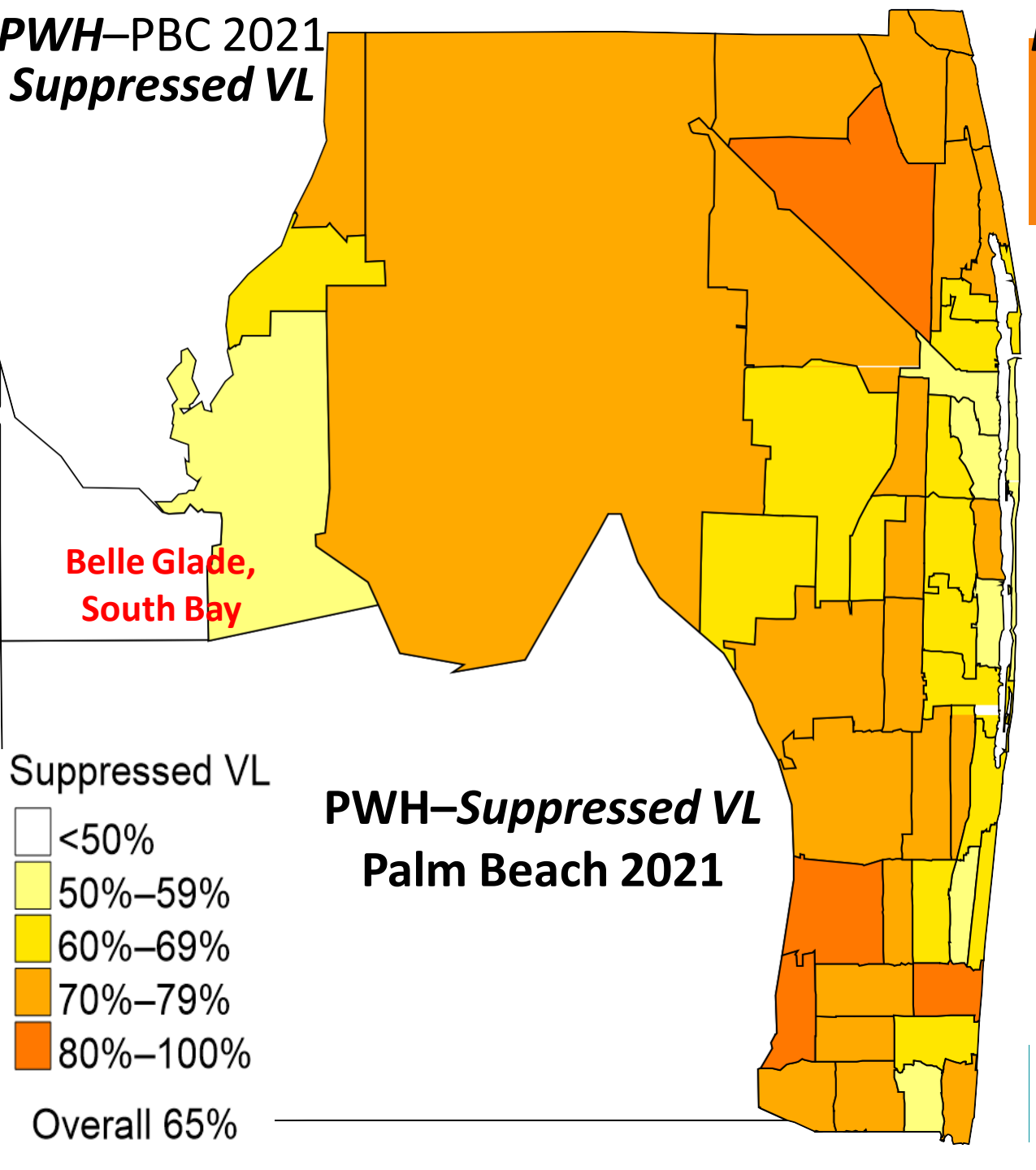


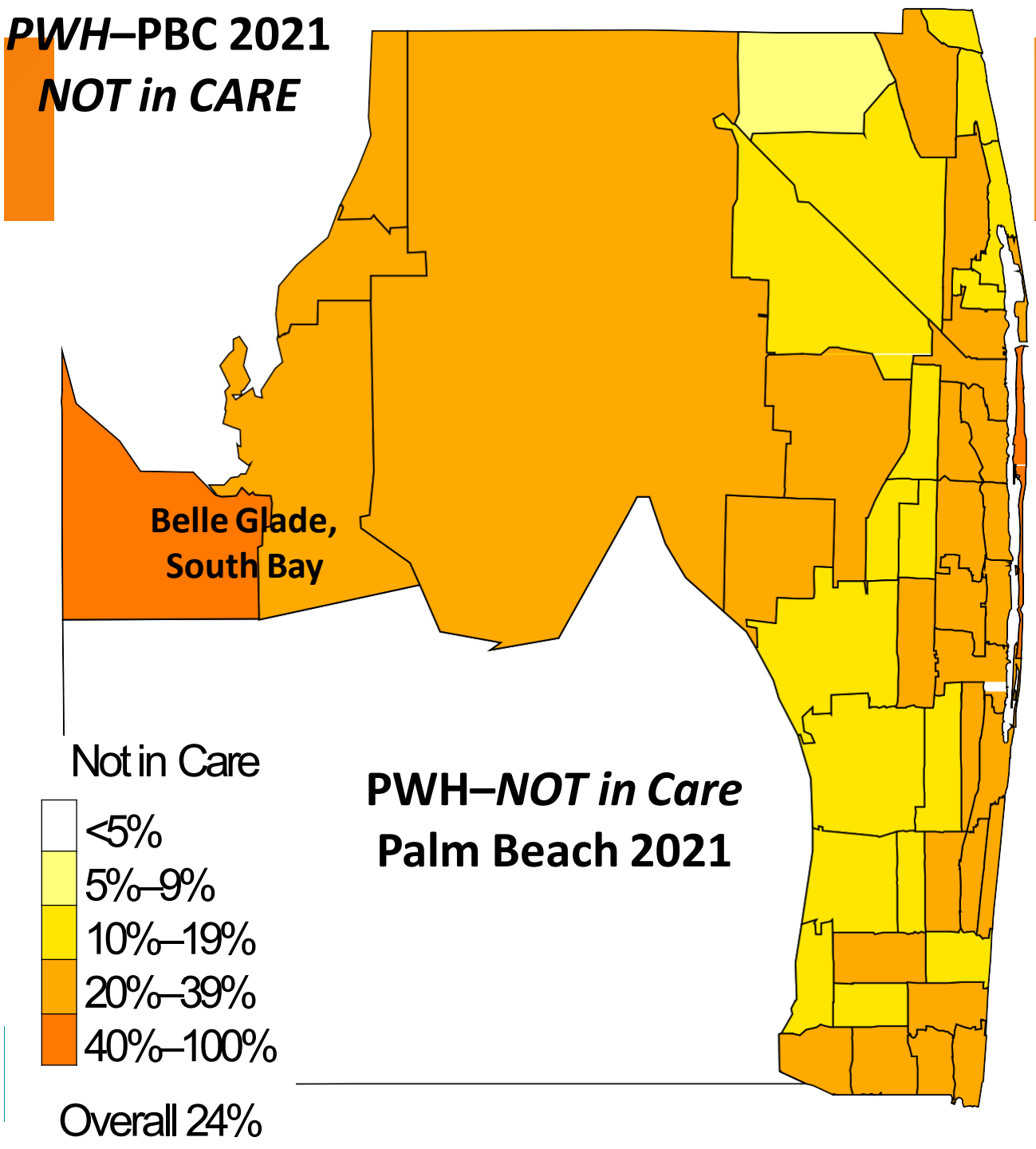
3-yr. Trend: PWH *Care Continuum* --2019-2021 Palm Beach



5-yr. Trend: PWH *Care Continuum* --2019-2021 Palm Beach

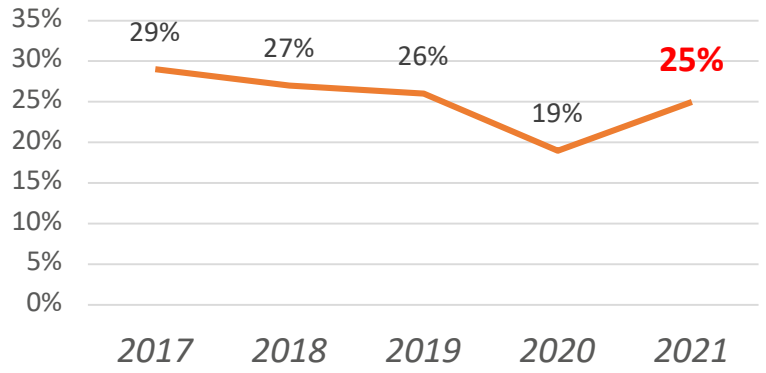



PWH–PBC 2021
Suppressed VL
Belle Glade,
South Bay
Suppressed VL
<50%
50%–59%
60%–69%
70%–79%
80%–100%
Overall 65%
PWH–Suppressed VL
Palm Beach 2021

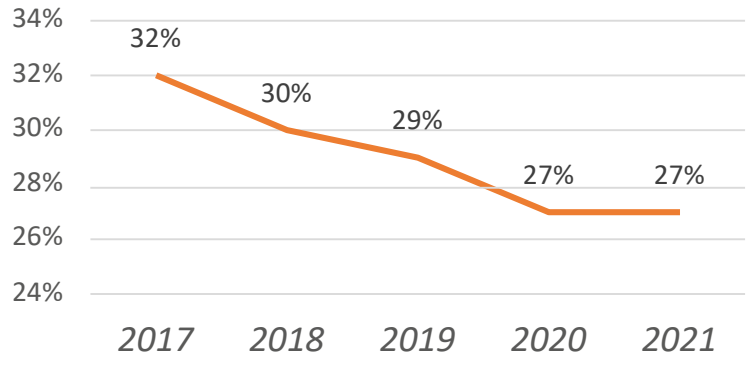

PWH–PBC 2021
NOT in CARE
Belle Glade,
South Bay
Not in Care
<5%
5%–9%
10%–19%
20%–39%
40%–100%
Overall 24%
PWH–NOT in Care
Palm Beach 2021

Palm Bch 5 yr-*Trends*: PWH/New HIV-*Not in Care*, No Viral load

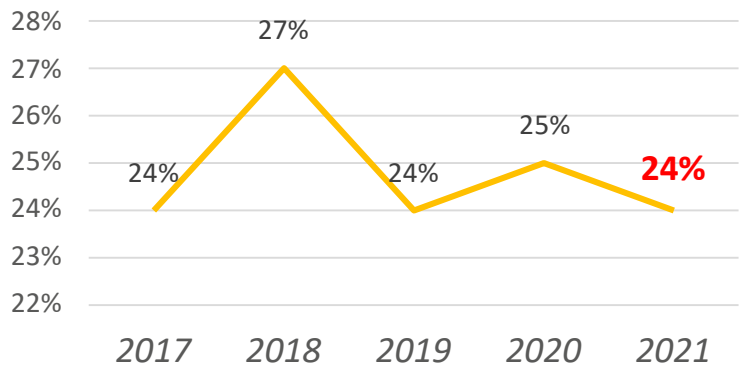
- **PWH- *Not in Care***



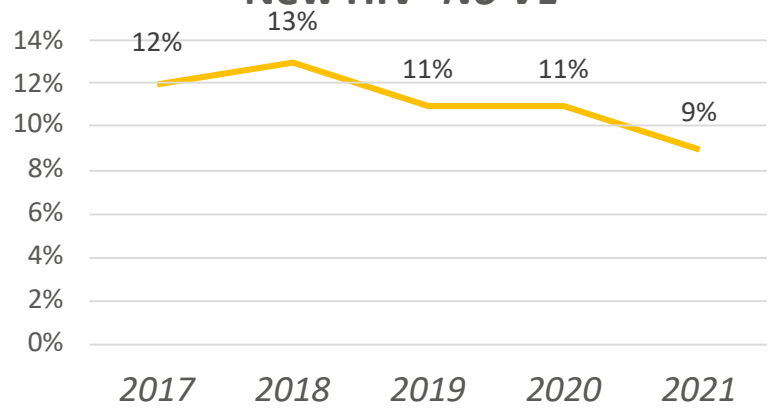
PWH- *No VL*



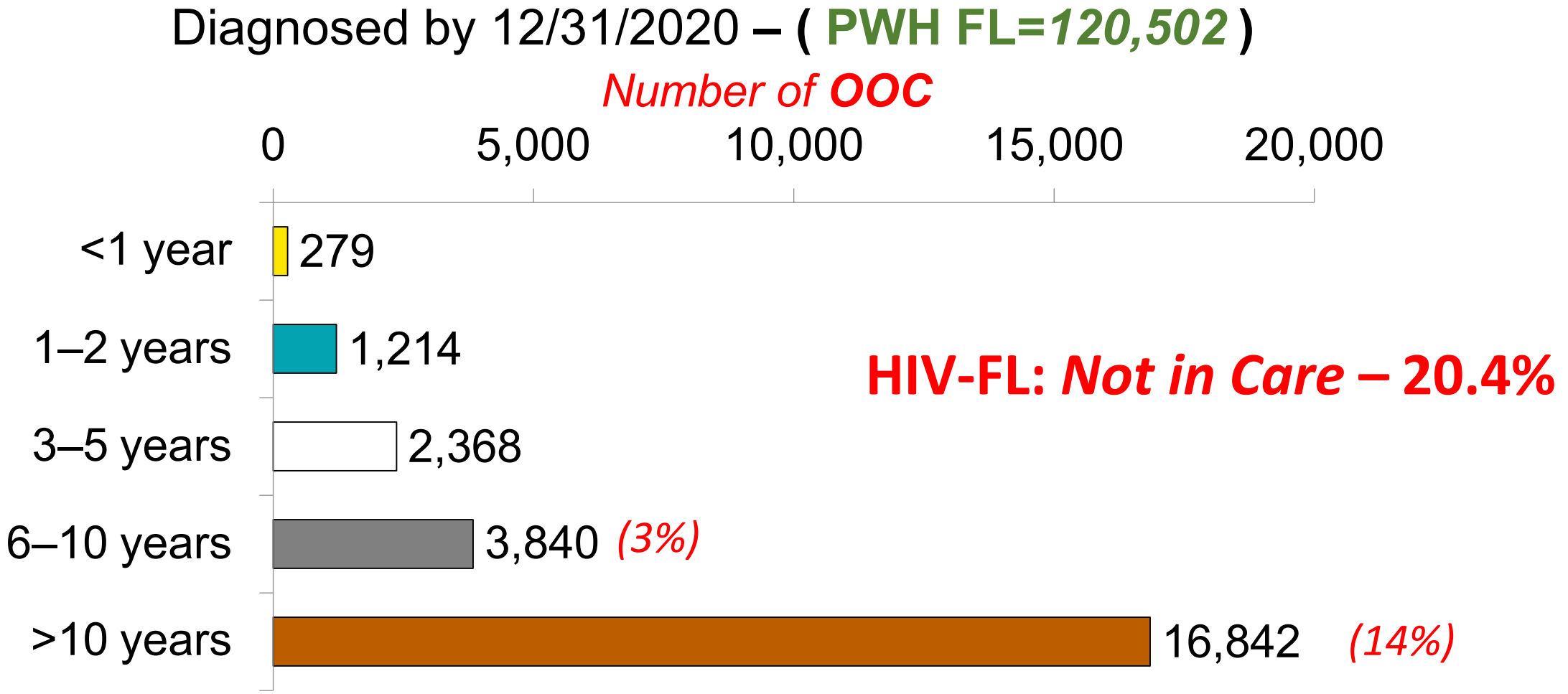
New HIV- *Not in Care*



New HIV- *No VL*

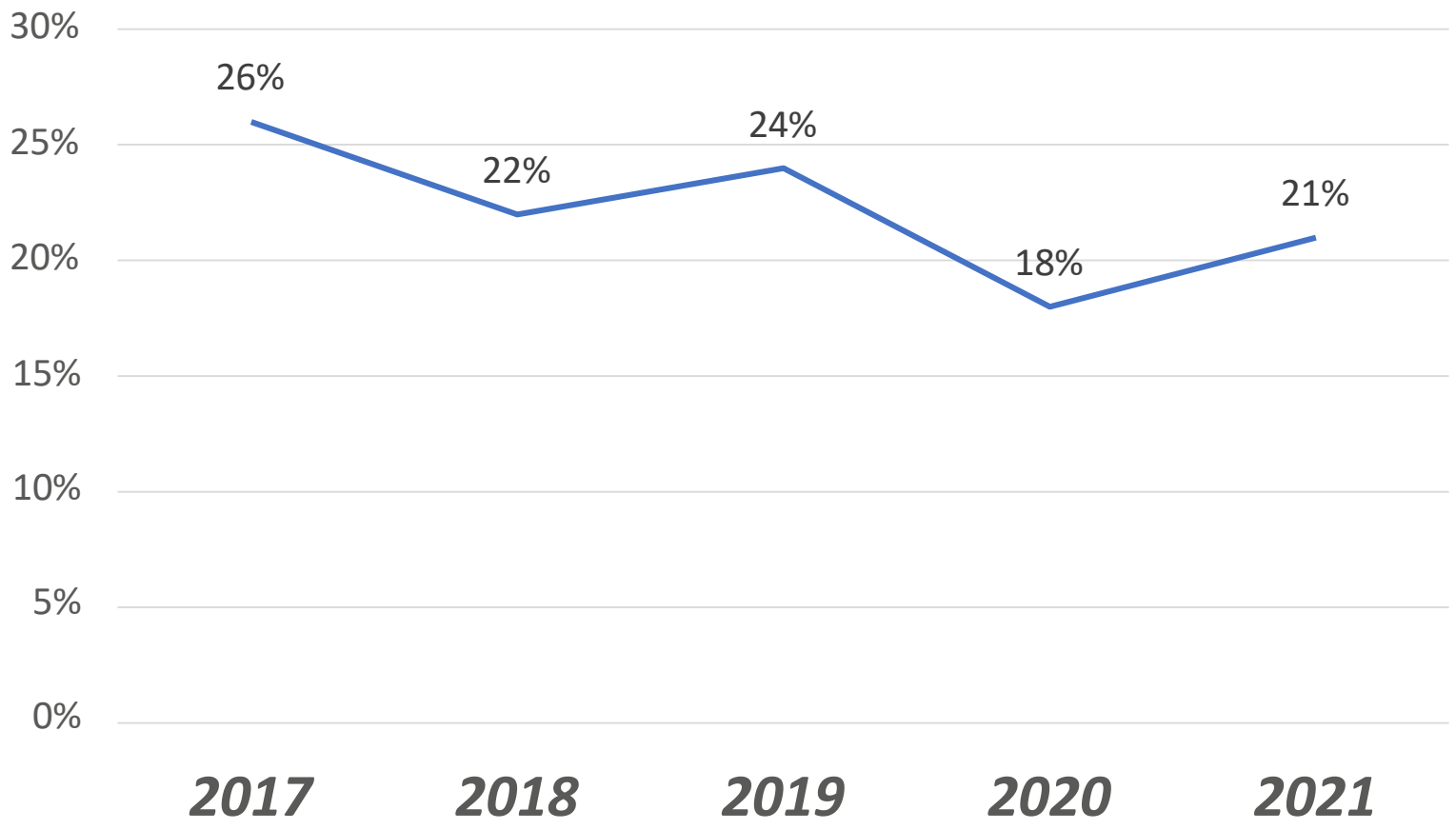


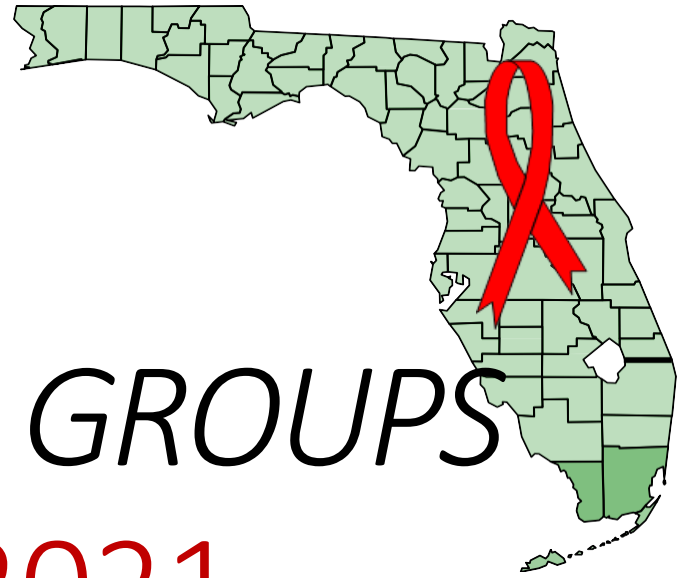
FLORIDA *Out of Care*: by # years since HIV Dx (*N=24,543* = [20.4%]



5 yr-*Trend*: Late AIDS Dx (3 mos. *after* HIV Dx) –Palm Beach

	Late AIDS Diagnoses	Count
2017	26%	78
2018	22%	64
2019	24%	58
2020	18%	39
2021	21%	66





Palm Beach *HIV Epi Profile* *by GROUPS* & Care Continuum TRENDS - 2021

PWH *Demographics* -- 2021 Palm Beach

		Male #	%	Female #	%	Total #	%
Race /Ethnicity	White	1,576	28.7%	350	12.0%	1,926	22.9%
	Black	2,661	48.5%	2,208	75.6%	4,869	57.9%
	Hispanic/Latino	1,139	20.8%	316	10.8%	1,455	17.3%
	Other	113	2.1%	47	1.6%	160	1.9%
Age Group	13-19	14	0.3%	13	0.4%	27	0.3%
	20-29	371	6.8%	121	4.1%	492	5.9%
	30-39	853	15.5%	358	12.3%	1,211	14.4%
	40-49	876	16.0%	702	24.0%	1,578	18.8%
	50+	3,375	61.5%	1,727	59.1%	5,102	60.7%
Mode of Exposure	MMSC	3,185	58.0%	0	0.0%	3,185	37.9%
	IDU	254	4.6%	249	8.5%	503	6.0%
	MMSC/IDU	199	3.6%	0	0.0%	199	2.4%
	Heterosexual Contact	1,764	32.1%	2,593	88.8%	4,357	51.8%
	Transgender Sexual Contact	17	0.3%	0	0.0%	17	0.2%
	Other risk	70	1.3%	79	2.7%	149	1.8%

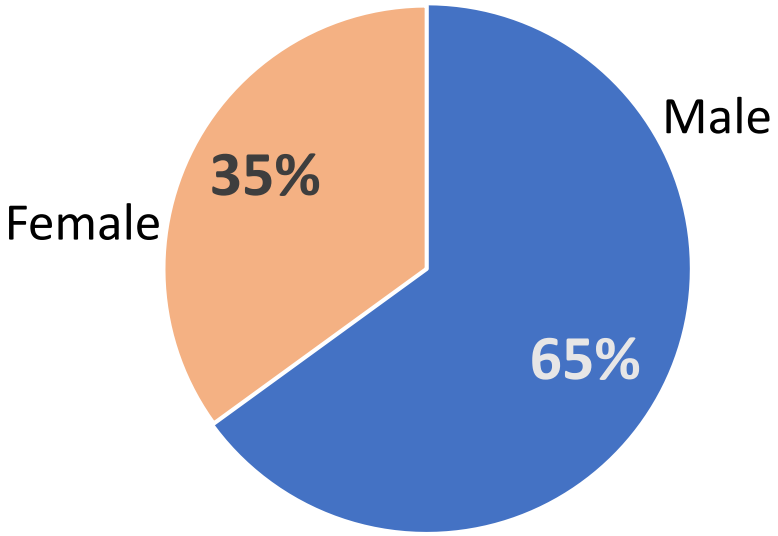
Florida HEALTH

Rounding may cause percentages to total more or less than 100.

PWH – compared by *Sex* – 2021 Palm Beach vs. FL

PalmBch	%	*Count*
Male	65%	5,491
Female	35%	2,926

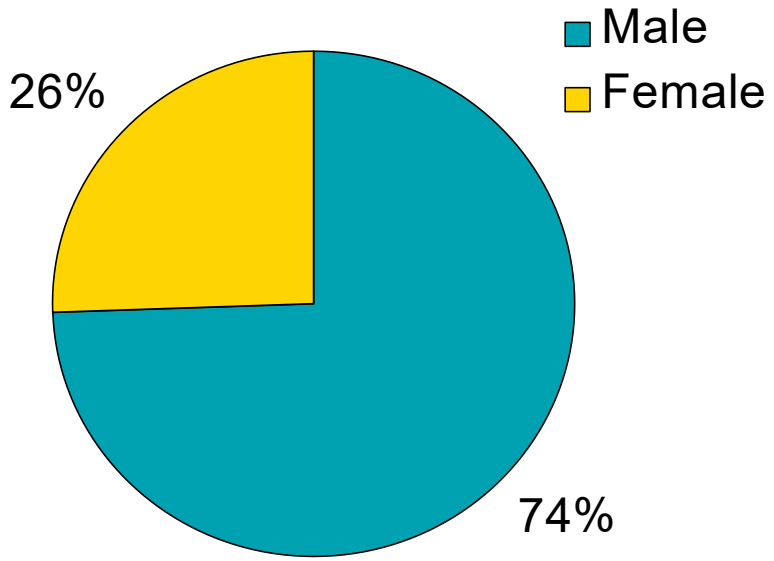
Palm Beach



Total *N*= 8,417

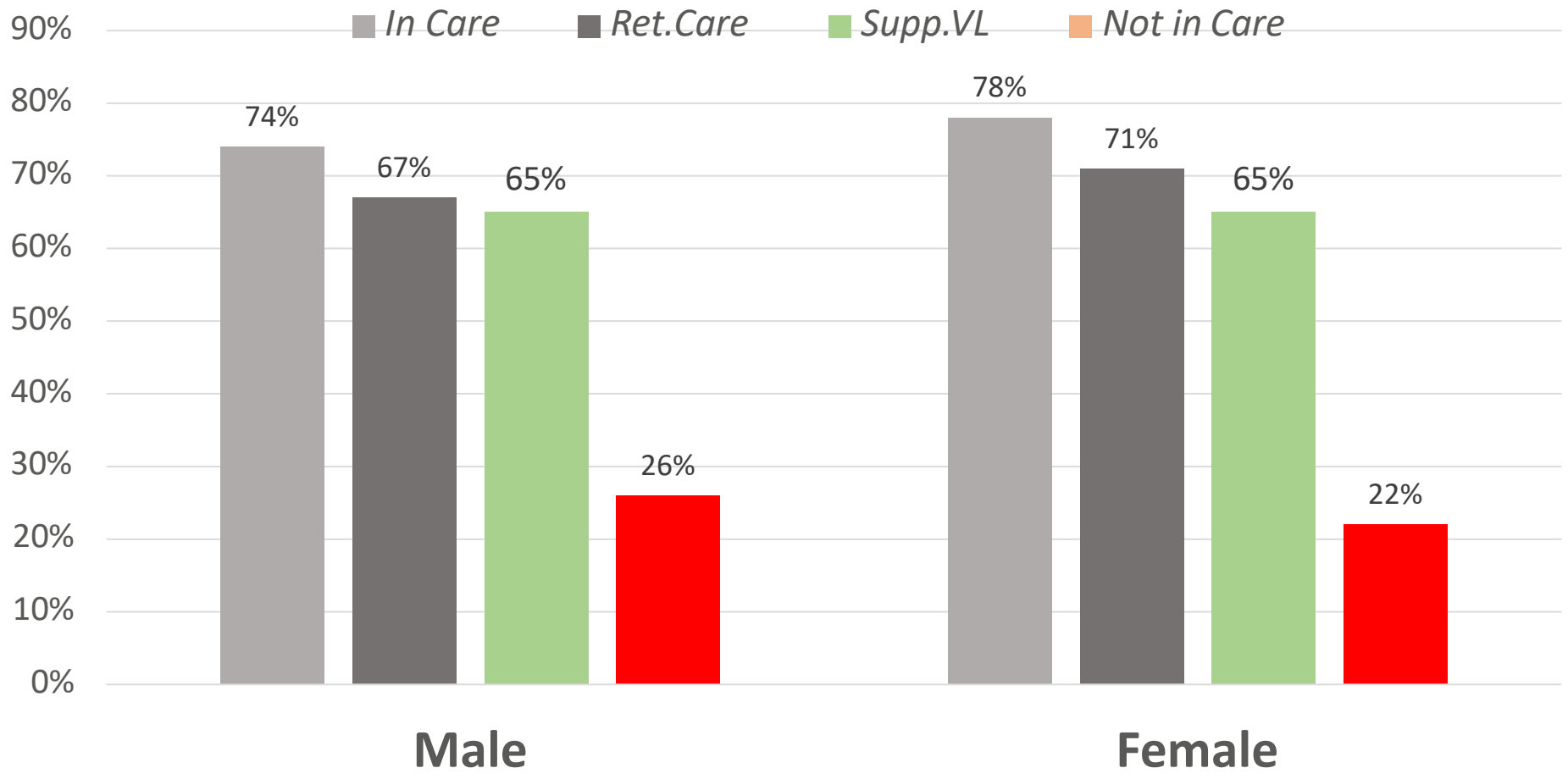
Florida	%	*Count*
Male	74%	89,021
Female	26%	31,358

Florida

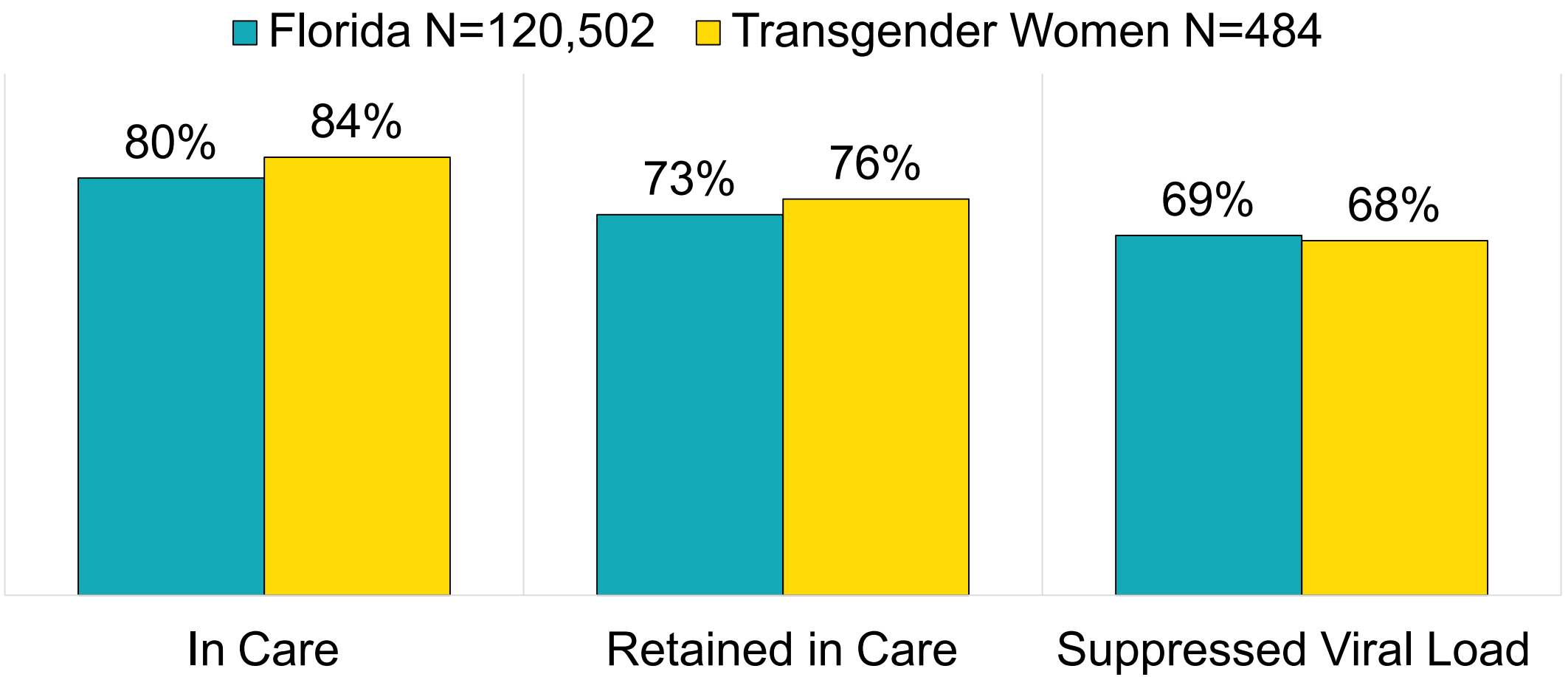


Total *N*= 120,502

PWH in *Care Continuum* by *Sex*–2021 Palm Beach

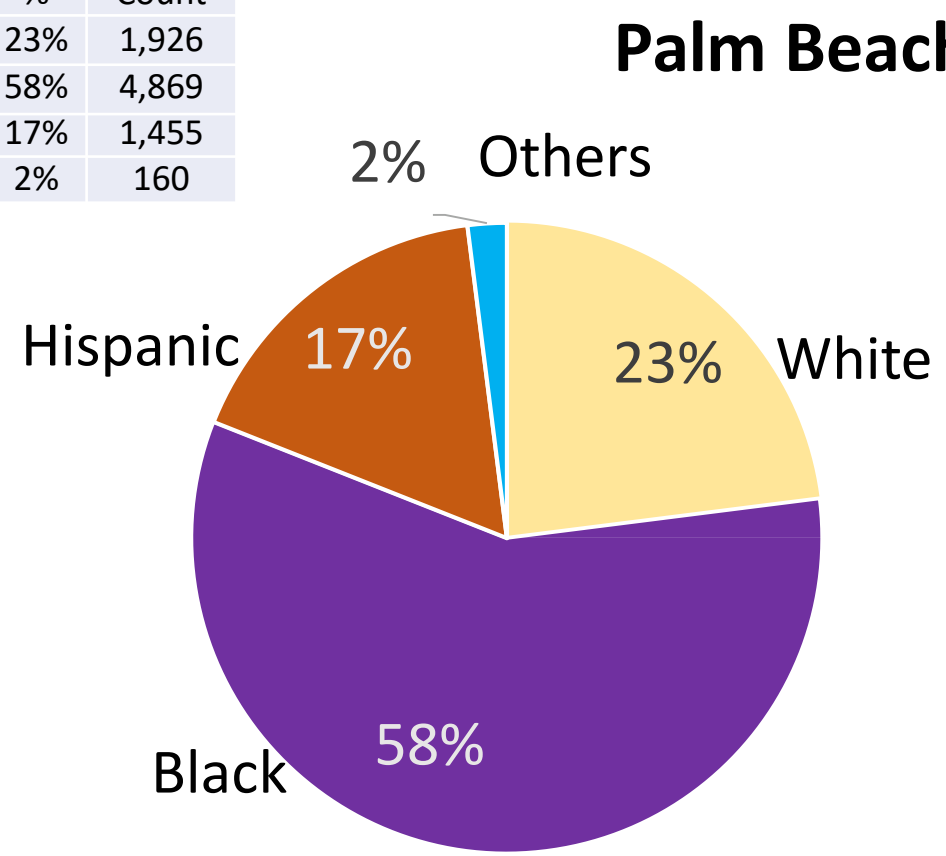


PWH: *Transgender Women* vs. PWH – 2021 FLORIDA



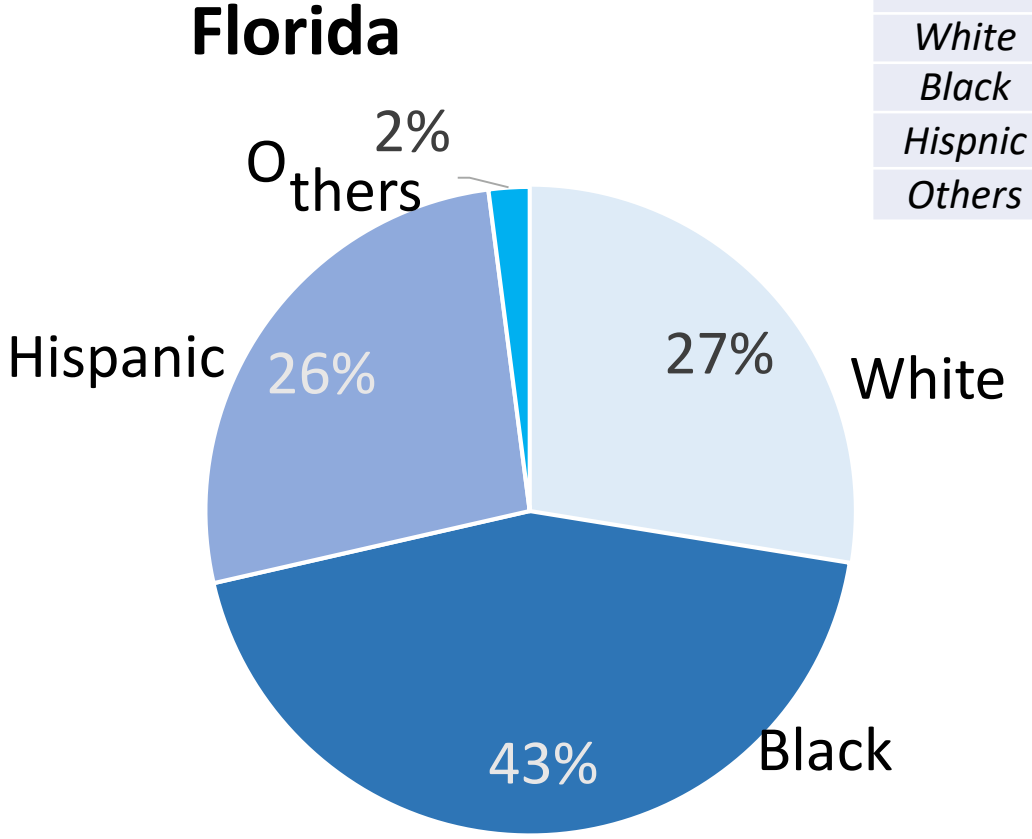
PWH – compared by *RACE* – 2021 Palm Beach vs. FL

PBC	%	Count
White	23%	1,926
Black	58%	4,869
Hispnic	17%	1,455
Others	2%	160



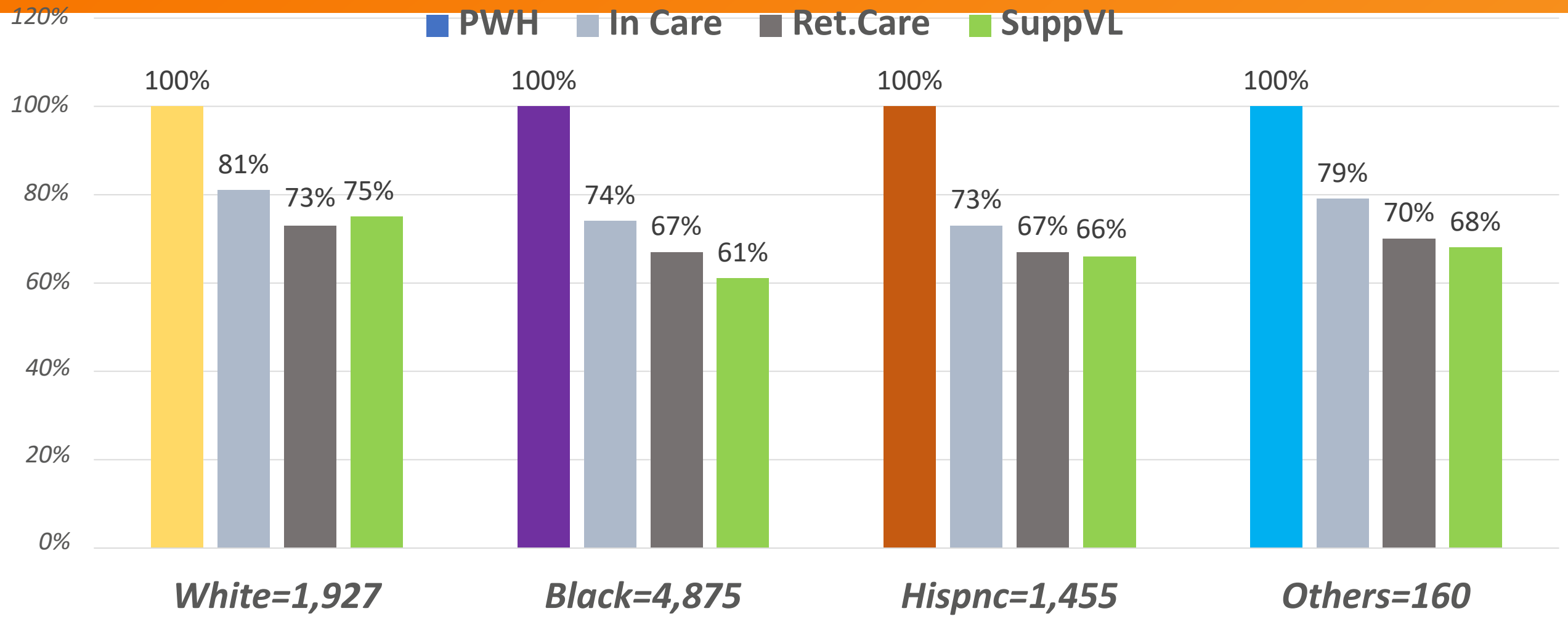
Total *N*= 8,417

Florida	%	Count
White	27%	33,537
Black	43%	52,880
Hispnic	26%	31,374
Others	2%	2,588

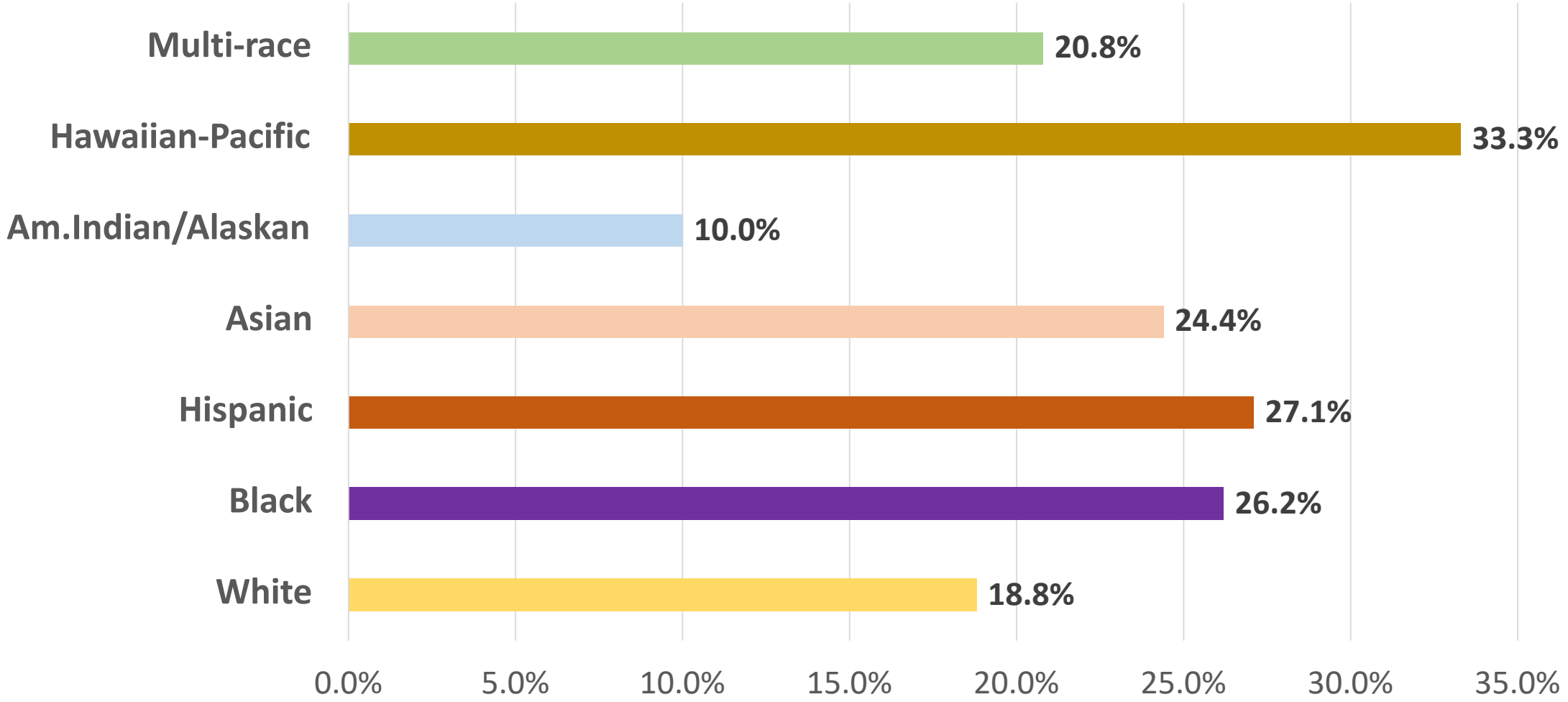


Total *N*= 120,502

PWH in *Care Continuum* by *RACE* –2021 Palm Beach



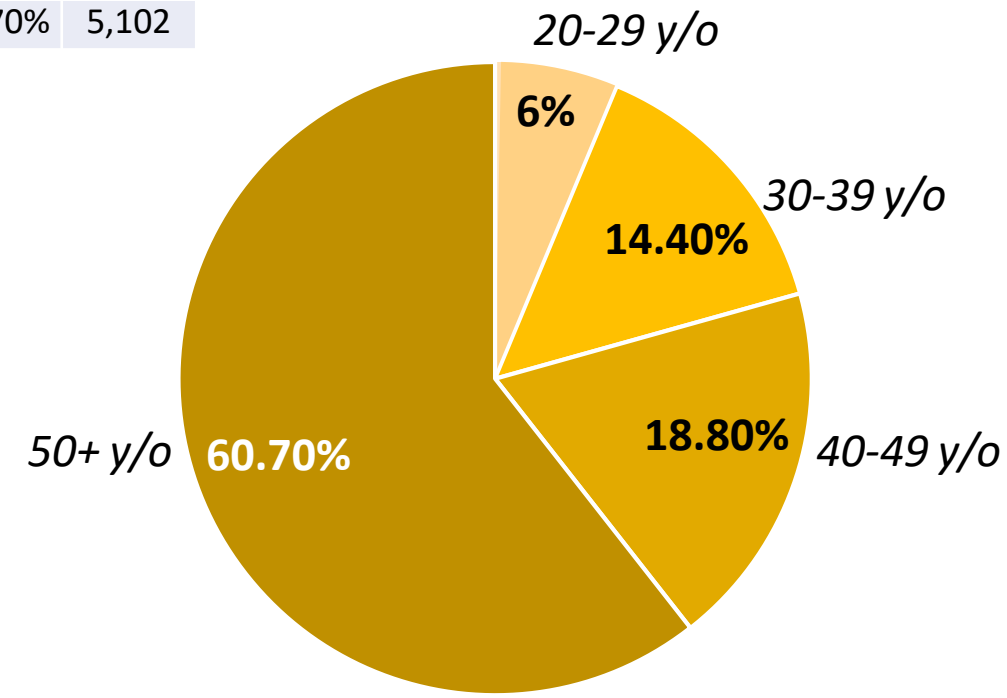
PWH *Not in Care*, by Race (*N= 2,069*) --2021 Palm Beach



PWH - compared by *AGE groups*- 2021 Palm Bch vs. FL

Age	PBC	Count
13-19	0.30%	27
20-29	6%	492
30-39	14.40%	1.211
40-49	18.80%	1,578
50+	60.70%	5,102

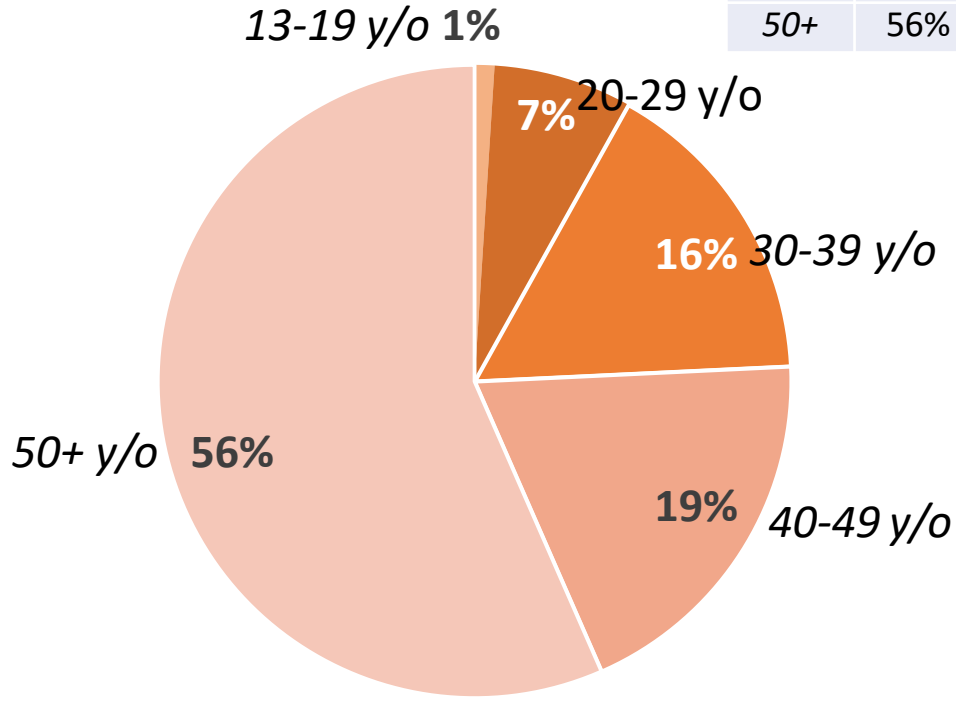
Palm Beach



Total *N*= 8,417

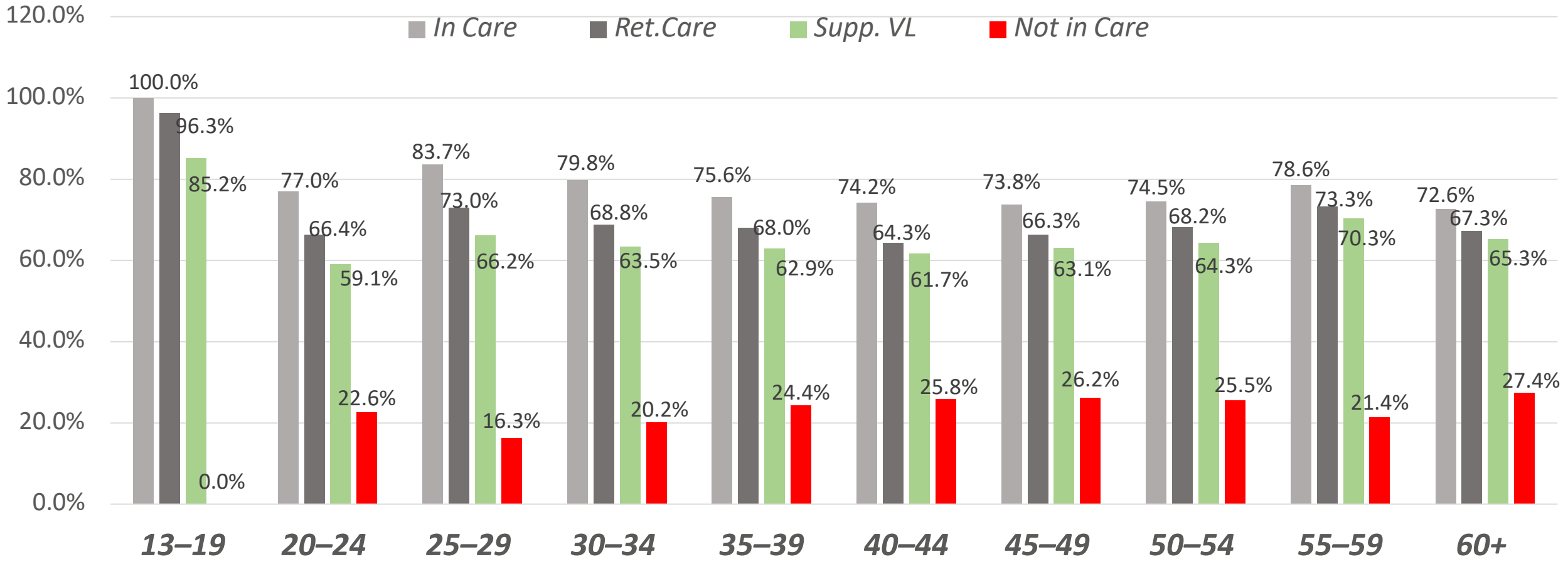
Age	FLA	Count
13-19	1%	321
20-29	7%	8,595
30-39	16%	20,388
40-49	19%	22,983
50+	56%	68,182

Florida



Total *N*= 120,502

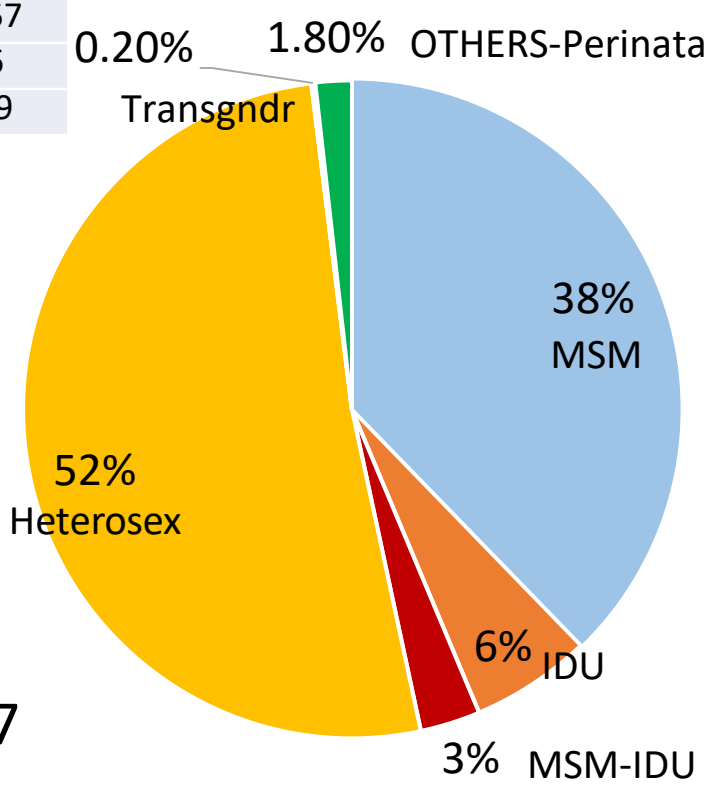
PWH in *Care Continuum* by *AGE groups*– 2021 Palm Beach



PWH – compared by *Risk Factors* – Palm Beach vs. FLORIDA

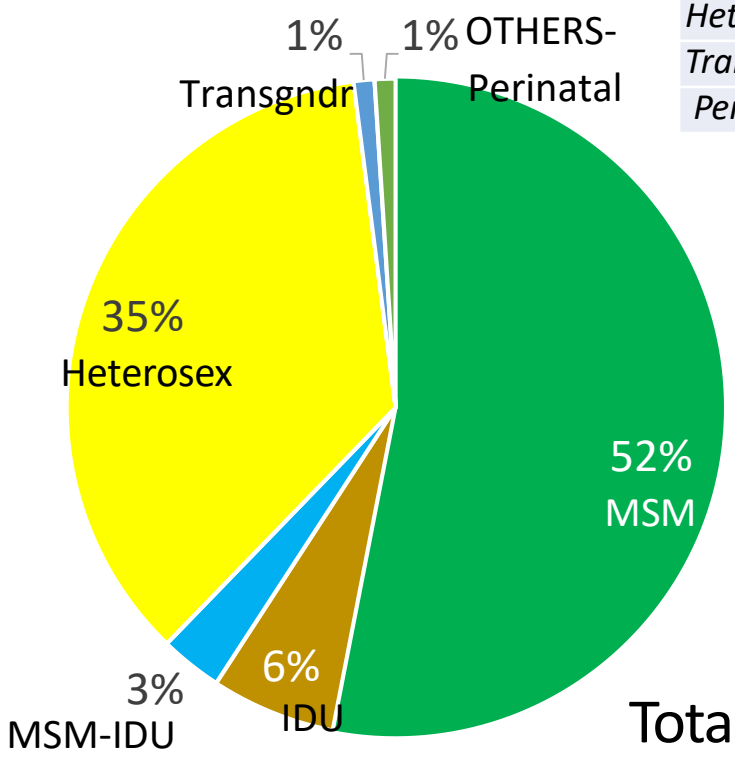
PALM BCH	%	Count
MSM	38%	3202
IDU	6%	503
MSM-IDU	3%	199
Heterosex	52%	4357
Transgndr	0.20%	16
Perinatal	1.80%	149

Palm Beach



Total *N*= 8,417

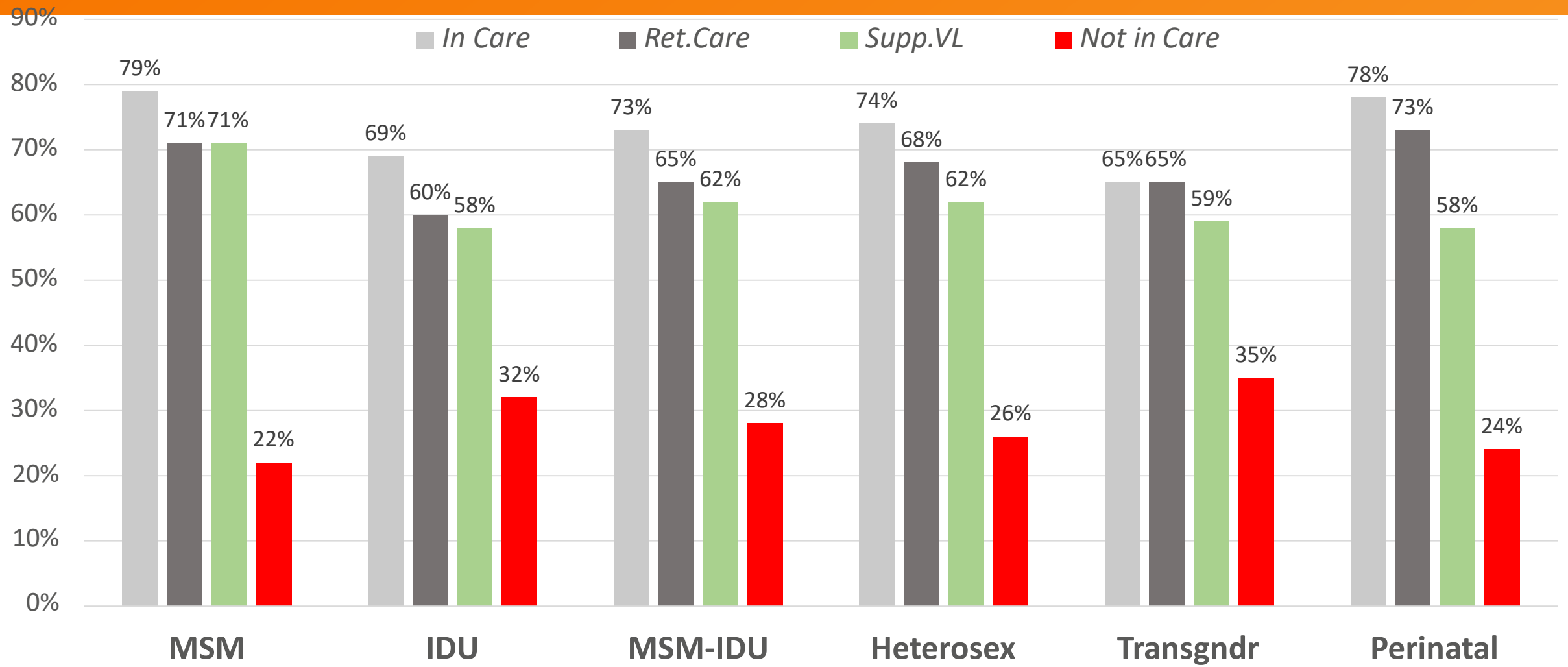
Florida

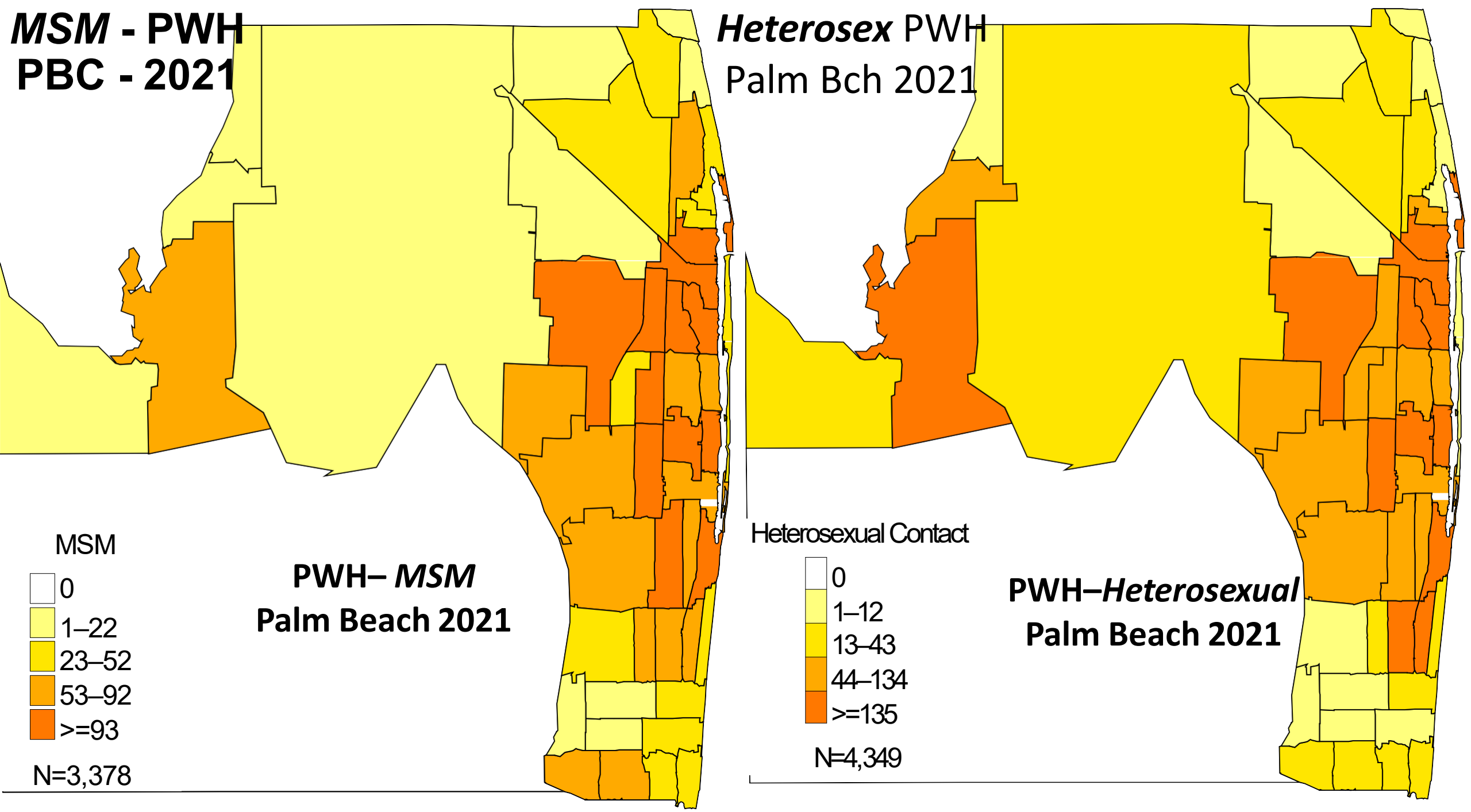


Total *N*= 120,502

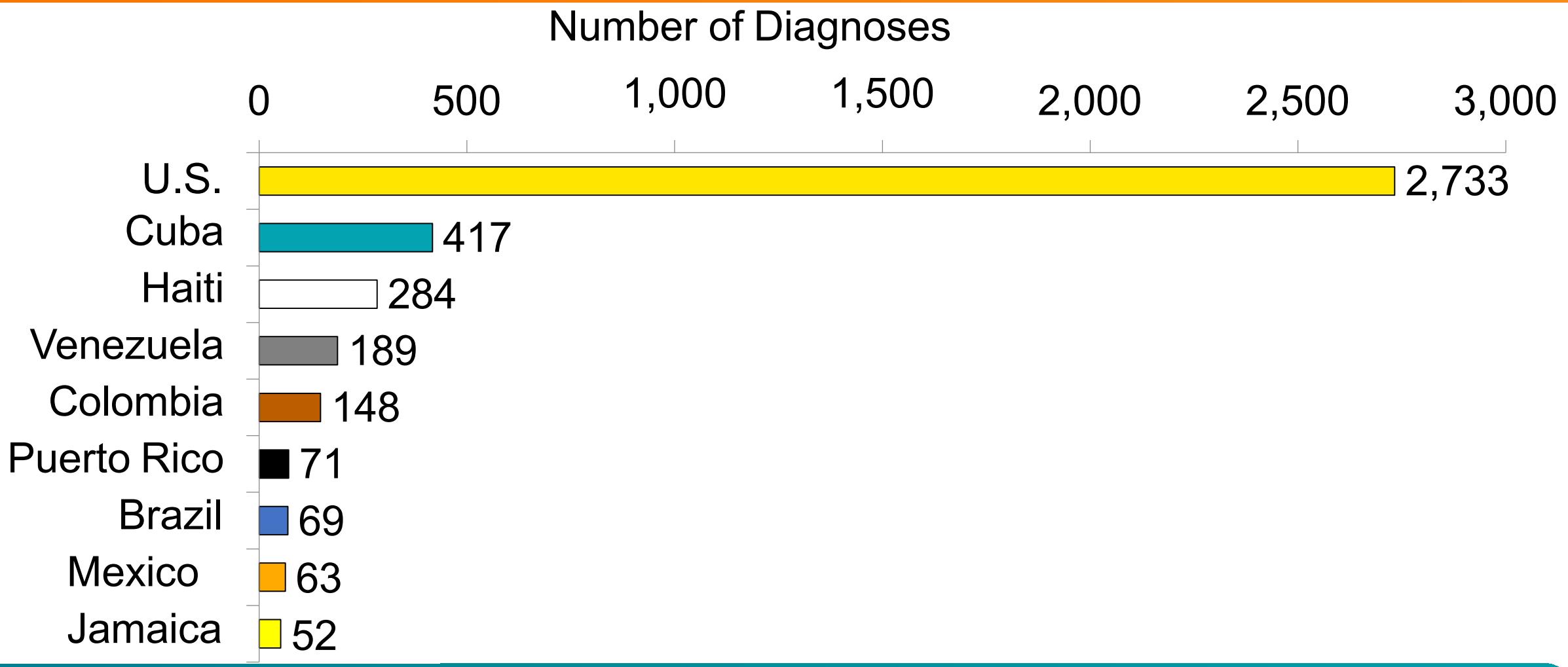
FLORIDA	%	Count
MSM	52%	63,072
IDU	6%	8,079
MSM-IDU	3%	4,064
Heterosex	35%	43,122
Transgndr	1%	459
Perinatal	1%	1,584

PWH: *Care Continuum* by *Risk factors*- 2021 Palm Bch

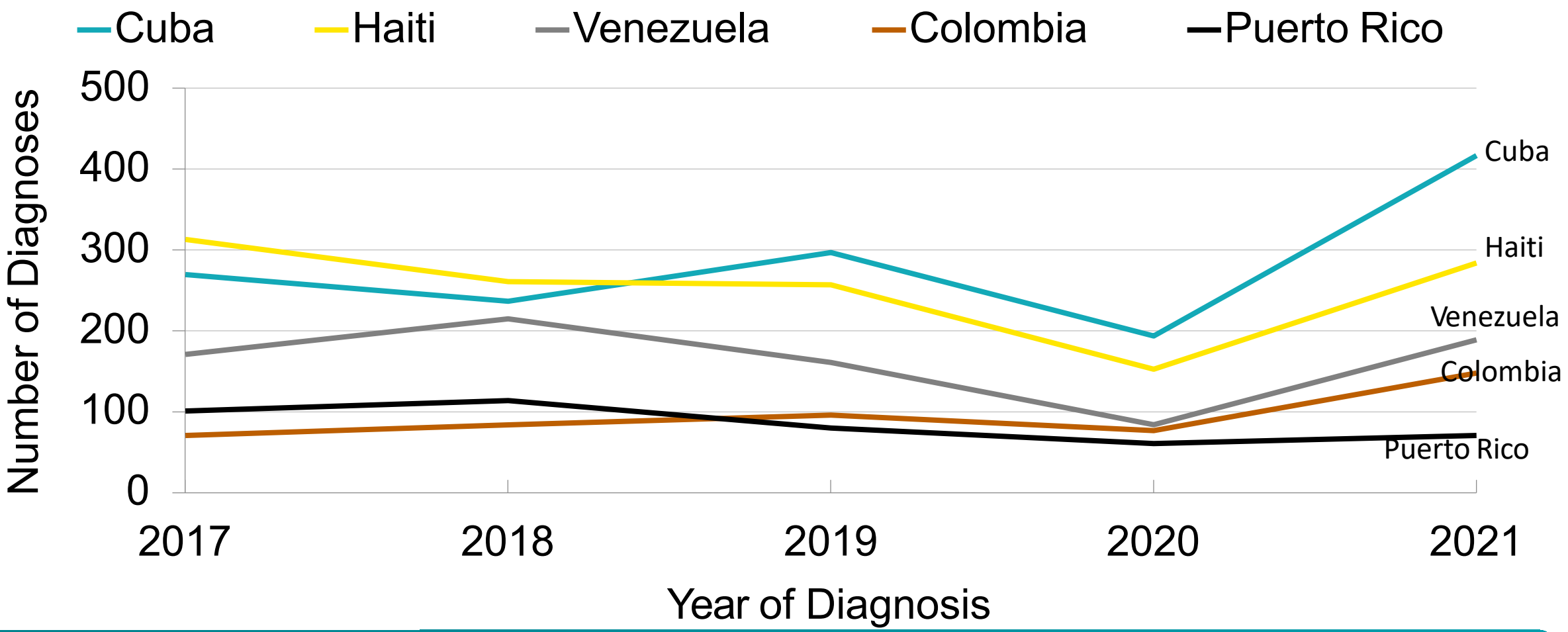



MSM - PWH
PBC - 2021
MSM
0
1–22
23–52
53–92
>=93
N=3,378
PWH– *MSM*
Palm Beach 2021
Heterosex PWH
Palm Bch 2021
Heterosexual Contact
0
1–12
13–43
44–134
>=135
N=4,349
PWH–*Heterosexual*
Palm Beach 2021

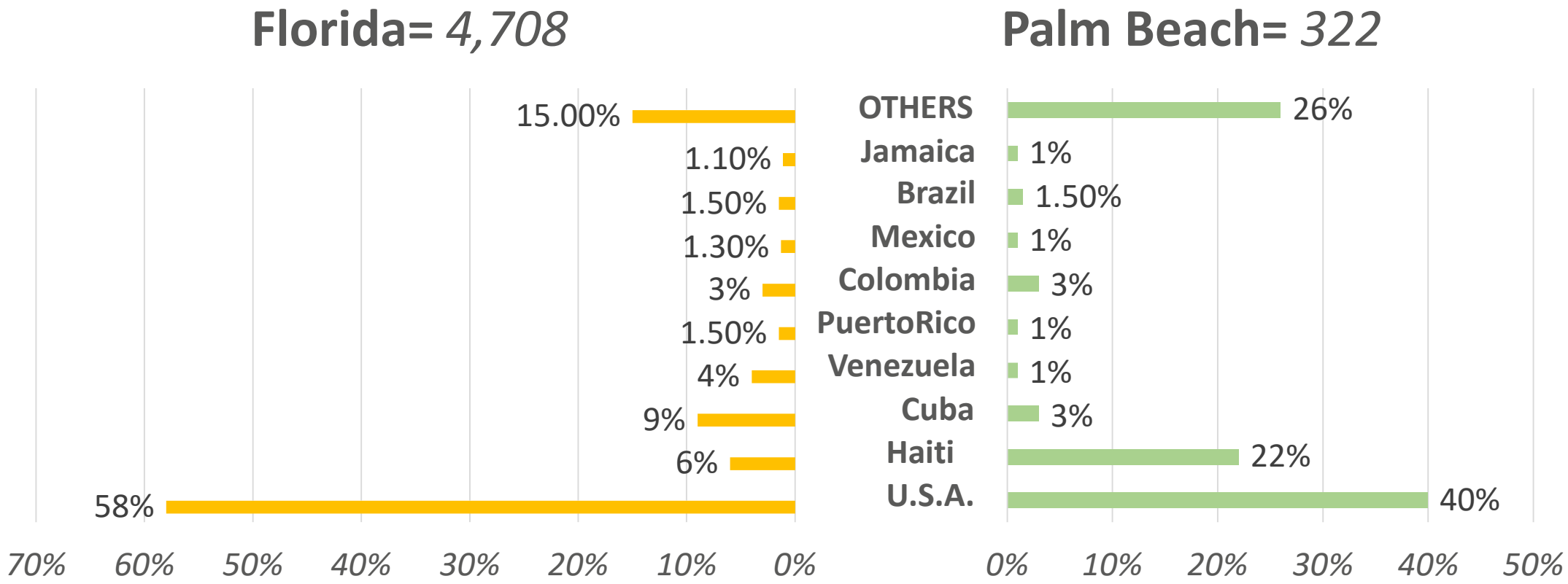
New HIV Dx : by *Country of Origin* – 2021 FLORIDA



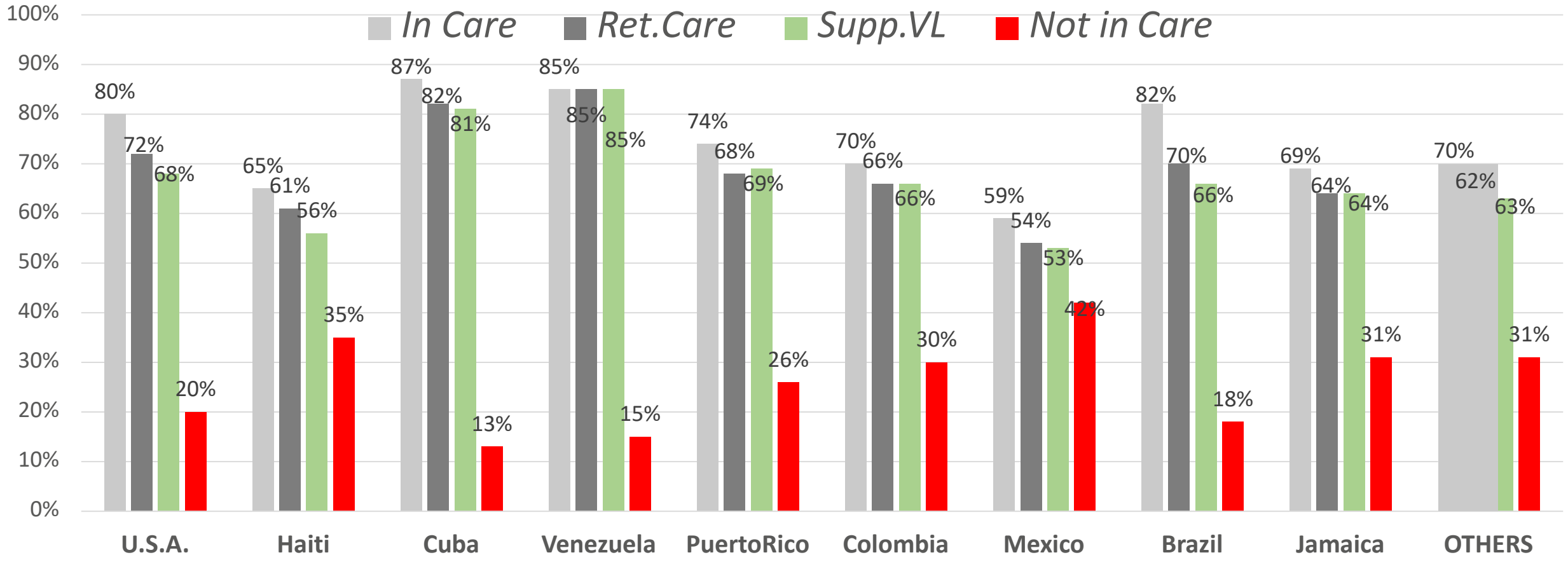
5-yr Trend: New HIV Dx by *Country of Origin* –2017-2021 FLORIDA



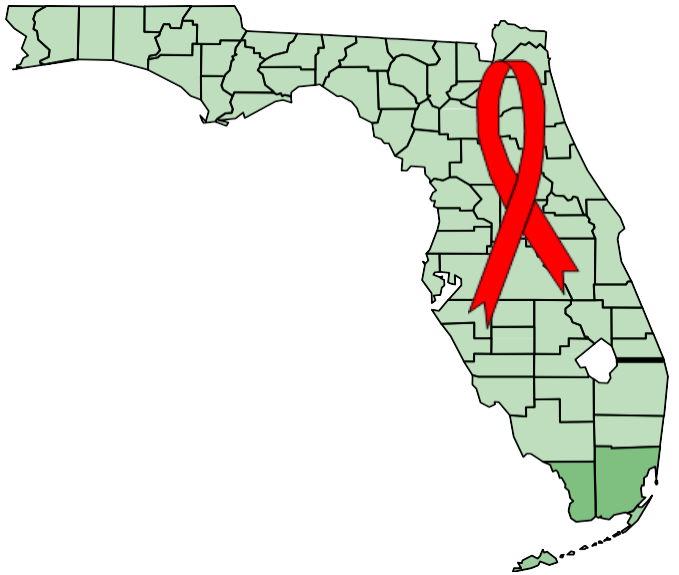
New HIV Dx by *Country of Origin* – 2021 FLORIDA vs. Palm Beach



PWH in *Care Continuum:* by *Country of Origin* – 2021 Palm Beach



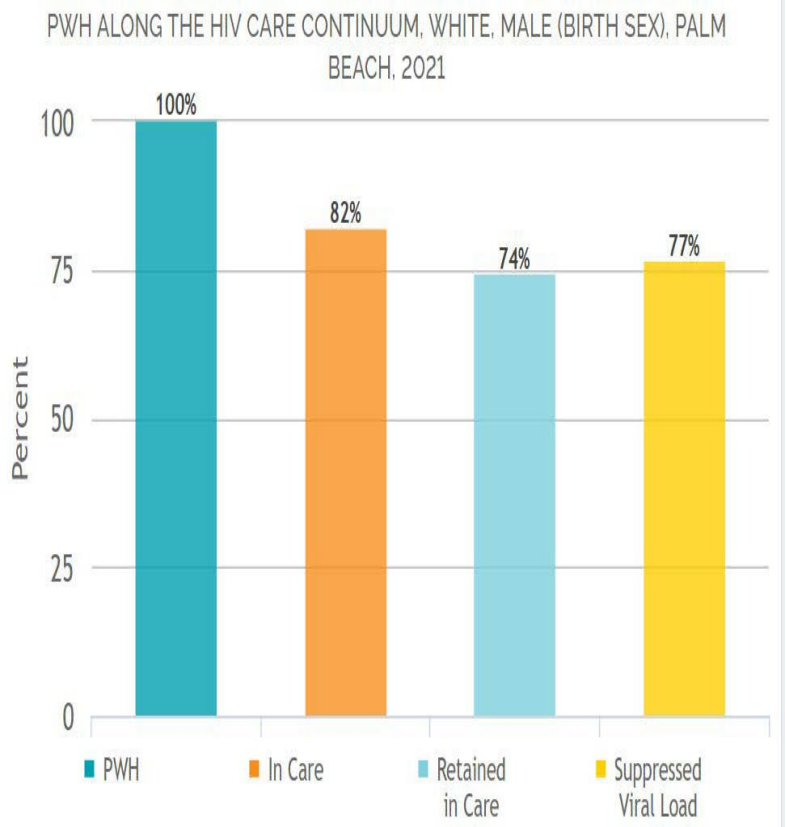
PWH Care Continuum: by **Special Groups** –2021 Palm Bch



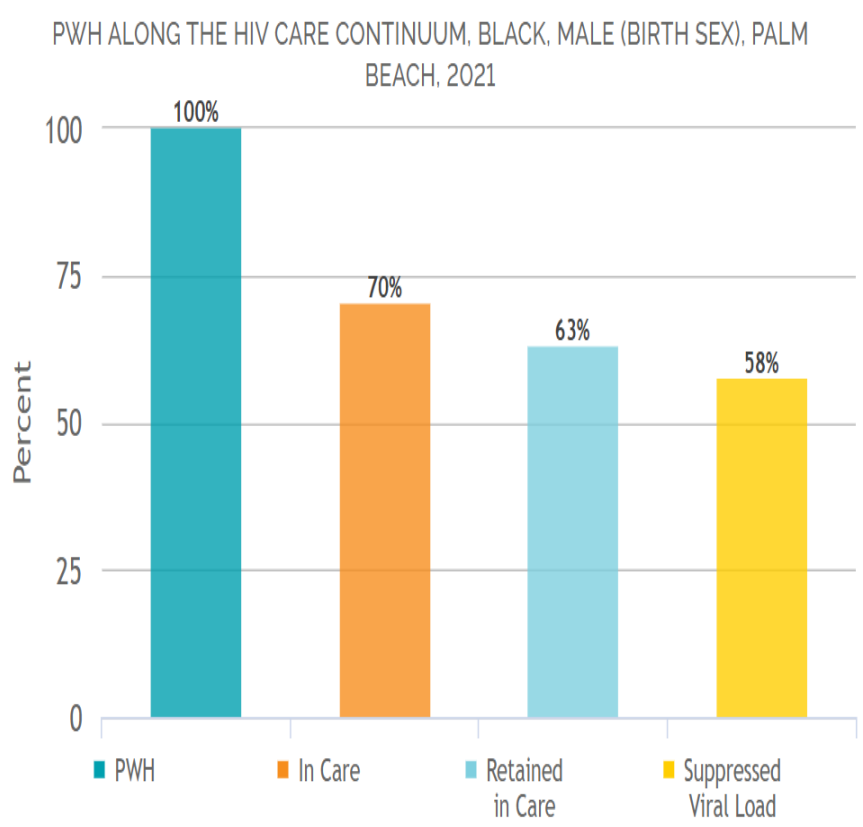
- by Race and Gender
- by Race and Age
- by Race and Risk factors
- by Gender and Age
- by Gender and Risk factors
- by Risk factors and Age

PWH Care Cont.: *Males– White, Black, Hispanic- 2021 PBC*

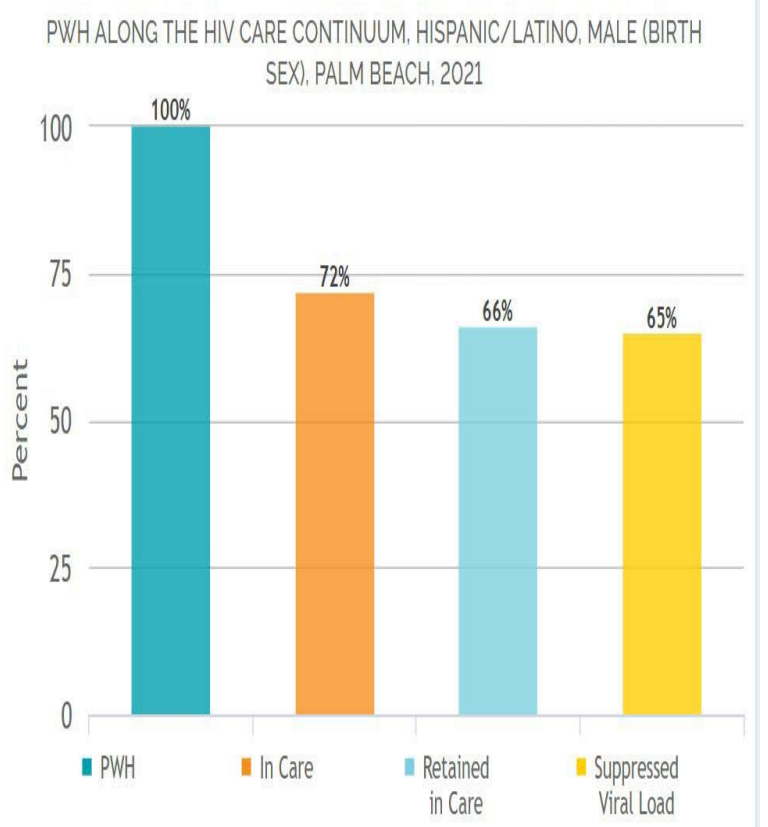
Palm Beach



Palm Beach

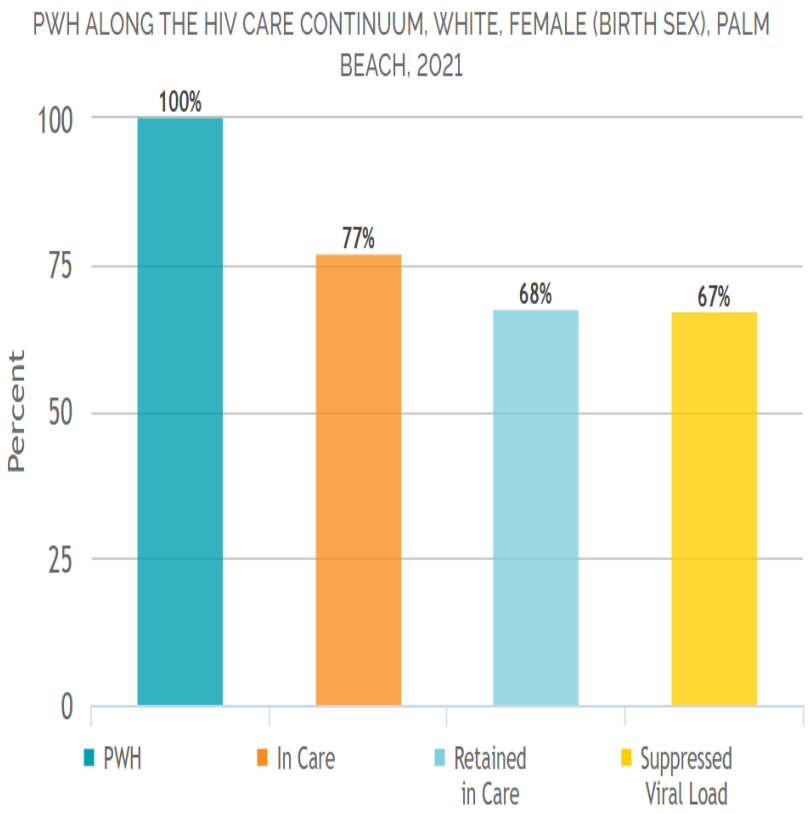


Palm Beach

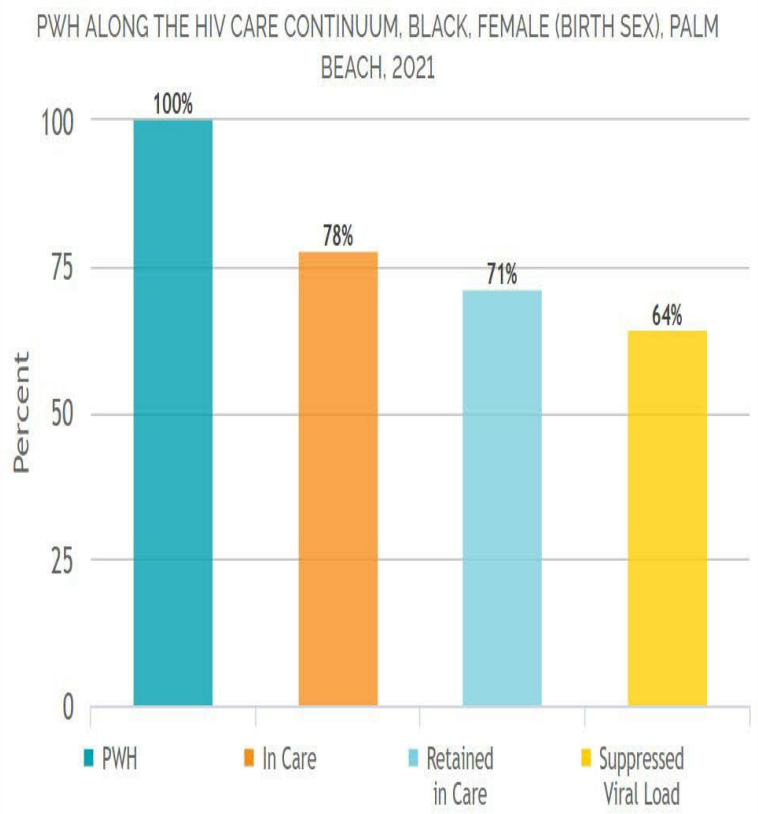


PWH Care Cont.: *Females– White, Black, Hispanic-2021 PBC*

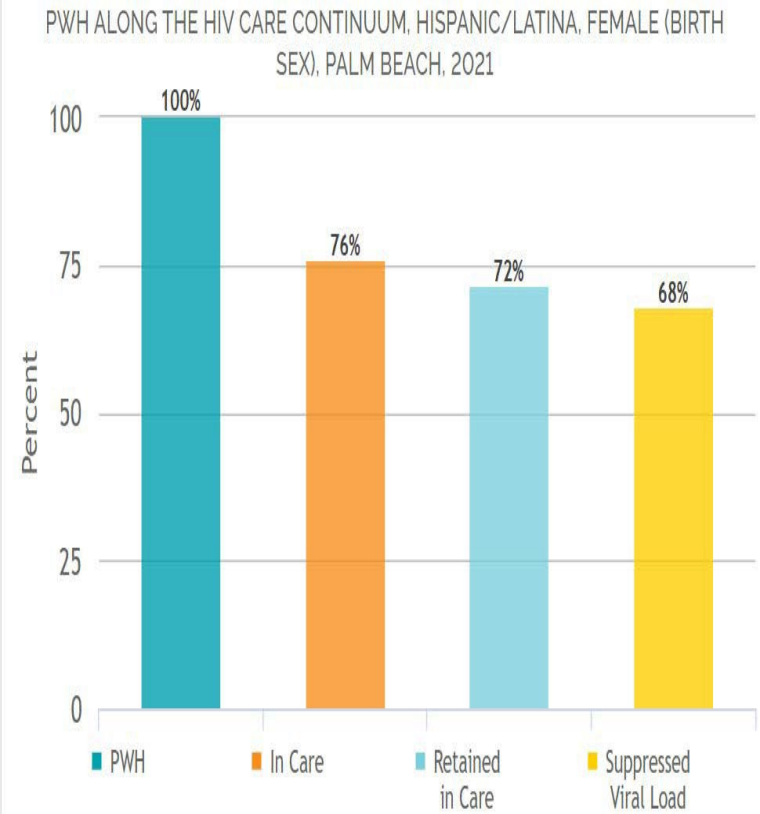
Palm Beach



Palm Beach

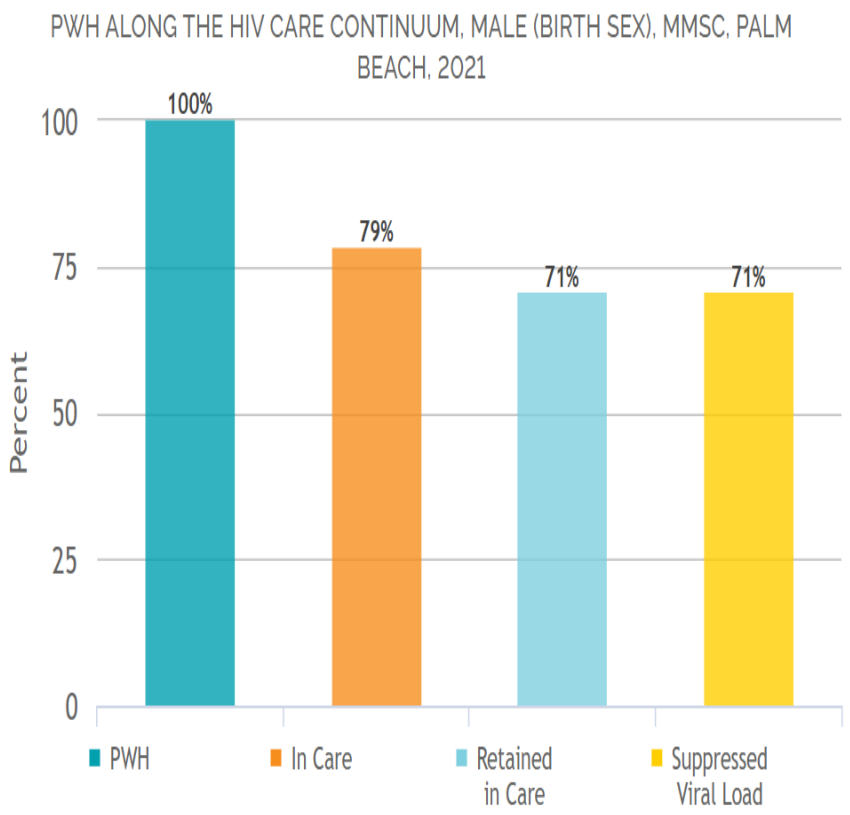


Palm Beach

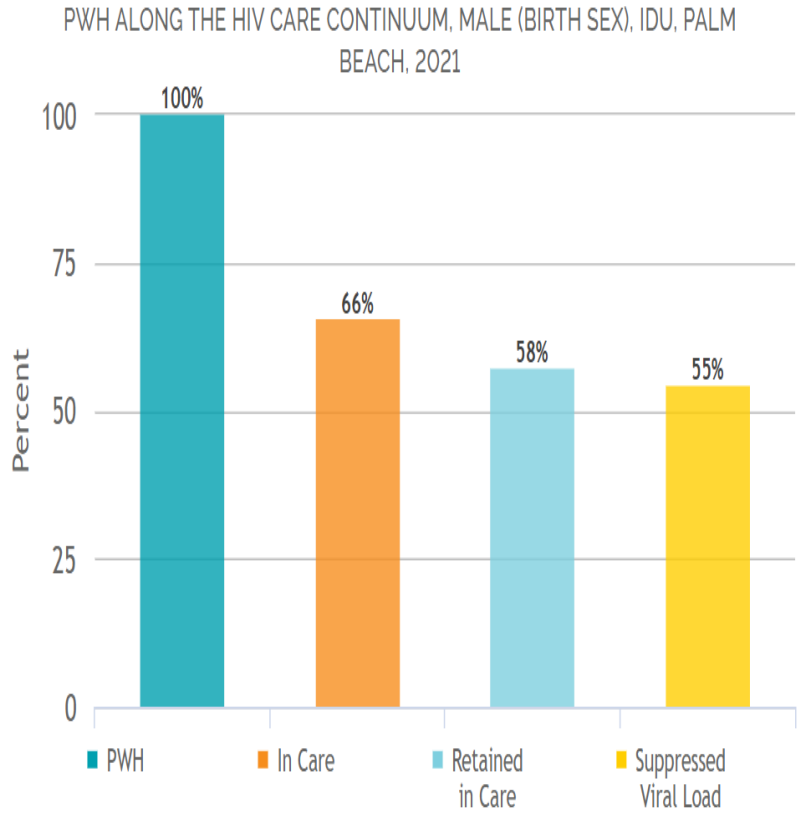


PWH Care Cont.: *Males– MSM, IDU, Heterosex-2021 PBC*

Palm Beach



Palm Beach



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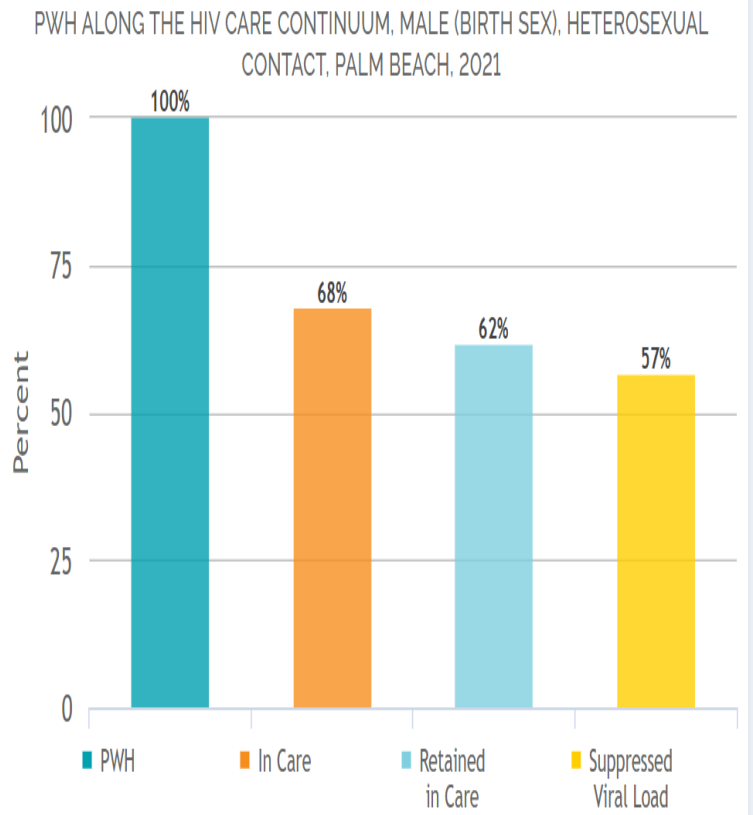
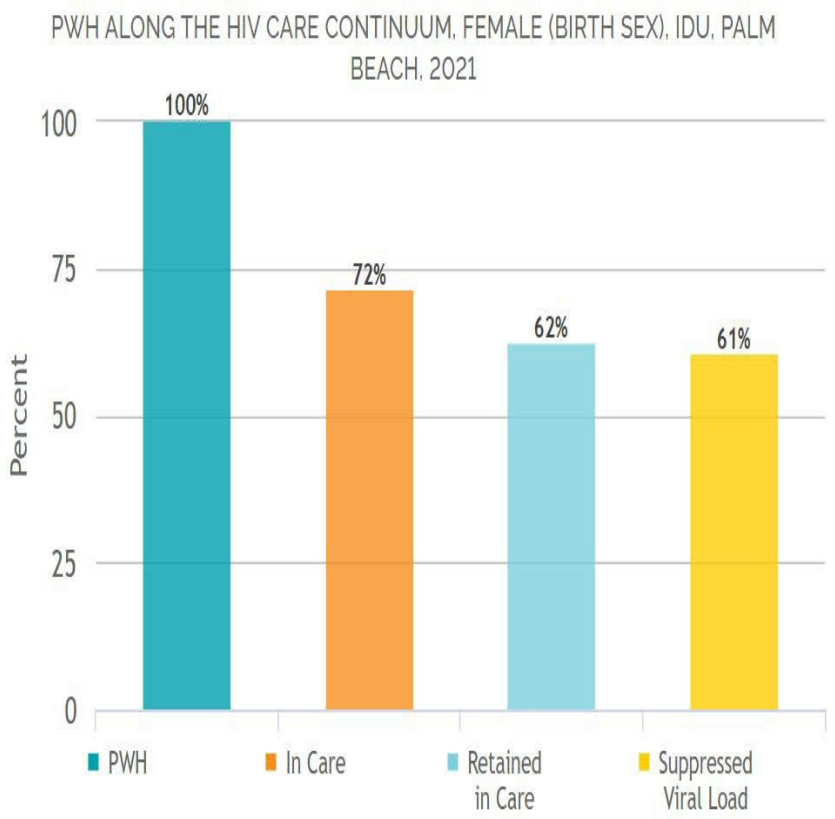


PWH Care Cont.: *Females- IDU, Hetero, Transgdr- 2021 PBC*

Palm Beach



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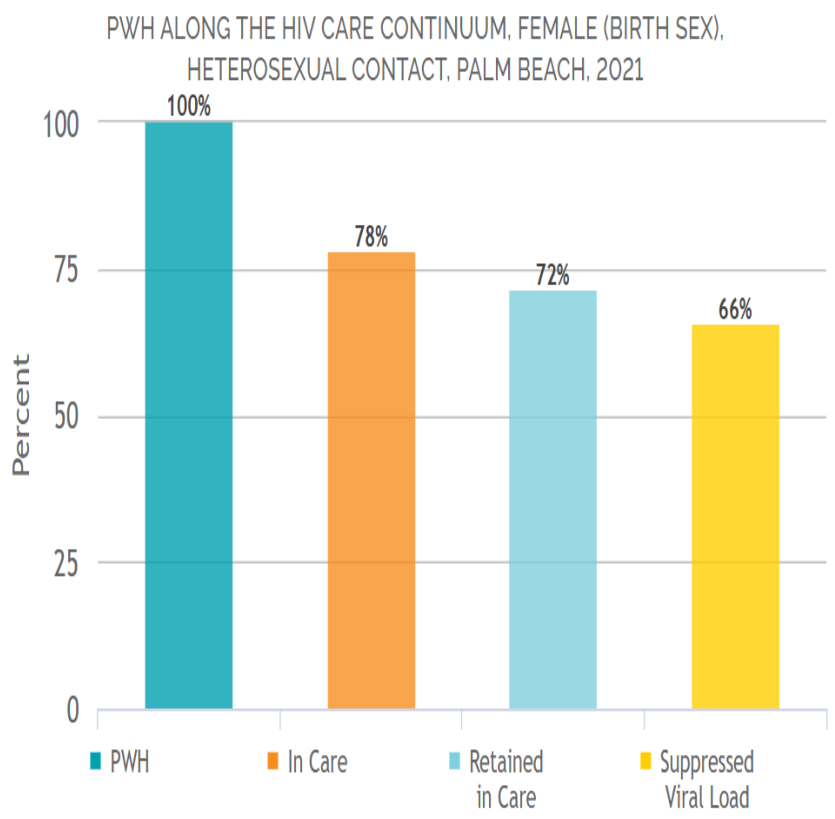

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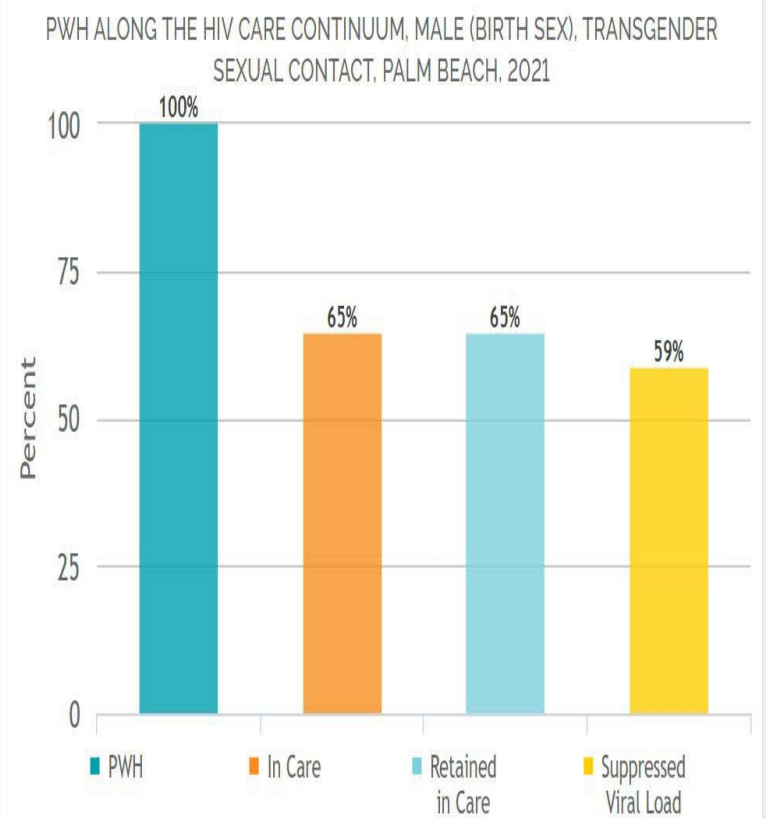
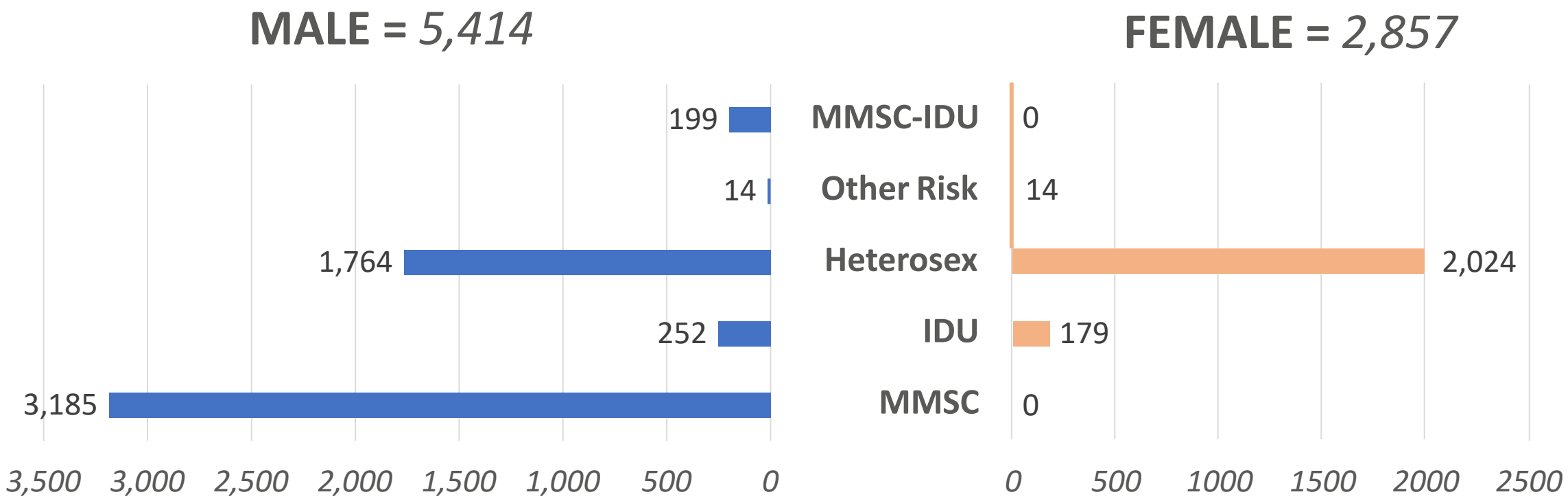
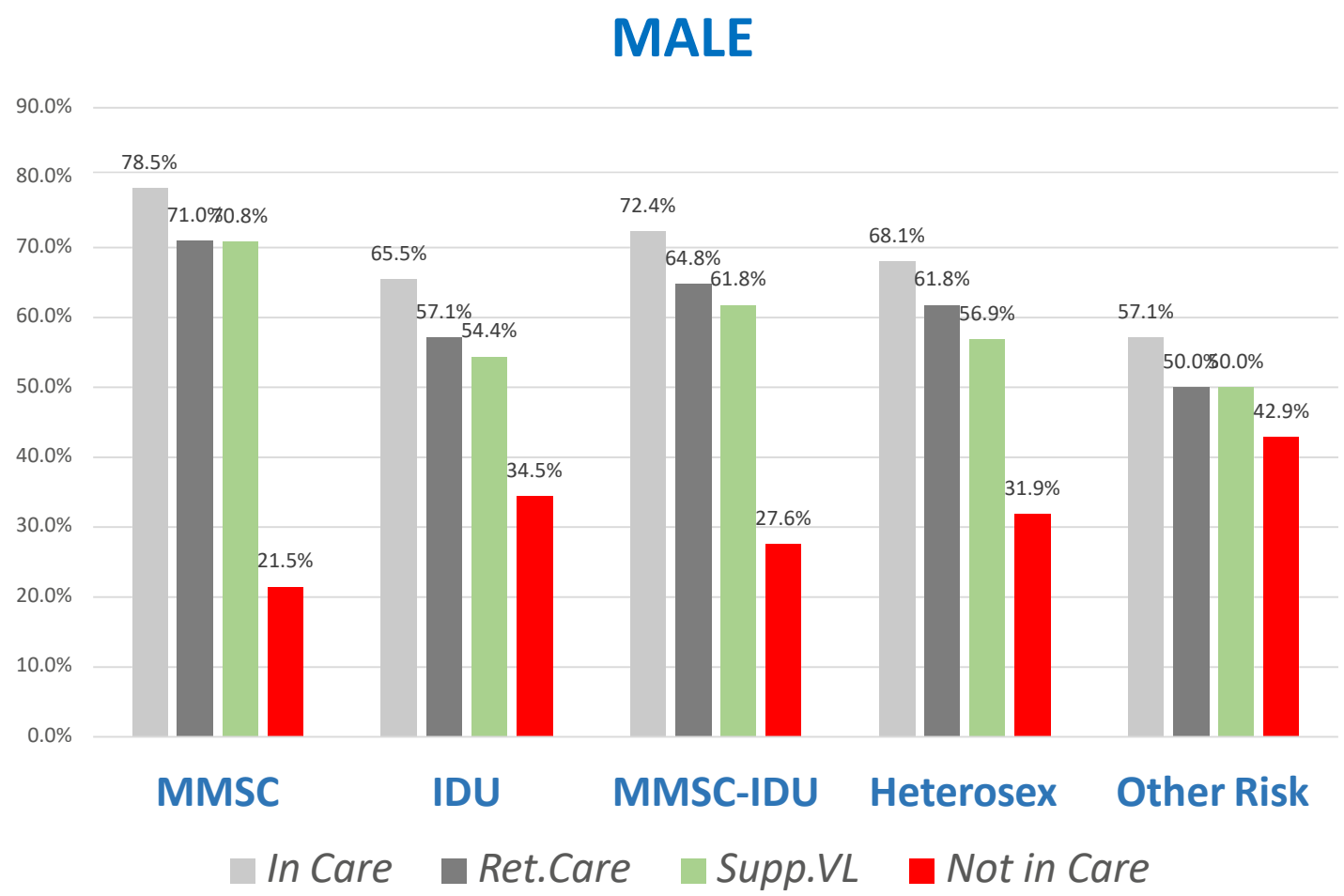
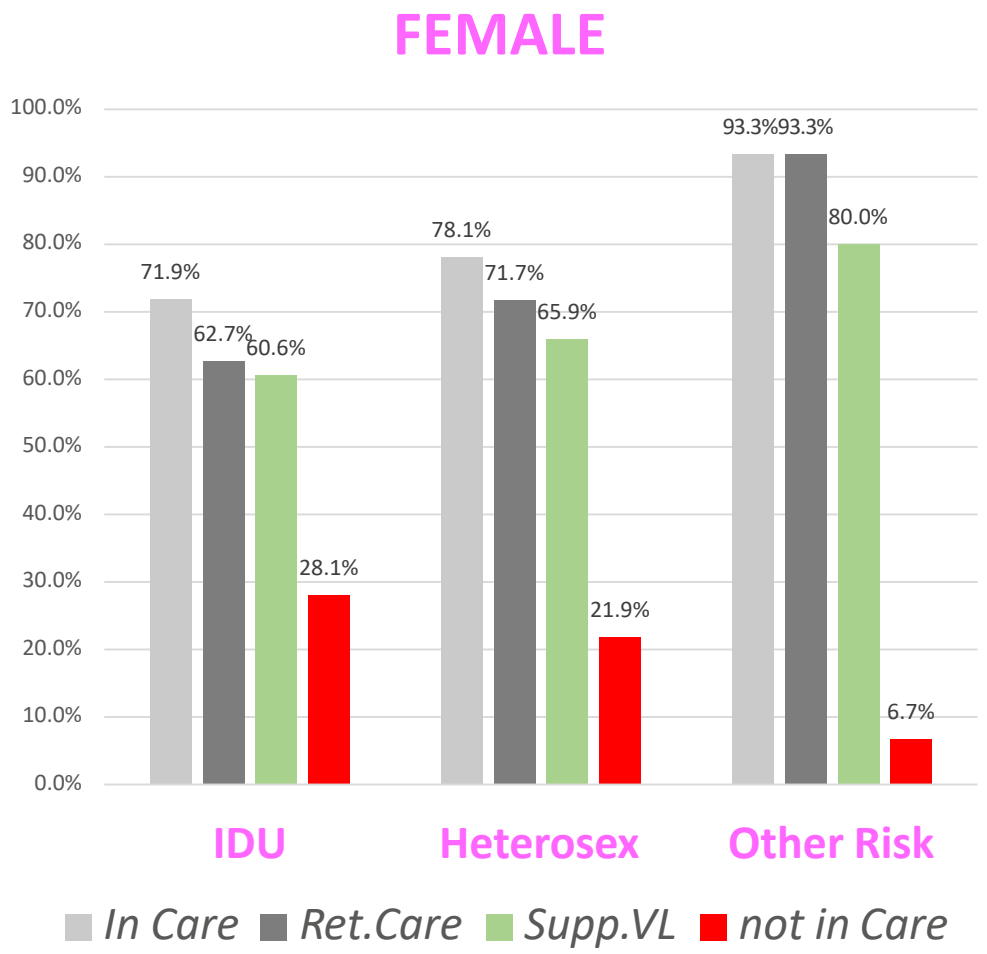


PWH by Risk factors & Gender–2021 Palm Beach



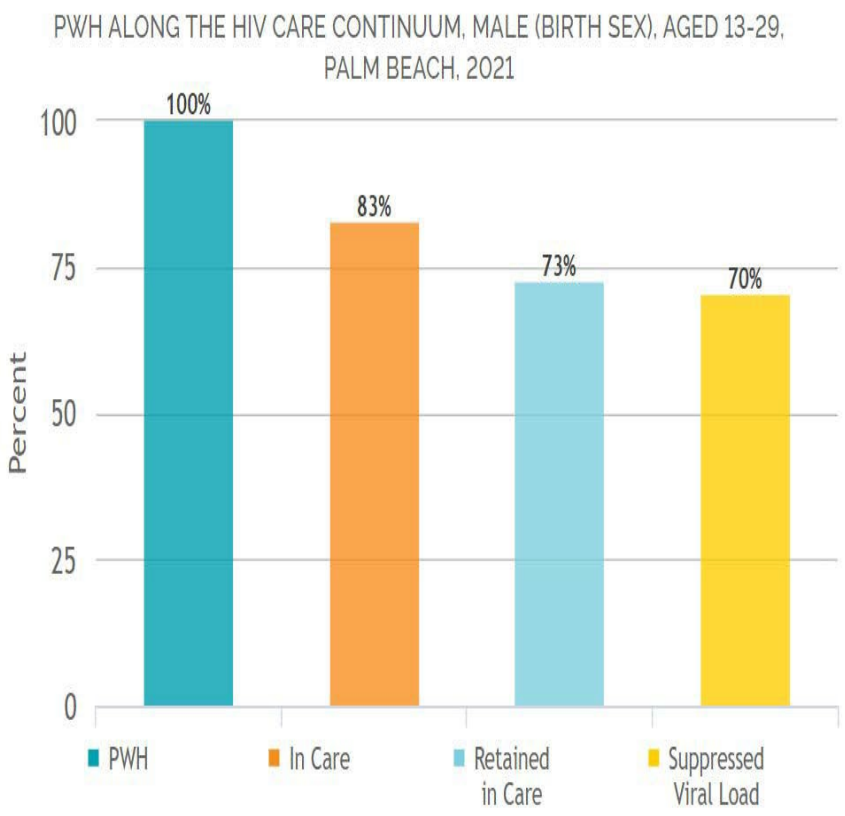
PWH Care Continuum: Risk factors-Gender–2021 Palm Bch





PWH Care Cont.: *Males*–- 13-29 y.o., 30-49 y.o., 50+ y.o.- *2021 Palm Beach*

Palm Beach



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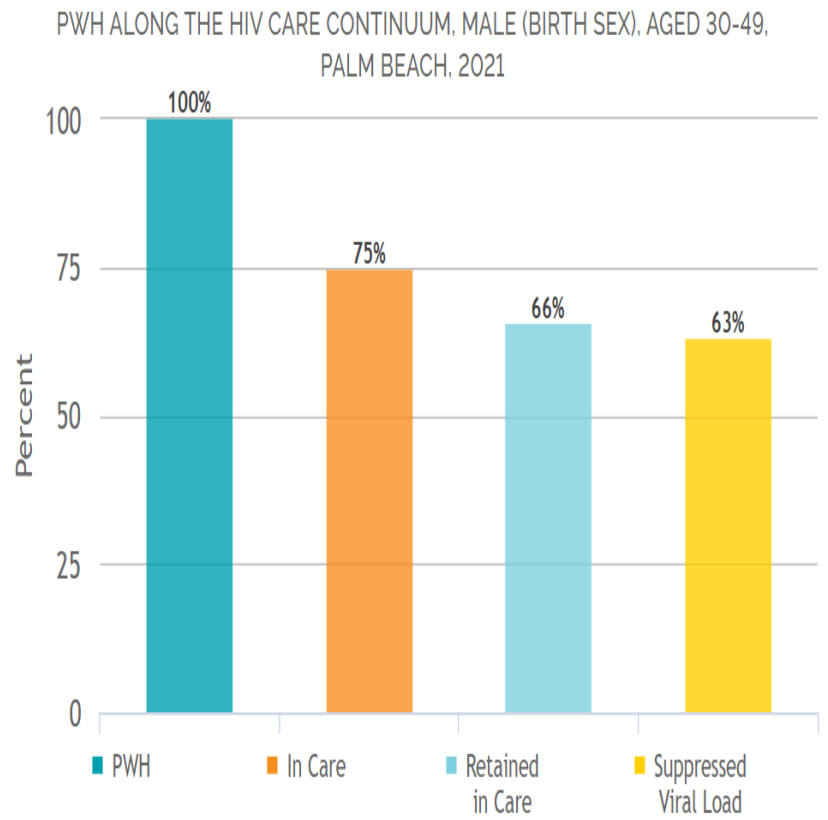

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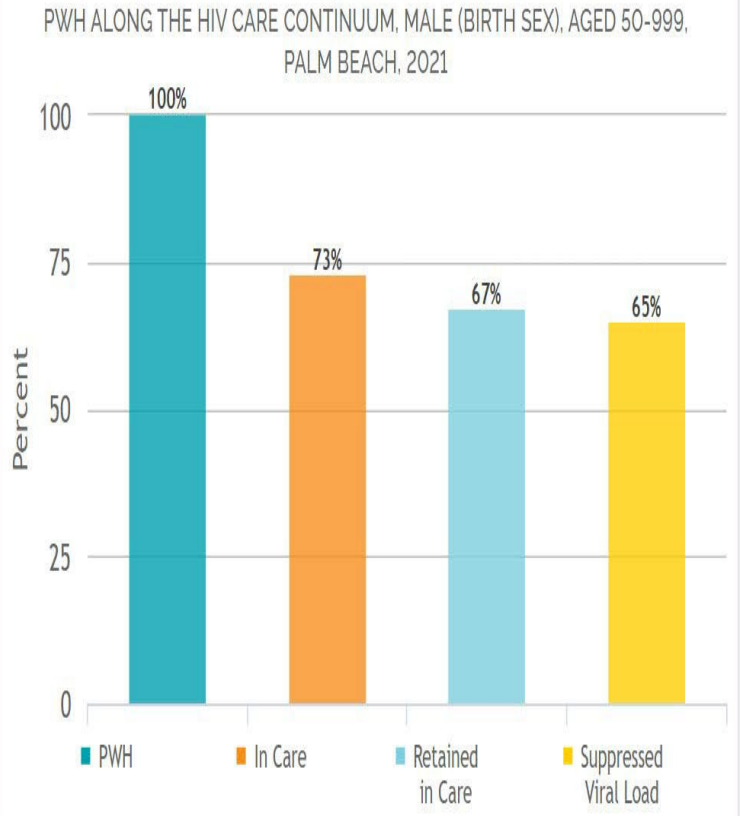
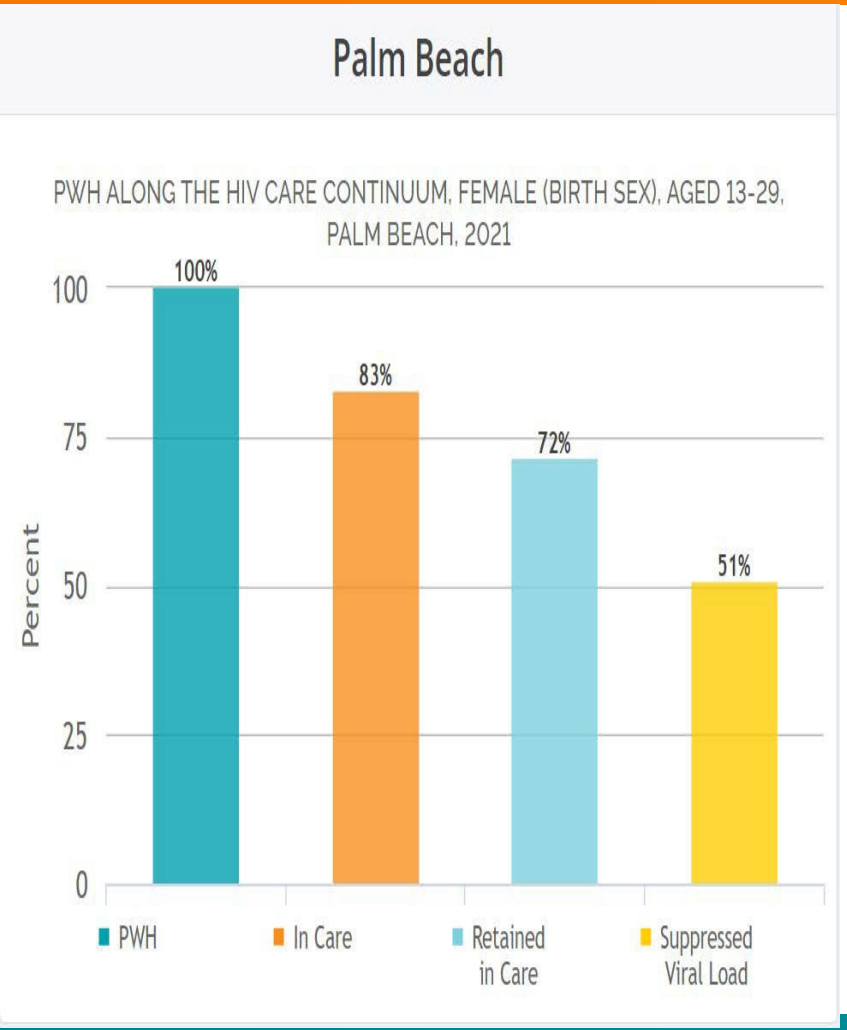
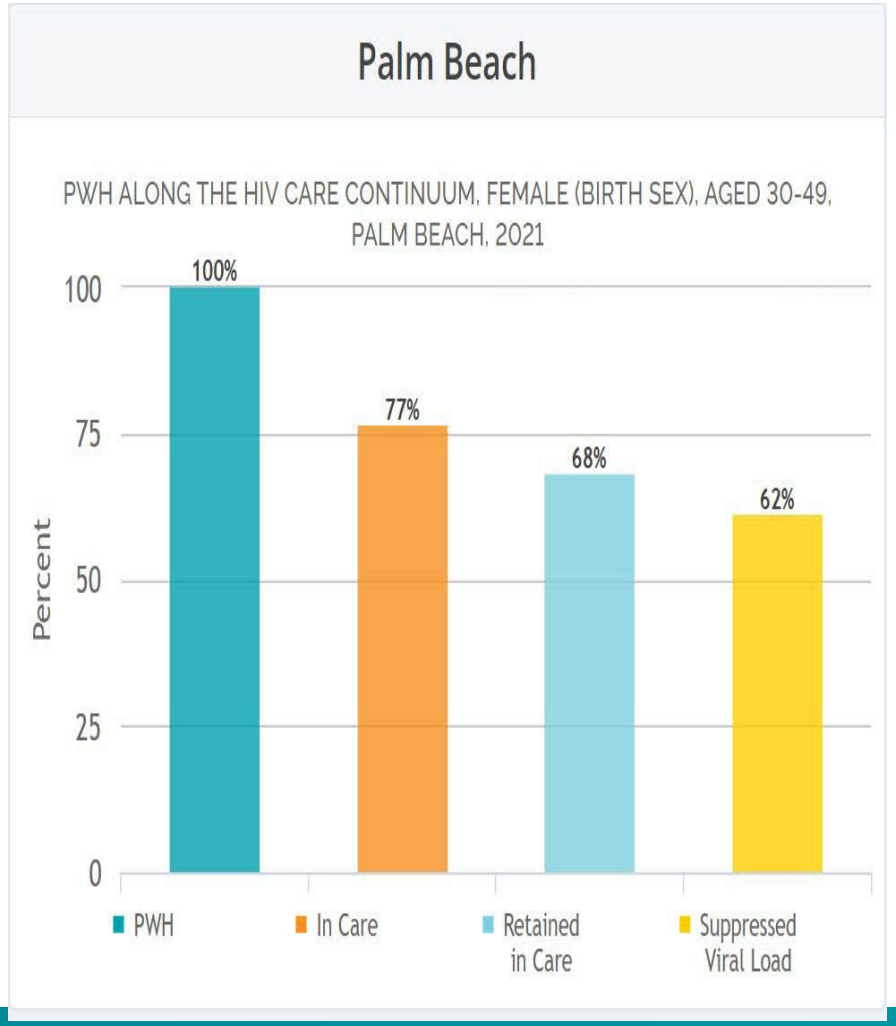
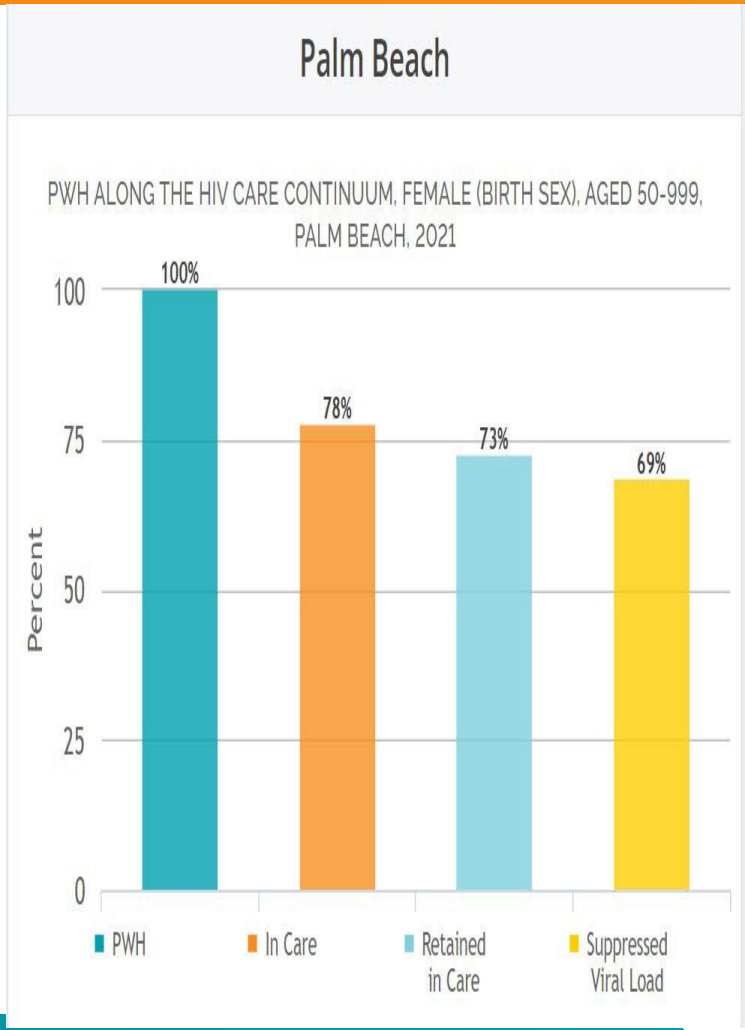
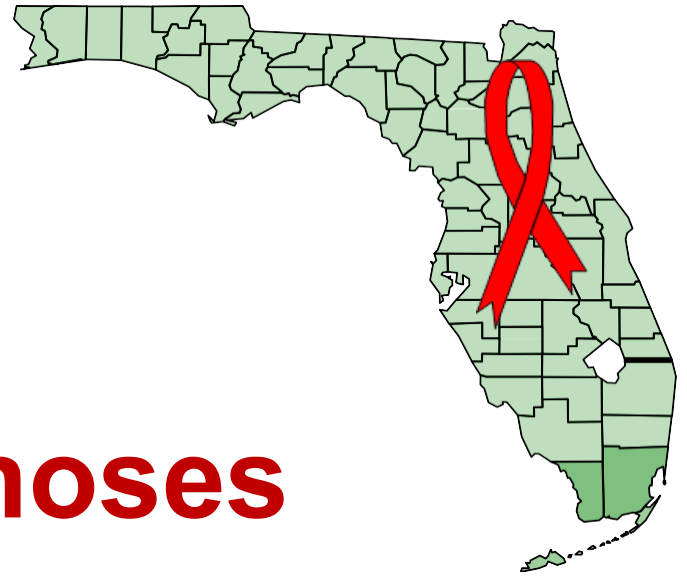


PWH Care Cont.: *Females*–- 13-29 y.o., 30-49 y.o., 50+ y.o.- *2021 Palm Beach*



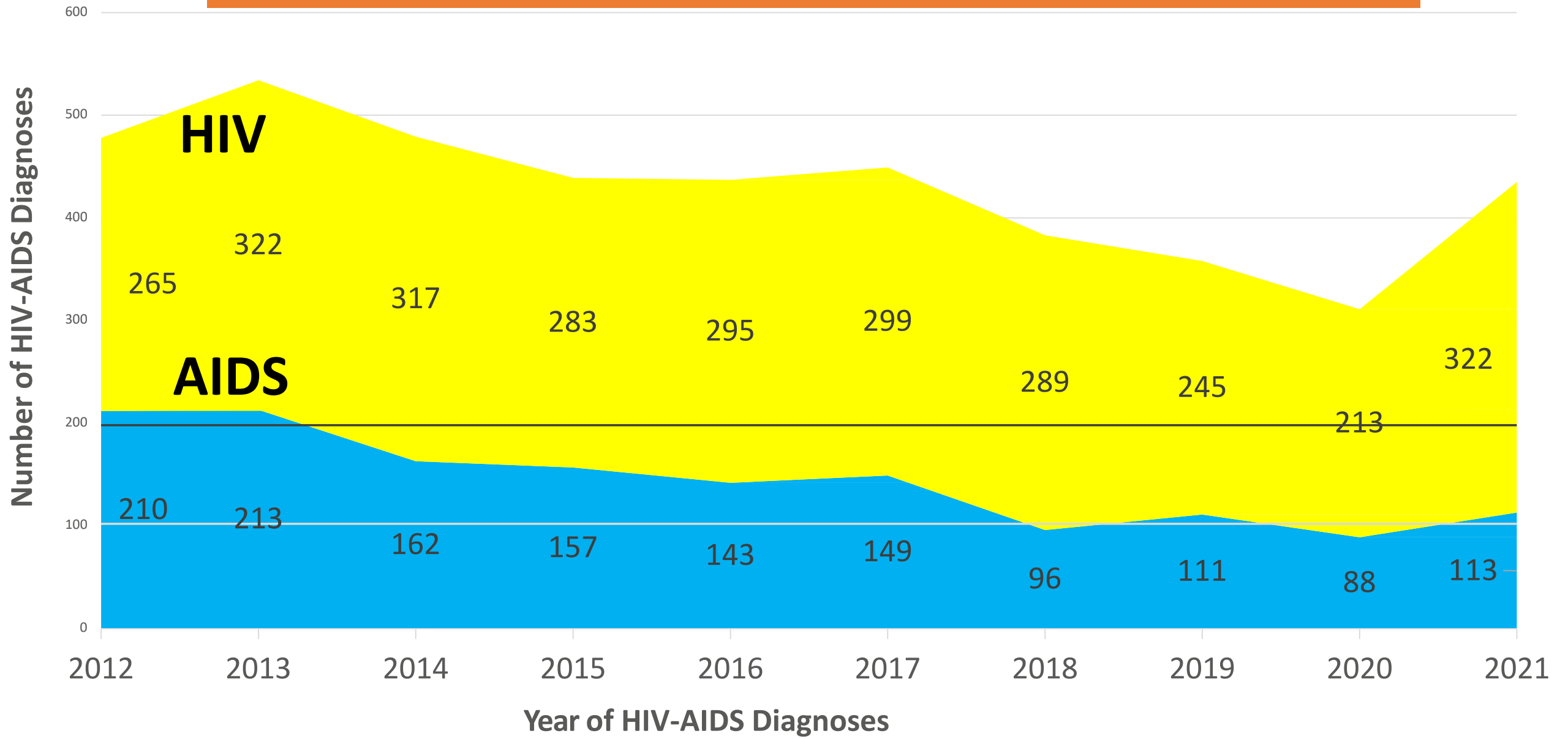




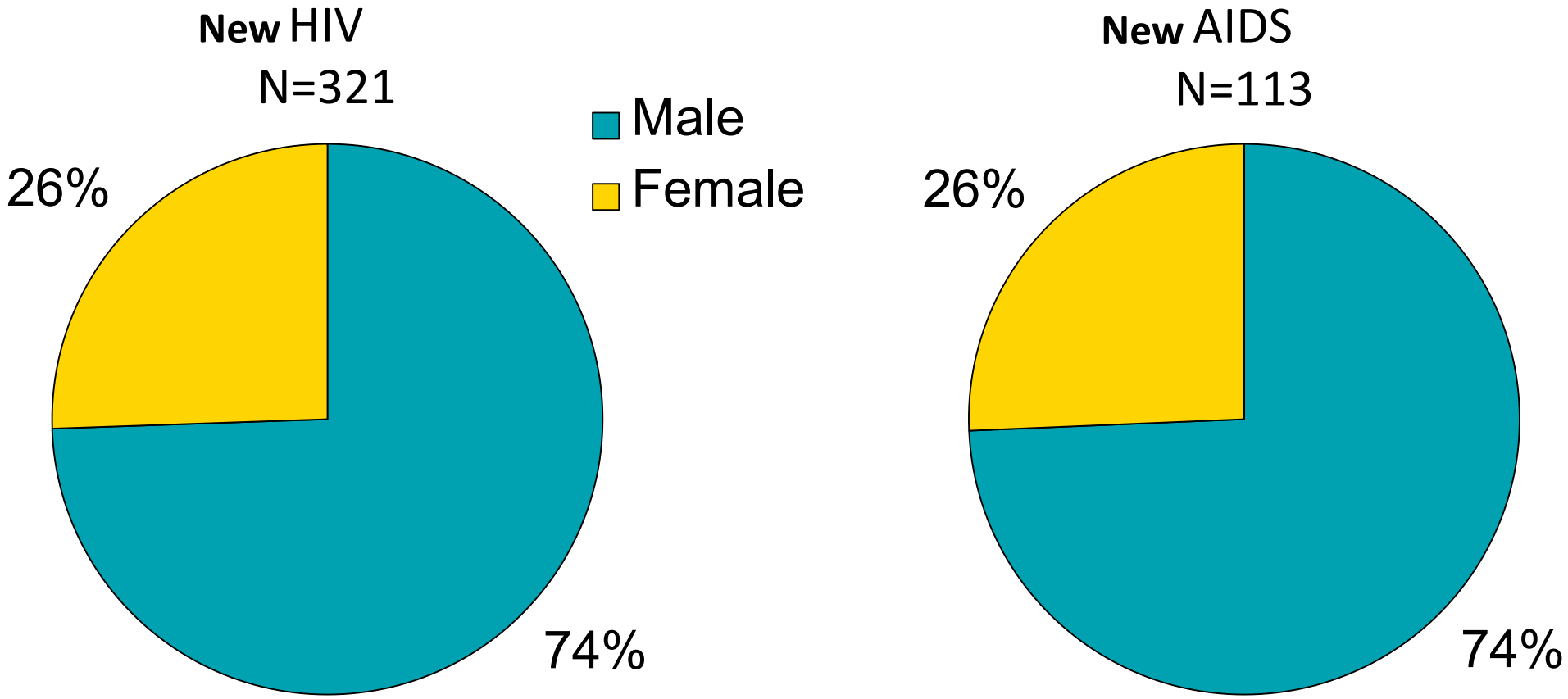


New HIV, *New* AIDS Diagnoses – 2021 Palm Beach

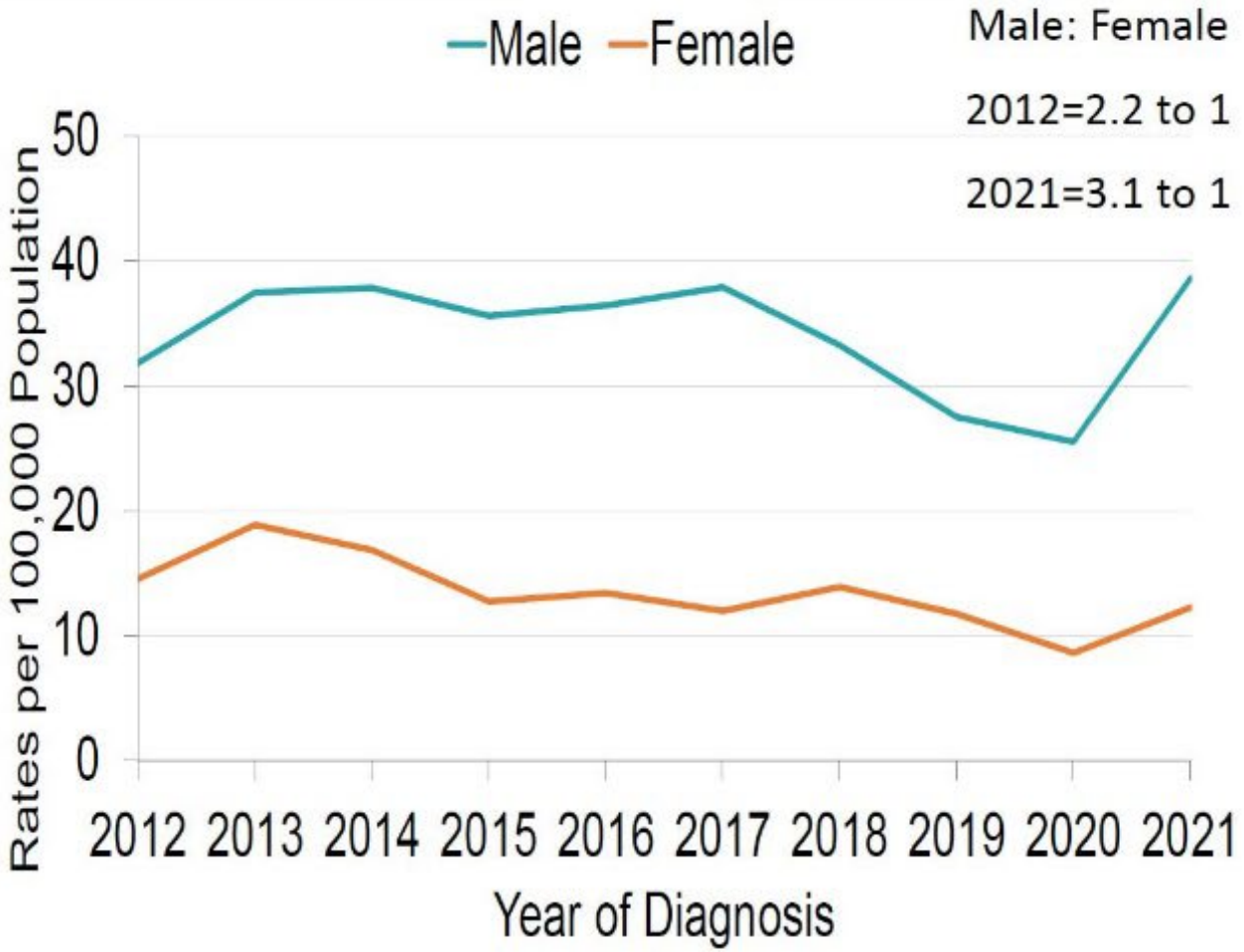
10-yr. Trend: *New Dx* HIV-AIDS - 2017-2021 (PBC)



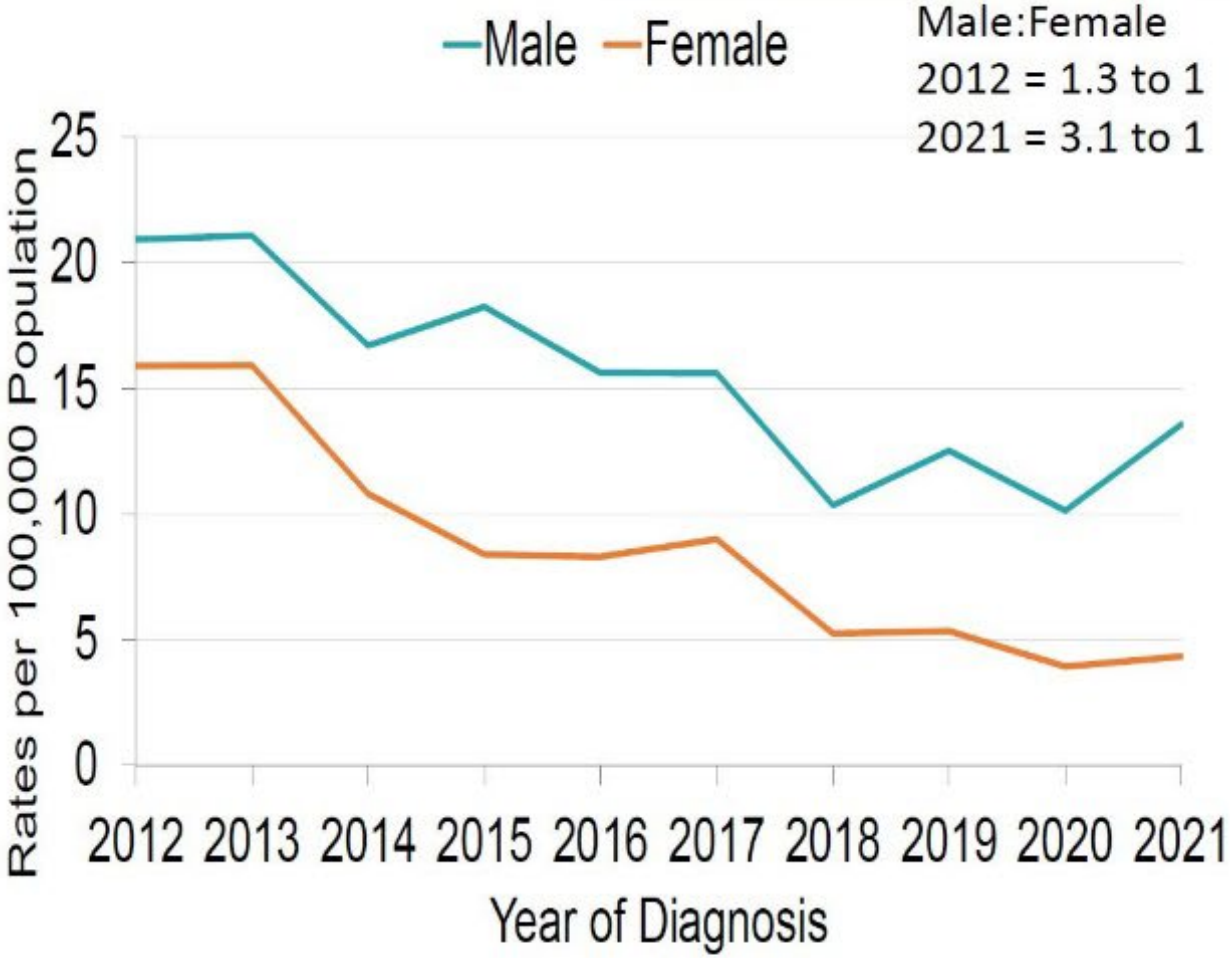
New HIV and New AIDS Diagnoses By SEX at Birth – 2021 Palm Beach County



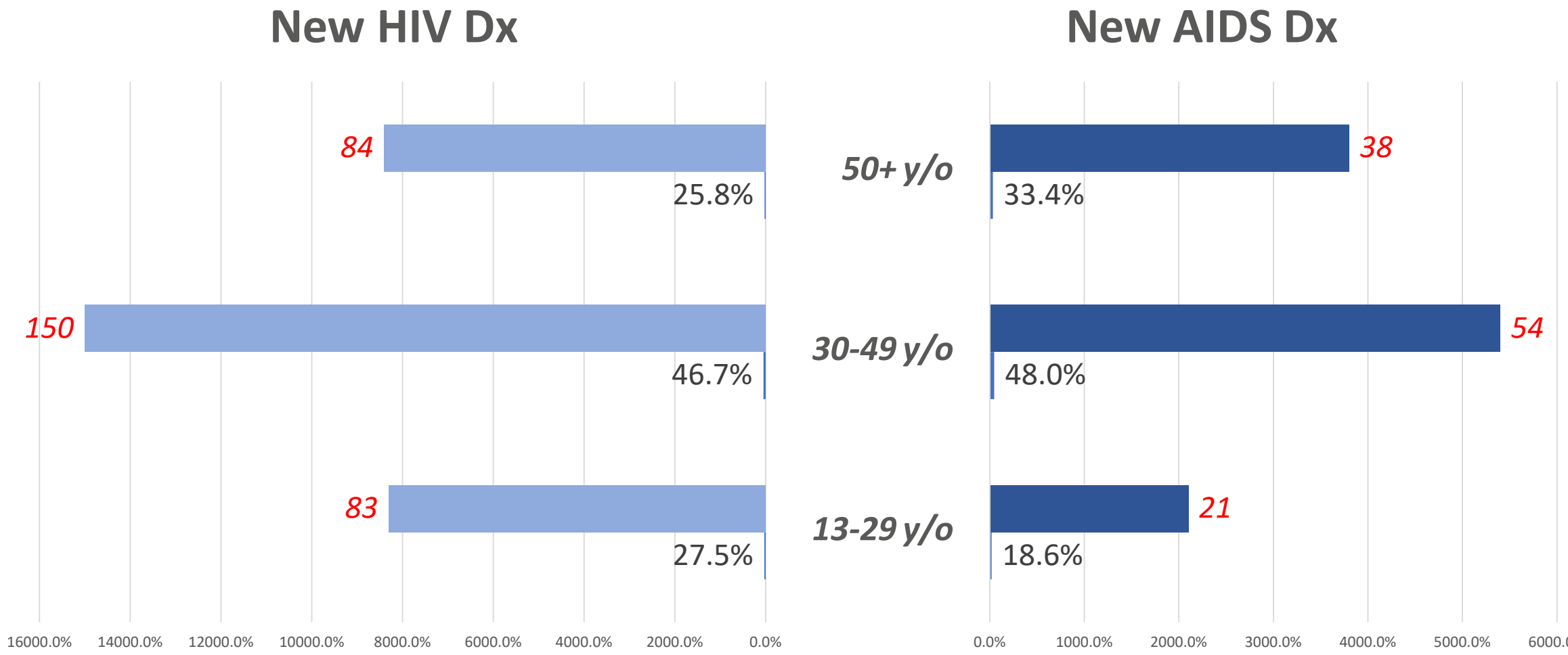
10-yr. Trend: New HIV Dx Rates -- by SEX 2012–2021, Palm Beach



10-yr. Trend: New AIDS Dx Rates --by SEX 2012–2021, Palm Beach

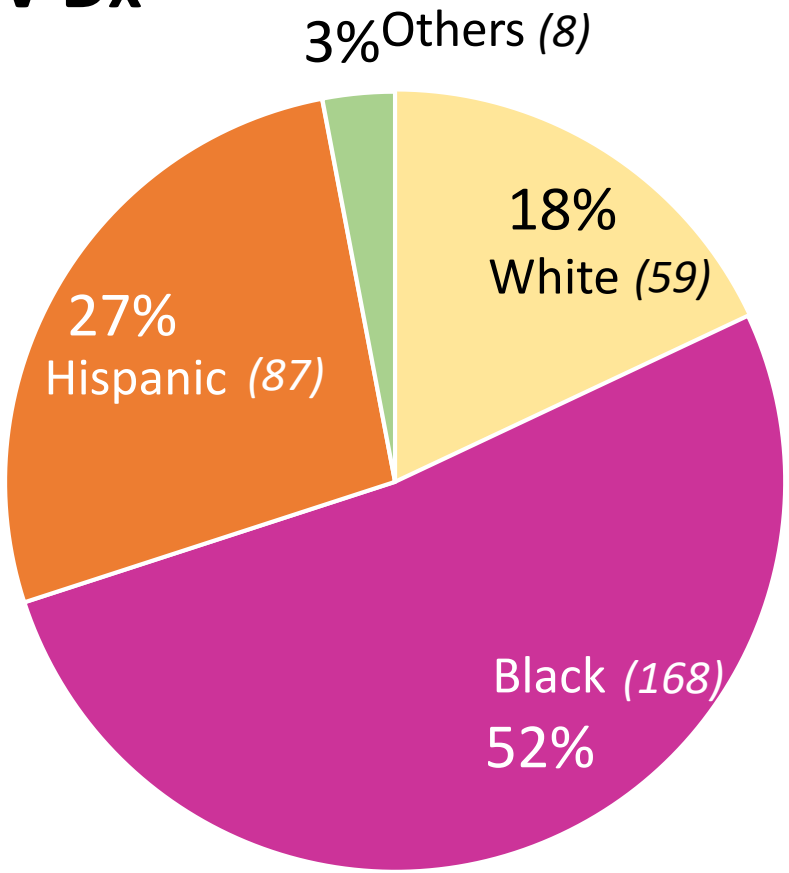


New HIV & AIDS Dx- by *AGE groups* -2021 Palm Beach



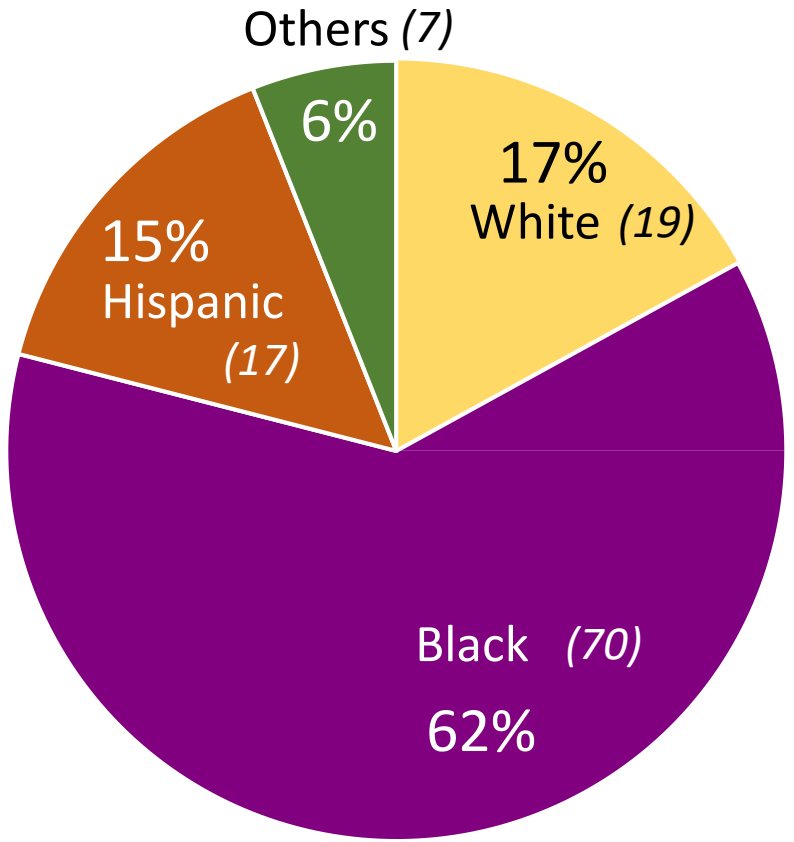
New Dx of HIV and AIDS by RACE -2021 Palm Beach

New HIV Dx



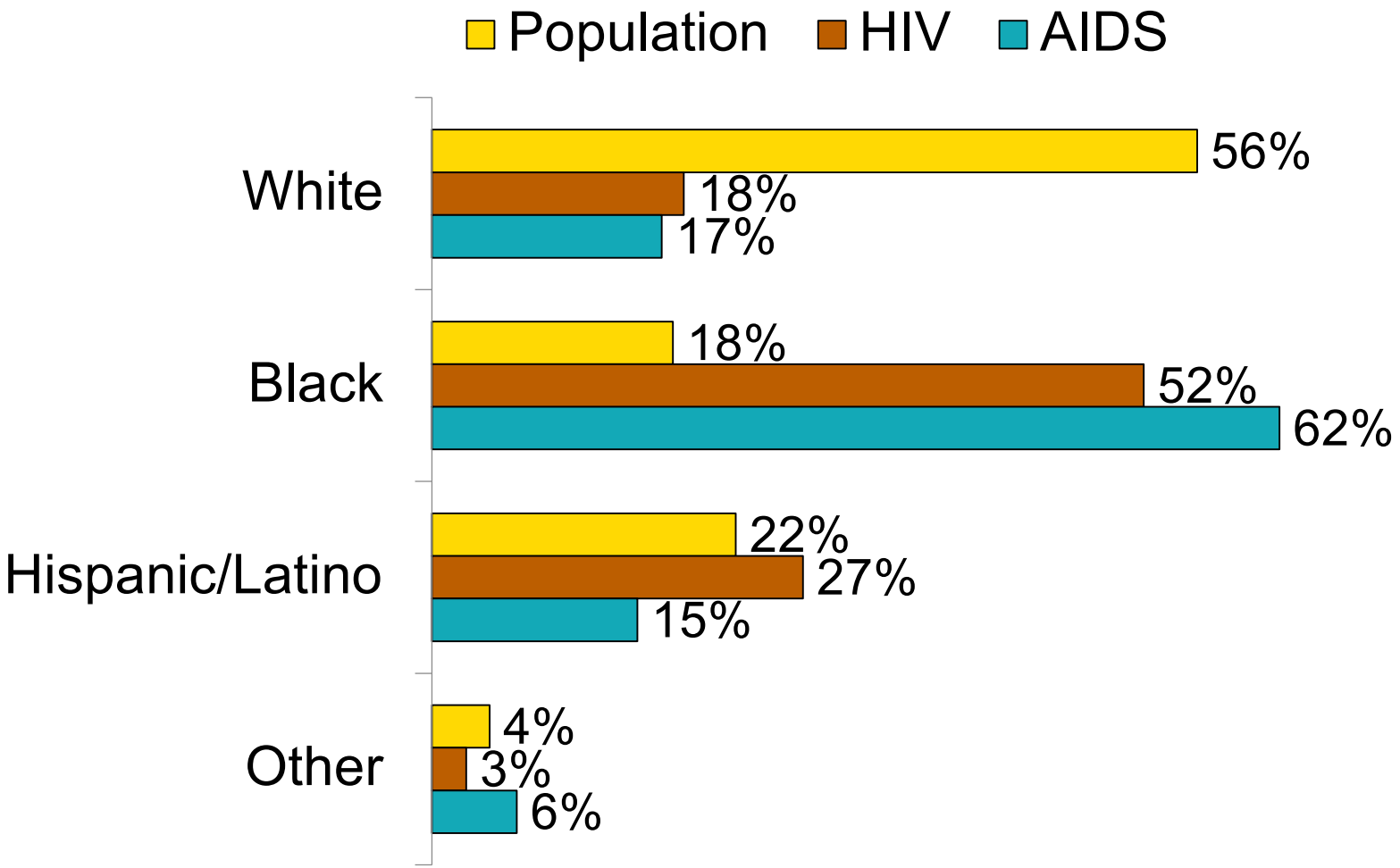
Total *N*= 322

New AIDS Dx



Total *N*= 113

NEW HIV and AIDS Diagnoses and Population By RACE, 2021, Palm Beach County



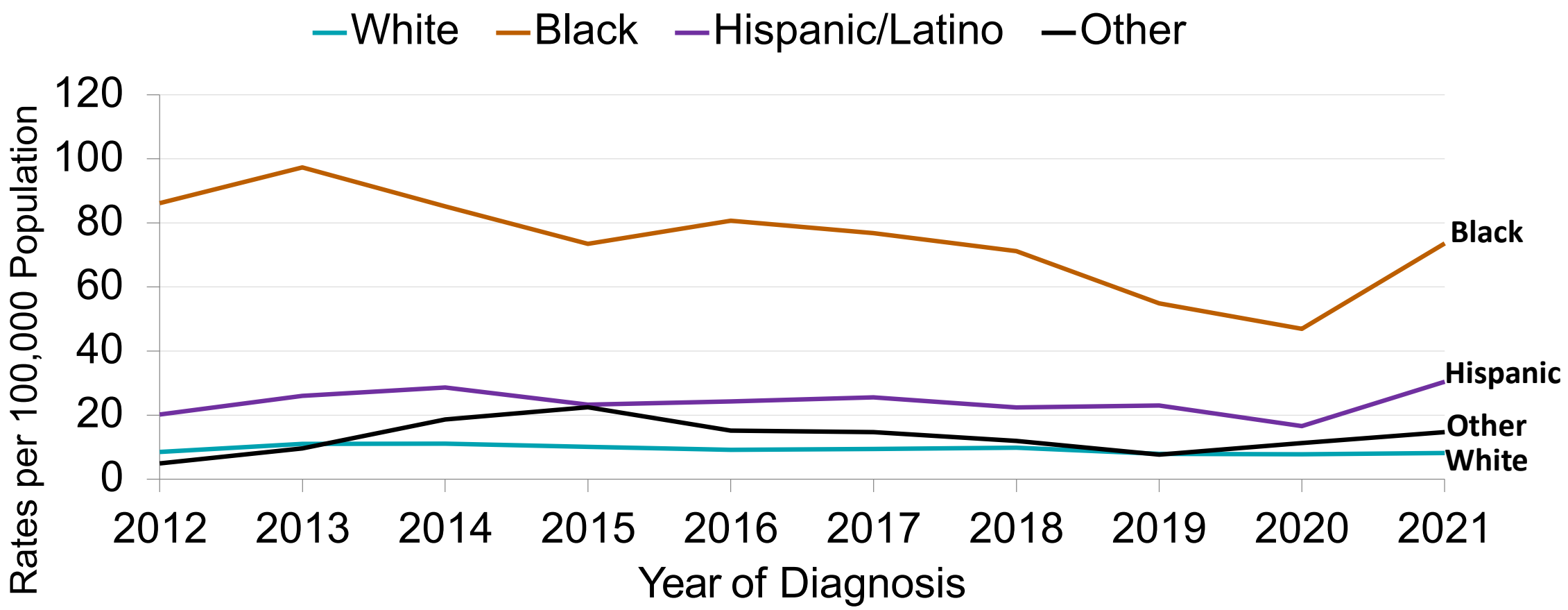
Palm Beach County Adult Population Estimate
N=1,288,033

HIV
N=321

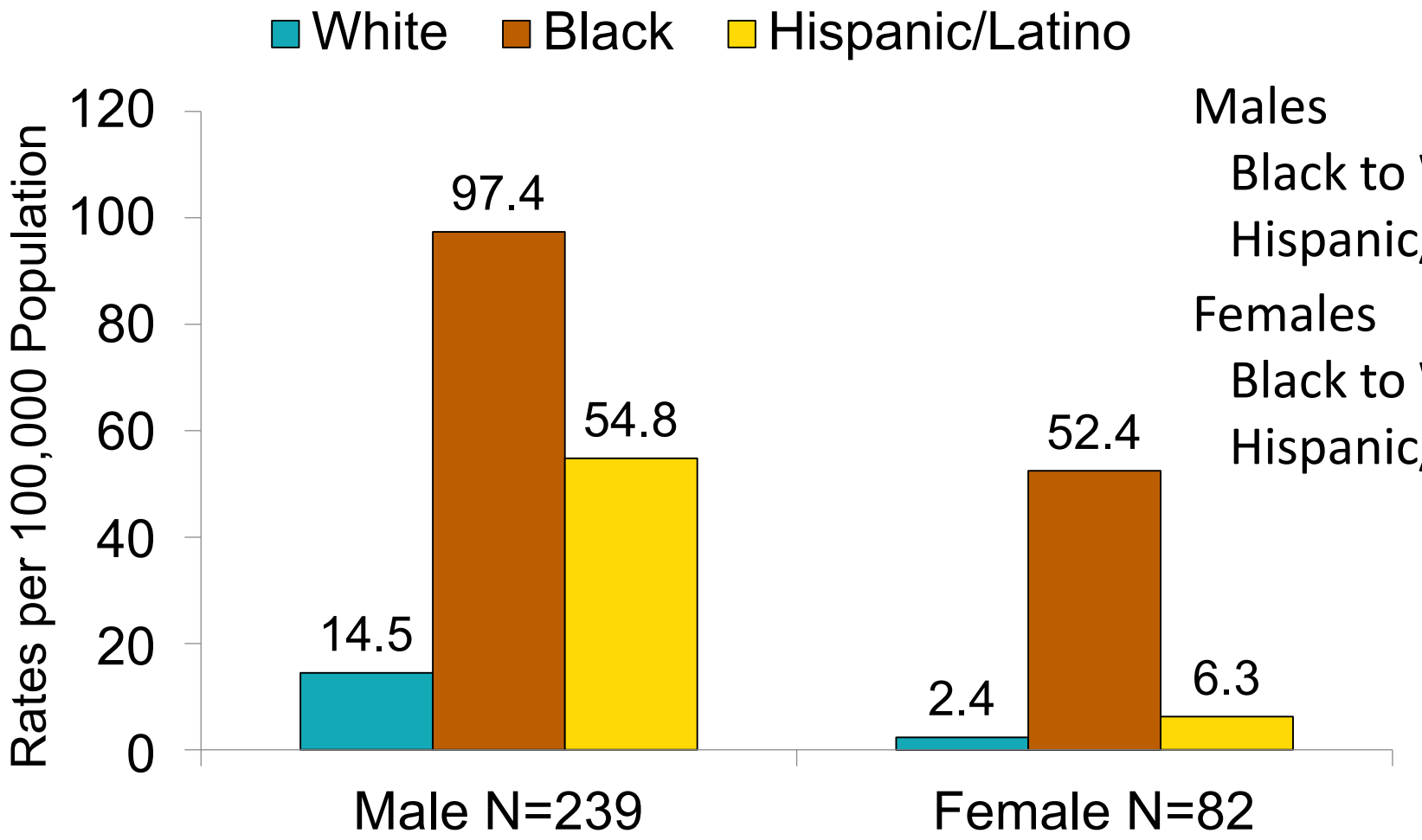
AIDS
N=113

Rounding may cause percentages to total more or less than 100.

10 yr. TREND : *New HIV Dx Rates*
By RACE -- 2017–2021 Palm Beach County



New HIV Dx Rates by *Sex & Race*
2021, Palm Beach



Rate Ratios

Males

Black to White: 6.7 to 1

Hispanic/Latino to White: 3.8 to 1

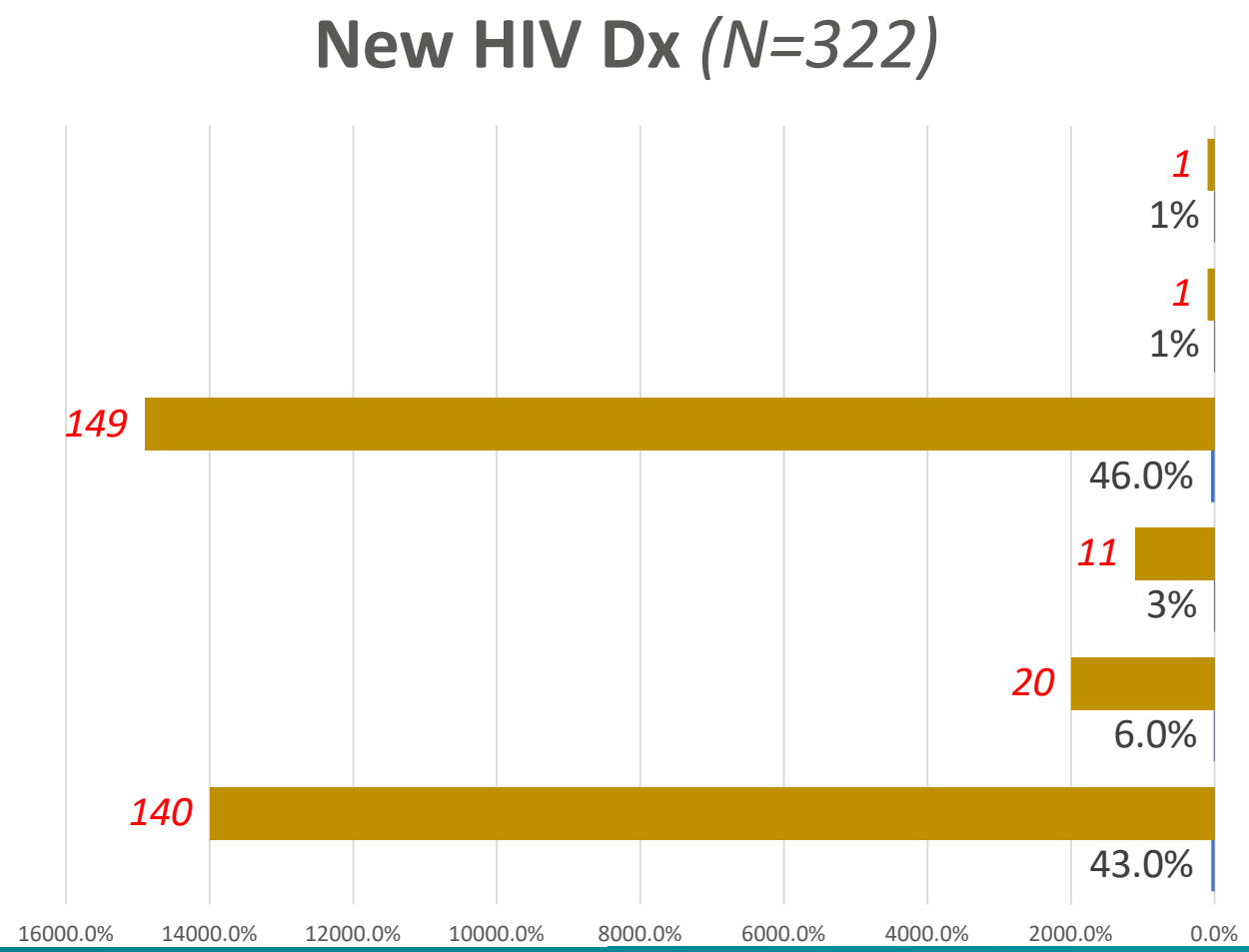
Females

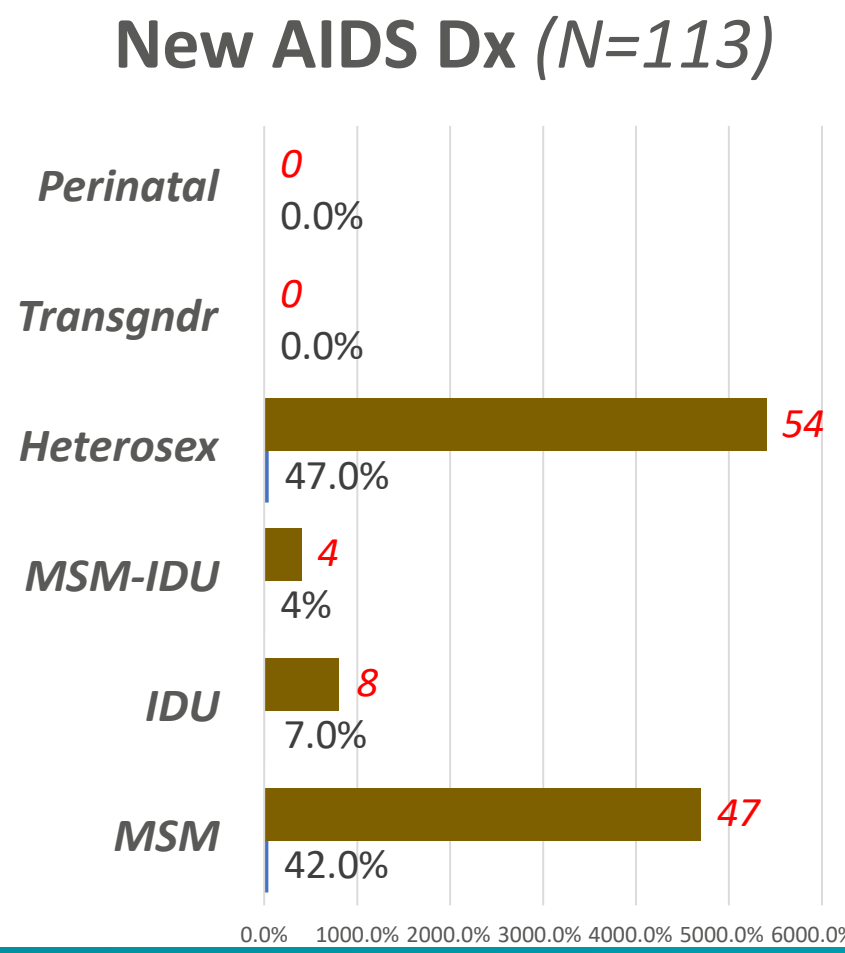
Black to White: 21.9 to 1

Hispanic/Latina to White: 2.6 to 1

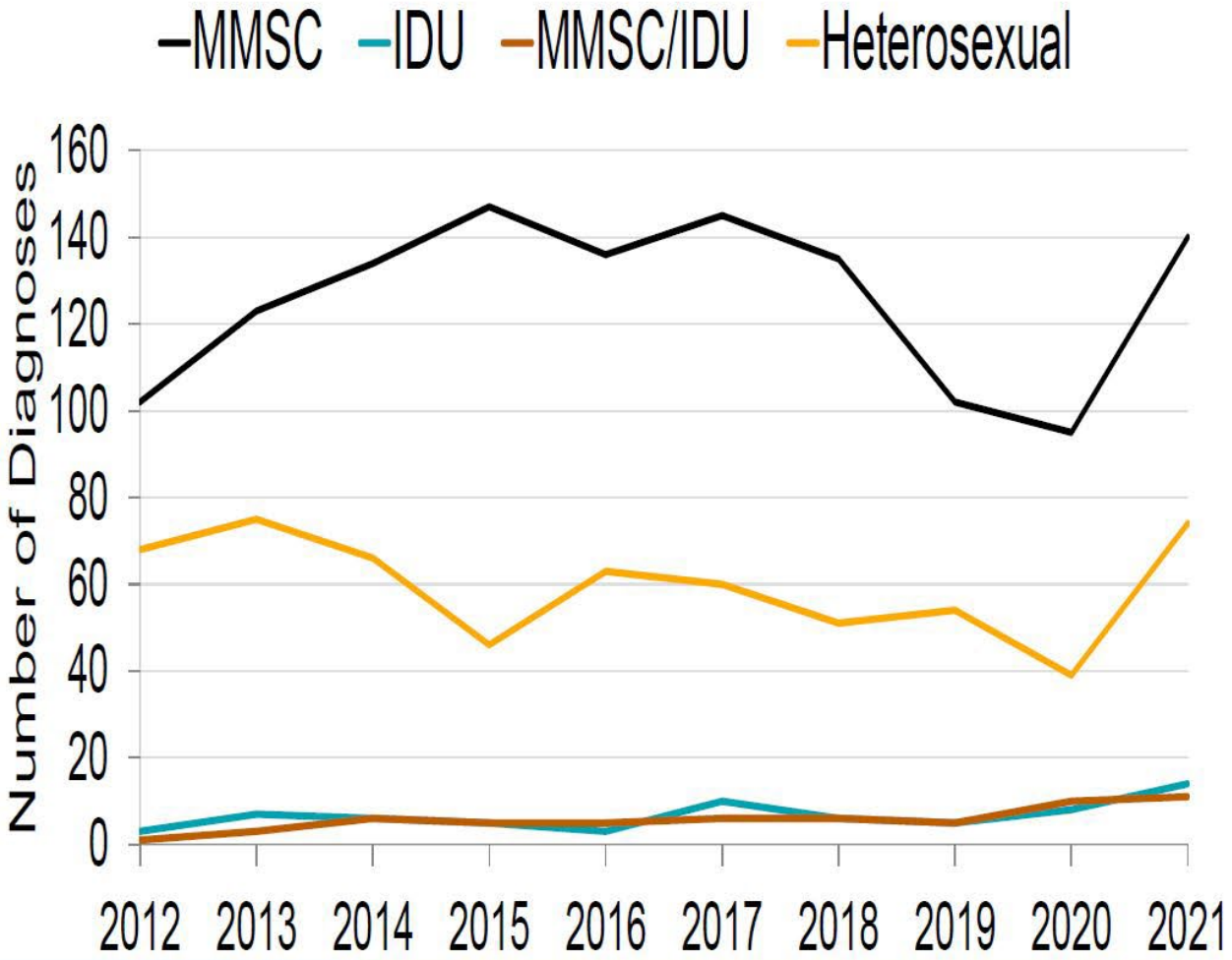
Rounding may cause percentages to total more or less than 100.

New HIV & AIDS Dx- by *Risk factors* -2021 Palm Beach

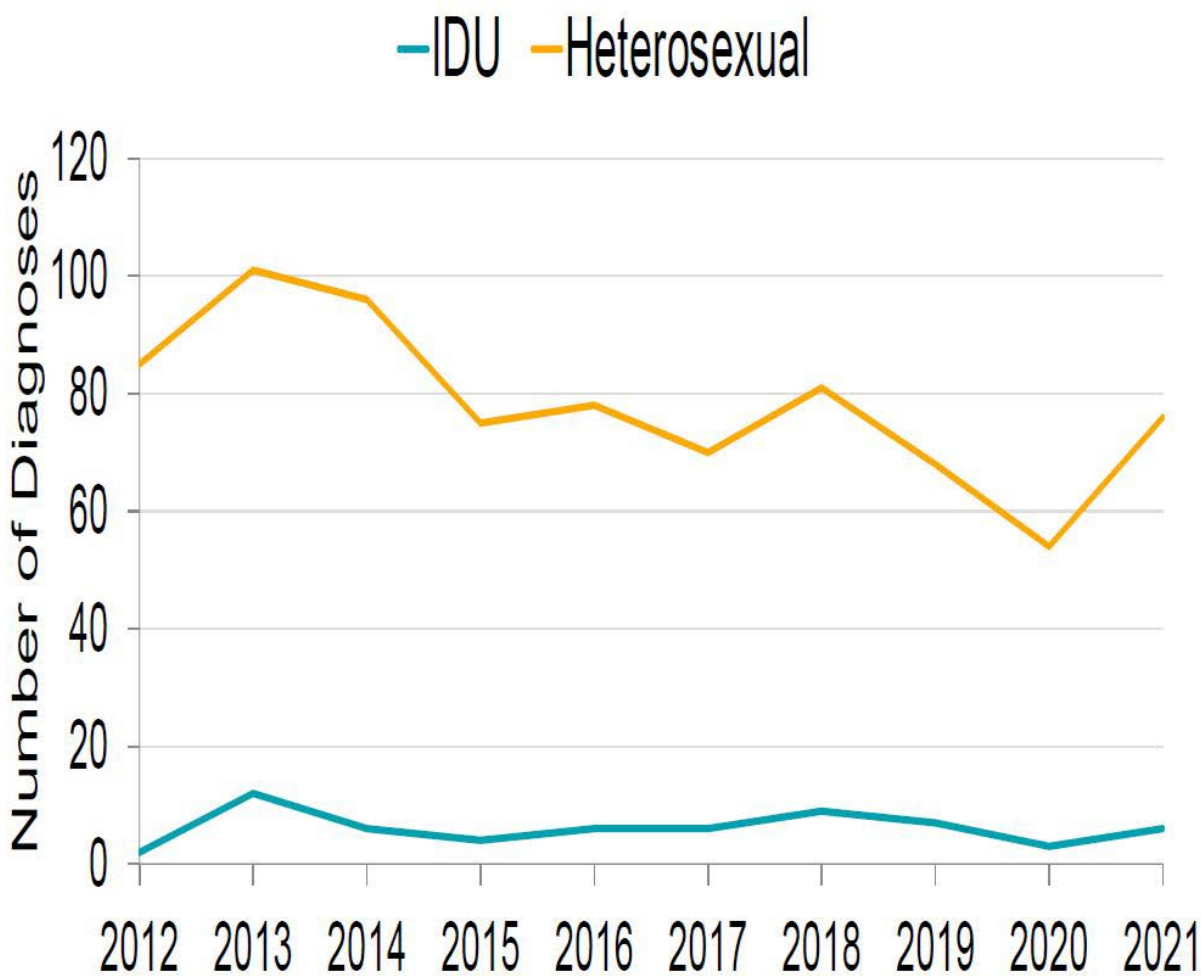




Male New HIV Dx by Risk Factors 2017–2021, Palm Beach



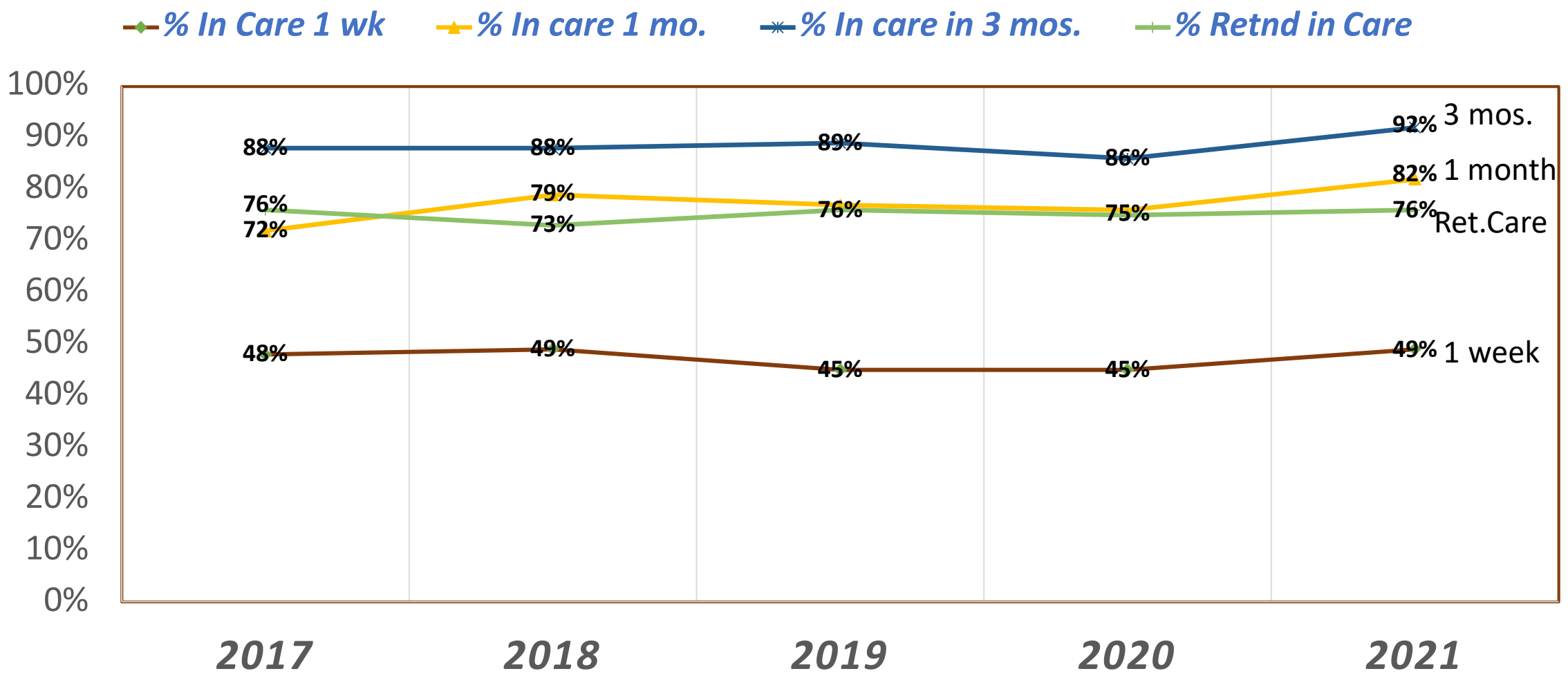
Female New HIV Dx by Risk Factors 2017–2021, Palm Beach

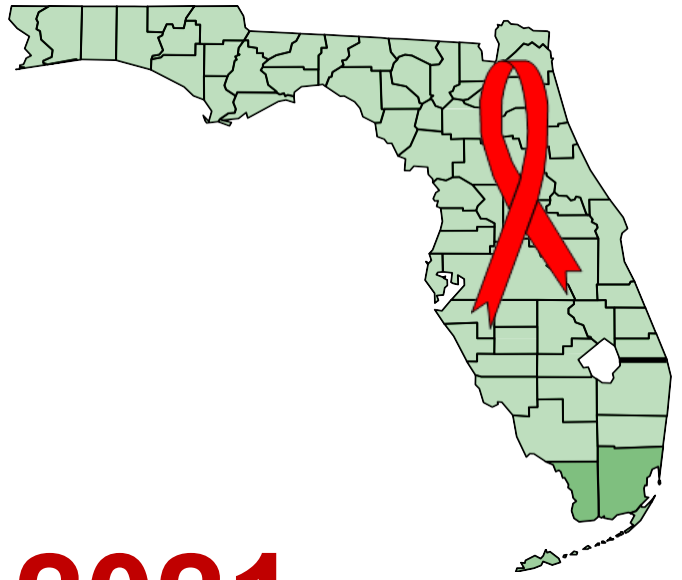


5-Yr. Trends: New HIV Dx – Care Continuum – 2017 to 2021

	New HIV Dx- ***Linkage to Care*** - PBC					
New HIV Dx	***2017***	***2018***	***2019***	***2020***	***2021***	**2020–2021 Relative point Change**
% In Care in 7 days	48%	49%	45%	45%	49%	+4
% In care in 30 days	72%	79%	77%	76%	82%	+6
% In care in 90 days	88%	88%	89%	86%	92%	+6
% Retained in Care	76%	73%	76%	75%	76%	+1

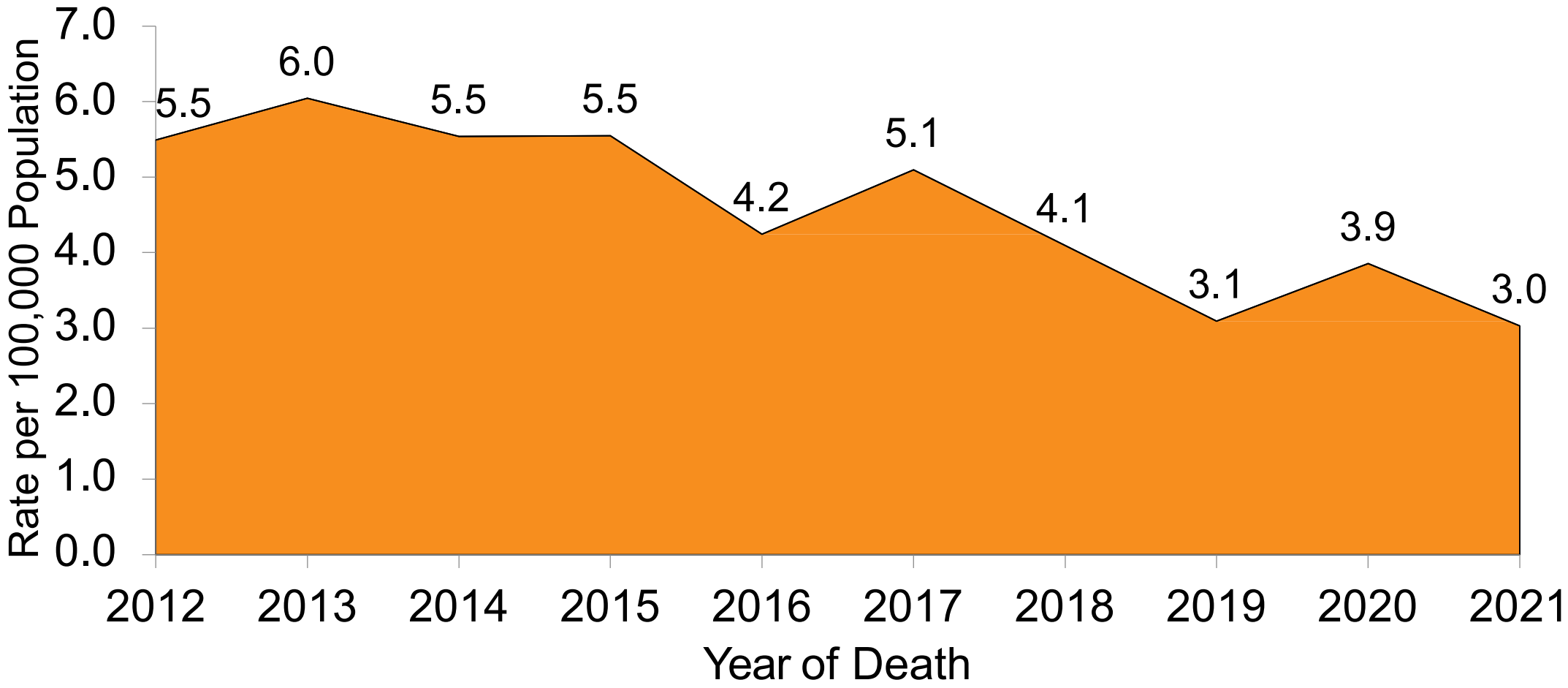
5-Yr. Trends: New HIV Dx - *Linkage to care* – 2017 to 2021





HIV Deaths – Palm Beach 2021

10-Year TREND: HIV Death Rates 2017–2021, Palm Beach

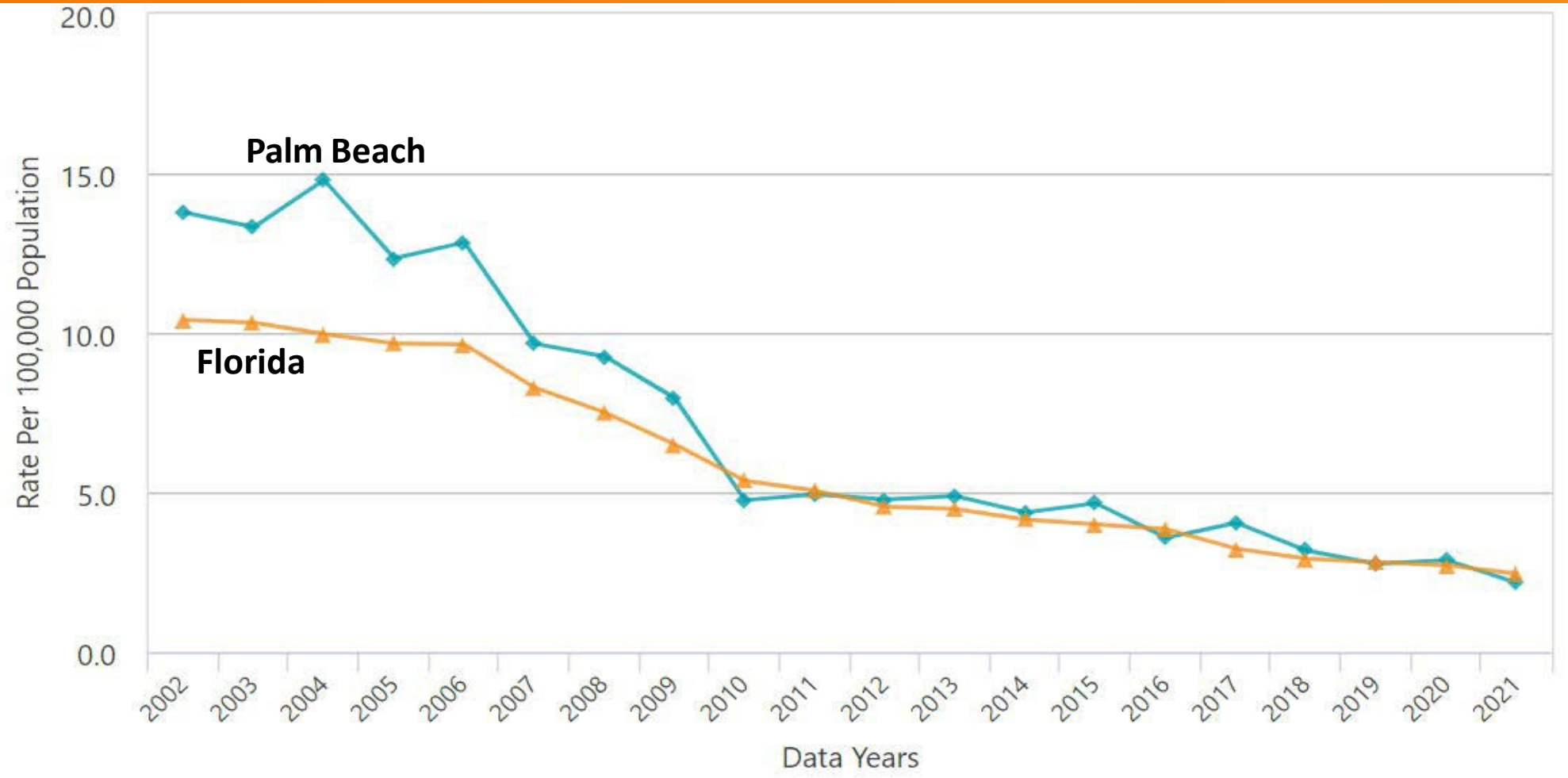


4-yr.Trend:*HIV Death rate, Case Fatality Rate*-Palm Bch vs. FL

Area 9 HIV	HIV Deaths	Death Rate *per 100,000 PBC people*	C F Rate *per 1000 HIV-PBC*
2021	39	3.0	4.6
2020	48	3.9	5.8
2019	45	3.1	5.4
2018	53	4.1	6.4

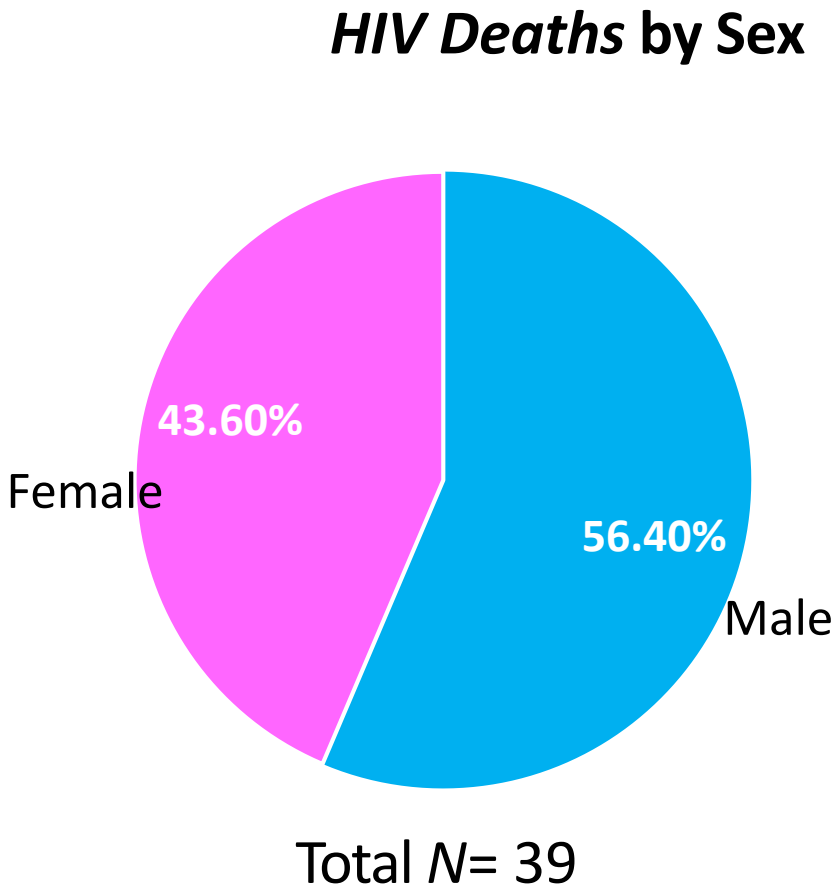
Florida HIV	HIV Deaths	Death Rate *per 100,000 FL people*	C F Rate *per 1000 HIV-FL*
2021	629	2.8	5.2
2020	672	3.0	5.7
2019	692	3.1	5.9
2018	693	3.2	5.9

20-Yr. Trend: HIV *Death Rates – Palm Beach vs. FL

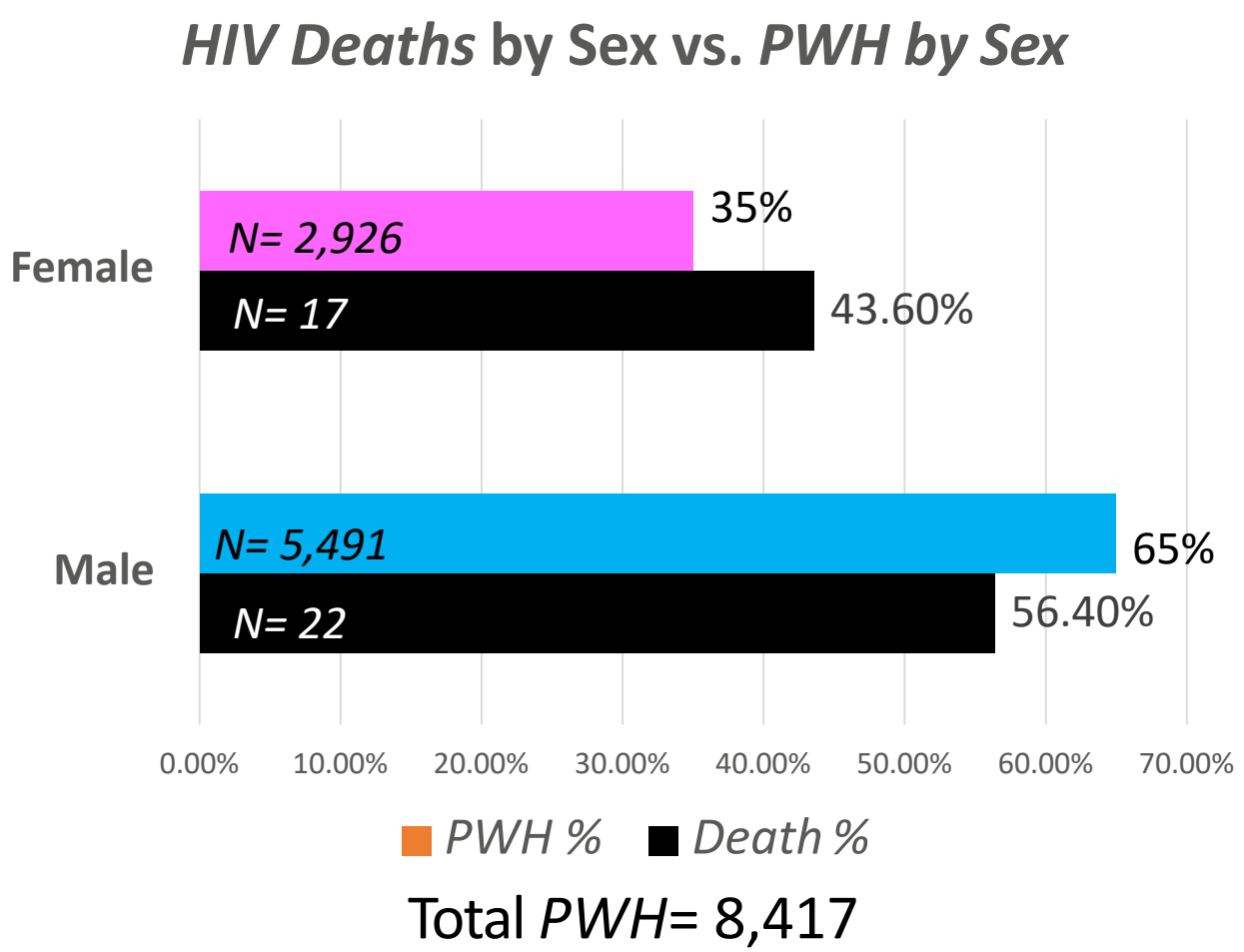


***-- *Age adjusted* death rates**

HIV Deaths by Sex – Palm Beach 2021

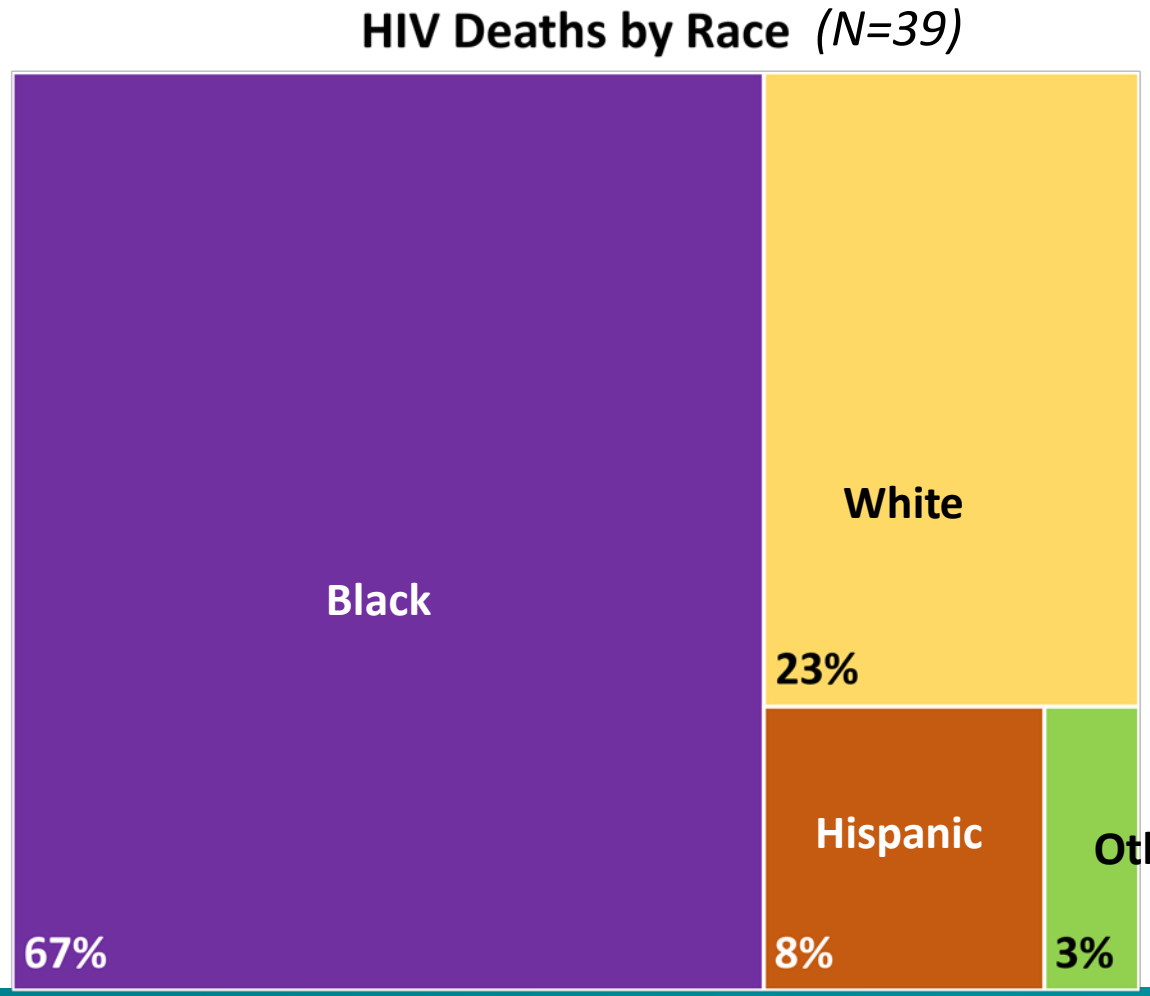


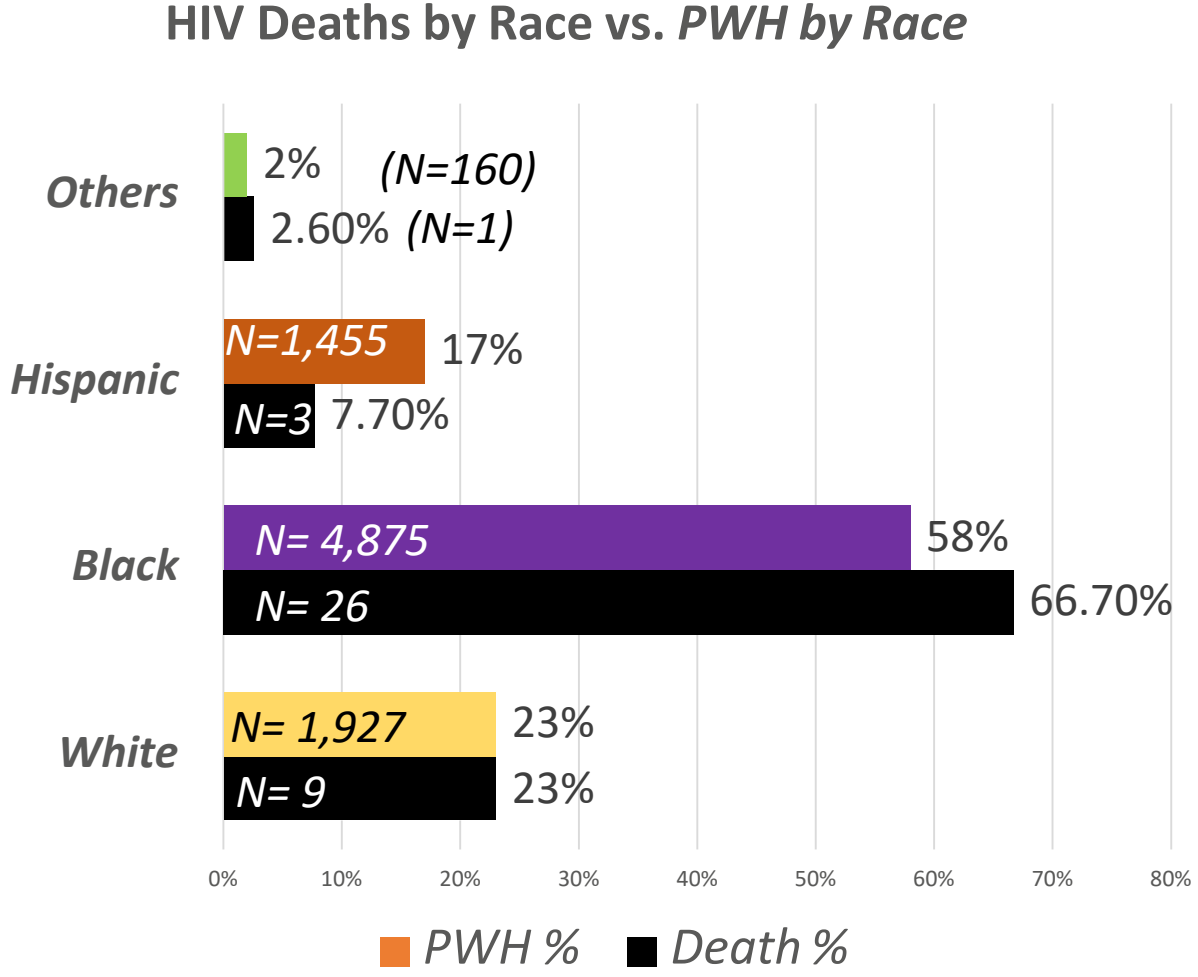
Total *N*= 39



Total *PWH*= 8,417

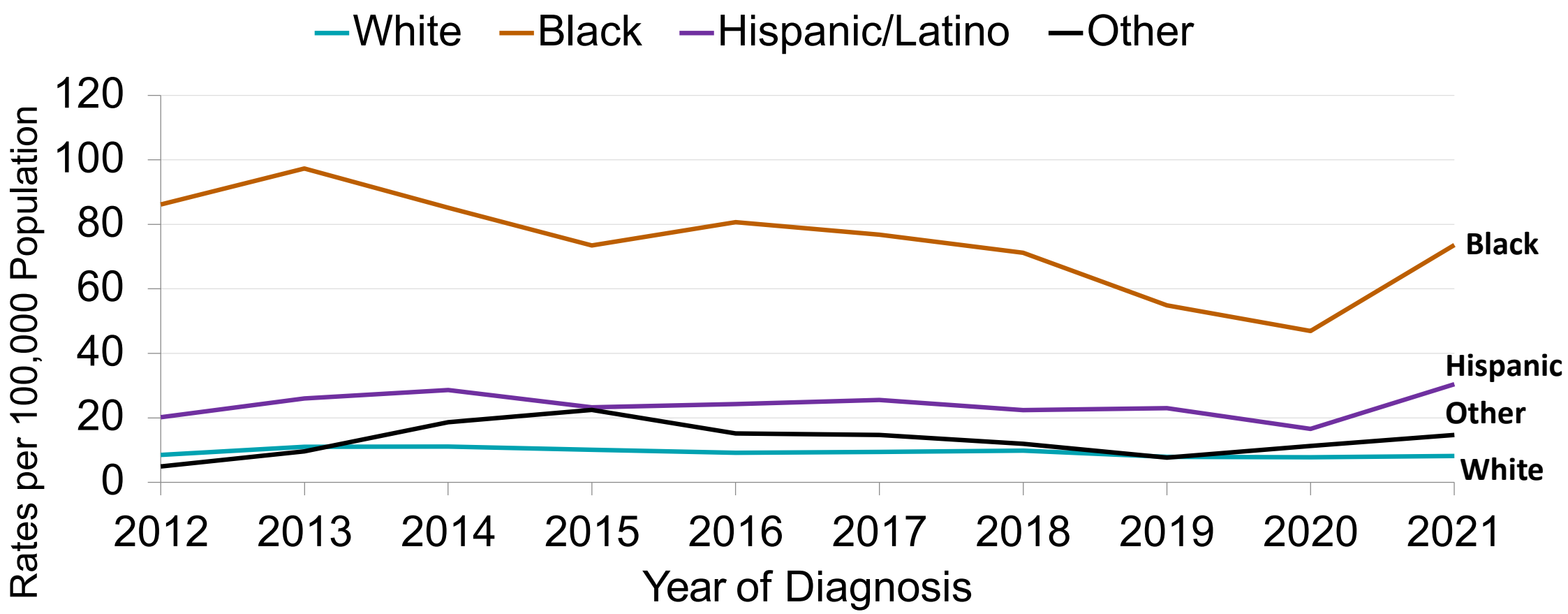
HIV Deaths by RACE – Palm Beach 2021





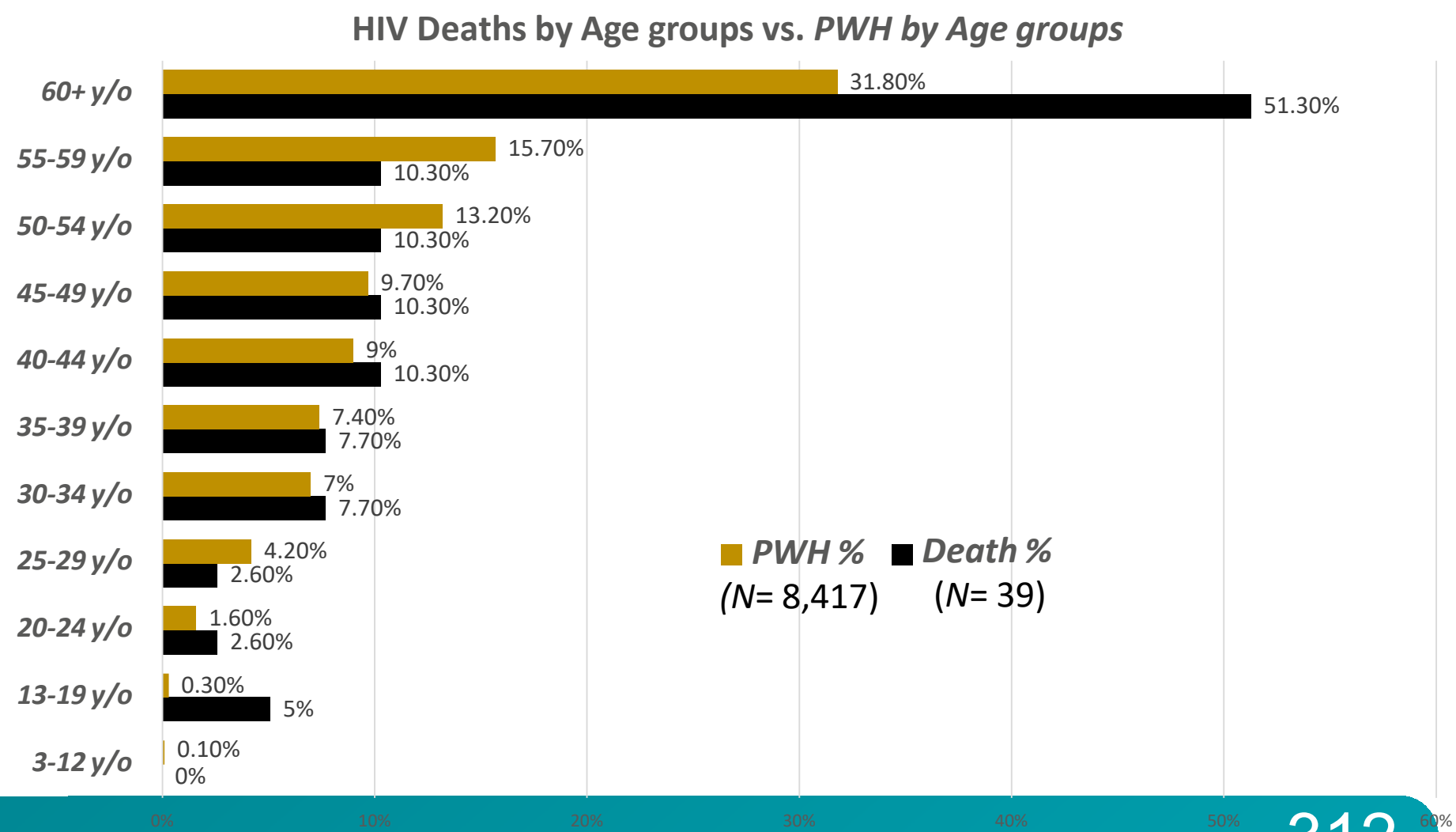
Total *PWH*= 8,417

10-Year TREND : HIV Death Rates - By RACE, 2017–2021 Palm Beach

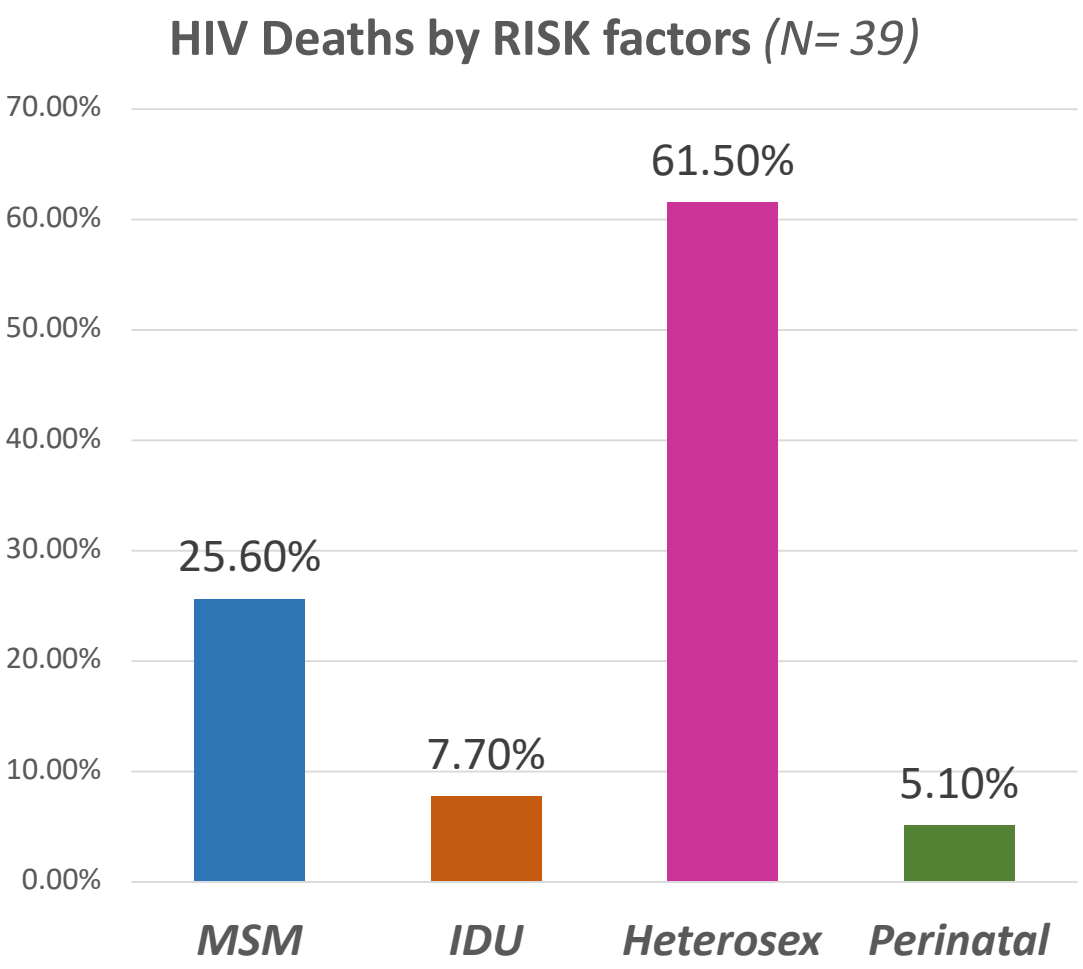


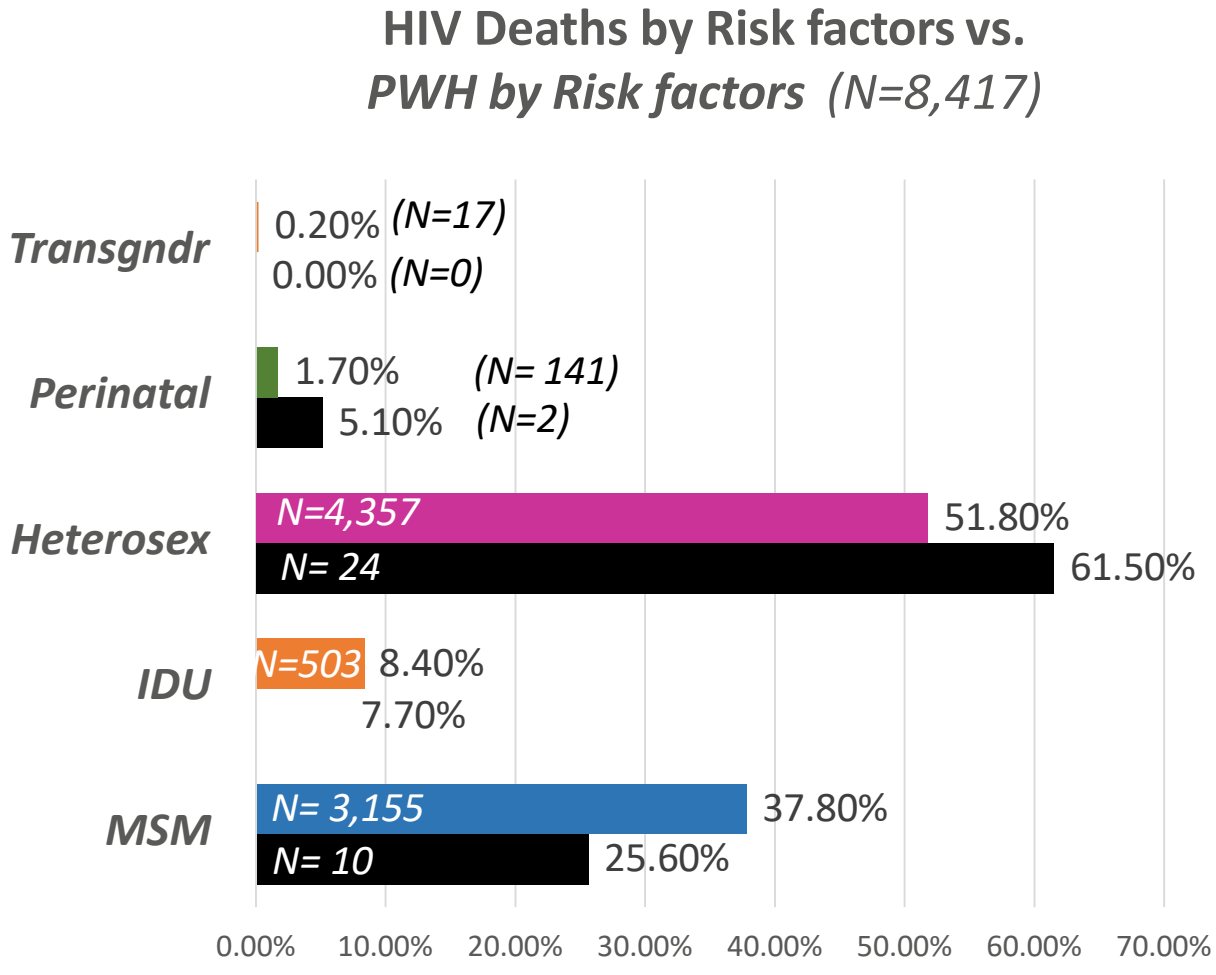
HIV Deaths by *AGE Groups* – Palm Beach 2021

AGE grps	*Death Ct.*	*PWH Ct.*
3-12 y/o	0	6
13-19 y/o	0	27
20-24 y/o	1	137
25-29 y/o	2	355
30-34 y/o	1	589
35-39 y/o	1	622
40-44 y/o	3	760
45-49 y/o	3	818
50-54 y/o	4	1108
55-59 y/o	4	1321
60+ y/o	20	2673



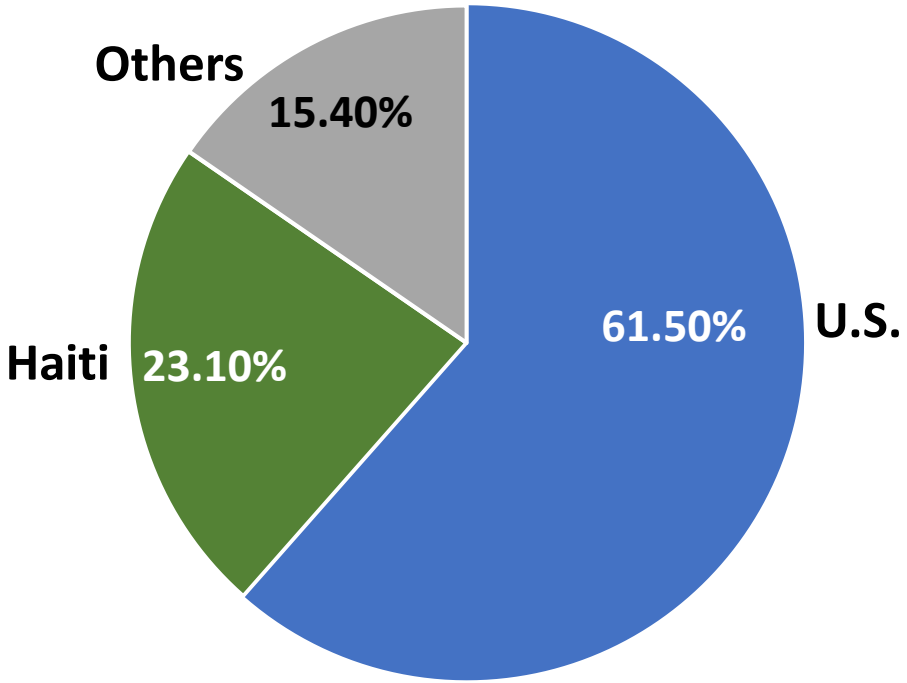
HIV Deaths by *RISK factors* – Palm Beach 2021



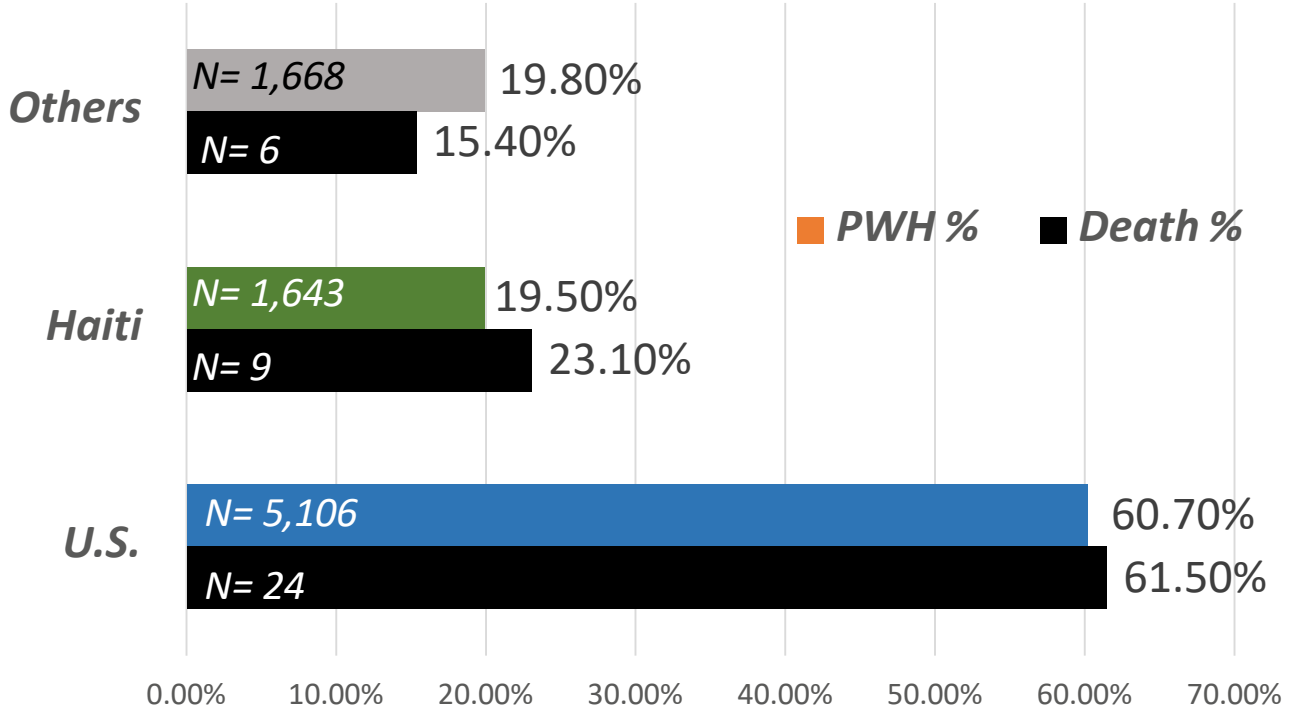


HIV Deaths by *Country of Birth* – Palm Beach 2021

HIV Deaths by *Country of Birth* *(N=39)*



HIV Deaths by Country of Birth vs.
PWH by Country of Birth *(N=8,417)*



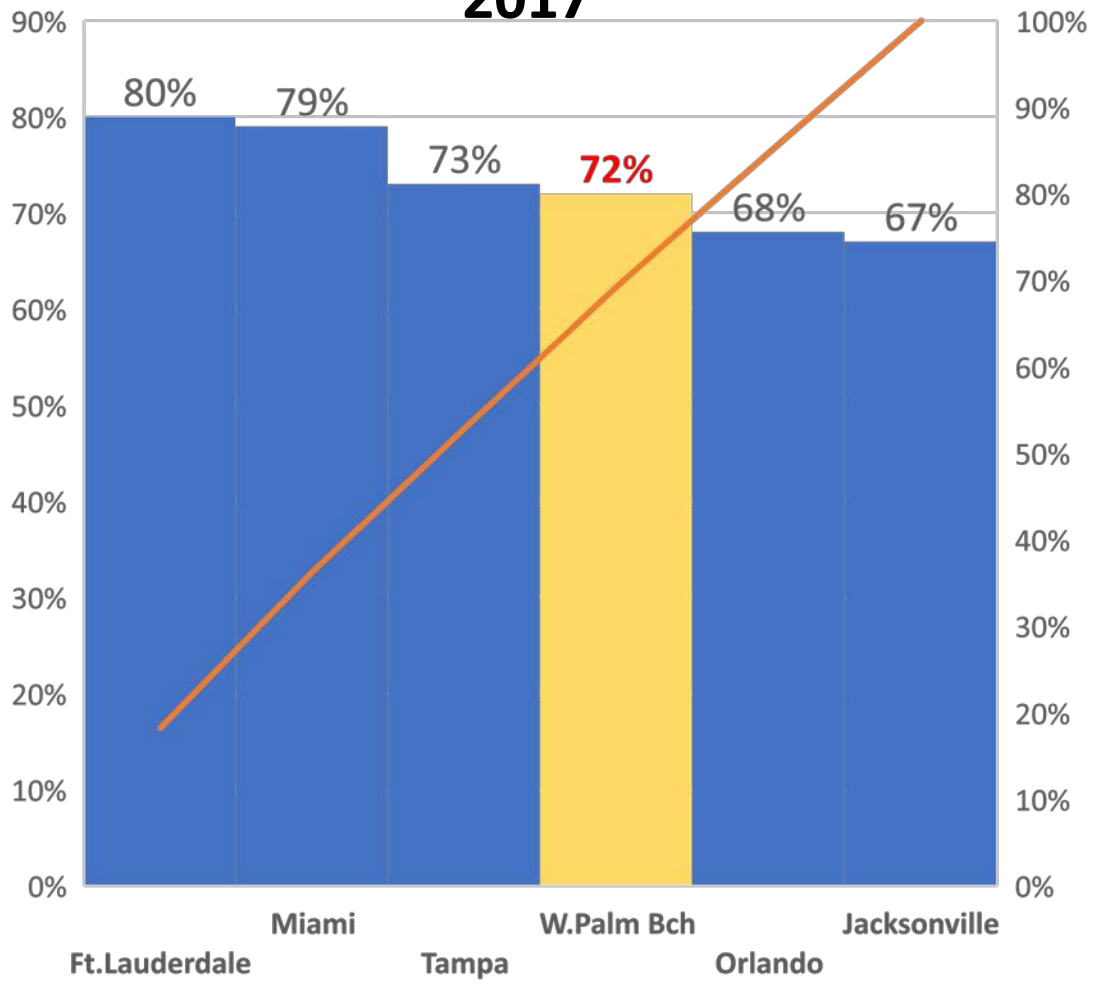
HIV Epi Profile & *Care Continuum* - Palm Beach

Notable changes in *New HIV Dx* stats –

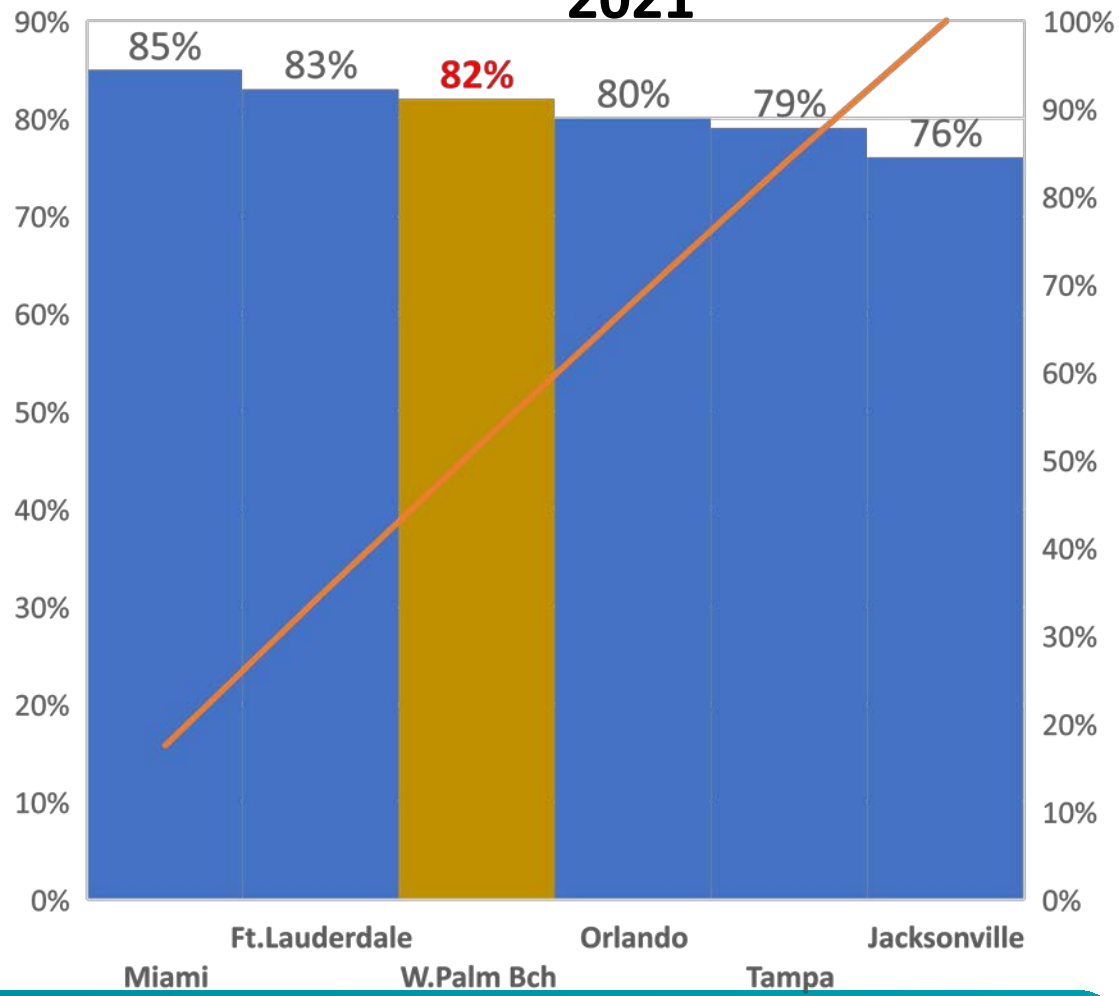
Palm Beach vs. EMAs (2017 to 2021)

2017 vs. 2021 : *In Care 30d* – EMAs vs. Palm Beach

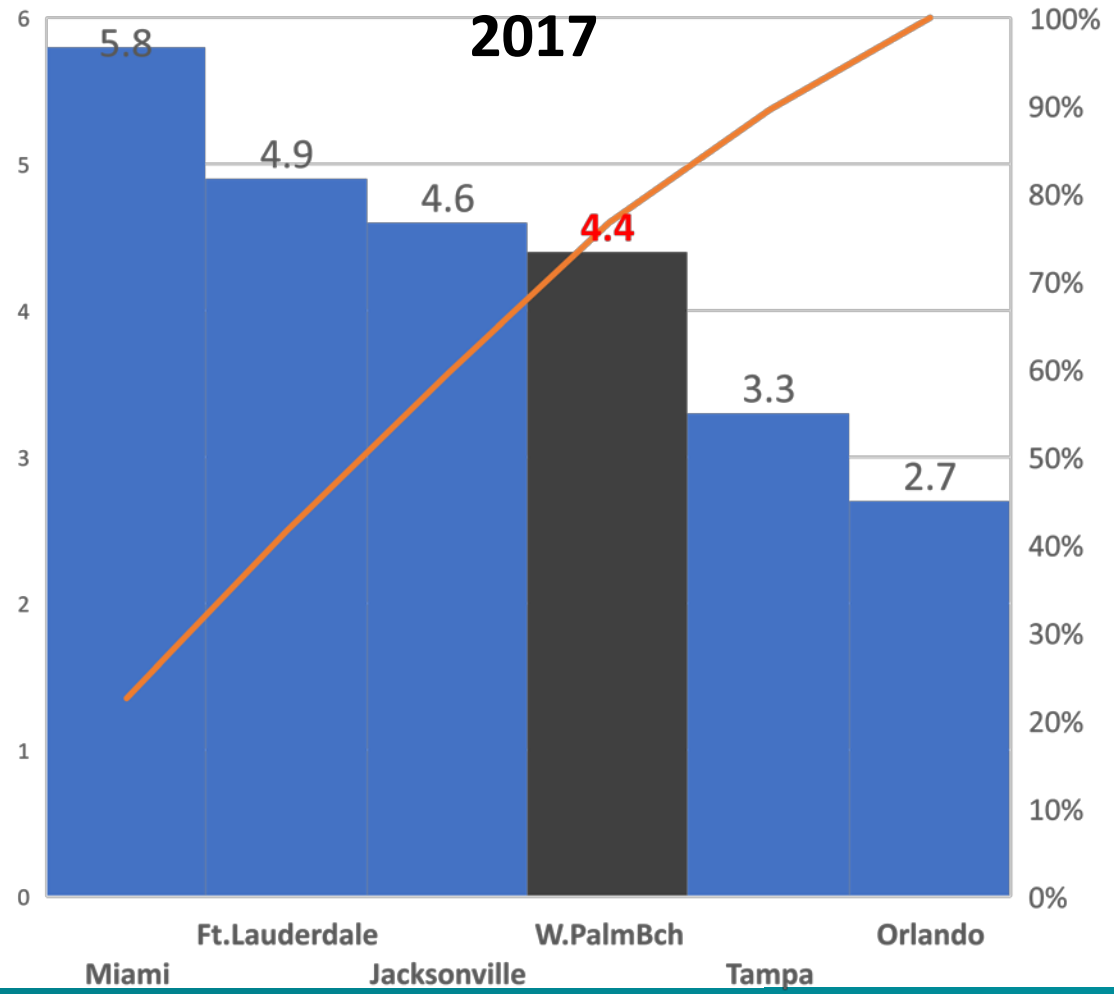
2017

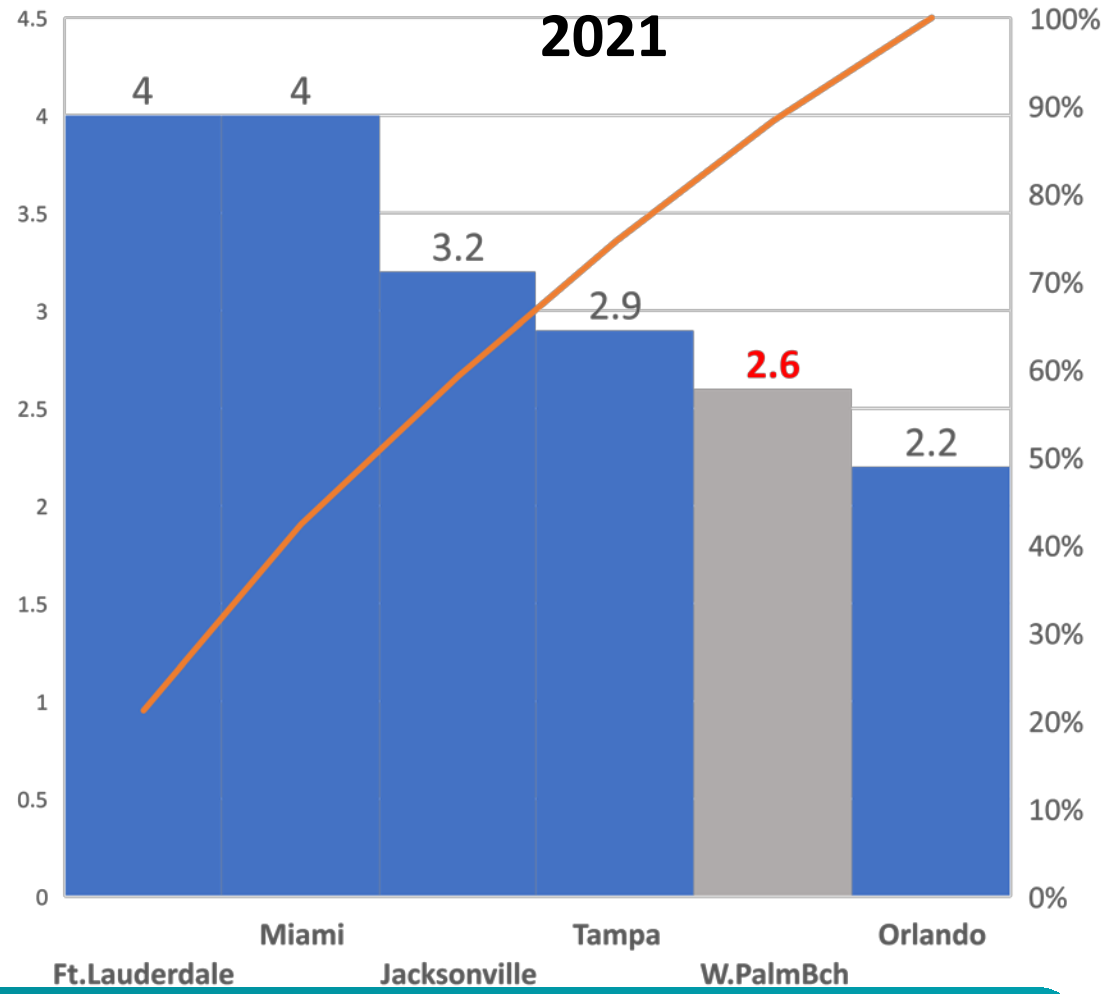


2021



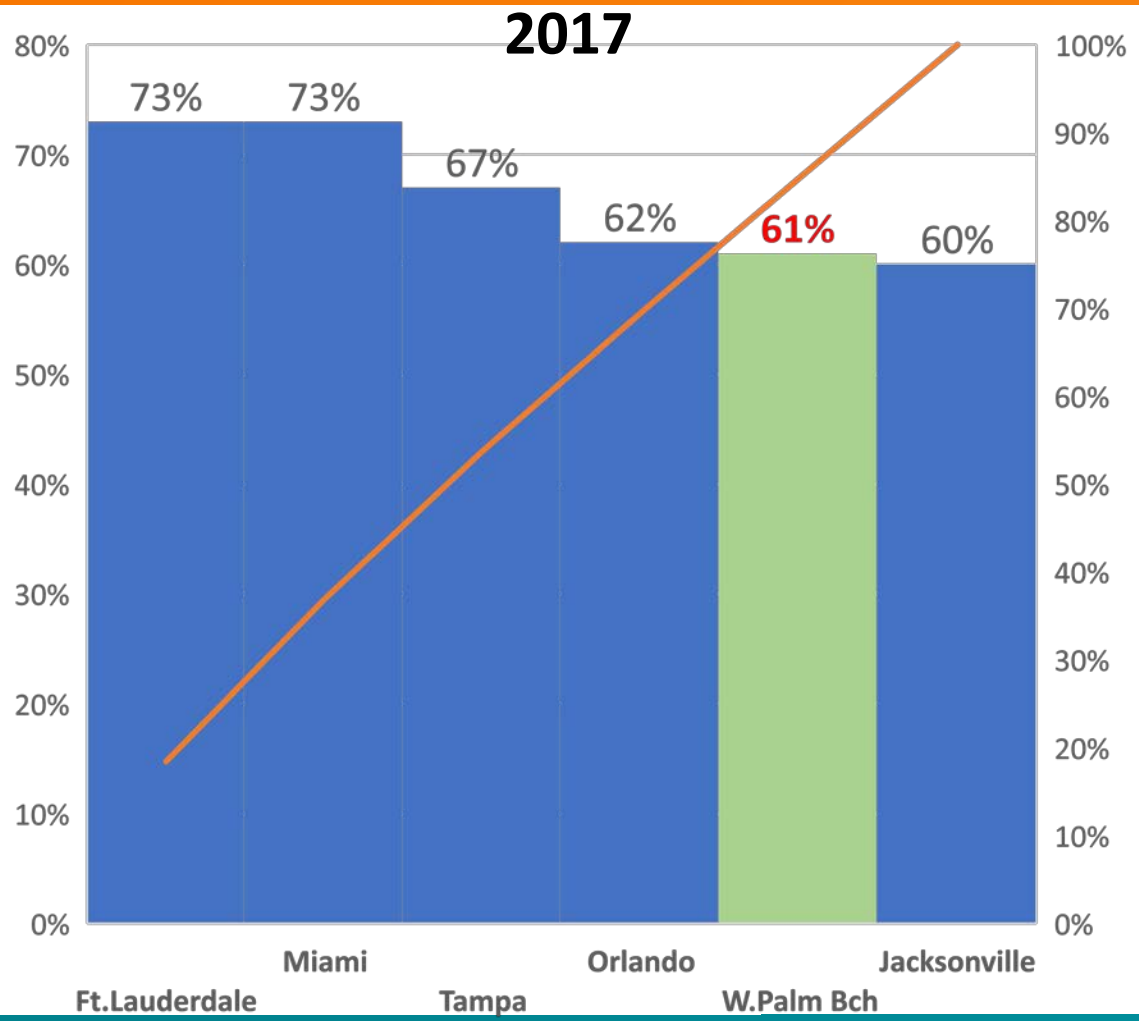
2017 vs. 2021 : *HIV *Death rates*–EMAs vs.Palm Beach

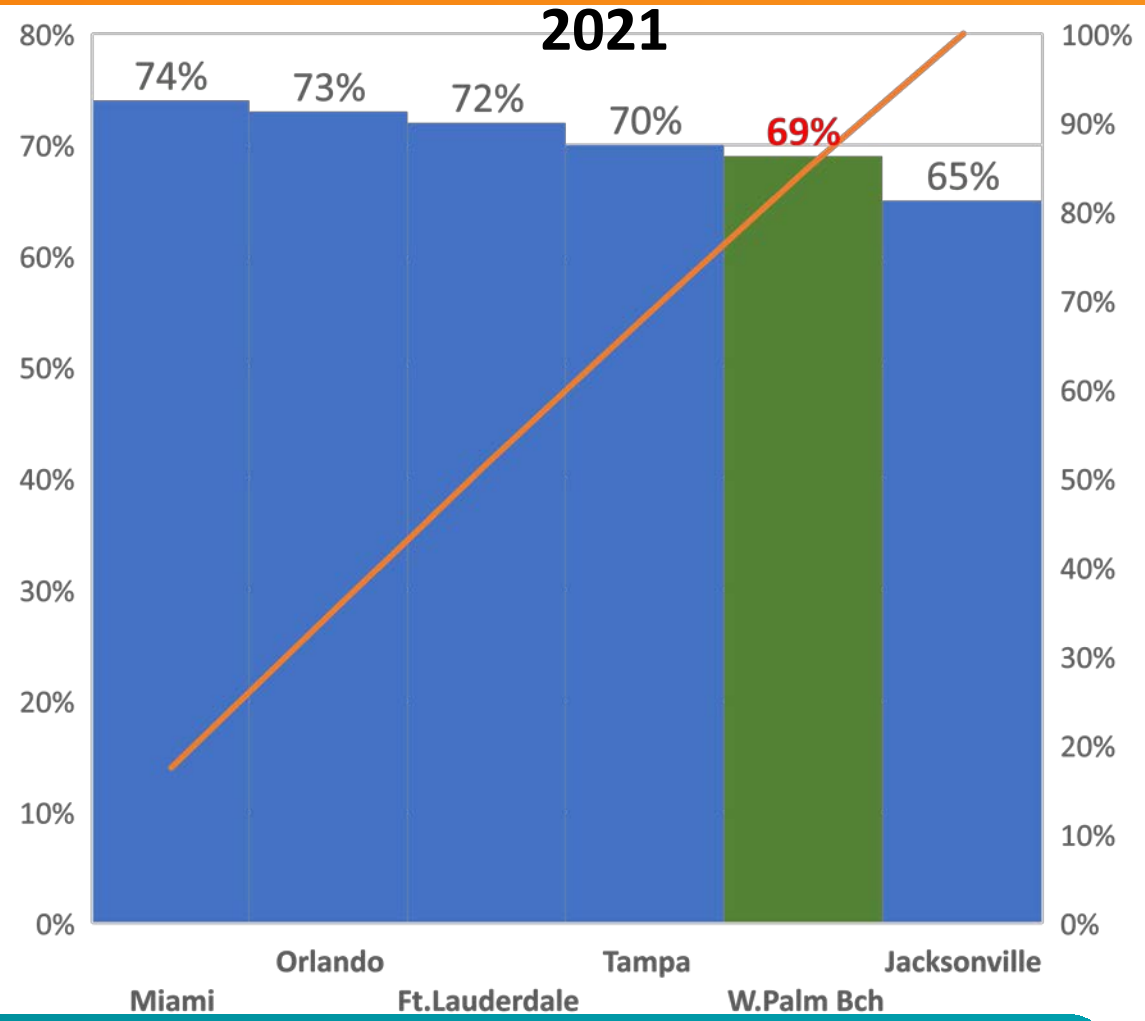




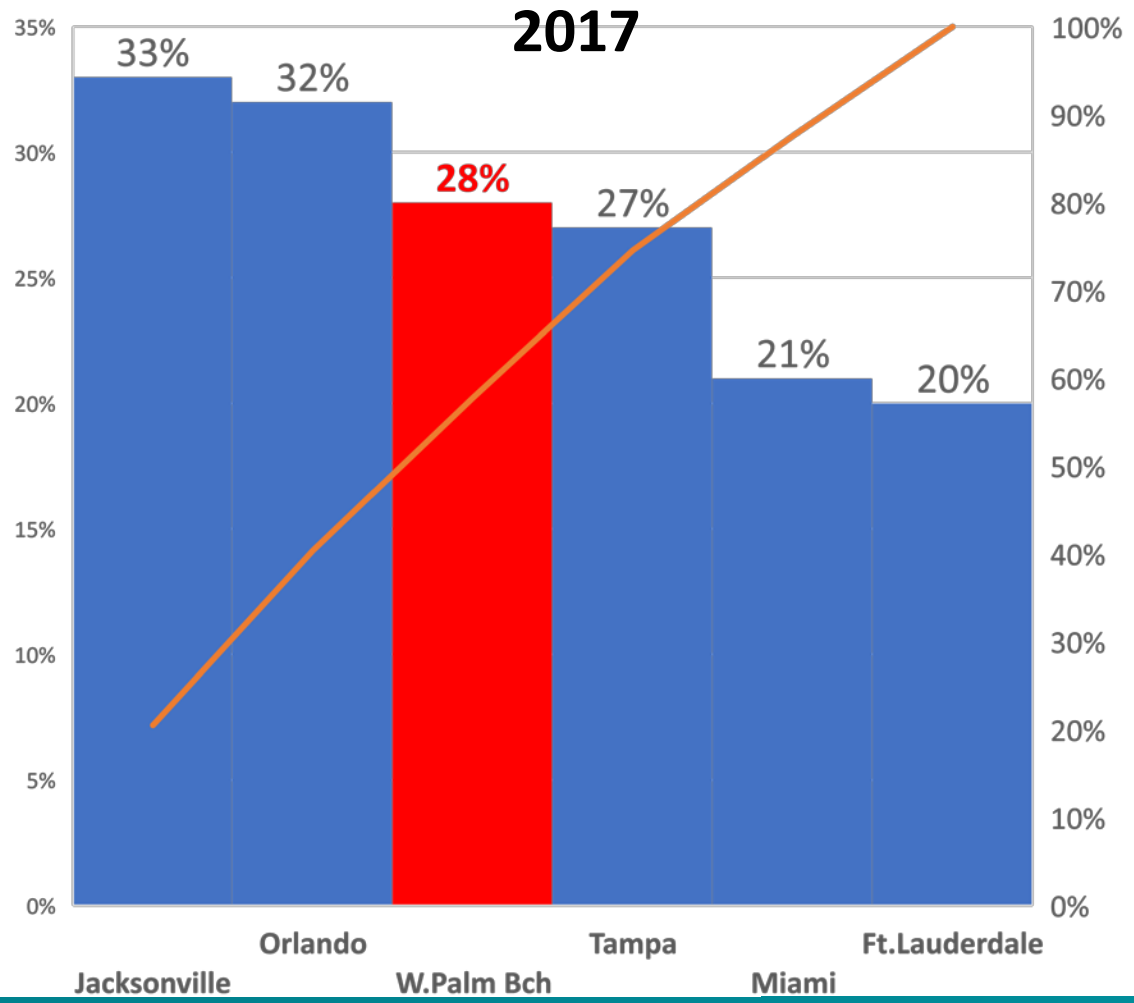
*-- *Age adjusted* death rates

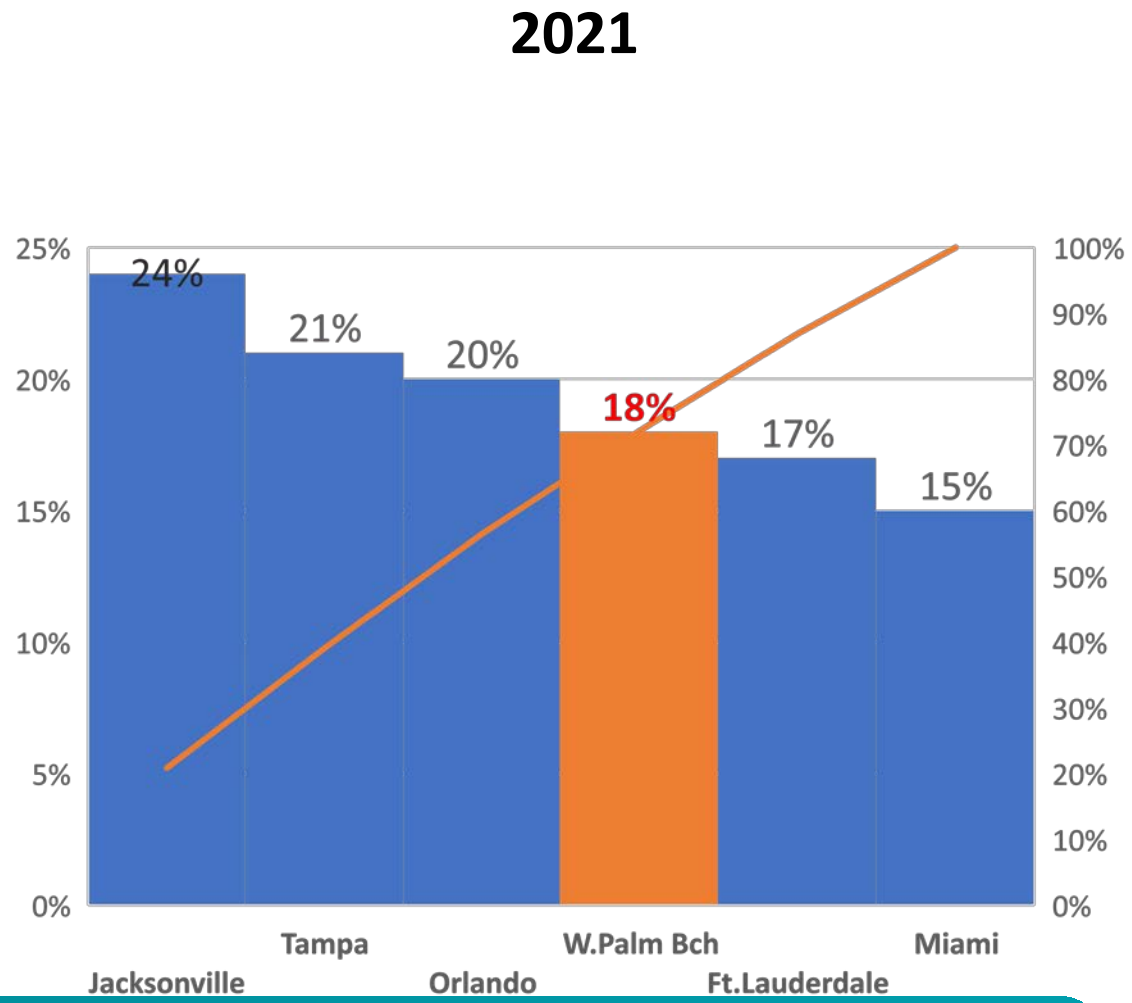
2017 vs. 2021 : *Suppressed VL* – EMAs vs. Palm Beach





2017 vs. 2021 : *NOT in Care* – EMAs vs. Palm Beach

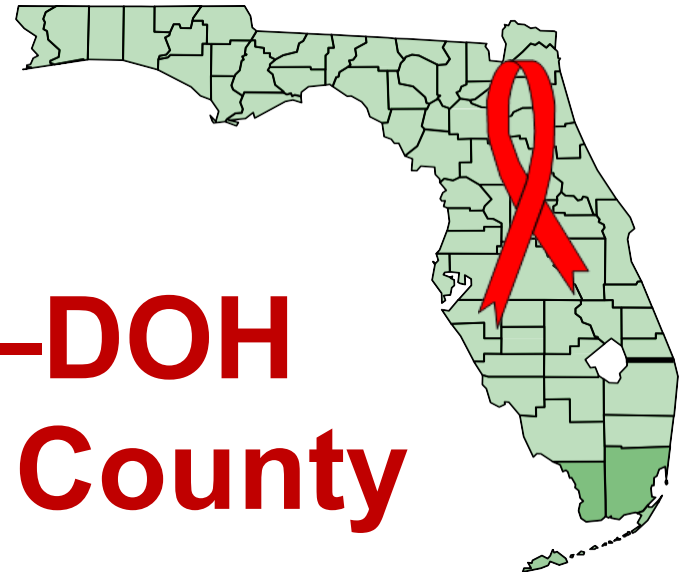




Florida HIV/AIDS Surveillance Data
Palm Beach County Contact

Irma Shute
Florida Department of Health in
Palm Beach County
Phone: 561-804-7948
Email: Irma.Shute@flhealth.gov

HIV/AIDS surveillance data are frozen on June 30 for the previous calendar year. These are the same data used for *FLHealthCHARTS* and all grant-related data.
flhealthcharts.com/charts/CommunicableDiseases/default.aspx



2021-2022 Ryan White Part B –DOH *Care Continuum* -Palm Beach County

Grant Year 7/1/2021 – 6/30/2022

IRMA SHUTE (AREA 9)

HIV Surveillance Unit

Florida Department of Health

Ryan White Part B – DOH Palm Beach County

RWHAP Part B – HRSA HAB awards the following grants to states/territories:

- ***RWHAP Part B HIV Care Grant Program*** (Activity Code X07), including:
  - **RWHAP Part B Base** funds to provide core medical and support services;
  - **RWHAP ADAP Base** funds for FDA-approved Rx and purchase of health care coverage for low-income HIV patients;
  - **RWHAP ADAP Supplemental** funds for applicants in severe need for medication;
  - **Emerging Communities (EC) supplemental** funds for metro areas (MSAs) with 500 to 9999 cases in last 5 years
  - **Minority AIDS Initiative (MAI)** funds to improve minority access to HIV medication assistance

- ***RWHAP Part B Supplemental Grant Program*** (Activity Code X08), including ADAP.

- ***ADAP Emergency Relief Funds (ERF)*** (Activity Code X09) to reduce ADAP waitlists
- ***Ending the HIV Epidemic (EHE) Initiative*** –to reduce new HIV infections in the U.S.7

Ryan White Part B – HIV *Care Continuum* defined

HIV Care Continuum

- HIV care continuum **has 5 stages** : HIV Dx, linked to care, retained in care, prescribed ART, and viral suppression.

- The HIV care continuum allows recipients and planning groups to measure progress and to direct HIV resources effectively. RWHAP recipients need to assess the outcomes of their programs along this continuum of care.

HIV *Care Continuum* Definitions

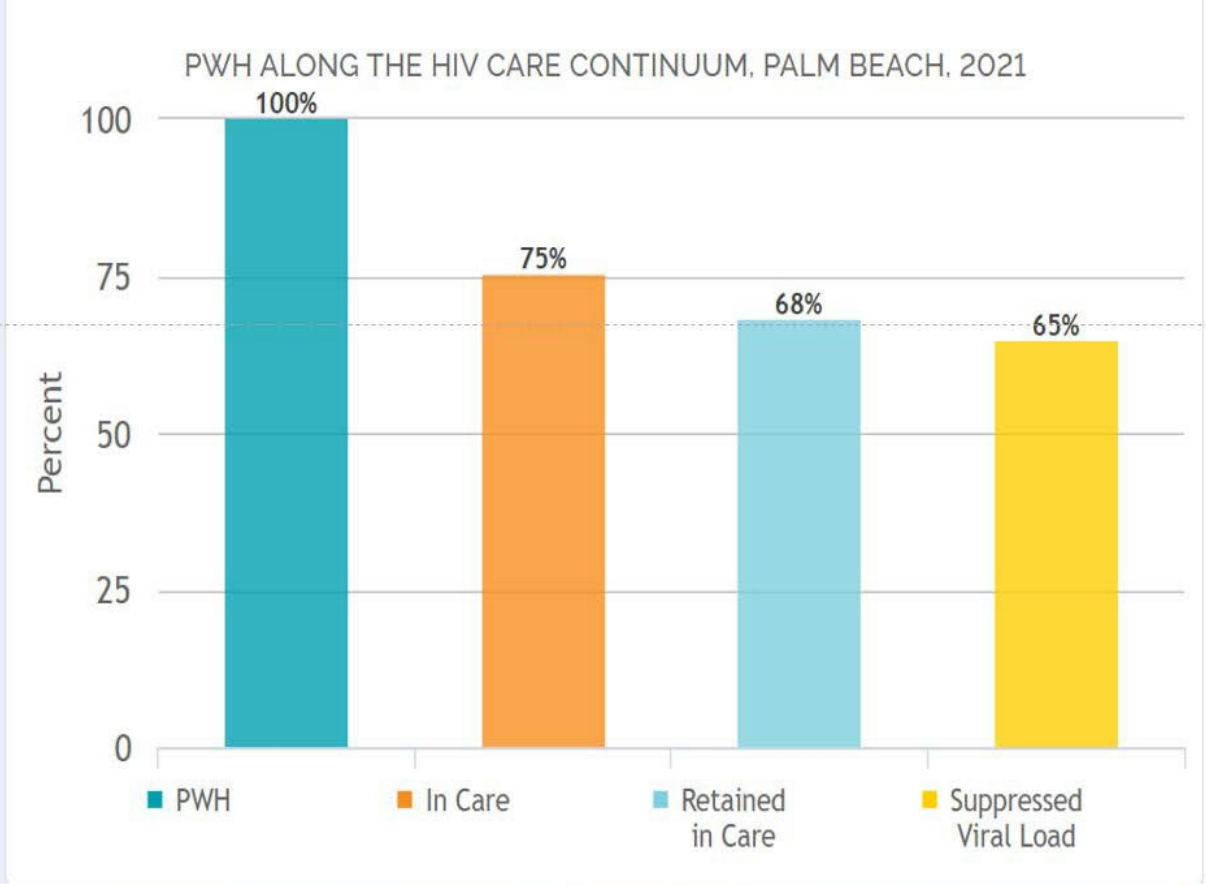
- ***PWH*: Persons with HIV living in Palm Beach at the end of 2021.**
- ***In Care*: PWH with at least one documented VL or CD4 lab, medical visit, or prescription from 1/1/2021 through 3/31/2022.**
- ***Retained in Care*: PWH with two or more documented VL or CD4 labs, medical visits or prescriptions at least three months apart from 1/1/2021 through 6/30/2022.**

HIV *Care Continuum* Definitions, cont.

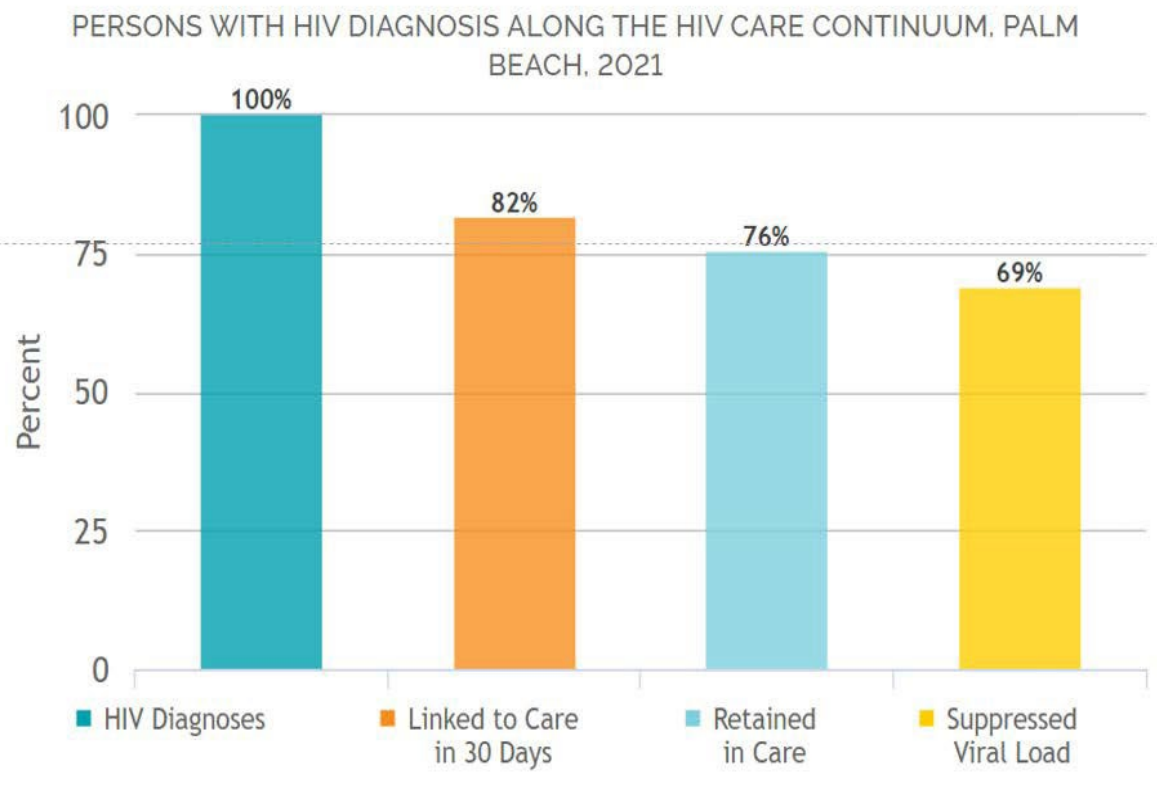
- ***Suppressed Viral Load***: PWH with a suppressed VL (<200 copies/mL) on their last VL lab from 1/1/2021 through 3/31/2022.
- ***Not in Care*:** PWH with no documented VL or CD4 lab, medical visit or prescription from 1/1/2021 through 3/31/2022.
- ***Linked to Care***: PWH with at least one documented VL or CD4 lab, medical visit, or prescription following their first HIV diagnosis date.

Care Continuum : PWH vs. New HIV Dx – 2021 Palm Beach

Palm Beach -PWH



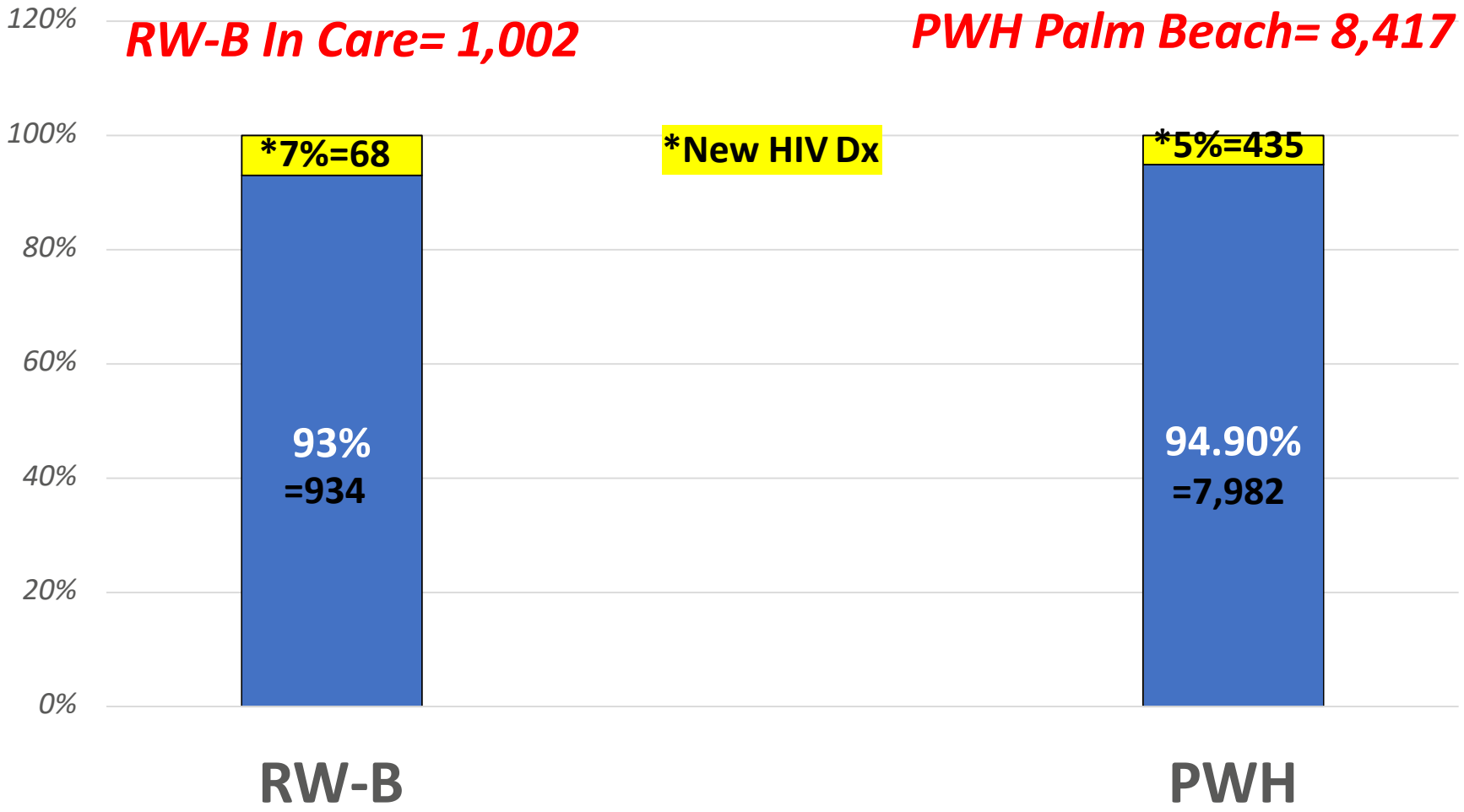
Palm Beach-New HIV Dx



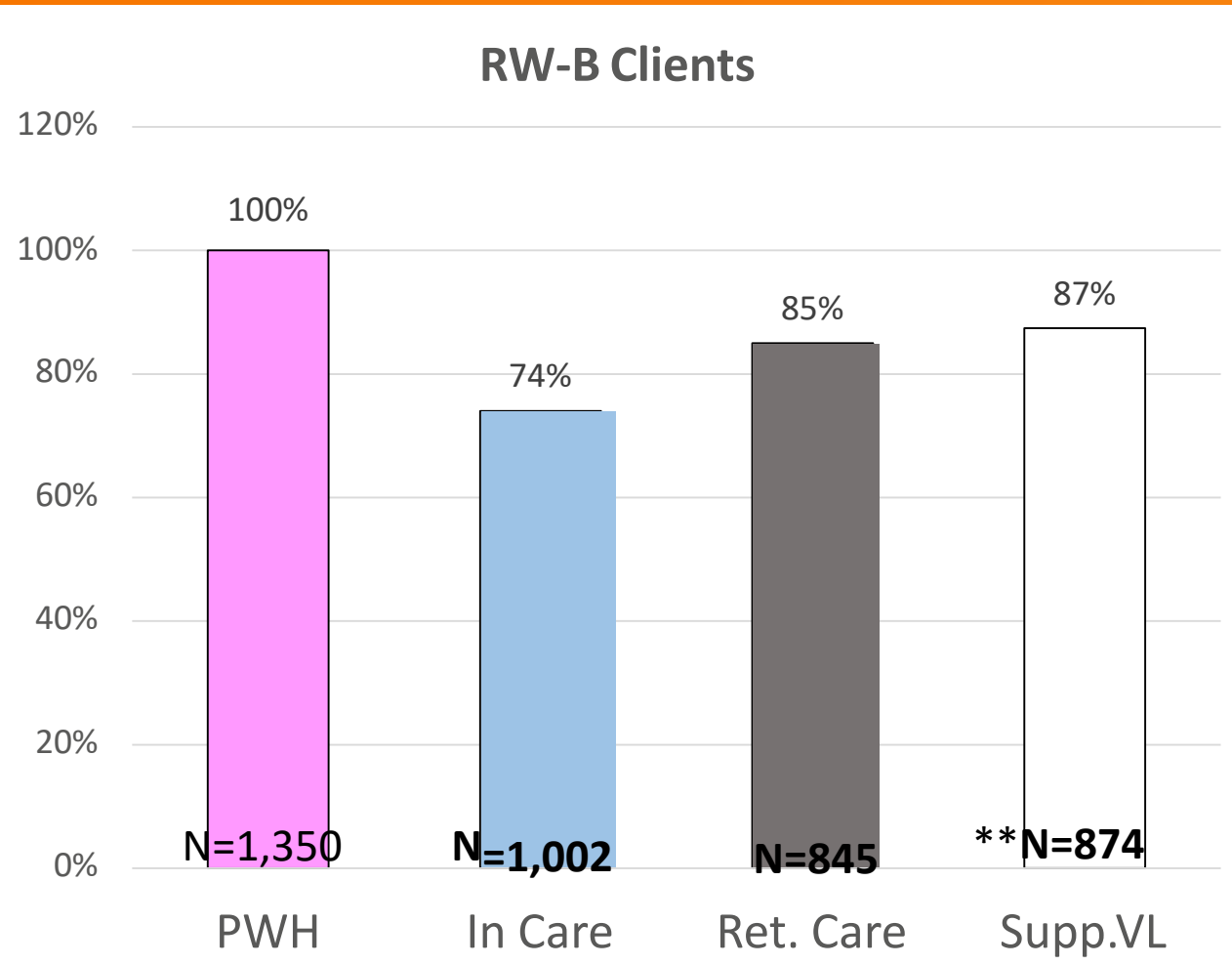
2021 HIV Epidemiology	AREA 9 = Palm Beach (2021 Pop'n= 1,487,272)	FLORIDA (2021 Pop'n = 22,005,587)
Incidence (New) = HIV	322	4,708
(New) = AIDS	113	1,860
Total New (H + A)	435	6,568
INCIDENCE Rate = HIV	21.7 /100,000	21.4 /100,000
= AIDS	7.6 /100,000	8.5 /100,000
DIAGNOSIS RATE = HIV + AIDS	29 /100,000	30 /100,000
Prevalence (PWH = H+A) (new + ongoing)	8,417	120,502
PREVALENCE Rate (PWH)	566/100,000	548/100,000
HIV Deaths	39	629

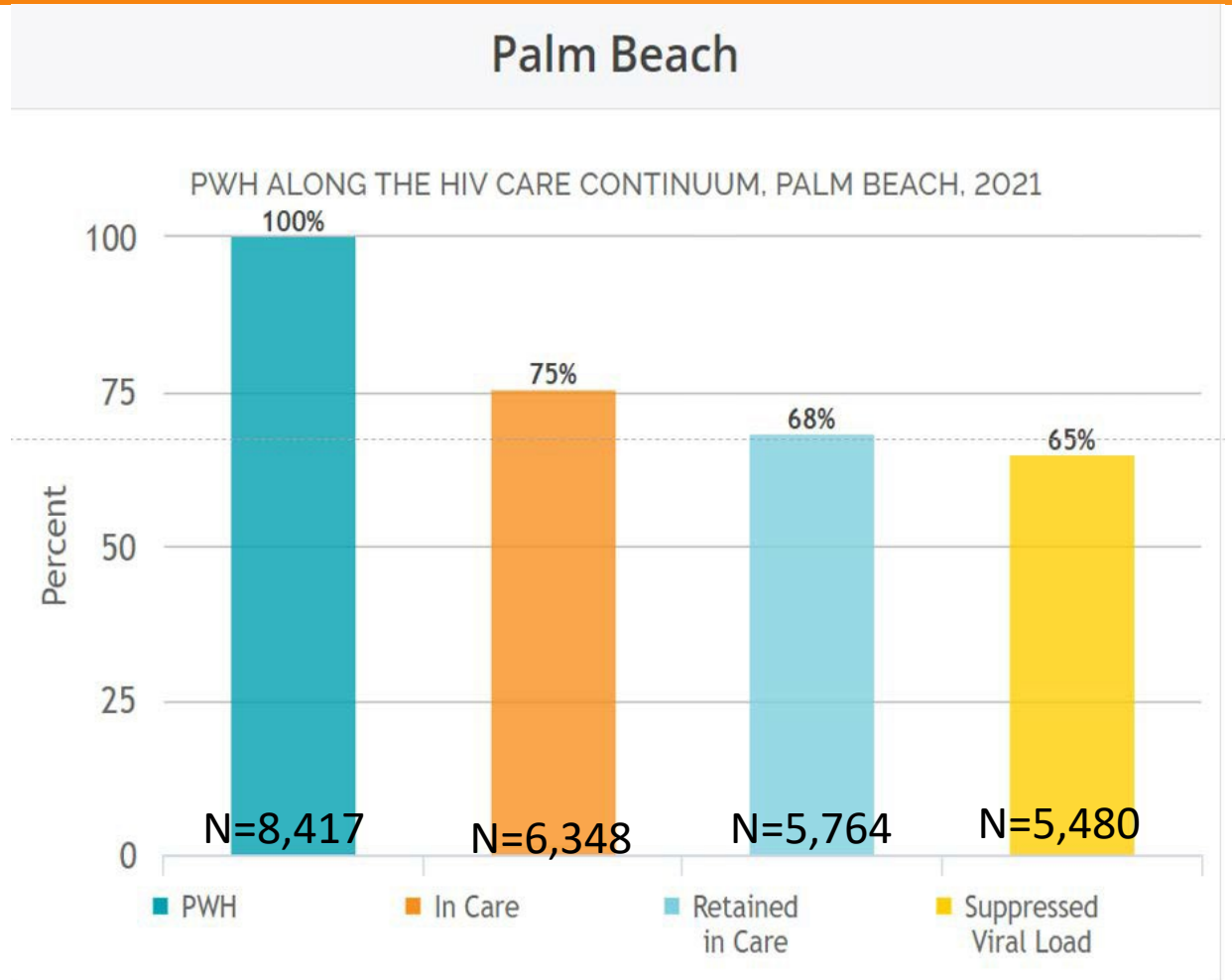
Retention in Care: *RW-Part B* clients vs. *PWH in Palm Beach County* – GY 2021 to 2022

Total *N:* RW-B clients vs. PWH - Palm Beach 2021



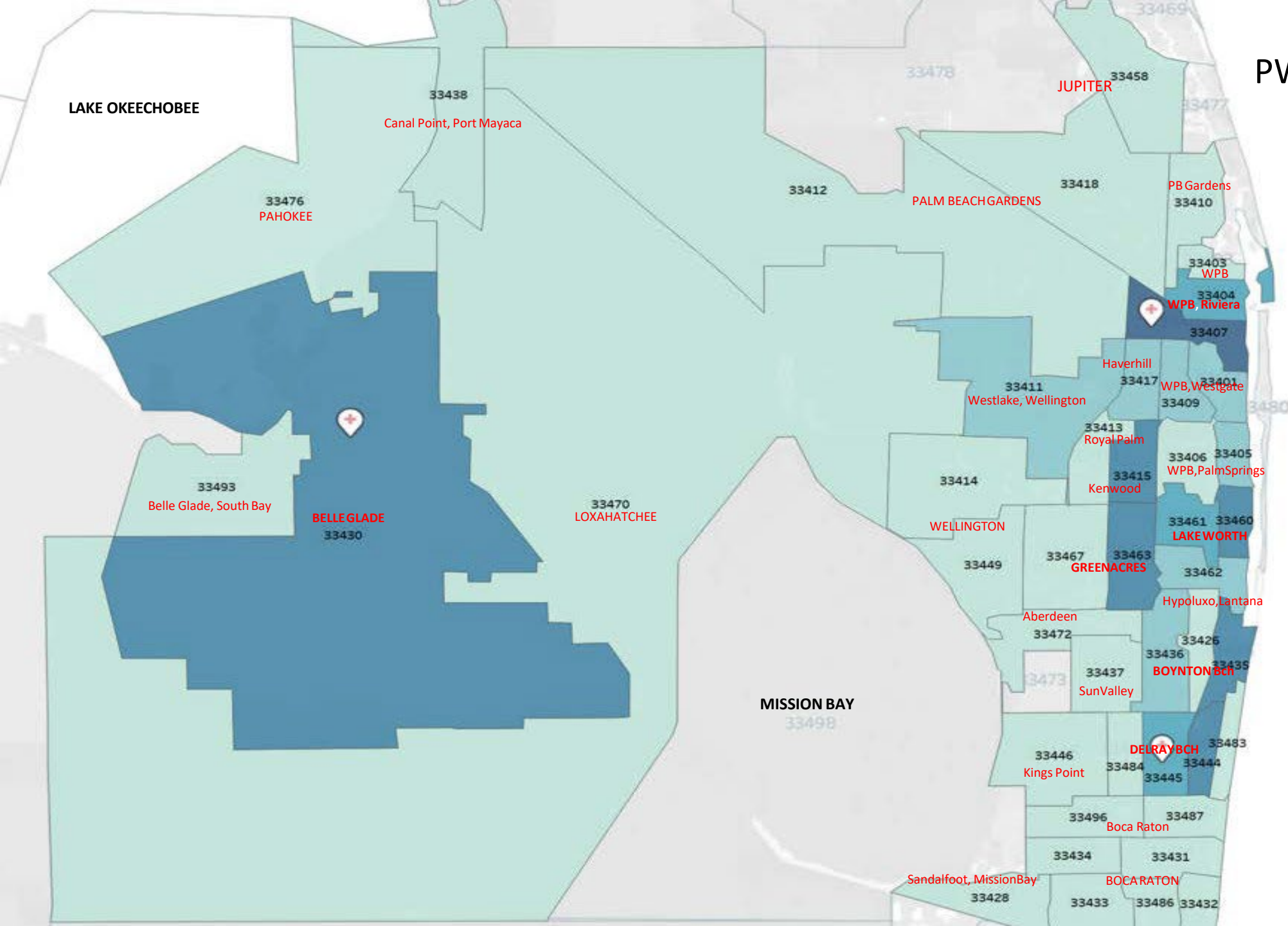
PWH in *Care Continuum:* RW-B clients vs. Palm Beach -2021





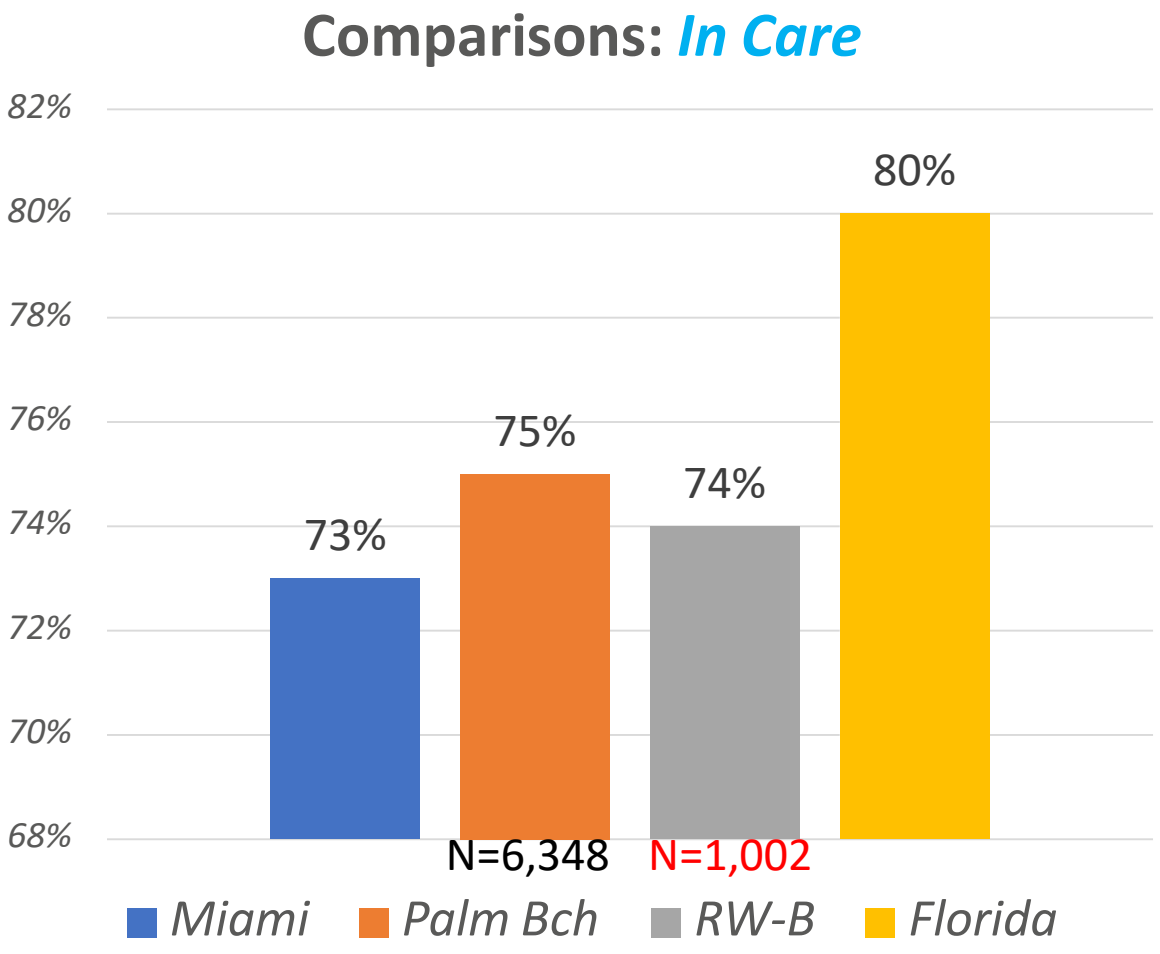
**= # *Supp.VL* > # *Ret. Care* because 29 *Supp.VL* clients had only 1 clinic visit (not '*Retained Care*' yet)

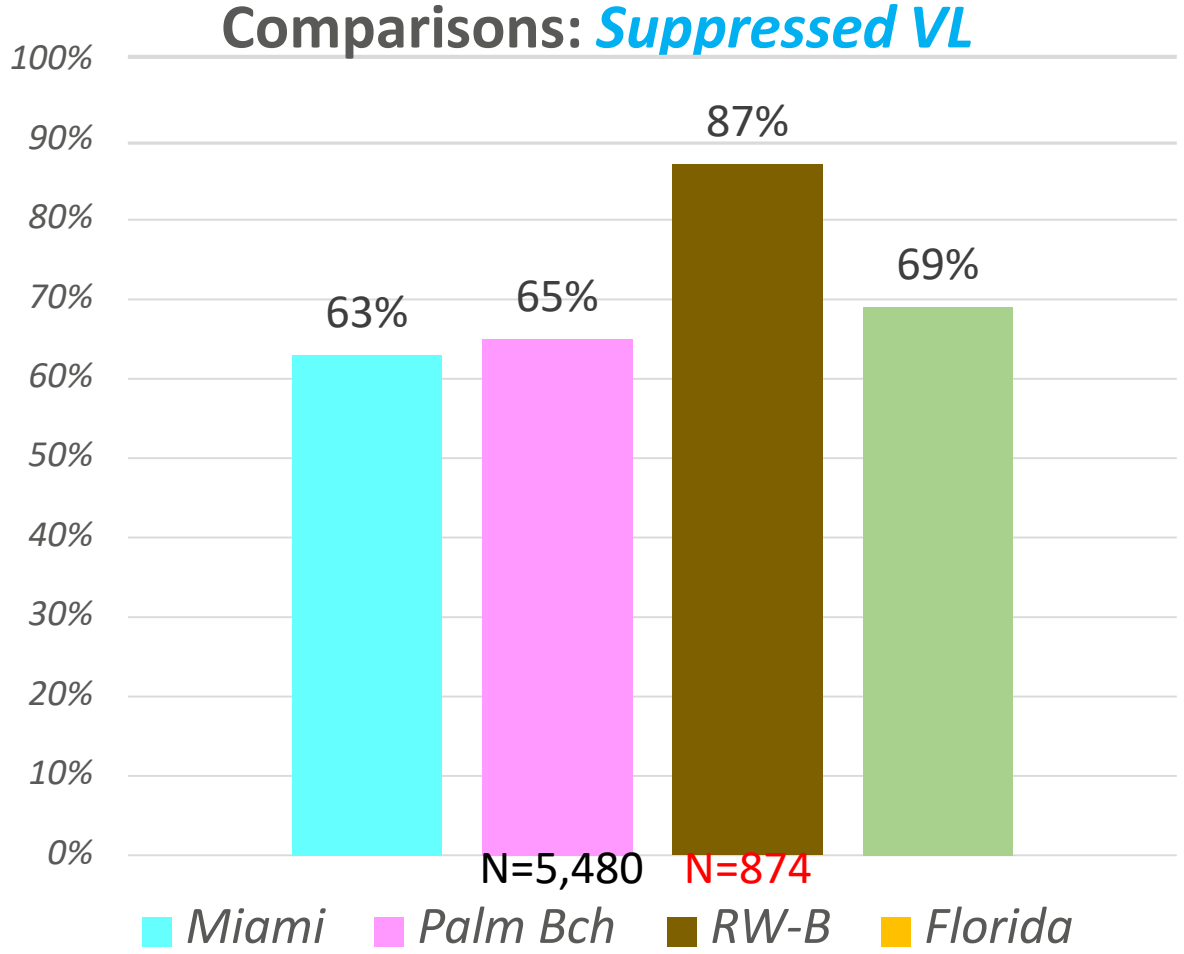
PWH by Zip Codes- ***2021***
Palm Beach County



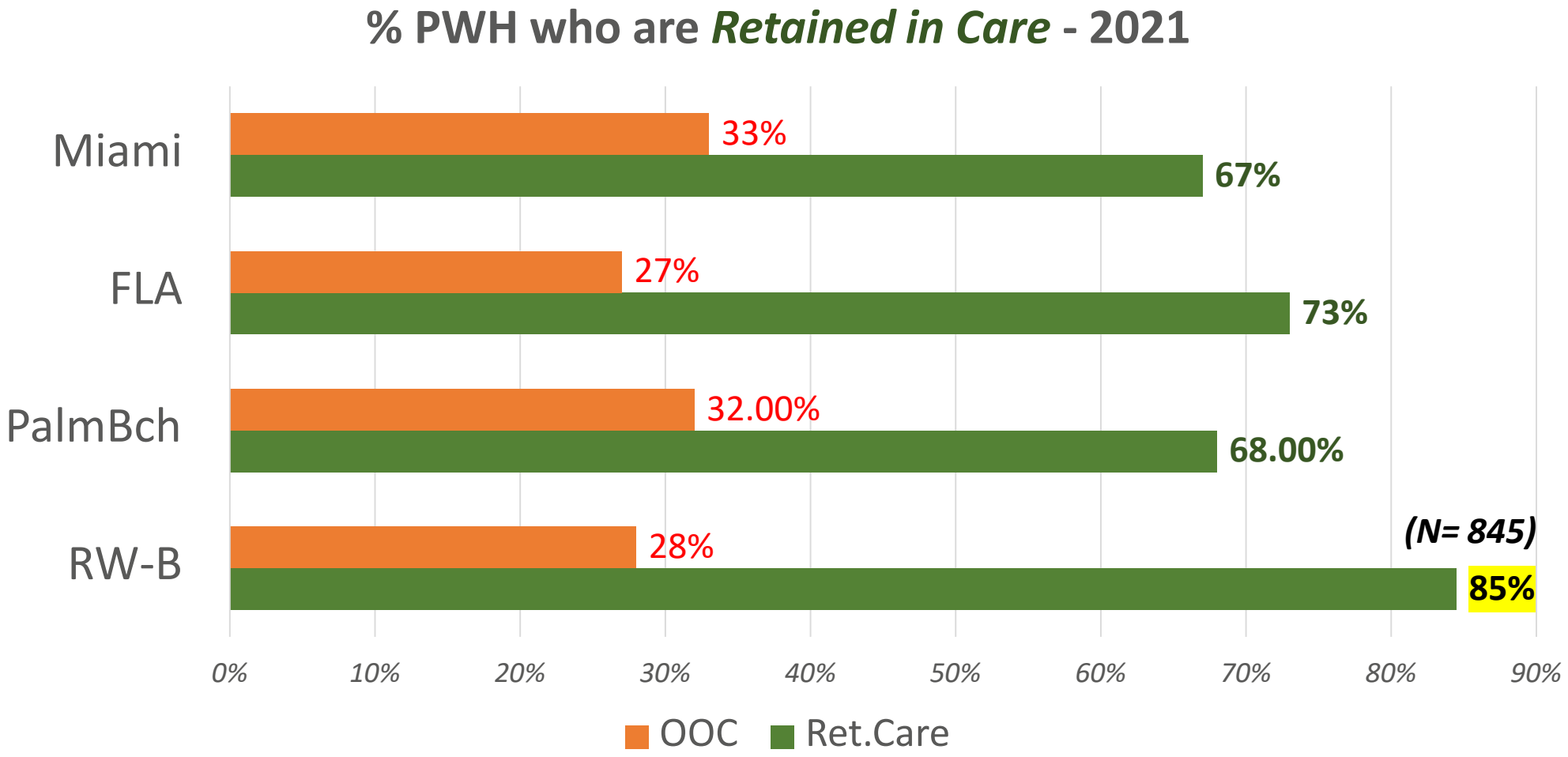
PWH 2021 – by Zip Codes --Palm Beach	(N)
33401 West Palm Beach	433
33403 Riviera Beach	126
33404 Riviera Bch / Lake Park/ North Palm Beach	543
33405 West Palm Beach	146
33406 CloudLake/ GlenRidge/ PalmSprings/ Pine Air	188
33407 Riviera Bch / Mangonia Park / Wes tPalm Bch	676
33409 WestGate / West Palm Beach	274
33411 Westlake/Royal Palm Beach/Golden Lakes	274
33414 Wellington / Royal Palm Beach	128
33415 RoyalPalm/ AcaciaVillas/ Haverhill /Kenwood	270
33417 Haverhill / Lakeside Green / Cypresss Lake	214
33426 Boynton Beach	164
33428 Sandalfoot Cove / Mission Bay	107
33430 Belle Glade	446
33431 33432 33434 Boca Raton	169
33433 Boca Pointe / Boca Del Mar / Sandalfoot	96
33435 Briny Breezes / Boynton Bch /Ocean Ridge	480
33436 Dunes Road / Boynton Beach / Golf	196
33437 Sun Valley	116
33444 Delray Beach	479
33445 Delray Beach	238
33458 Limestone Creek / Jupiter	88
33460 Lake Worth	441
33461 Lake Worth / Palm Springs	296
33462 Hypoluxo/ San Castle/ Lantana / Manalapan	229
33463 Greenacres	328
33467 Greenacres	136
33476 Pahokee	92

RW-B /PBC /Miami /FL :*In Care,Suppressed VL-* PWH 2021



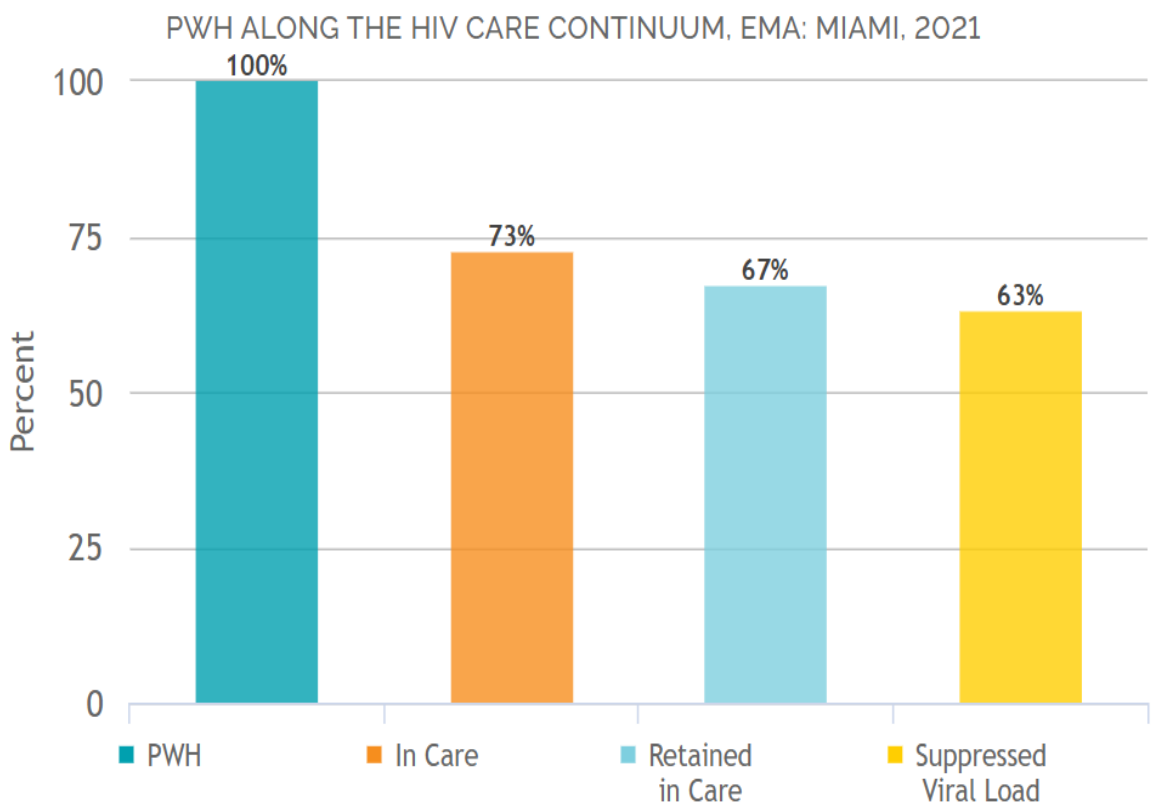


RW-B *vs.* PBC *vs.* Miami vs. FL *Retained Care*--PWH 2021

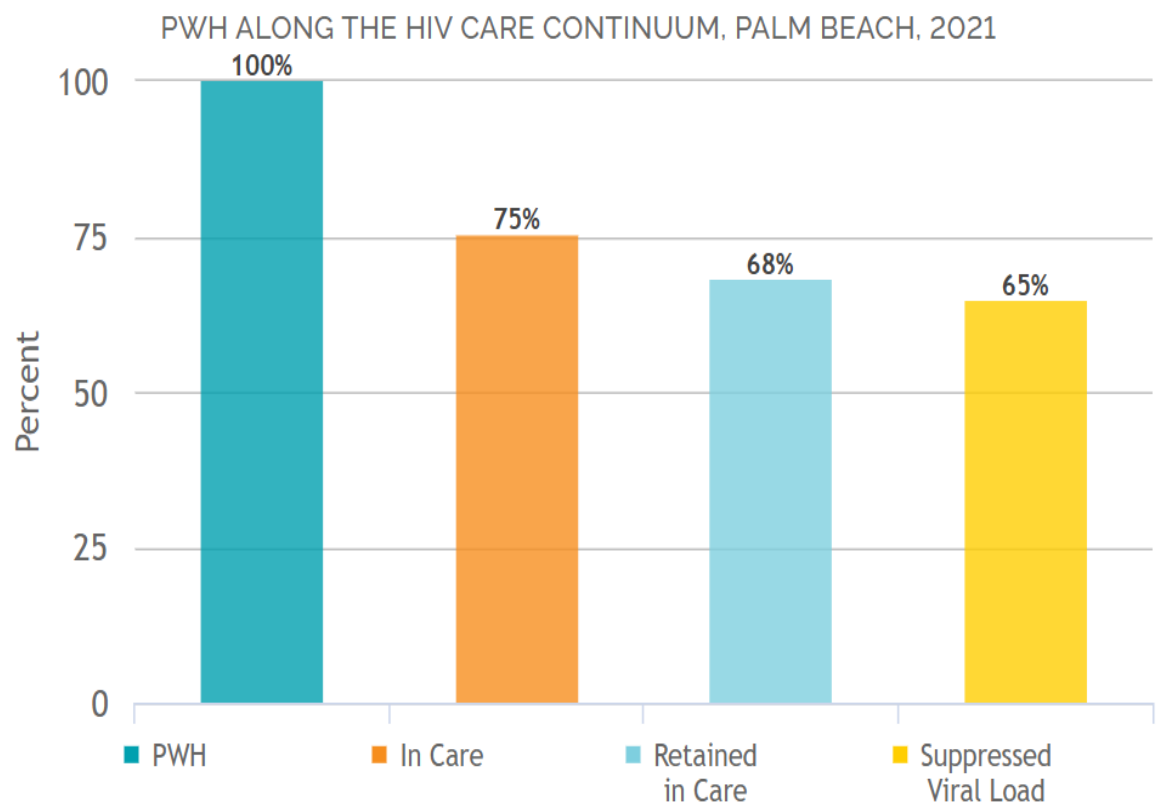


PWH in *Care Continuum* – Miami vs. Palm Beach-2021

EMA: Miami

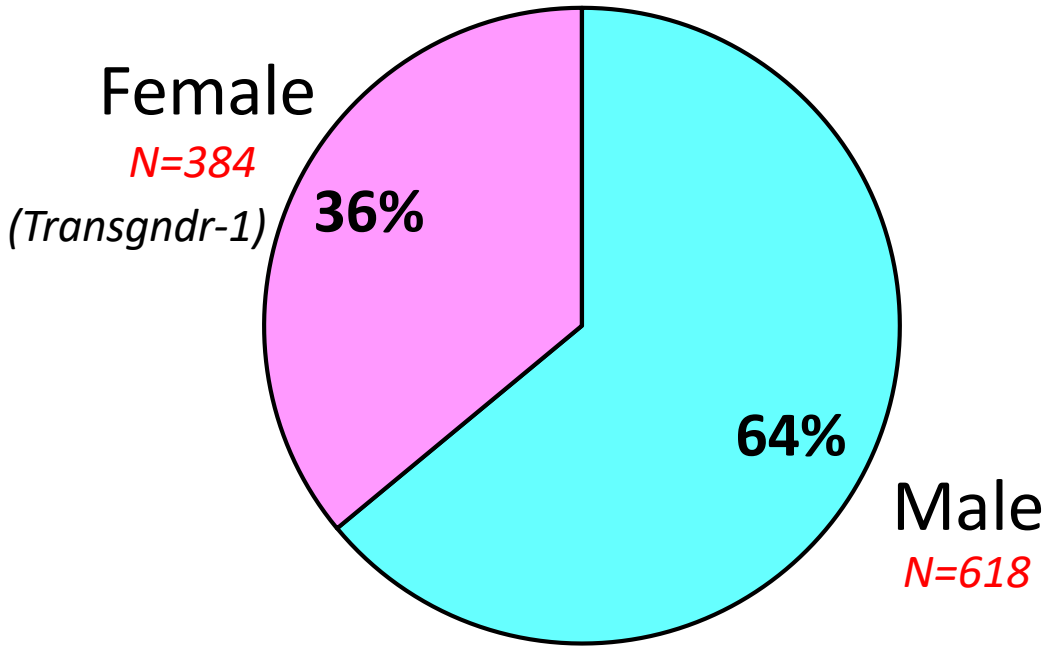


Palm Beach



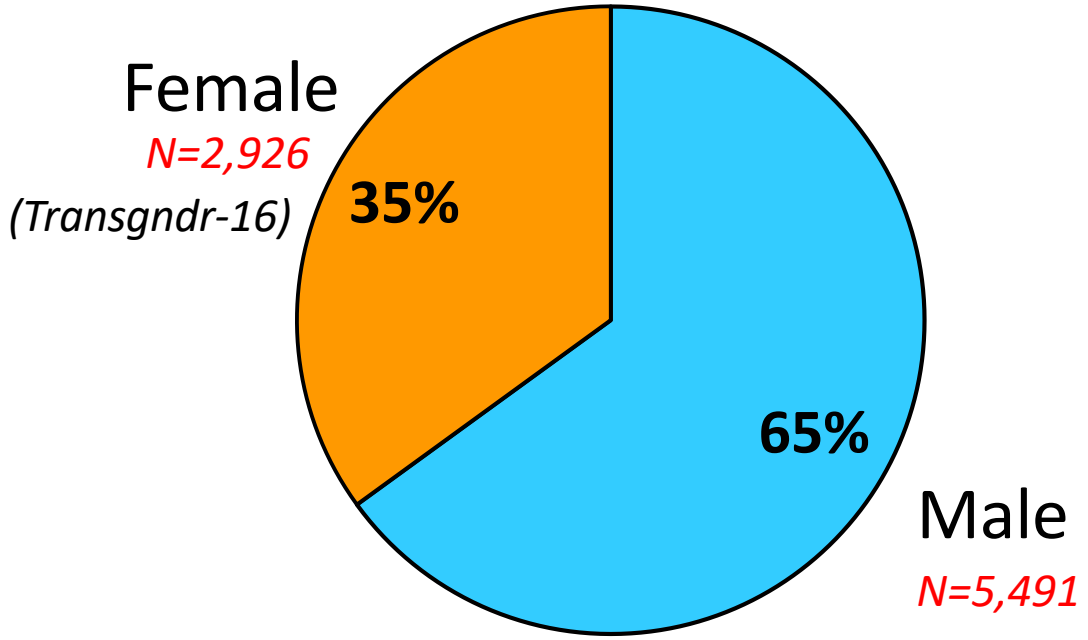
RW-B clients vs. PWH *by Sex* -Palm Beach 2021

RW-Part B



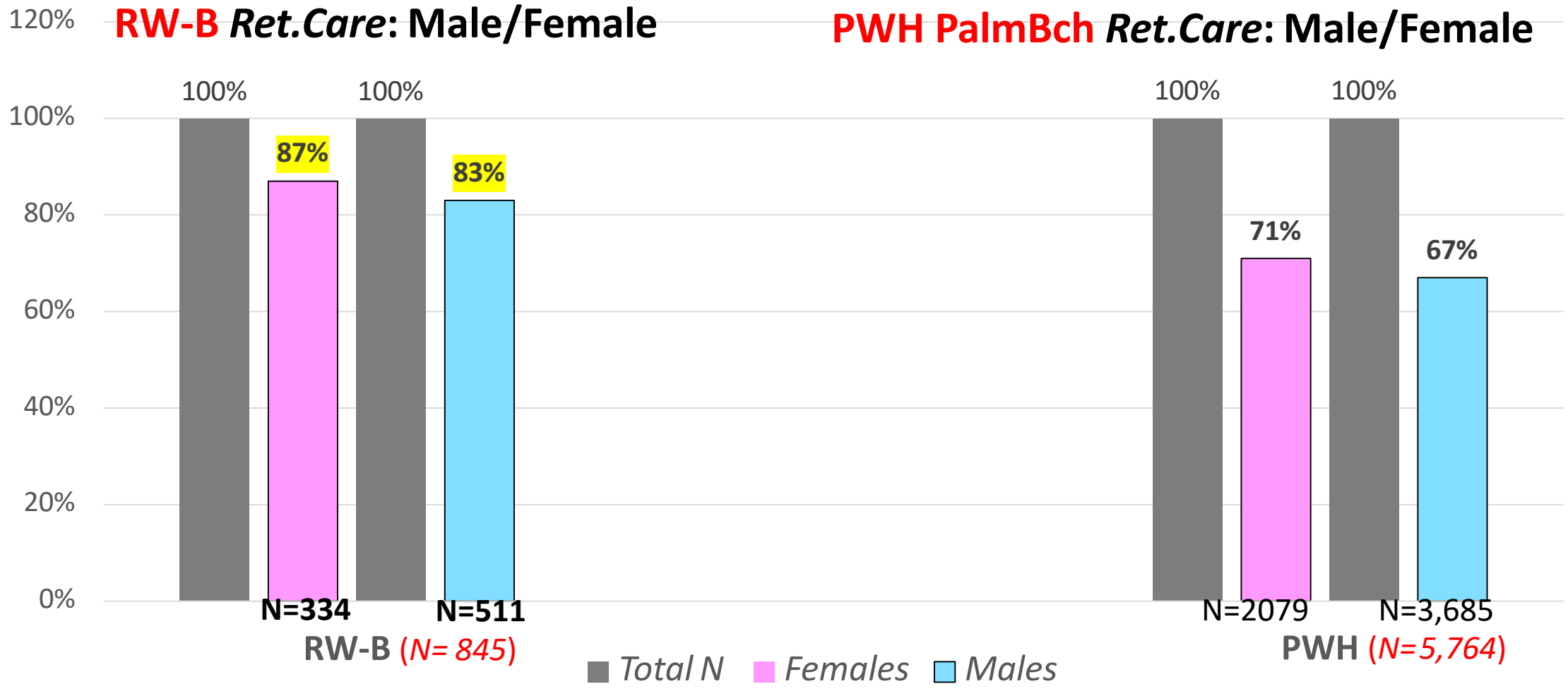
Total *N* = 1,002

PWH-Palm Bch



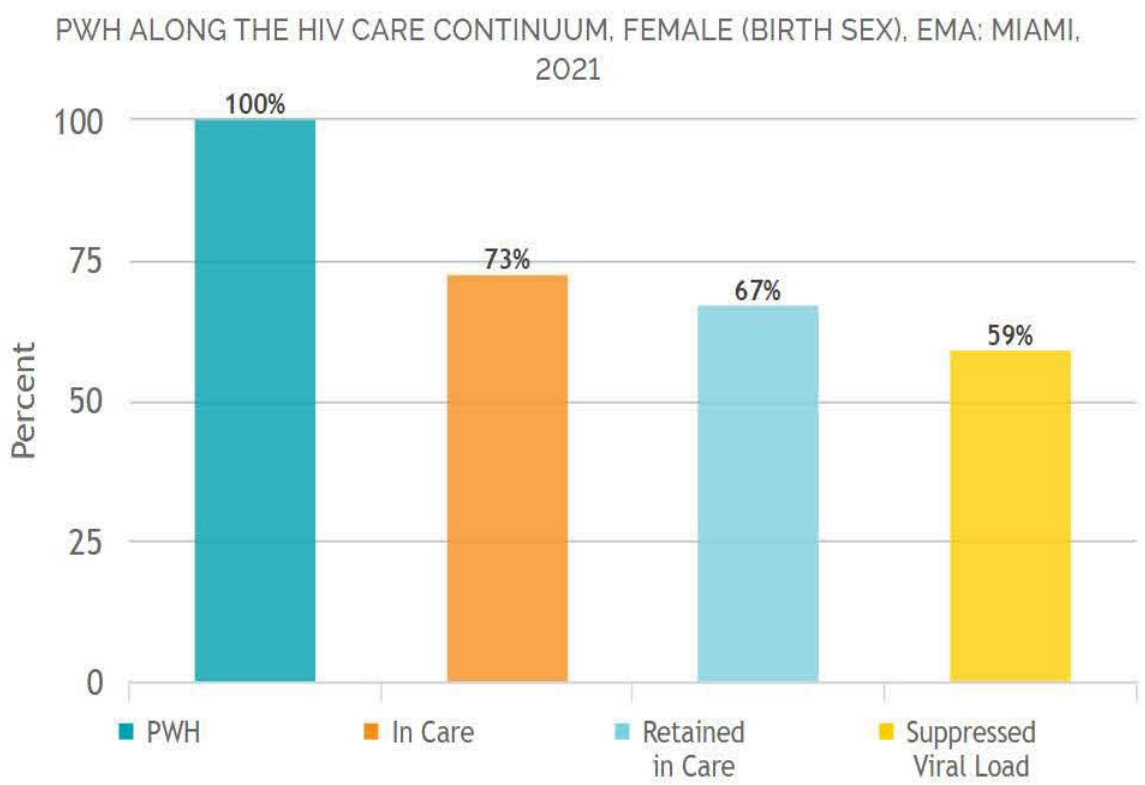
Total *N* = 8,417

RW-B vs. PWH *Retained Care* by **Sex** -Palm Bch 2021

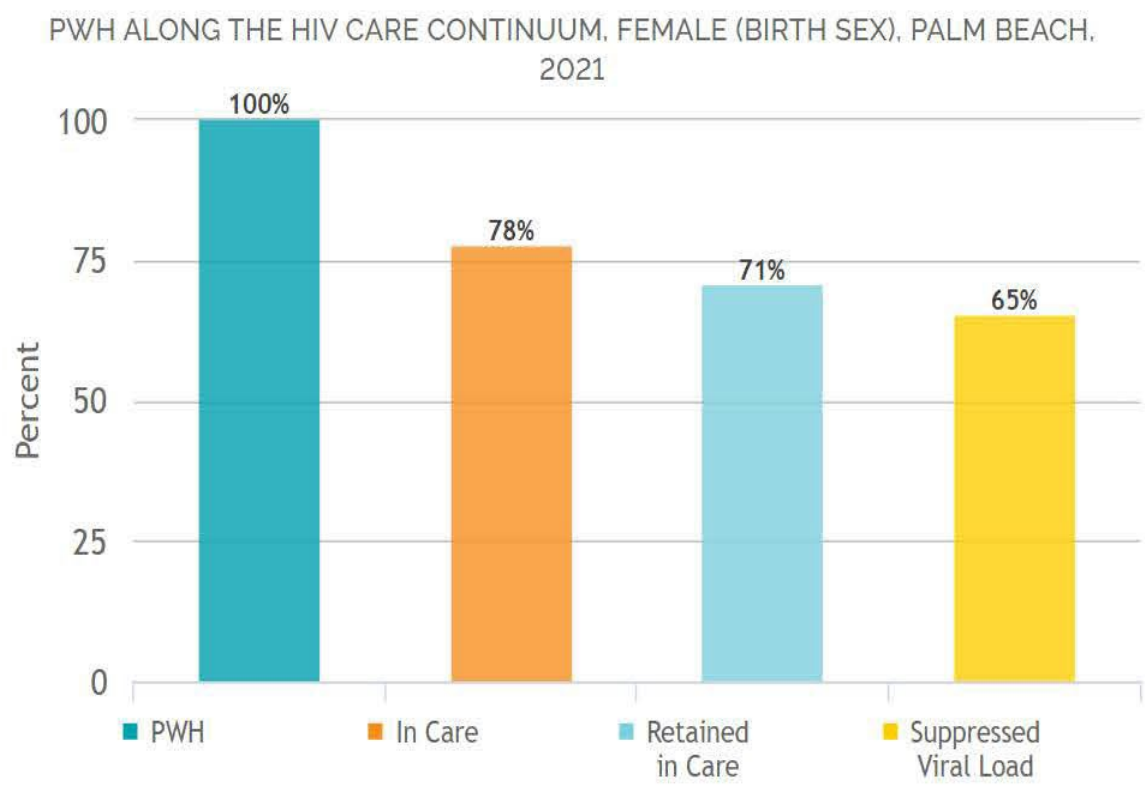


PWH *Females* in *Care Continuum* – Miami vs. Palm Beach -2021

EMA: Miami



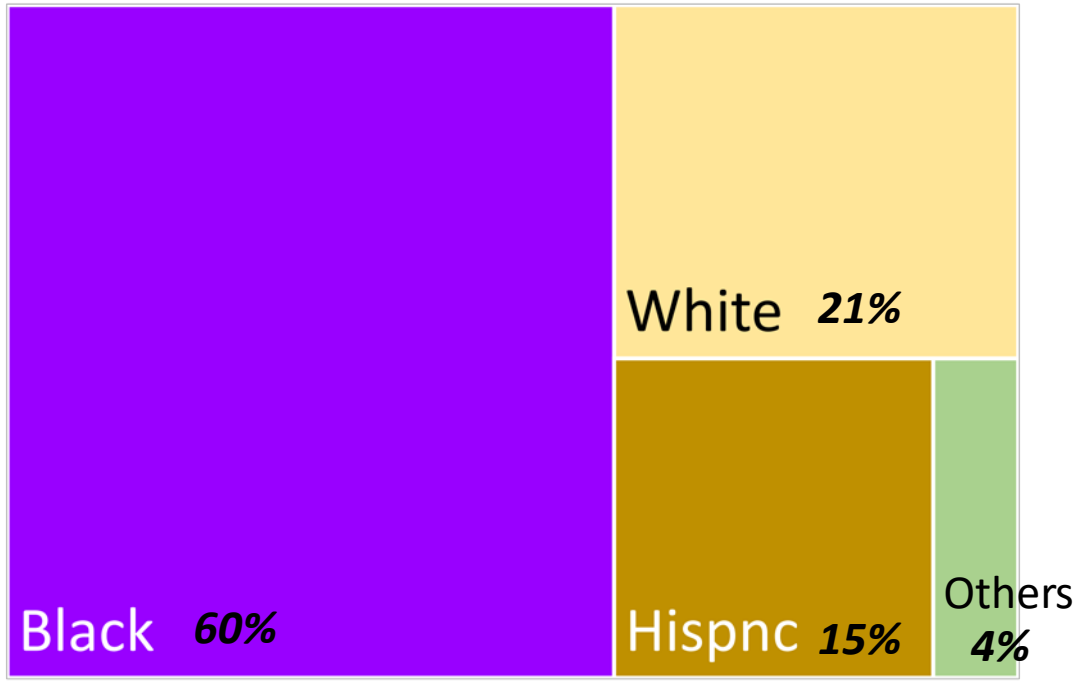
Palm Beach



RW-B clients vs. PWH by *Race* - Palm Beach 2021

RW-B		Count
White	21%	212
Black	60%	601
Hispanic	15%	150
Others	4%	39

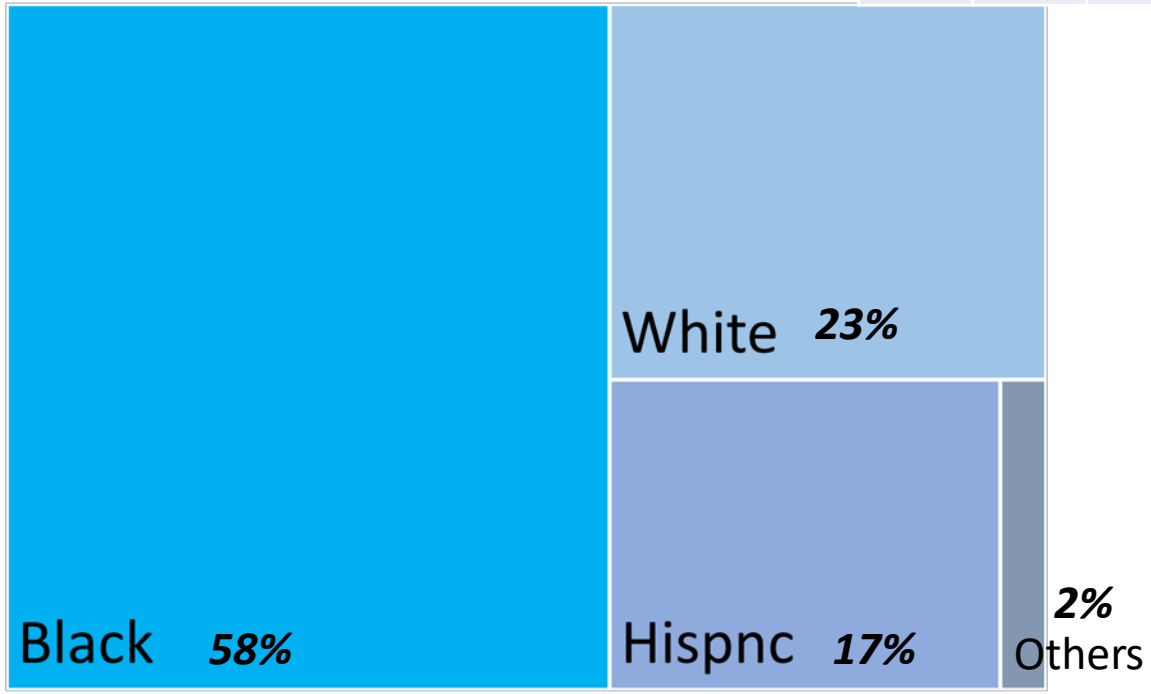
RW-Part B



Total *N* = 1,002

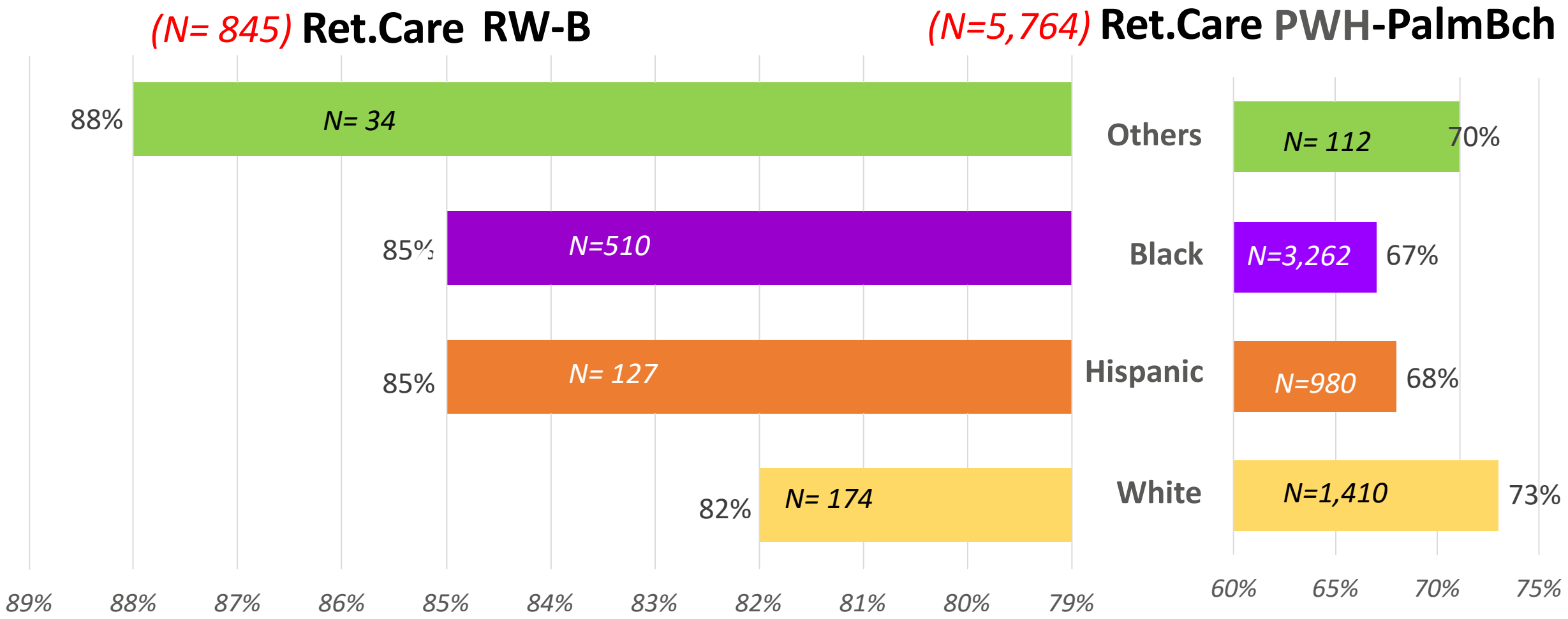
PWH PalmBch

PWH		Count
White	23%	1,926
Black	58%	4,869
Hispanic	17%	1,455
Others	2%	160



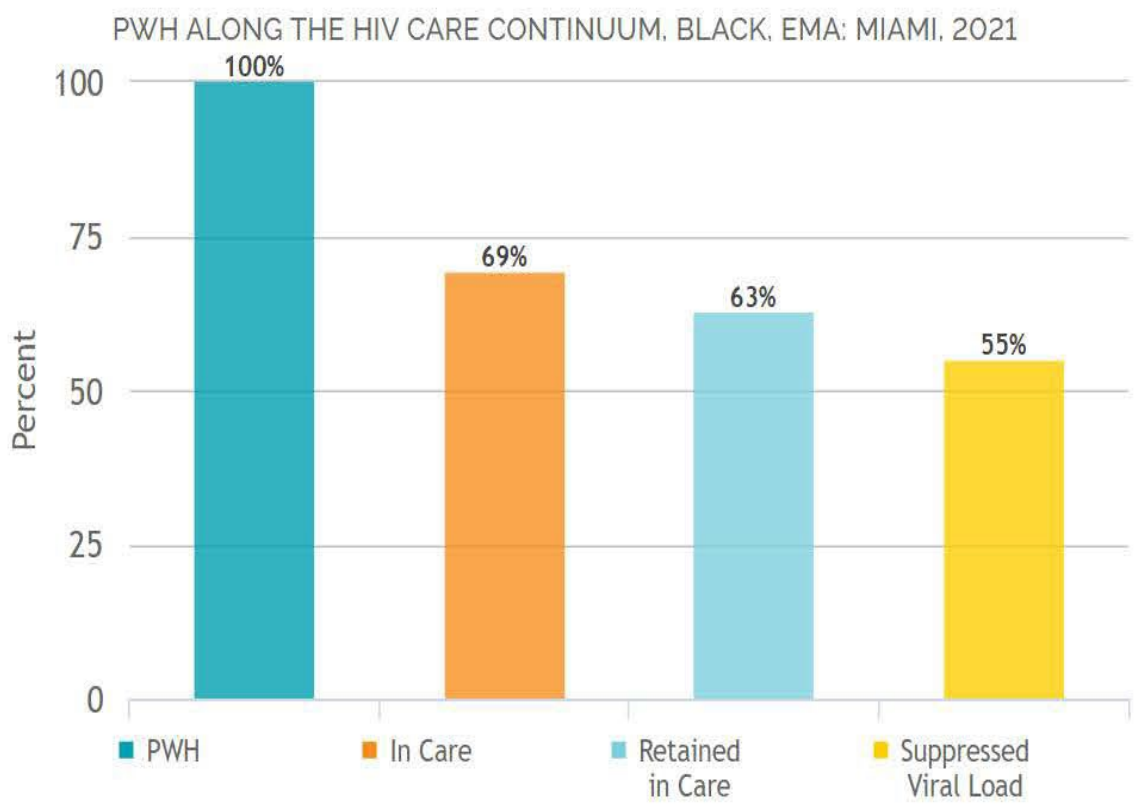
Total *N* = 8,417

RW-B vs. PWH *Retained Care* by **Race** -Palm Bch 2021

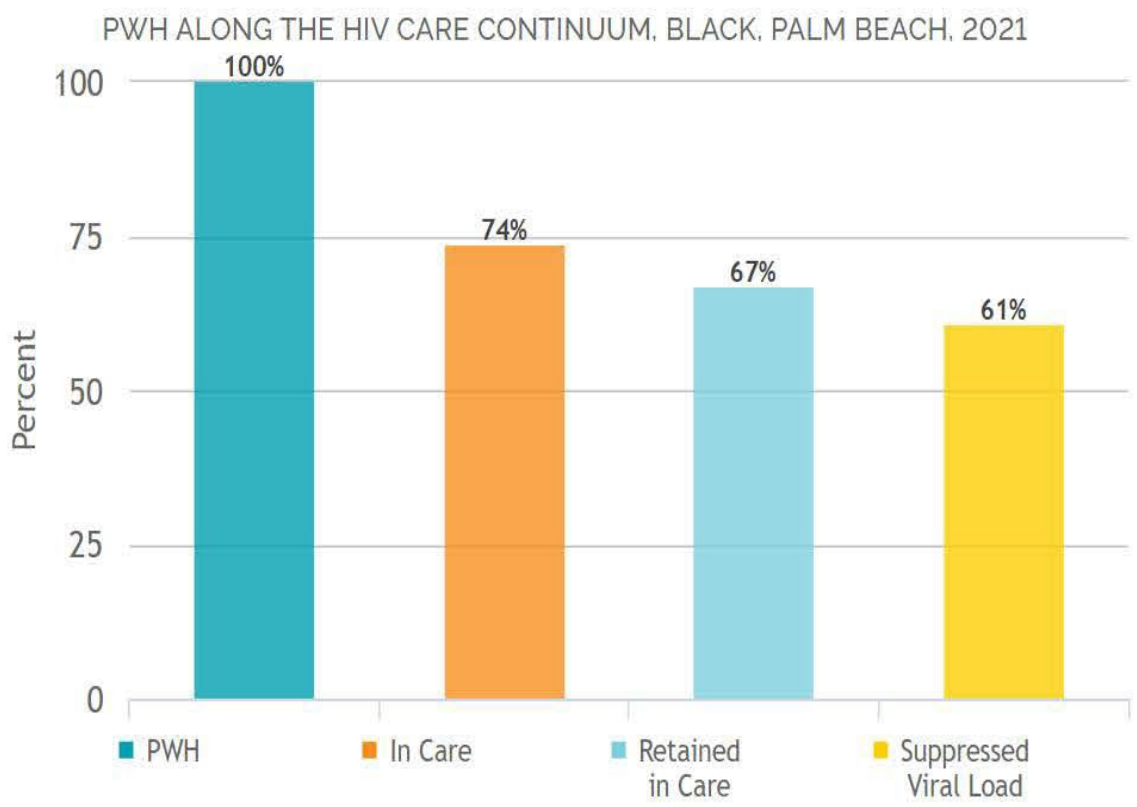


PWH *Blacks* in *Care Continuum* – Miami vs. Palm Beach -2021

EMA: Miami



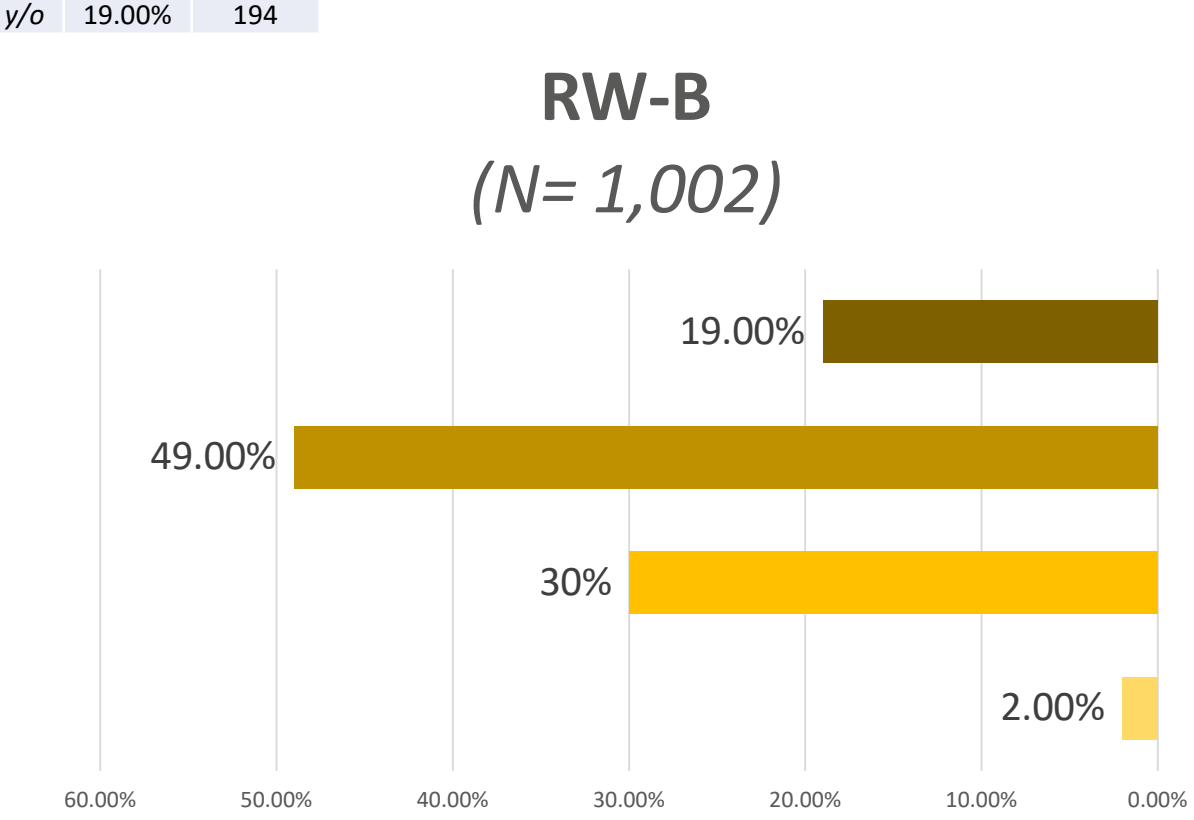
Palm Beach

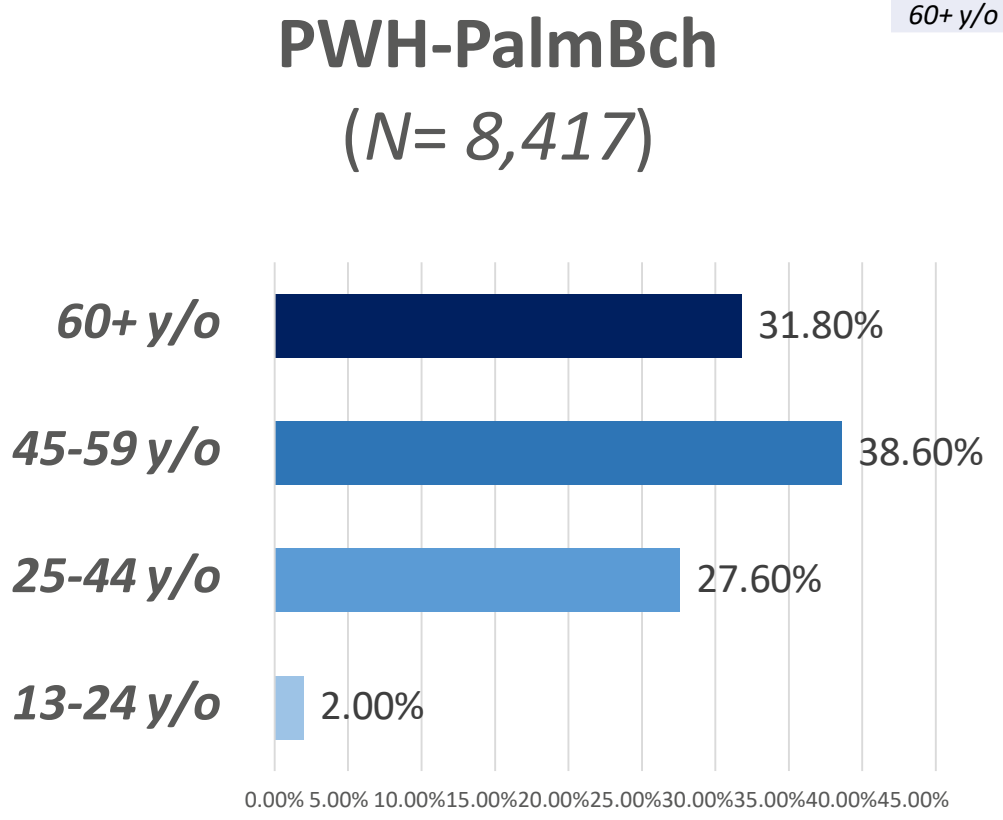


RW-B clients vs. PWH by *Age groups* -Palm Beach 2021

Age	RW-B	Count
13-24 y/o	2.00%	22
25-44 y/o	30%	297
45-59 y/o	49.00%	489
60+ y/o	19.00%	194

Age	PWH	Count
13-24 y/o	2.00%	164
25-44 y/o	27.60%	2326
45-59 y/o	38.60%	3,254
60+ y/o	31.80%	2,673

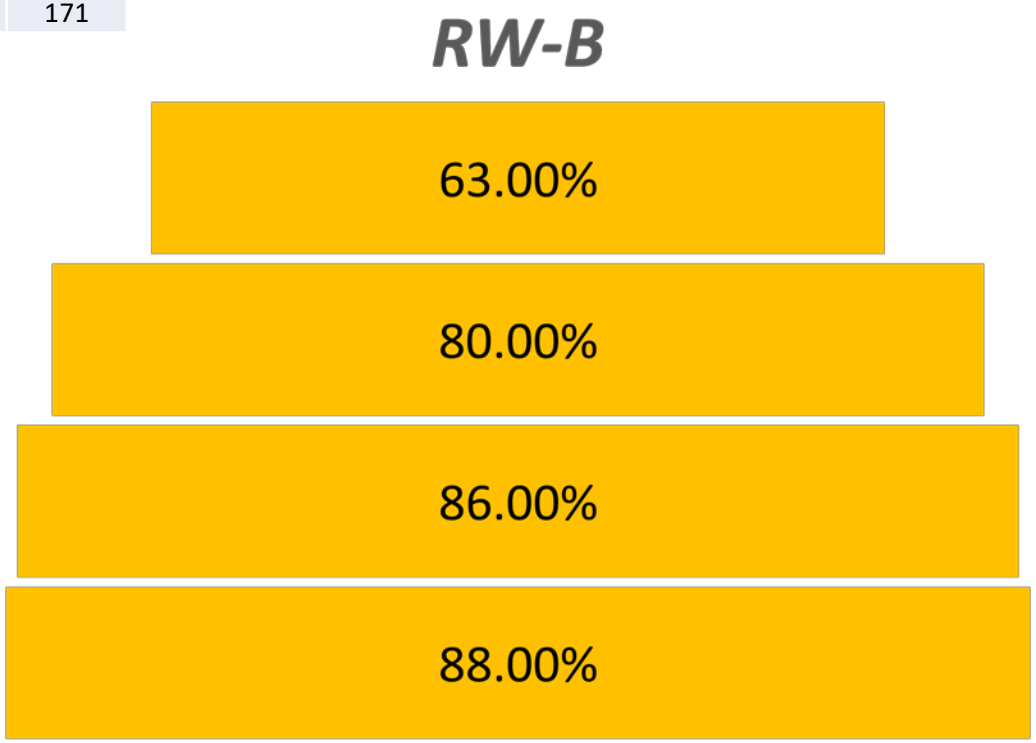


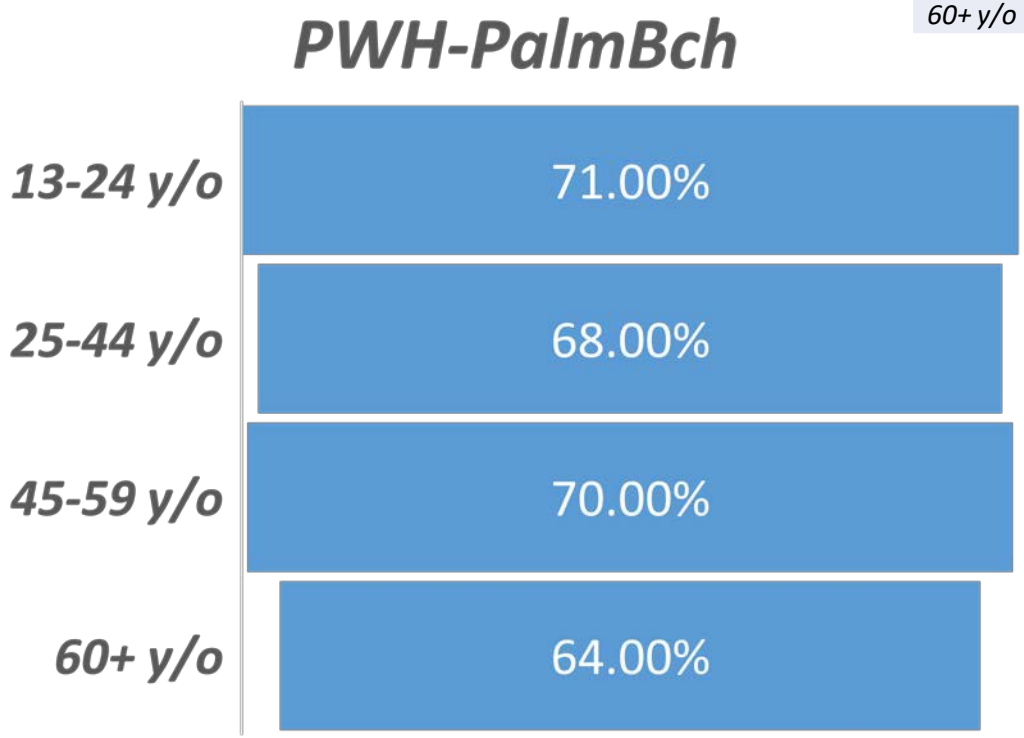


RW-B vs. PWH *Retained Care* by **Age** -Palm Bch 2021

Age	RW-B	N= 845
13-24 y/o	63.00%	14
25-44 y/o	80%	239
45-59 y/o	86.00%	421
60+ y/o	88.00%	171

Age	PWH	Count
13-24 y/o	71.00%	117
25-44 y/o	68.00%	1576
45-59 y/o	70.00%	3,080
60+ y/o	64.00%	985



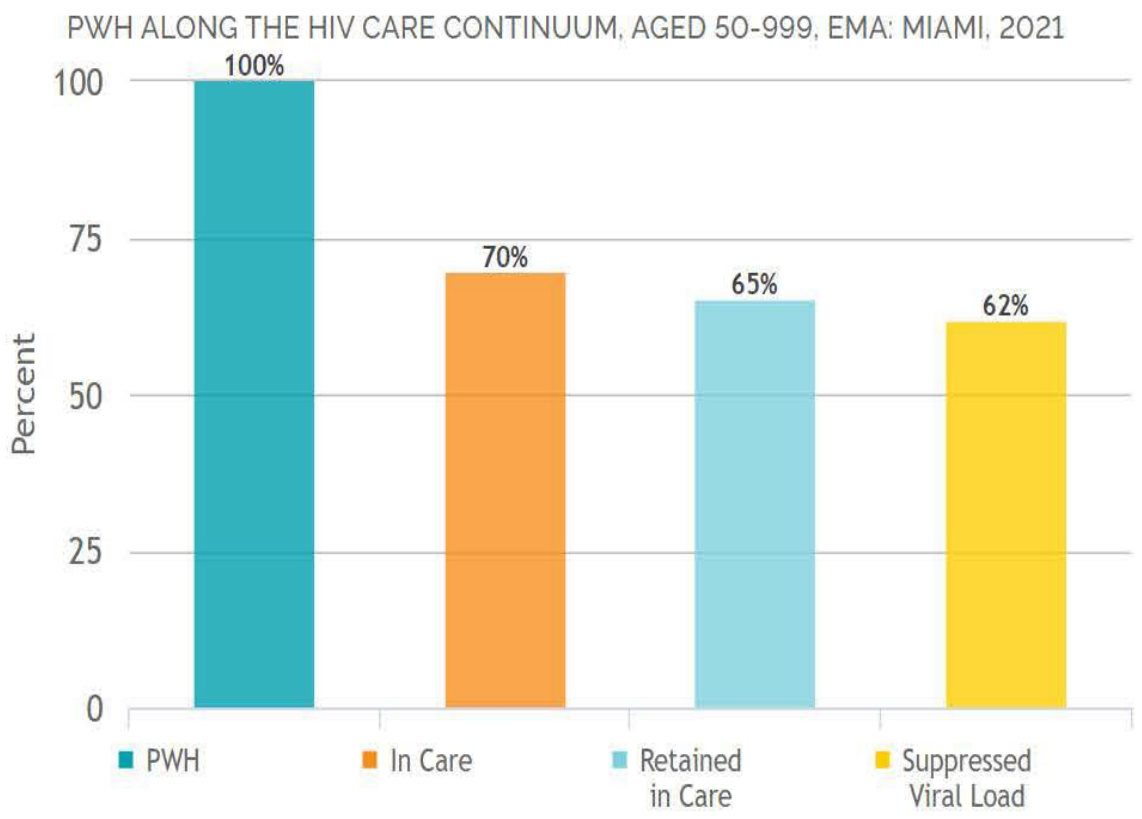


RW-B (Ret. Care)= *845*

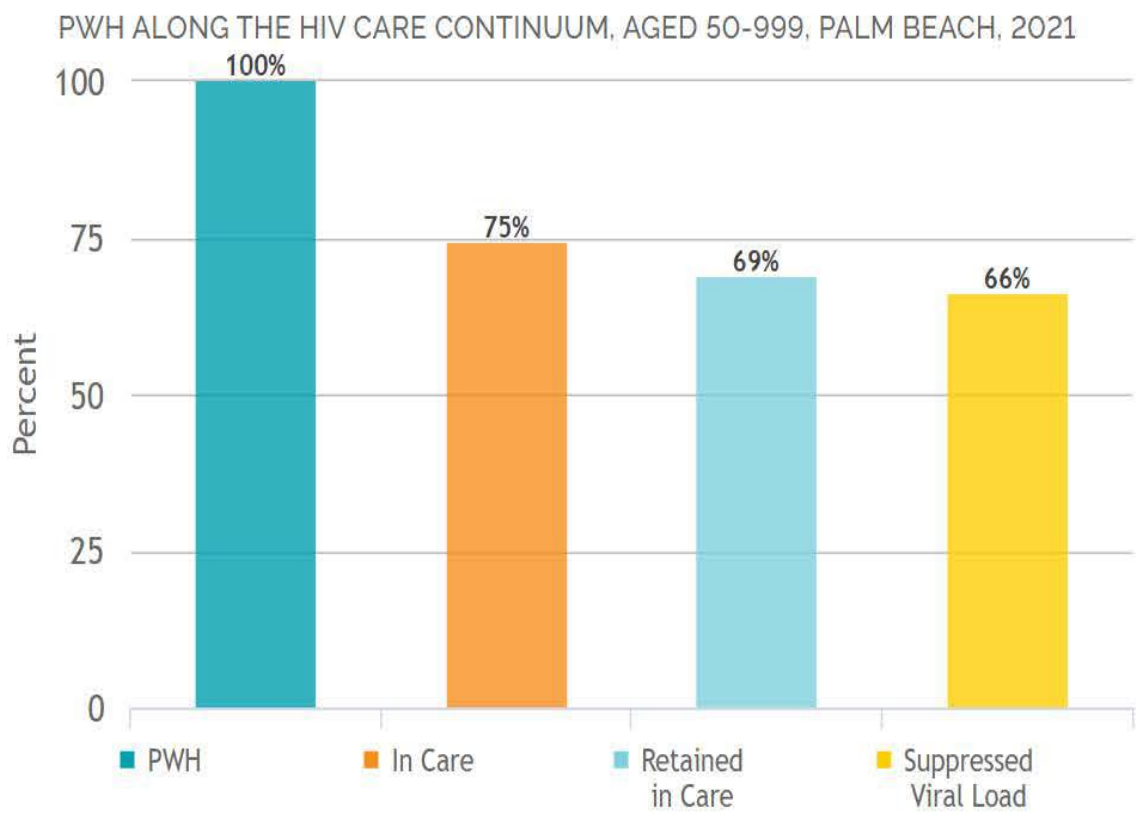
PWH (Ret. Care)= *5,764*

PWH *50+ y.o.* in *Care Continuum*–Miami vs. Palm Beach -2021

EMA: Miami



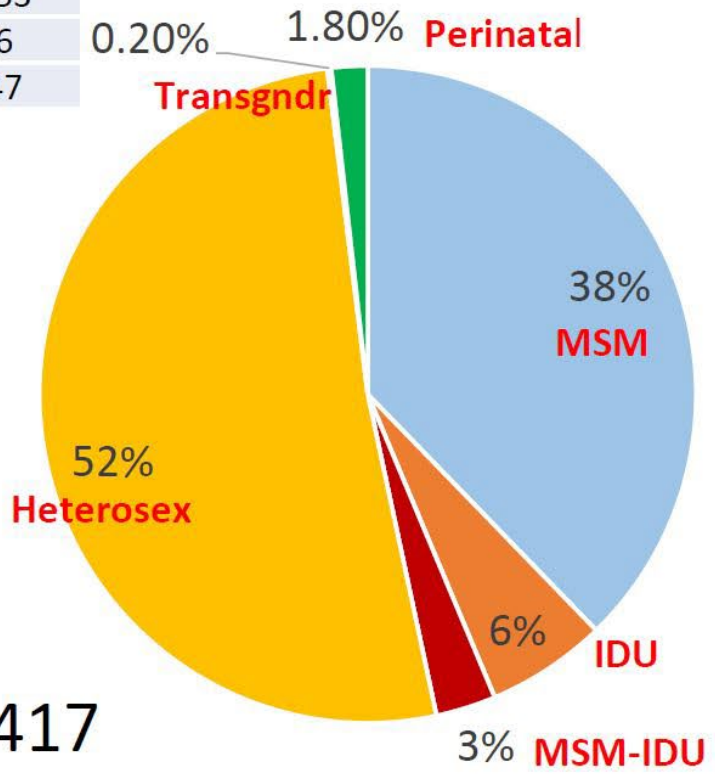
Palm Beach



RW-B clients vs. PWH by *Risk factors* -Palm Beach 2021

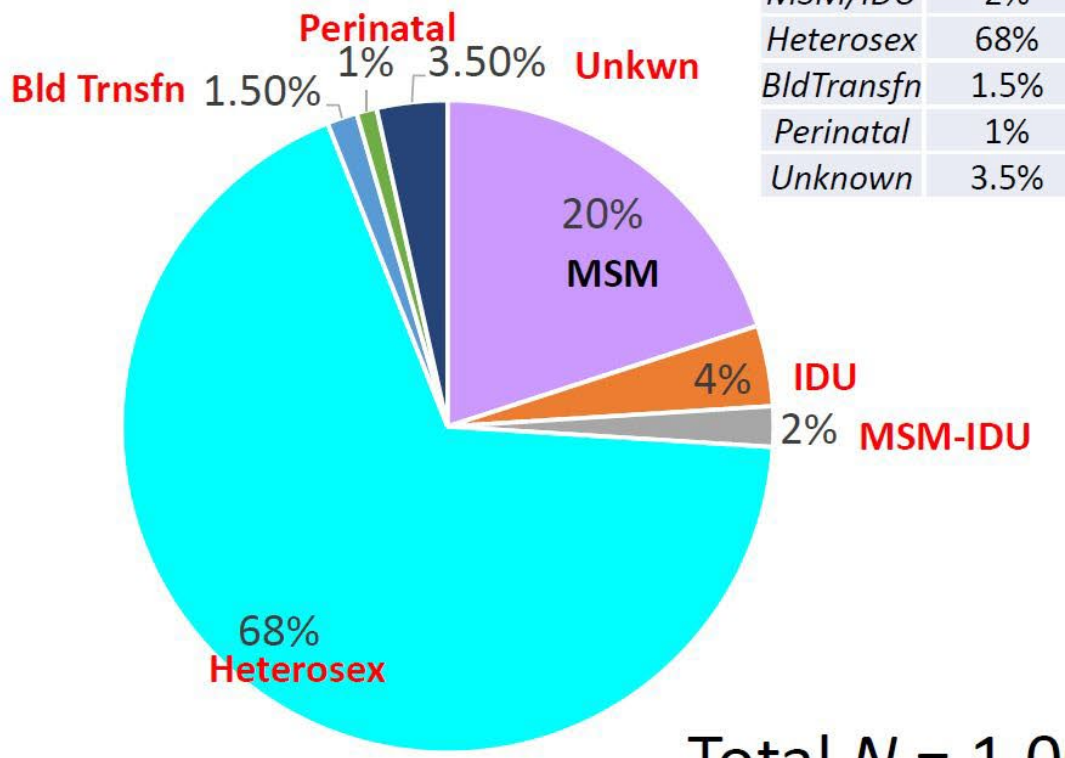
Risk factor	PALM BCH	*Count*
MSM	38%	3201
IDU	6%	503
MSM-IDU	3%	198
Heterosex	52%	4353
Transgndr	0.20%	16
Perinatal	1.80%	147

PWH-PalmBch



Total *N* = 8,417

RW-Part B



Total *N* = 1,002

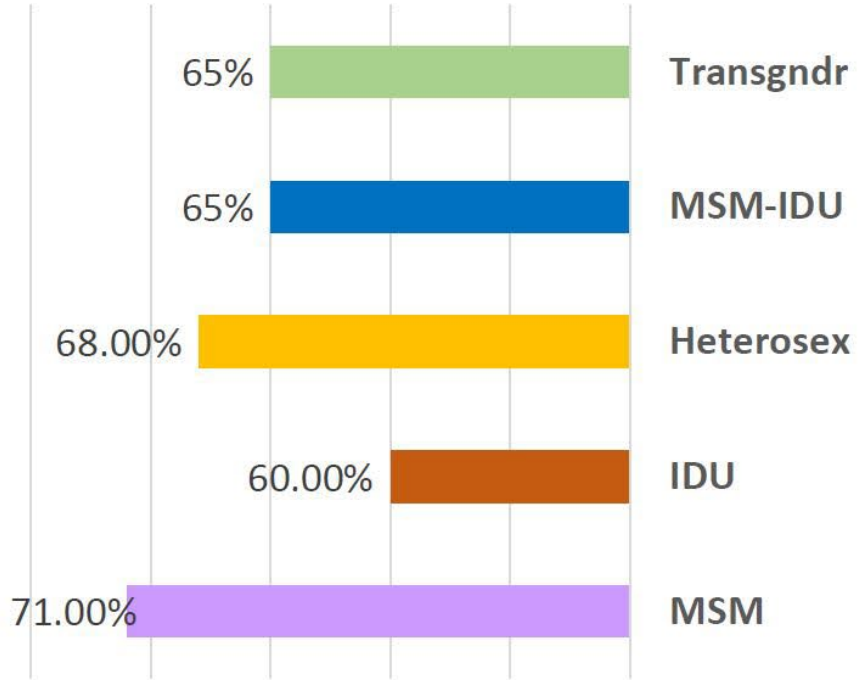
Risk factor	RW-B	*Count*
MSM	20%	202
IDU	4%	42
MSM/IDU	2%	21
Heterosex	68%	675
BldTransfn	1.5%	15
Perinatal	1%	11
Unknown	3.5%	36

RW-B vs.PWH *Retained Care* by Risk factors- 2021

RISK factor	PWH	N=5,764
MSM	71.00%	2,260
IDU	60.00%	302
Heterosex	68.00%	2,950
MSM-IDU	65%	129
Transgndr	65%	11

Ret. Care: *PWH-PalmBch*

(N=5,764)



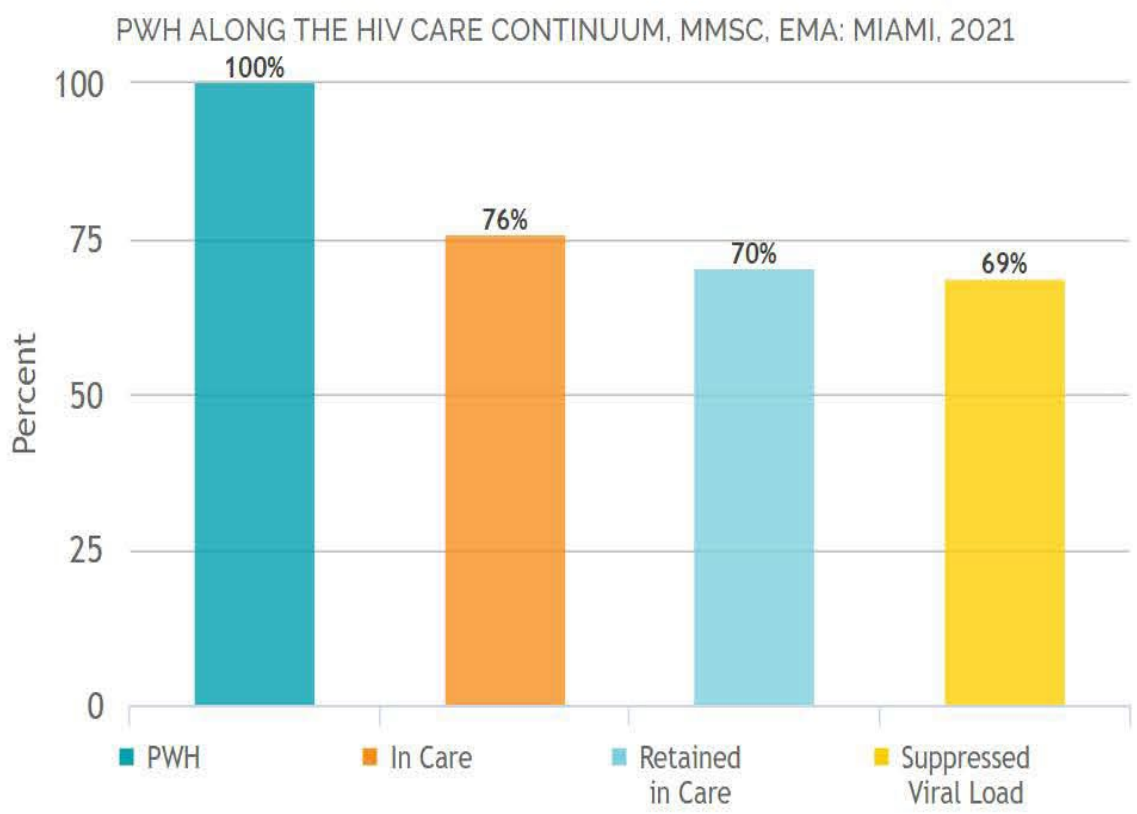
Ret. Care: *RW-B*

(N=845)

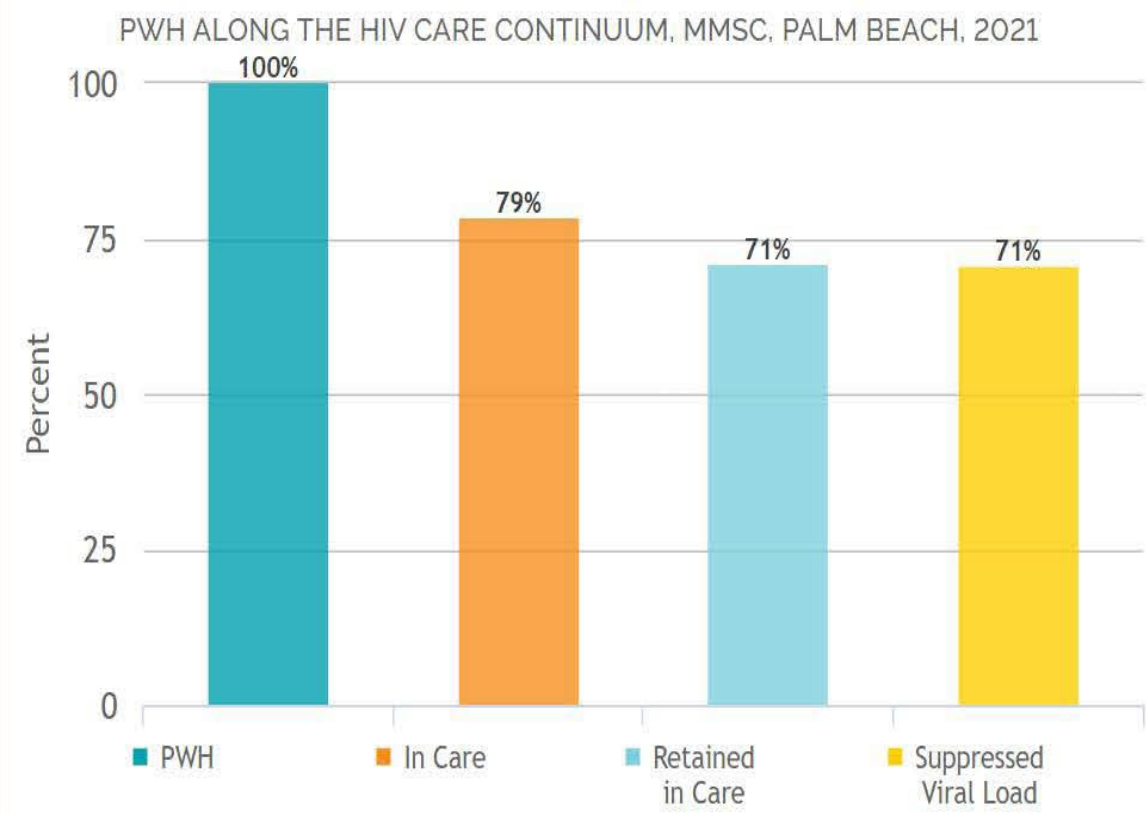
RISK factor	RW-B	N= 845
MSM	85.00%	172
IDU	79.00%	33
Heterosex	85.00%	573
MSM-IDU	75%	16
BloodTrnsfn	87%	13
Perinatal	91%	10
Unknown	78%	28

PWH *MSM* in *Care Continuum* – Miami vs. Palm Beach-2021

EMA: Miami



Palm Beach

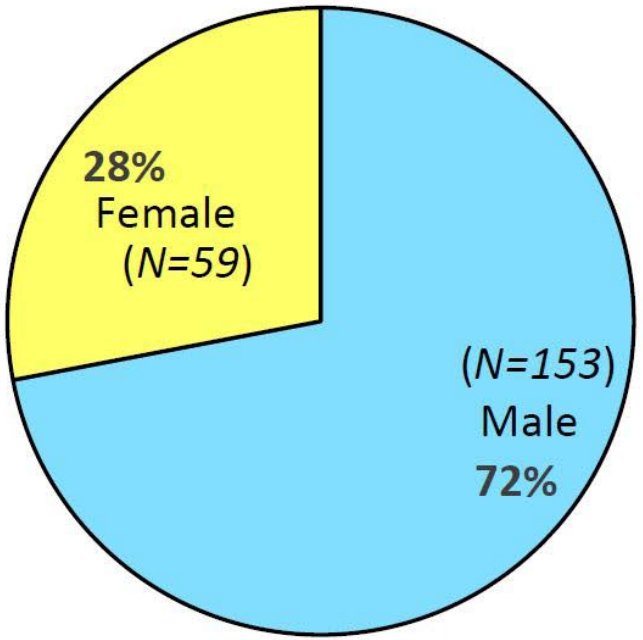


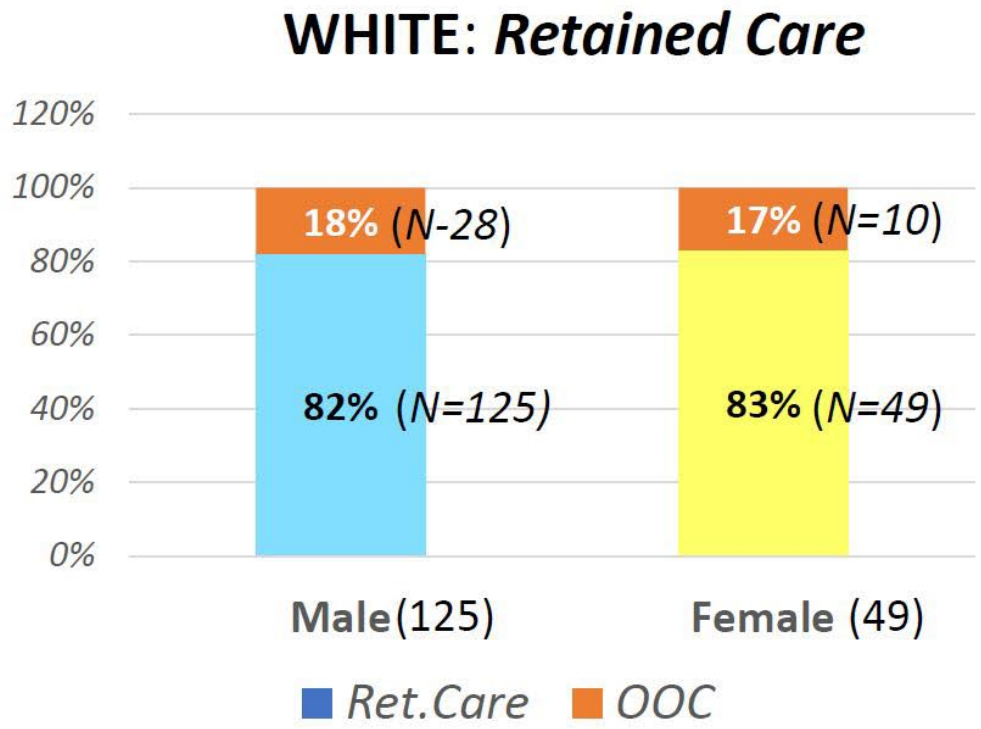
RW-B clients: Retention in Care by Sub-groups

Palm Beach County – GY 2017 to 2022

RW-B Retained in Care *White male/female*-Palm Bch 2021

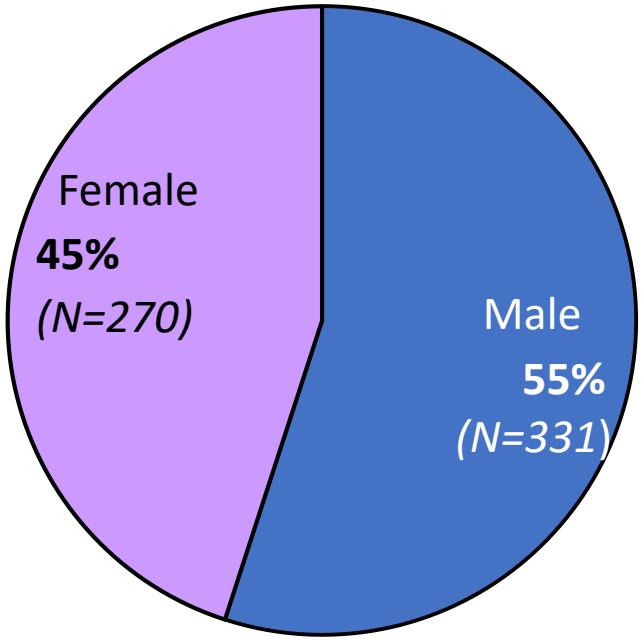
White: *In Care* = 212

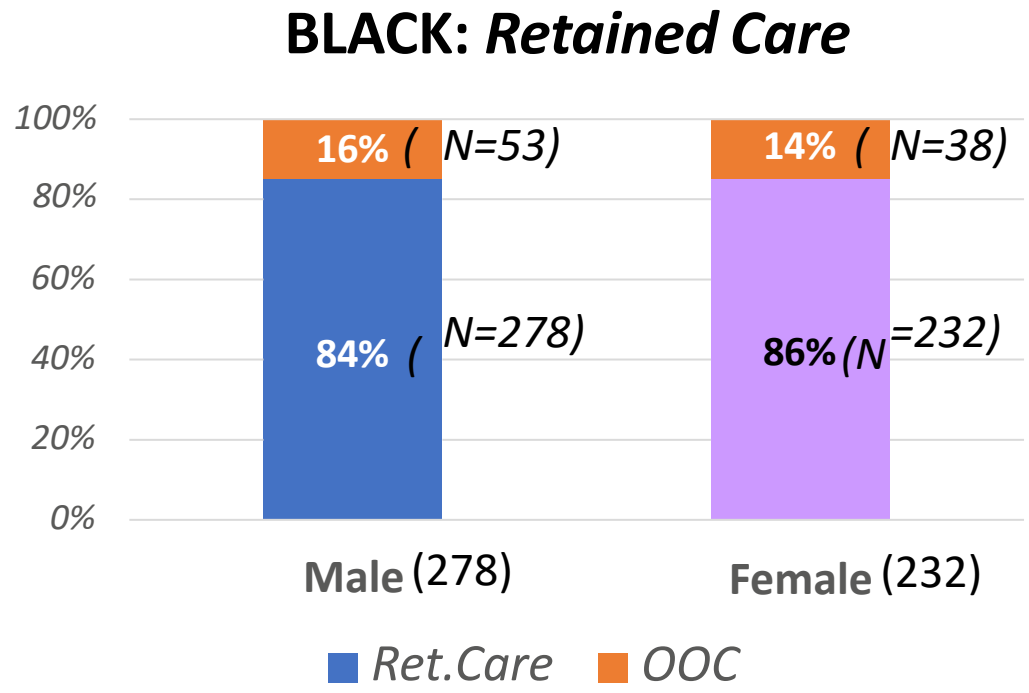




RW-B Retained in Care *Black male/female*-Palm Bch 2021

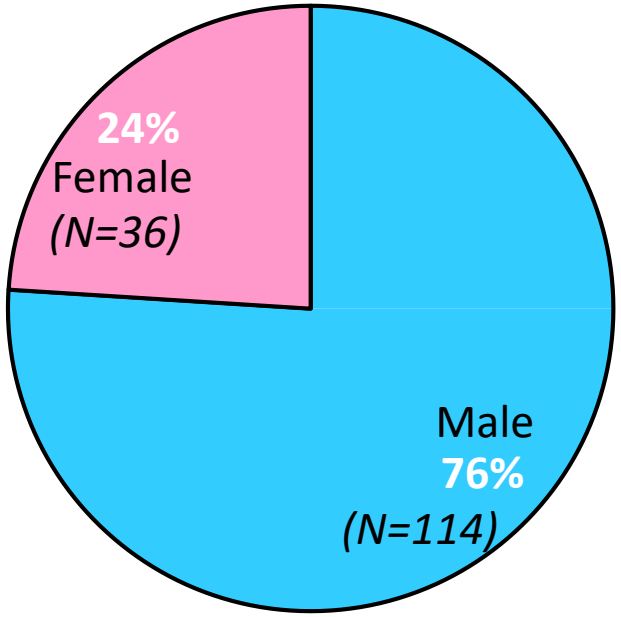
Black: *In Care* = 601

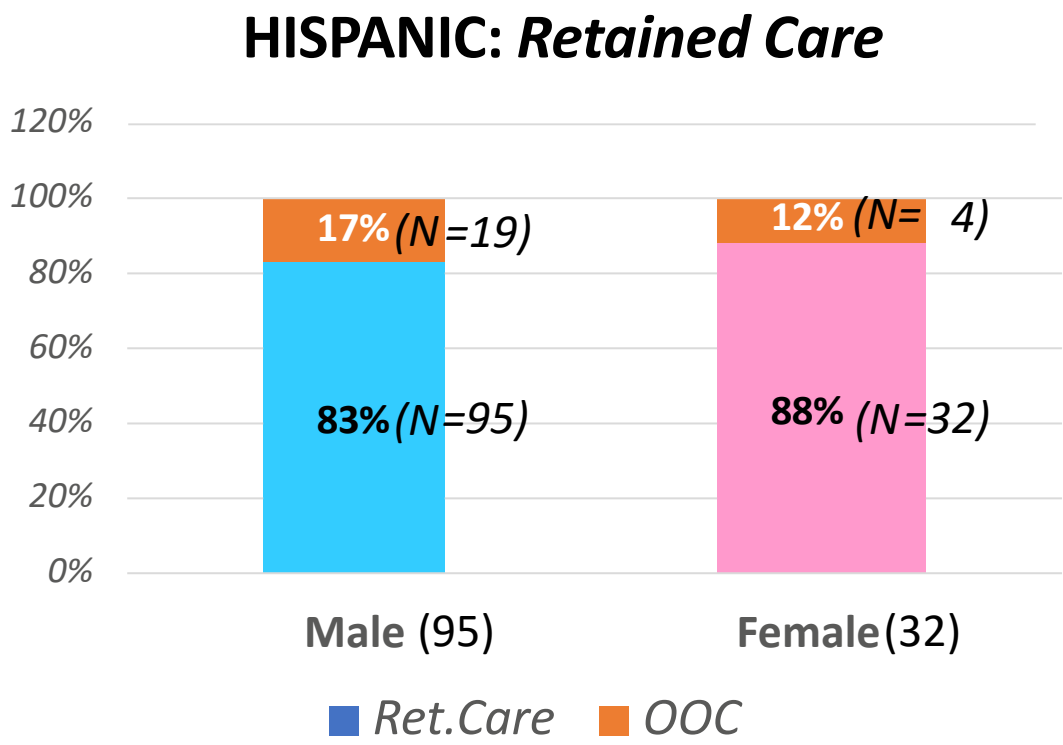




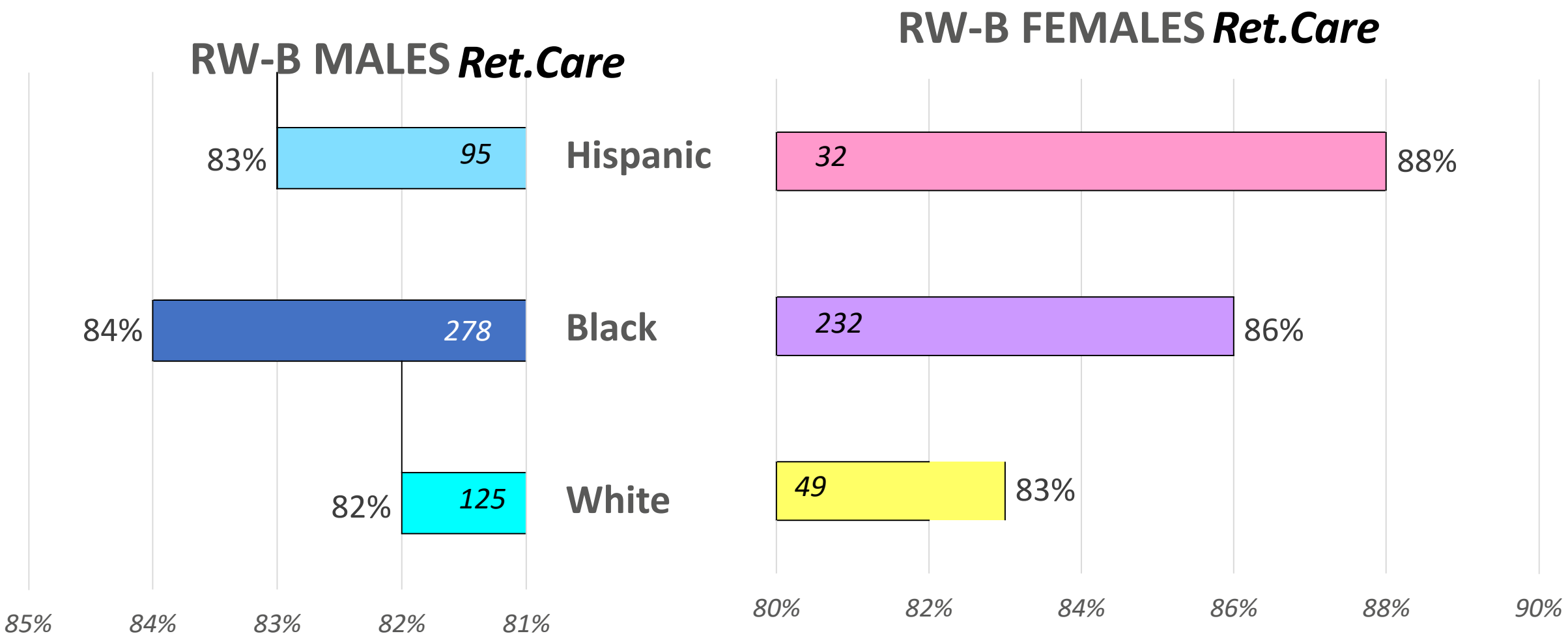
RW-B Retained Care *Hispanic male/female*-Palm Bch 2021

Hispanic: *In Care* = 150





RW-B clients *Retained in Care* by **Race / Gender** - 2021

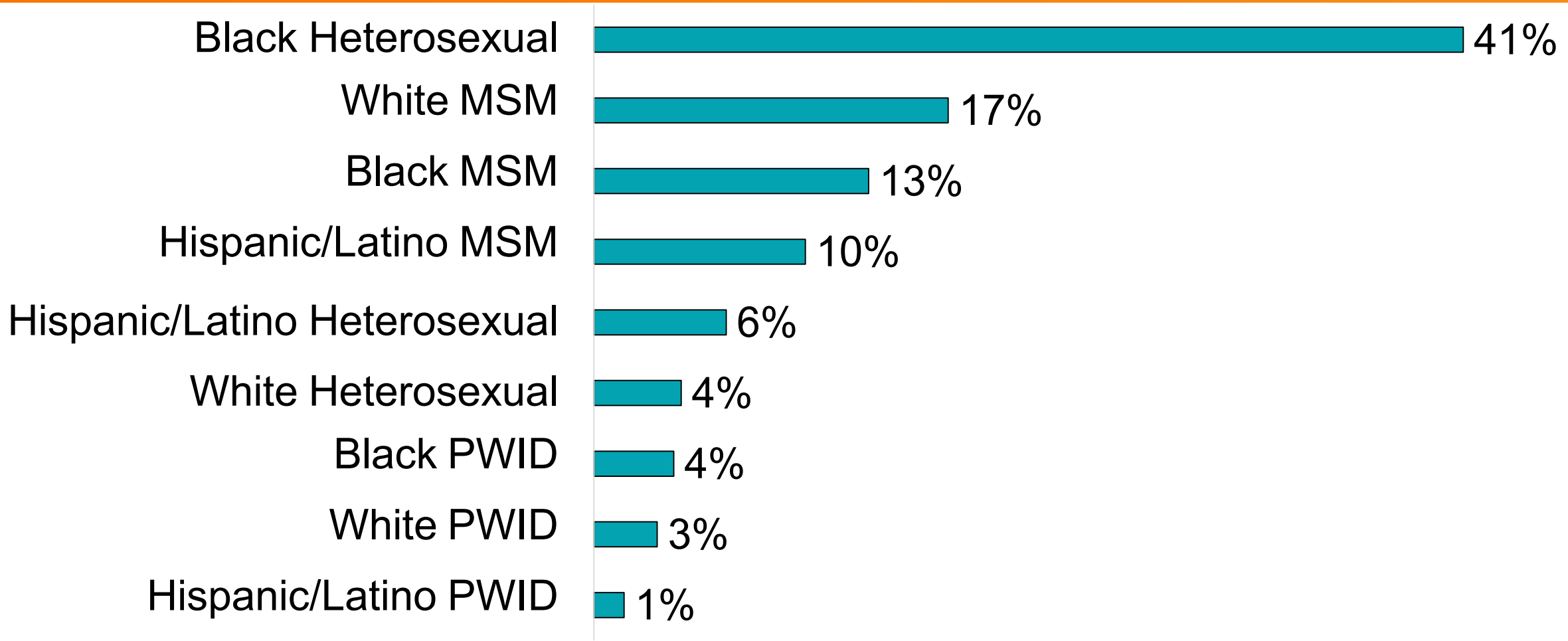


PBC Priority Populations to Prevent HIV spread among *PWH*

- The following data were calculated from ***PWH living in Palm Beach*** at year-end 2020 and shows the proportion of each race or mode of exposure (risk factor) to the total PWH count.

- These data are used to prevent further transmission of HIV for those already diagnosed with HIV by providing linkage to care and other services to improve health outcomes and promote viral suppression to those who need it.

Priority Populations to Prevent HIV spread among *PWH* –2021 PBC



MSM=MMSC and MMSC/IDU diagnoses, and PWID=IDU and MMSC/IDU diagnoses; thus, the data are not mutually exclusive.
Rounding may cause percentages to total more or less than 100.

Ryan White Part B – DOH Palm Beach County

RW-Part B **CARE SERVICES given -**

Palm Beach County **– GY 2021 to 2022**

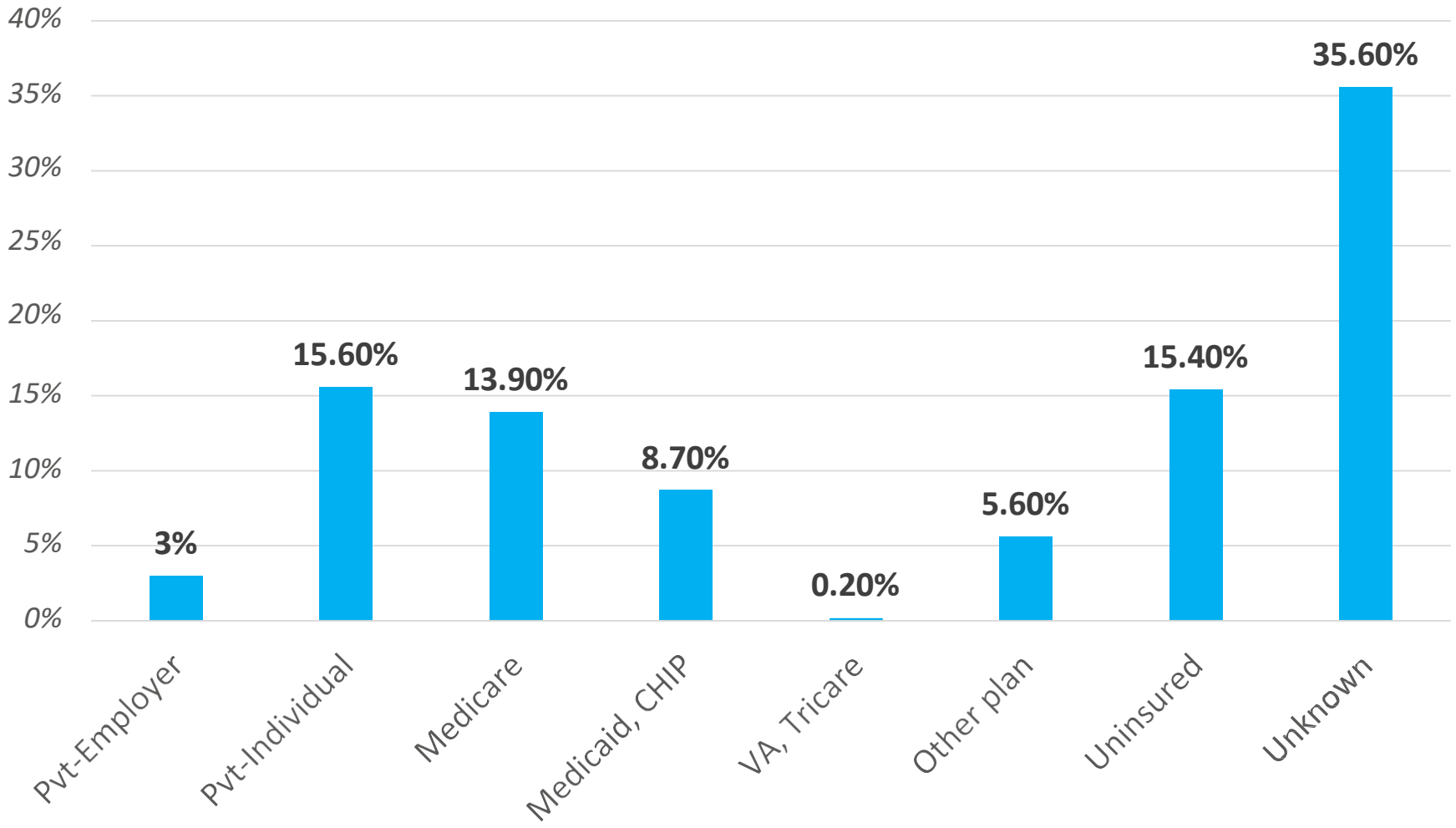
Ryan White Part B – DOH Palm Beach County

Eligibility for RWHAP services is based on HIV status, low-income status (as defined by the recipient), and residency (as defined by the recipient). *Core Medical Services* **:**

- AIDS Drug Assistance Program Treatments
- AIDS Pharmaceutical Assistance
- EIS
- Health Insurance Premium and Cost Sharing Assistance for Low-Income
- Home and Community-Based Health Services
- Home Health Care
- Hospice
- Medical Case Management, including Treatment Adherence Services
- Medical Nutrition Therapy
- Mental Health Services
- Oral Health Care
- Outpatient/Ambulatory Health Services
- Substance Use Outpatient Care

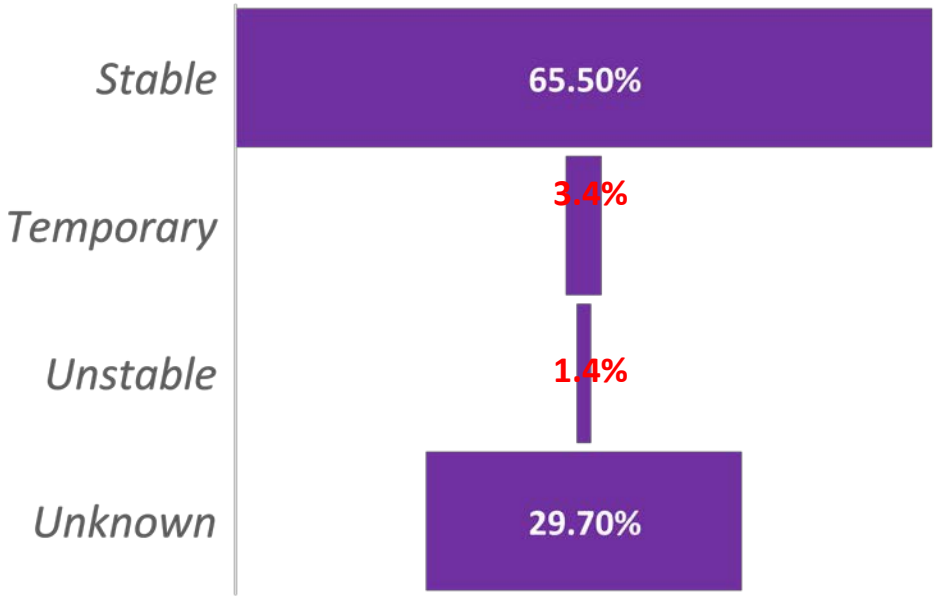
RW-B clients by *Health Care Coverage* -Palm Bch 2021

Health Care Coverage		*Count*
Private-Employer	3%	30
Private-Individual	15.60%	158
Medicare	13.90%	142
Medicaid, CHIP, Public	8.70%	89
VA, Tricare, Military	0.20%	2
Other plans	5.60%	56
Un-insured	15.40%	156
Unknown	35.60%	359

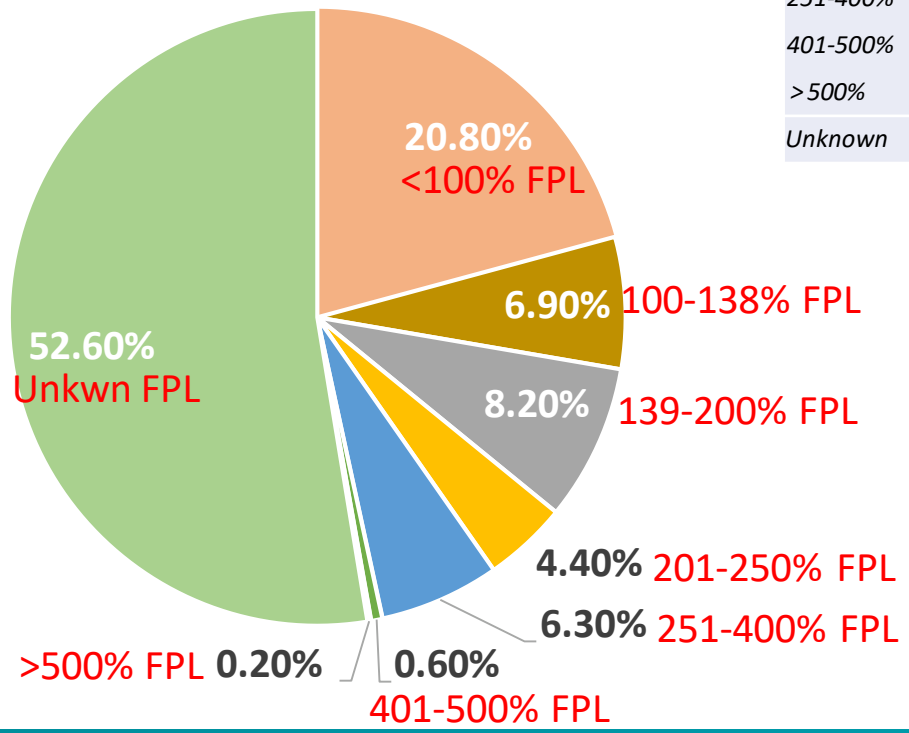


RW-B clients : *Housing, Poverty level-* Palm Beach 2021

HOUSING		*N=1002*
Stable	65.50%	656
Unstable	1.40%	
		298

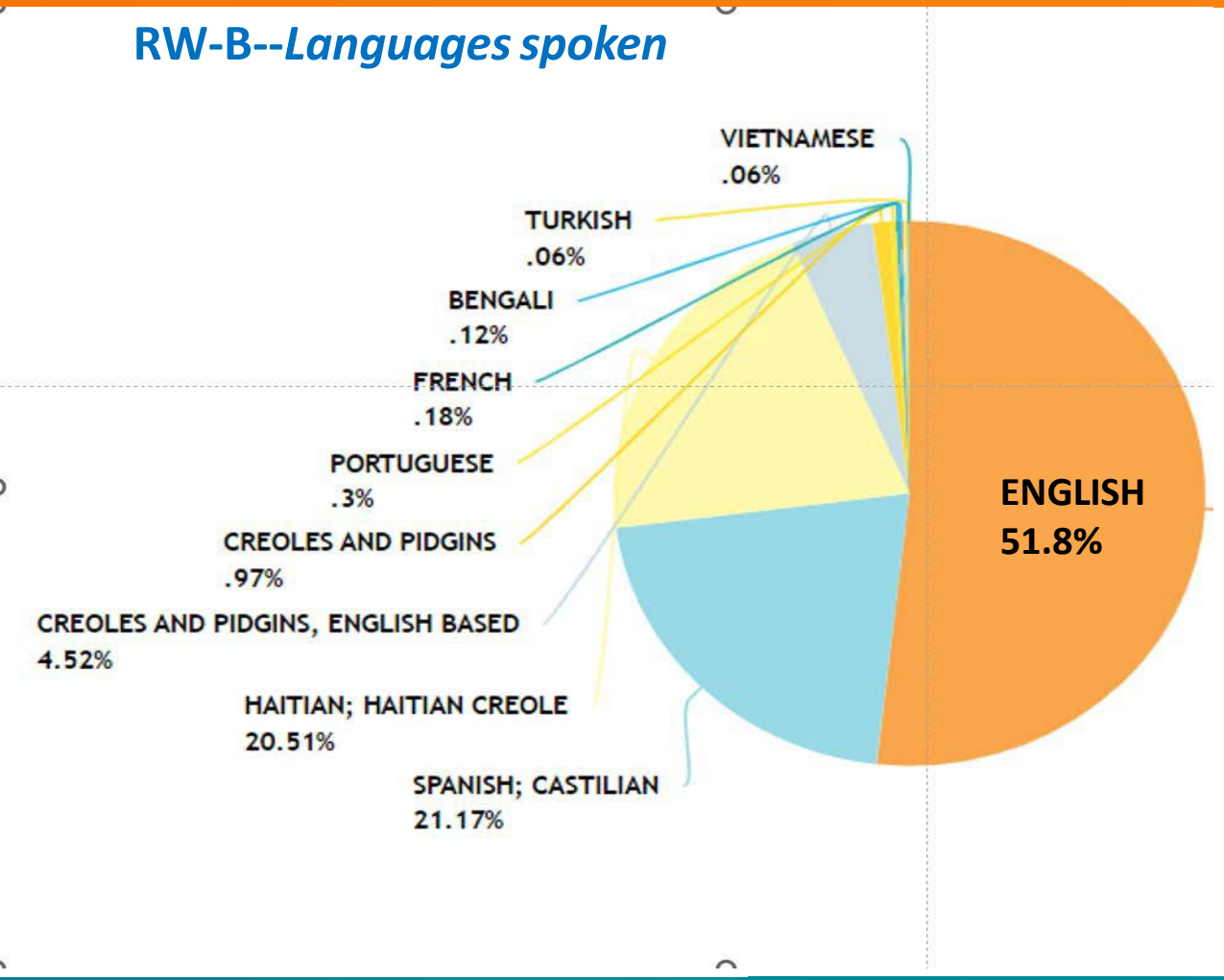


Poverty Level- *FPL*		Count
< 100%	20.80%	206
100-138%	6.90%	69
139-200%	8.20%	81
201-250%	4.40%	44
251-400%	6.30%	63
401-500%	0.60%	7
>500%	0.20%	3
Unknown	52.60%	528

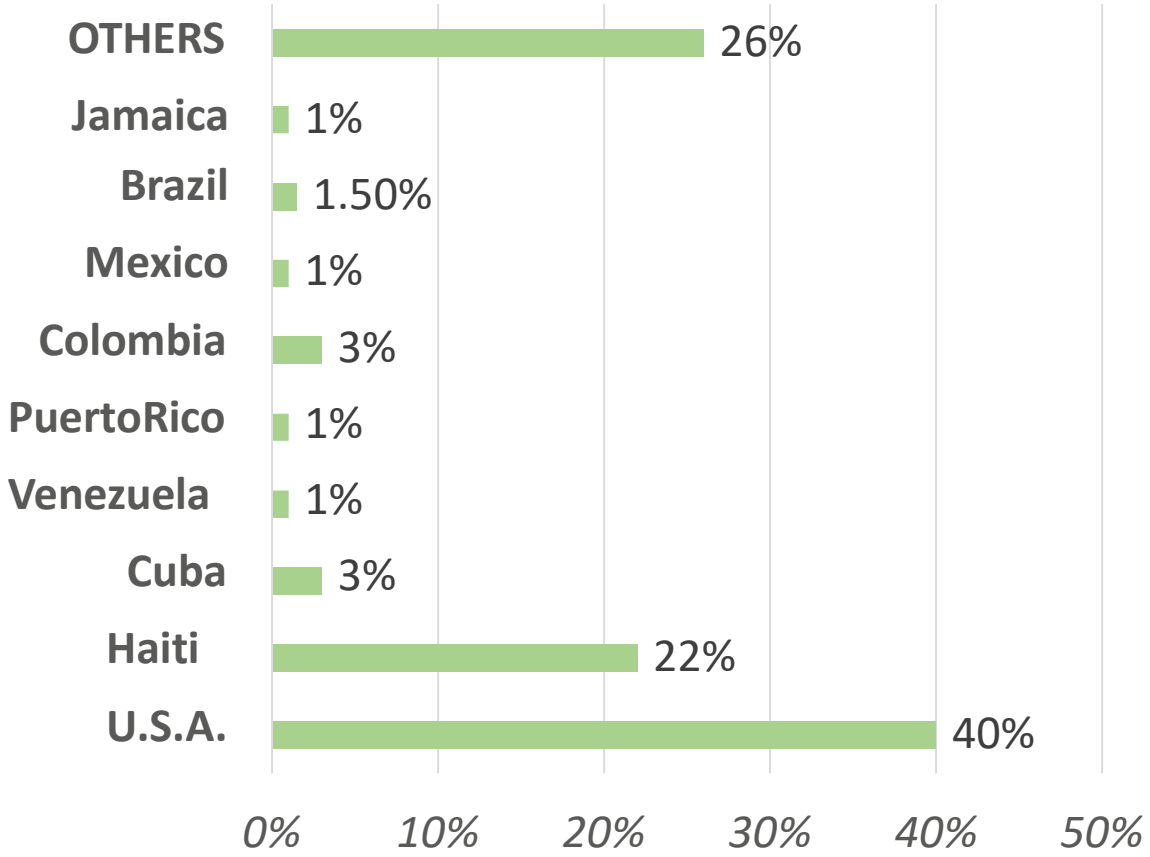


RW-B clients: *Countries of Birth, Languages*--Palm Bch

RW-B--*Languages spoken*



PWH PalmBch--*Countries of Birth*



RW-Part B CARE SERVICES given – GY 2021 to 2022

Services given	# RW-B clients	%	# Ptt. Visits
Outpt. Amb. Hlth Svcs.	1,002	74.1	4,602
Oral Health Care	454	33.6	2,189
Mental Health Svc.	229	17	1,178
Medical Nutrition	92	6.8	126
Food, Meal deliveries	361	26.7	839
Referrals for support	871	64.5	6,574
AIDS Pharma- *LPAP, CPAP*	116	8.6	214

PWH : Unmet Care Service Needs
Medical Monitoring Project,[1] -- 2020 FLORIDA

Care Services	Unmet Need of Service (%)	Received Services (%)
Dental Services	35	58
Case Management	14	52
Ryan White or ADAP	12	62
Mental Health Counseling	9	27
Food Assistance	8	38
Peer Support Groups	6	19
Transportation Assistance Services	6	17
Patient Navigation Services	6	11
Meals or Food Services	5	12
Shelter or Housing Services	4	10
SSDI	N/A	17
SSI	N/A	24

[1]The Medical Monitoring Project is a surveillance system designed to learn more about the experiences and needs of PWH.

[2]AIDS Drug Assistance Program.

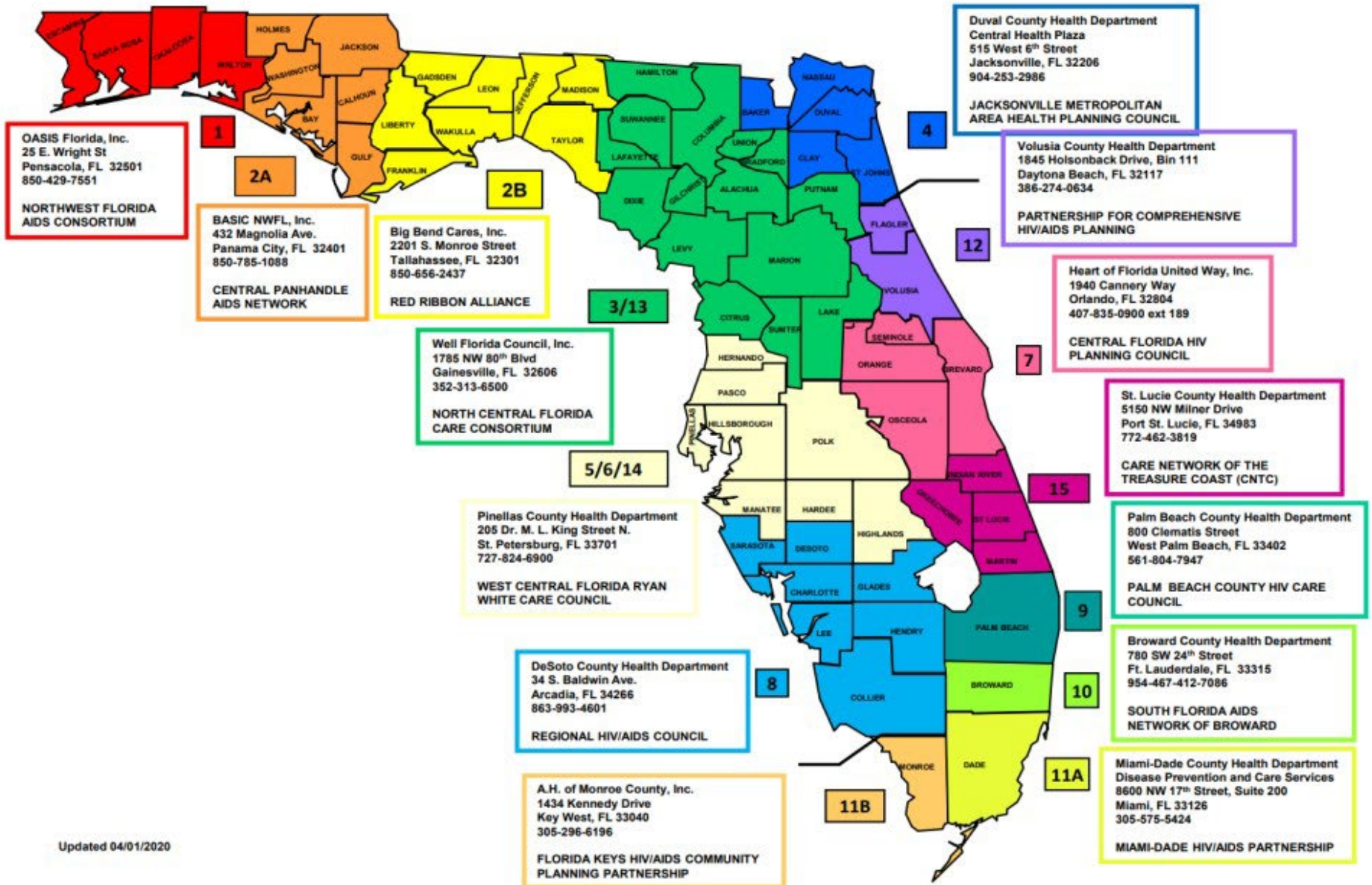
RW-Part B clinical care indices – GY 2021 to 2022

- % HIV Clients on ART (Rx) = 85%

- # HIV Deaths = 6 clients (0.6%)
- # PWH who progressed to AIDS= 58 clients (6%)--CD4 < 200 cells or w/ opport. infection
  -- CD4 > 200 cells = 924 clients
- # Suppressed Viral Load : VL < 200 copies = 874 clients (>200 copies = 108 clients)

- Screening for Hep C = 94 tests (positive – 6)
- Screening for Syphilis = 481 tests (positive – 159)
- Screening for TB = 107 tests (positive – 1)
- Cervical Pap smears = 56 tested positive for HPV

State of Florida
Ryan White CARE Act Part B Service Areas
Consortia – Lead Agencies



Updated 04/01/2020

Florida HIV/AIDS Surveillance Data
Palm Beach County Contact

Irma Shute
Florida Department of Health in
Palm Beach County
Phone: 561-804-7948
Email: Irma.Shute@flhealth.gov

HIV/AIDS surveillance data are frozen on June 30 for the previous calendar year. These are the same data used for FLHealth CHARTS and all grant-related data.
flhealthcharts.com/charts/CommunicableDiseases/default.aspx

PBC Ryan White Part A/MAI Continuum of Care

Daisy Wiebe, PhD, MPH
Quality Management Clinician
PBC Ryan White HIV/AIDS Program
dwiebe@pbcgov.org
(561) 355-4760

Palm Beach County
Ryan White HIV/AIDS Program

Care Continuum Optimized Report Performance Measures Definitions

- **In Care**
  - Percentage of PWH who had at least one medical care service in 90 days
  - Numerator: Number of clients who are HIV+ who had medical care within 90 days of opening a client to an agency
    a) Client has a "Kept" medical appointment within 90 days OR
    b) Client had a CD_4 or Viral Load test result within 90 days OR
    c) Client has a Payment Request "Paid" within 90 days (Co/pay or Deductible) OR
    d) Client had a prescription dispensed within 90 days
  - Denominator: HIV+ Clients

Care Continuum Optimized Report Performance Measures Definitions

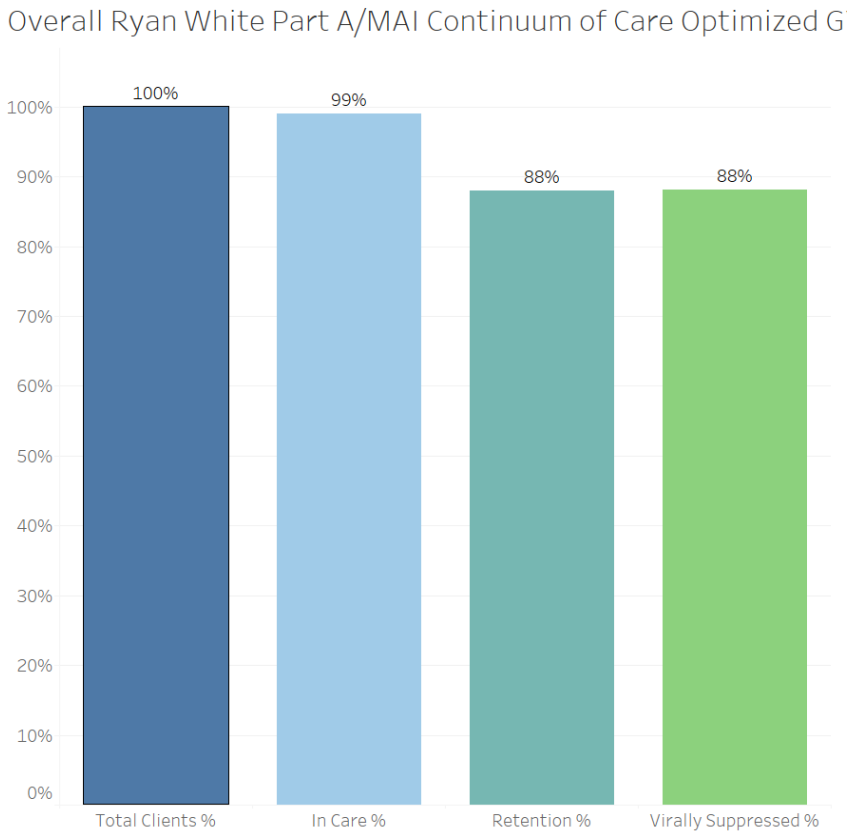
- **Retention in Care:**
  - Percentage of PLWH who had two or more medical care services at least three months apart in reporting period
  - Numerator- Retention in Care Svc First 6 Mo: Number of clients that are HIV+ who had two or more HIV medical care services (with the first occurring in the first 6 months) at least 90 days apart within a 12-month measurement year.
    a) Client has a "Kept" medical appointment during the reporting period OR
    b) Client had a CD_4 or Viral Load test result during the reporting period OR
    c) Client has a Payment Request "Paid" during the reporting period (Co/pay or Deductible) OR
    d) Client had a prescription dispensed during the reporting period

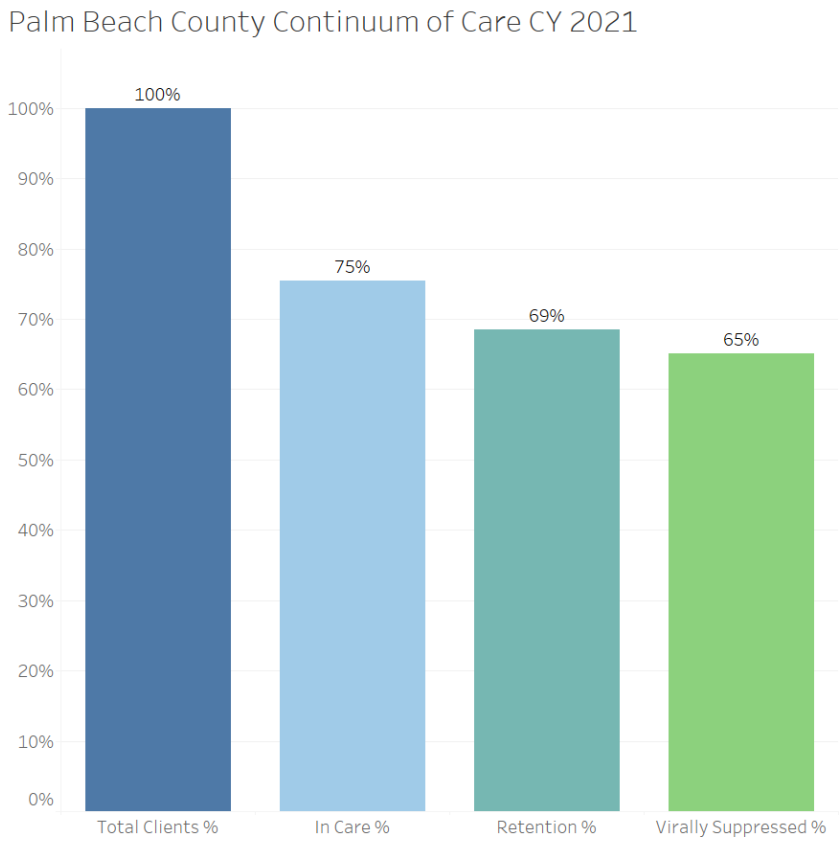
    WHO ALSO RECEIVED AT LEAST ONE SERVICE FROM THE SELECTED SERVICE CATEGORY(S) IN THE FIRST 6 MONTHS OF THE REPORTING PERIOD FROM THE SELECTED AGENCY(S)
  - Denominator- Svc in First 6 Mo: Clients that are HIV+ and received at least one service from the selected service category(s) in the FIRST 6 MONTHS of the reporting period from the selected agency(s)

Care Continuum Optimized Report Performance Measures Definitions

- **Viral Load Suppression:**
  - Numerator: HIV+ clients whose most recent viral load test result record is less than 200 and the test result is from the reporting period.
  - Denominator: Clients that are HIV+ and received at least one service from the selected service category(s) in the reporting period from the selected agency(s)

Ryan White Part A/MAI to Palm Beach County

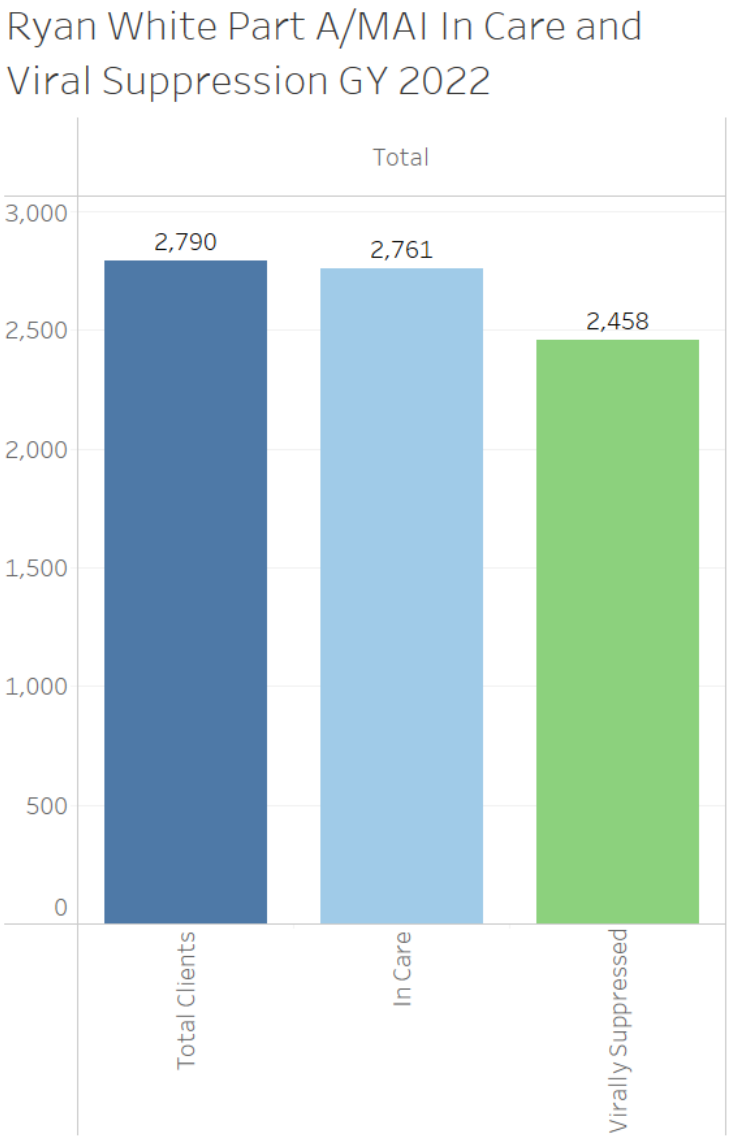


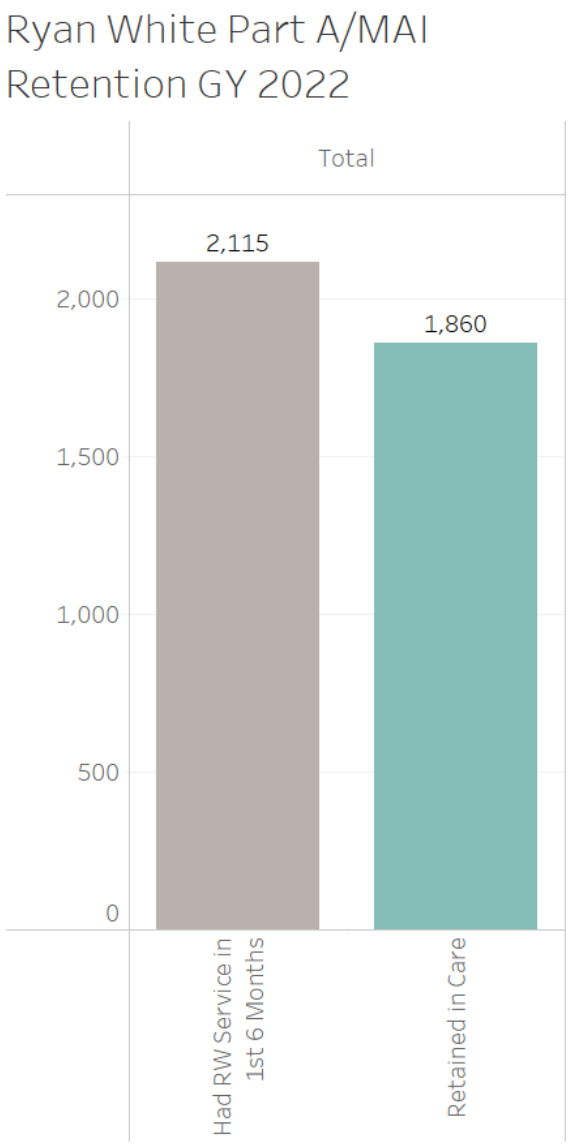


Outcomes along the Continuum of Care are better for those in Ryan White Part A/MAI than for total PWH in Palm Beach County

Palm Beach County
Ryan White HIV/AIDS Program

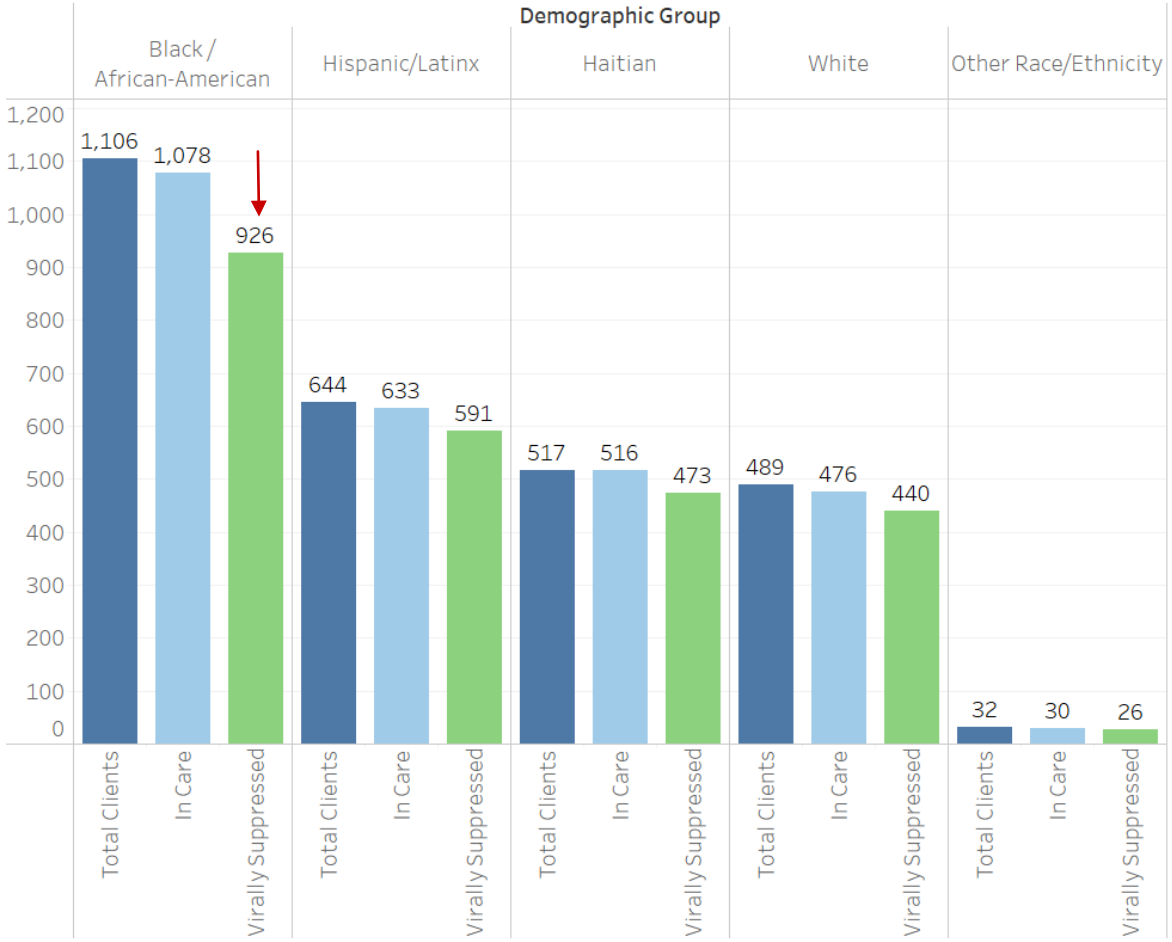
The largest gaps for Ryan White Part A/MAI are clients **who were not virally suppressed (n=332),** followed by clients **who were not retained (n=255)**



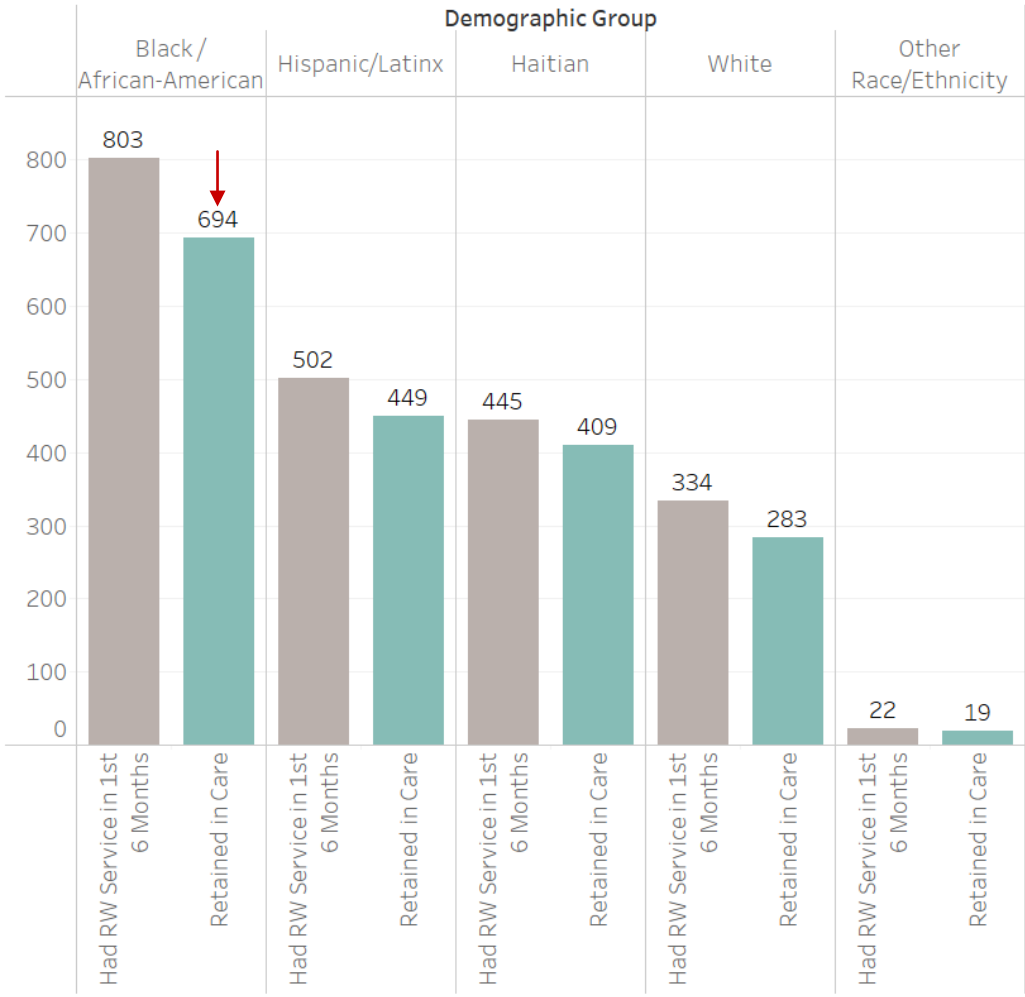


Palm Beach County
Ryan White HIV/AIDS Program

Ryan White Part A/MAI In Care and Viral Suppression GY 2022: By Race/Ethnicity

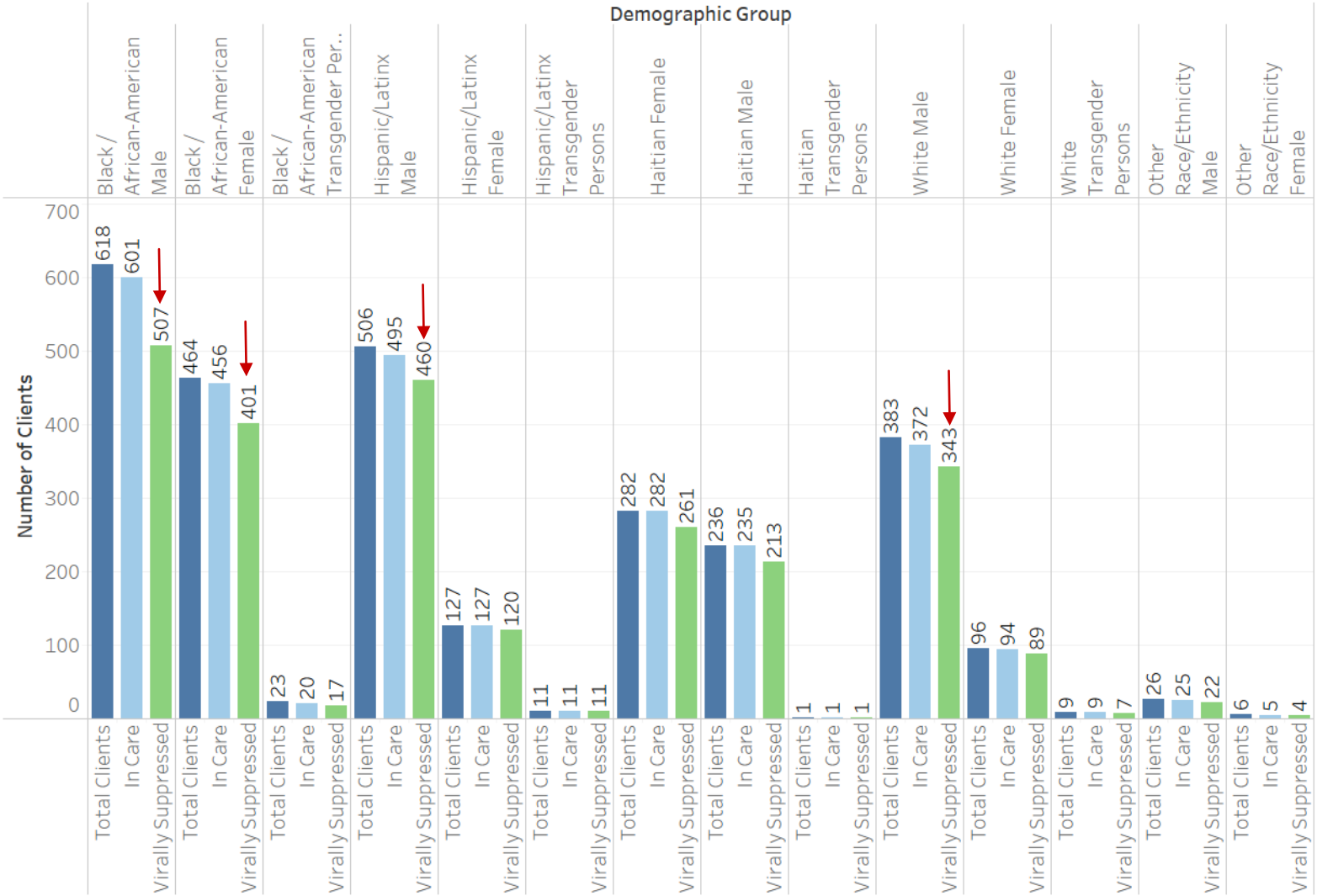


Ryan White Part A/MAI Retention GY 2022: By Race/Ethnicity



Black/African-Americans in Ryan White Part A/MAI are **largest demographic group who is not retained (n=109) and not virally suppressed (n=180)**

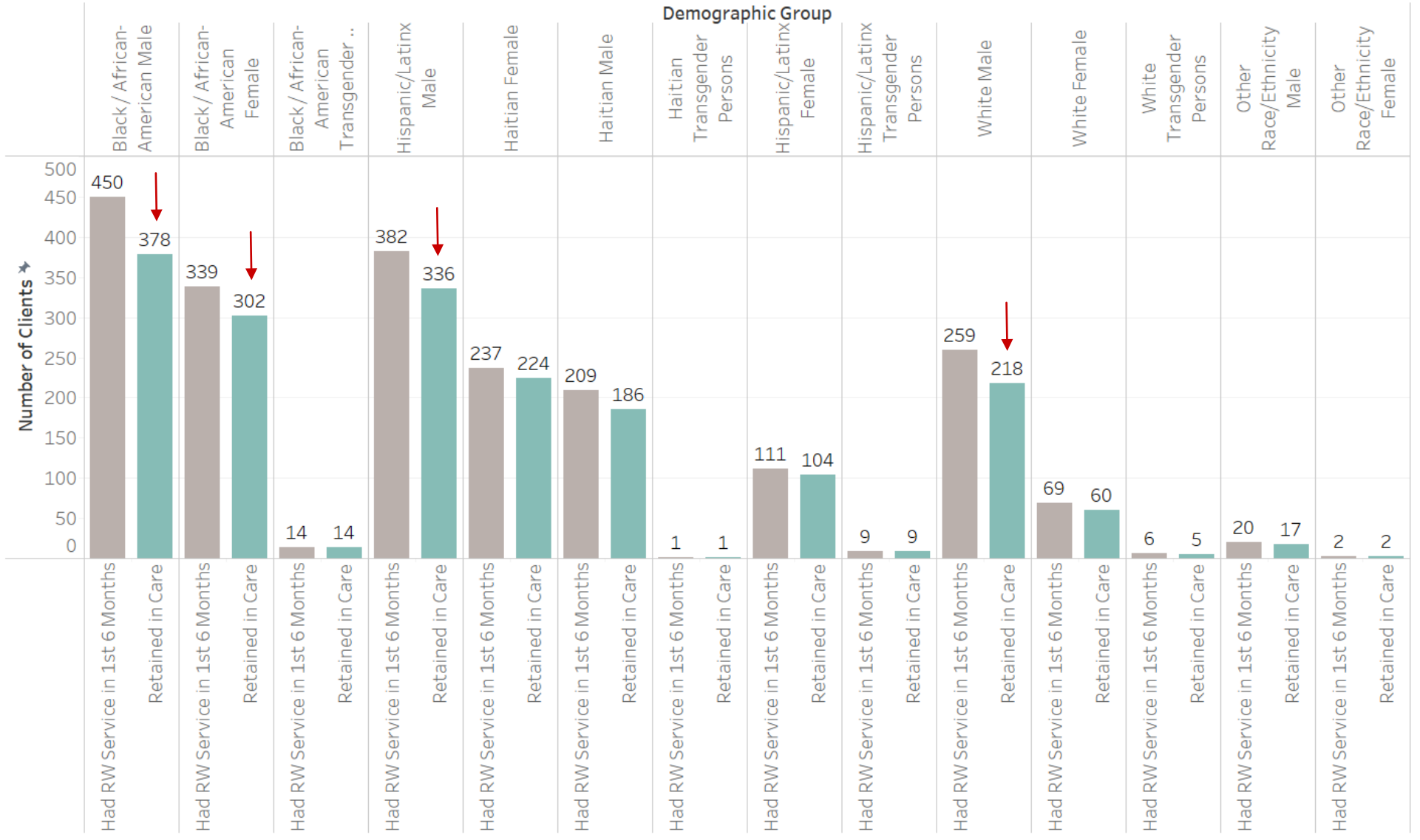
Ryan White Part A/MAI In Care and Viral Suppression GY 2022: By Race/Ethnicity & Gender



Black/African-American male and females in Ryan White Part A/MAI are the largest group **who are not virally suppressed (n=111 and n=63),** followed by **Hispanic/Latinx males (n=46)** and **White males (n=40)**

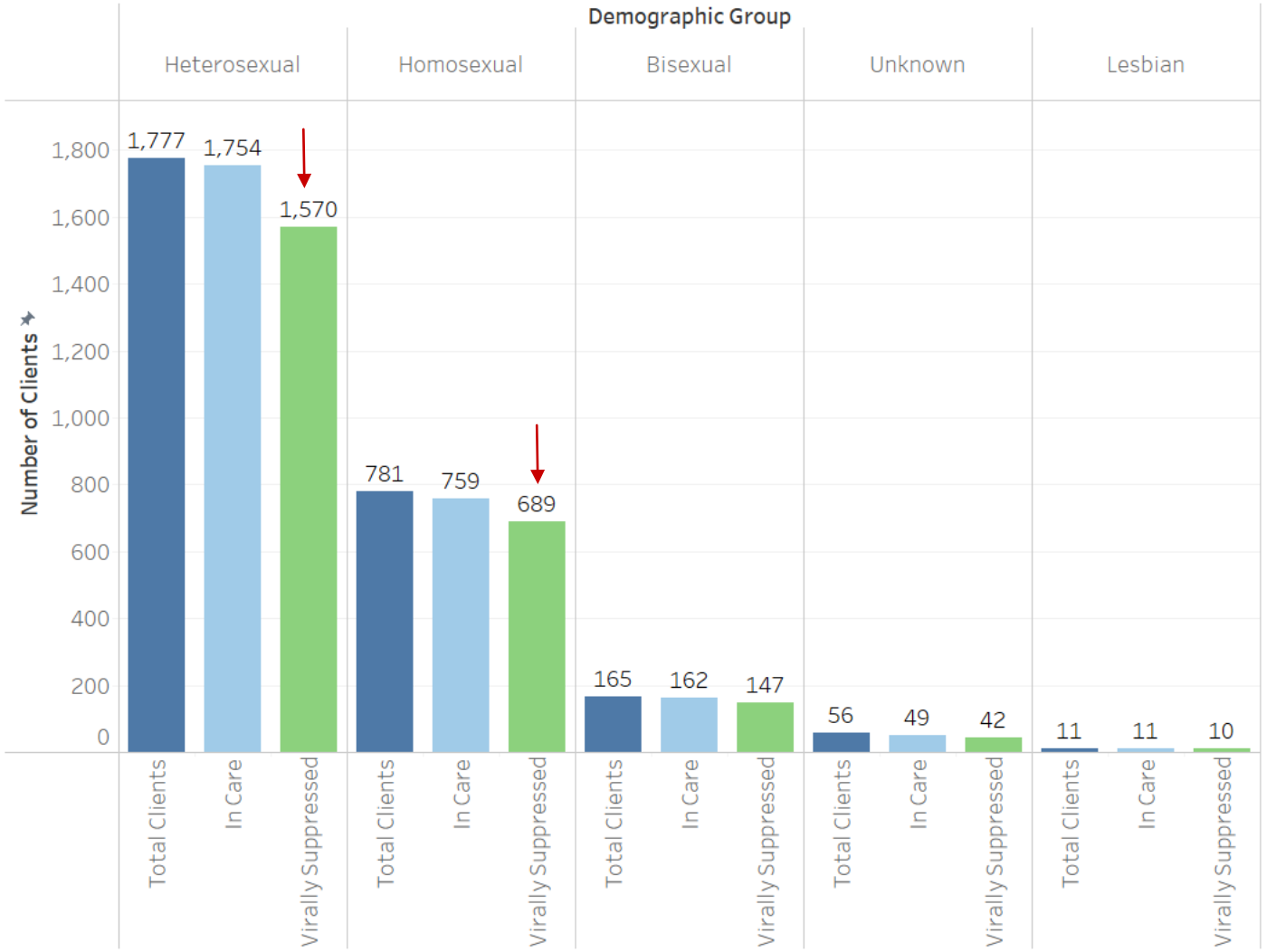
Palm Beach County
Ryan White HIV/AIDS Program

Ryan White Part A/MAI Retention GY 2022: By Race/Ethnicity & Gender



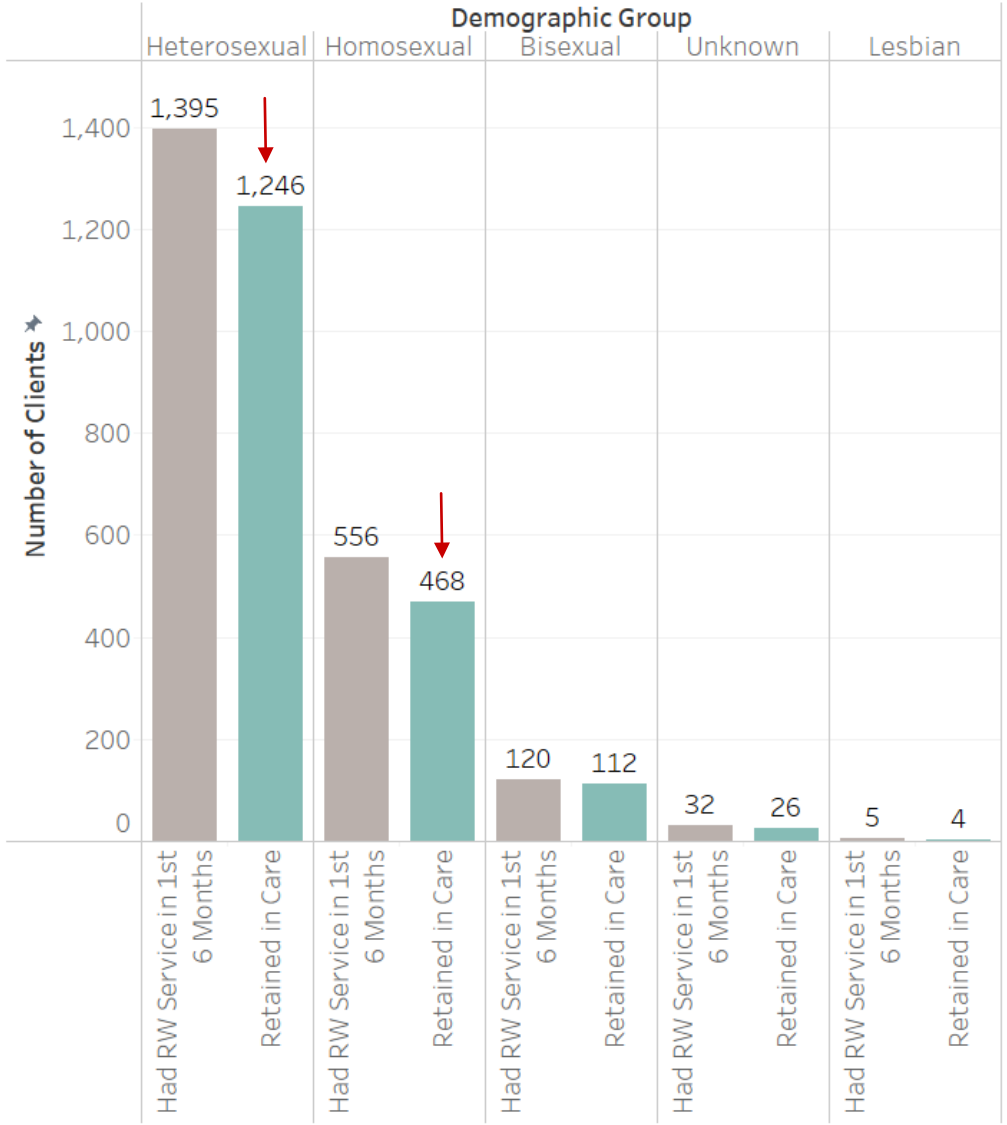
Black/African-American male and females in Ryan White Part A/MAI are the largest group **who are not retained (n=72 and n=37),** followed by **Hispanic/Latinx males (n=46)** and **White males (n=41)**

Ryan White Part A/MAI In Care and Viral Suppression GY 2022: By Sexual Orientation



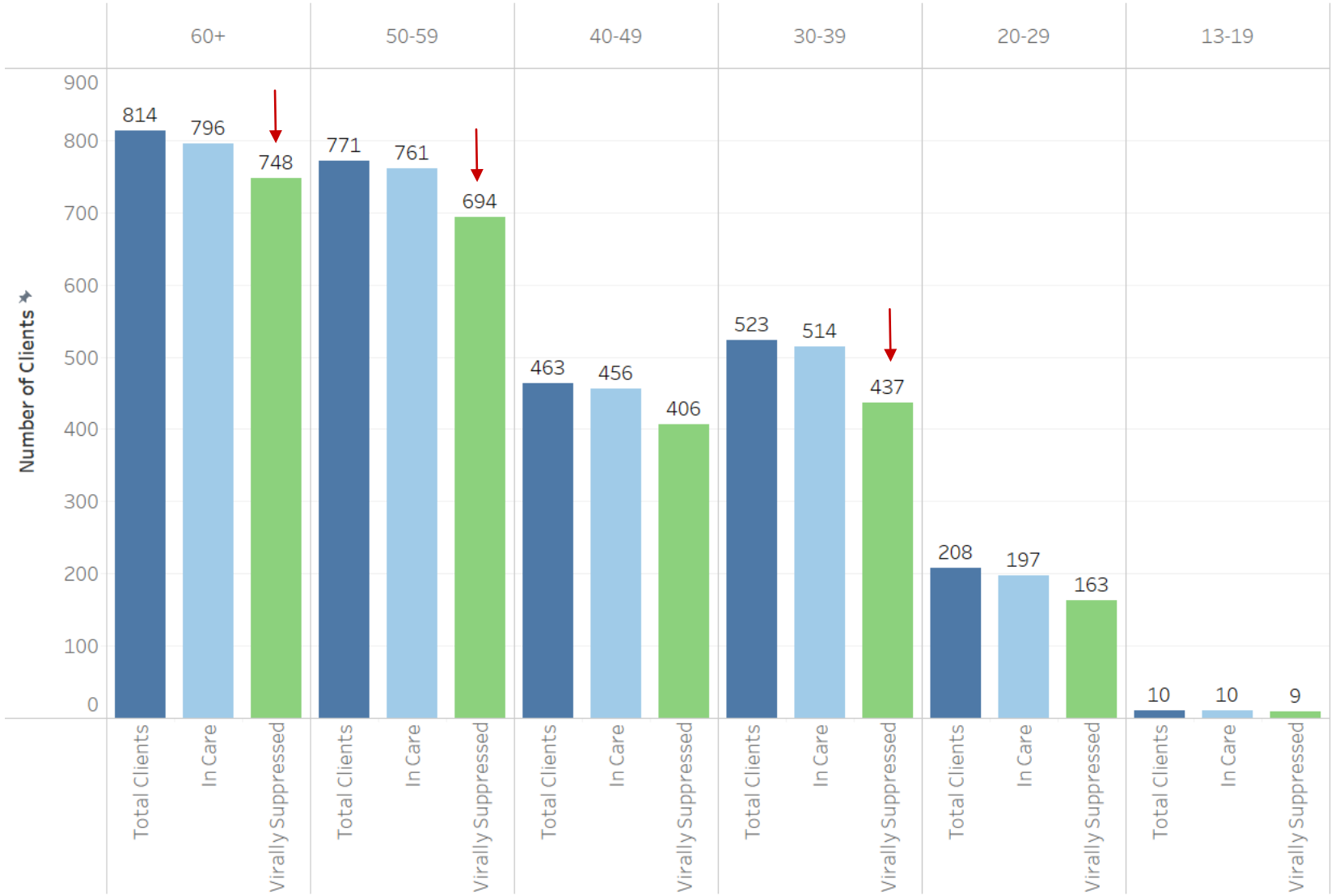
Those who identify as heterosexual in Ryan White Part A/MAI are the largest group **who are not virally suppressed (n=207),** followed by **those who identify as homosexual (n=92)**

Ryan White Part A/MAI GY 2022 Retention: By Sexual Orientation



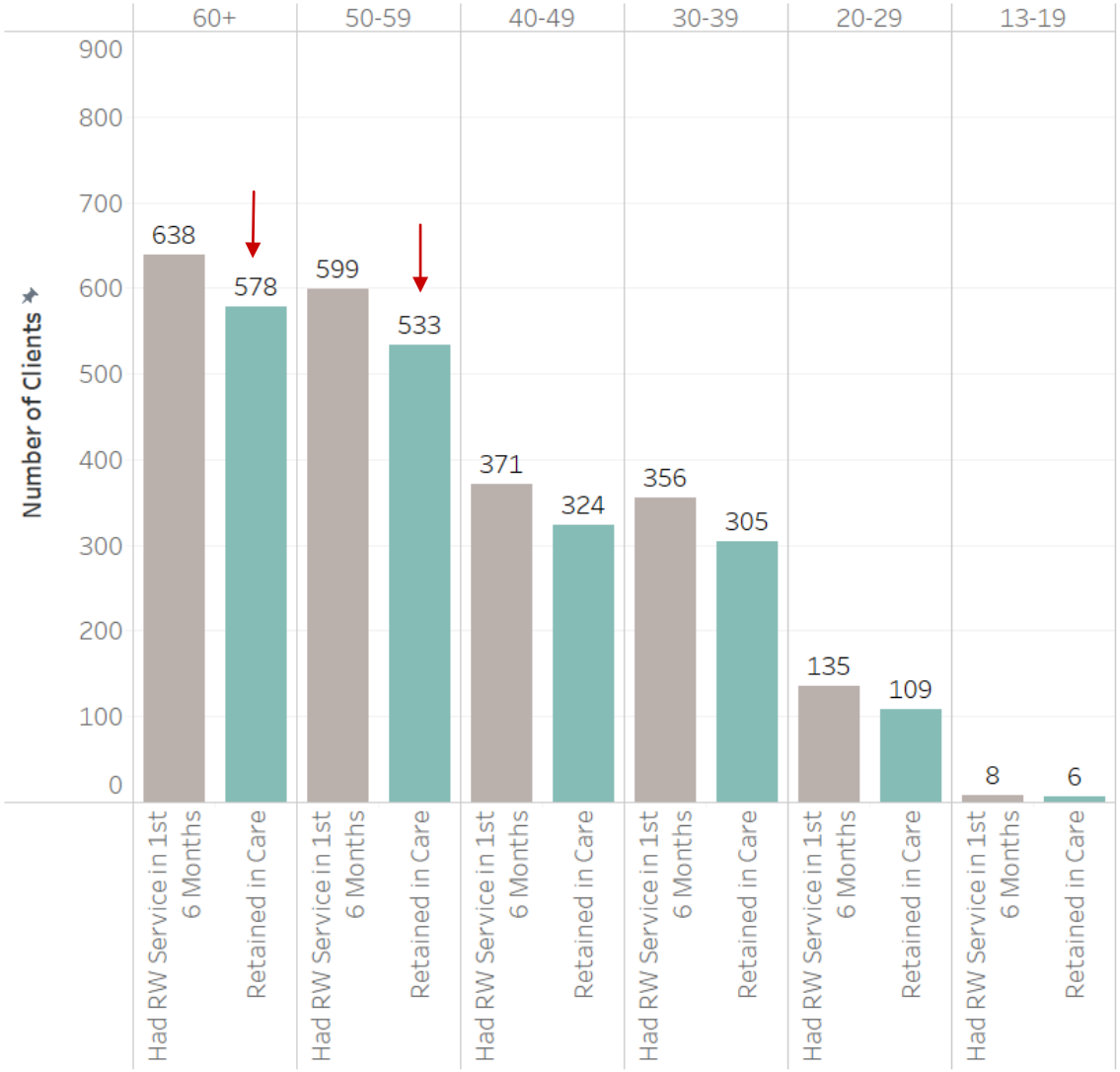
Those who identify as heterosexual in Ryan White Part A/MAI are the largest group **who are not retained in care (n=149),** followed by **those who identify as homosexual (n=88)**

Ryan White Part A/MAI In Care and Viral Suppression GY 2022: By Age

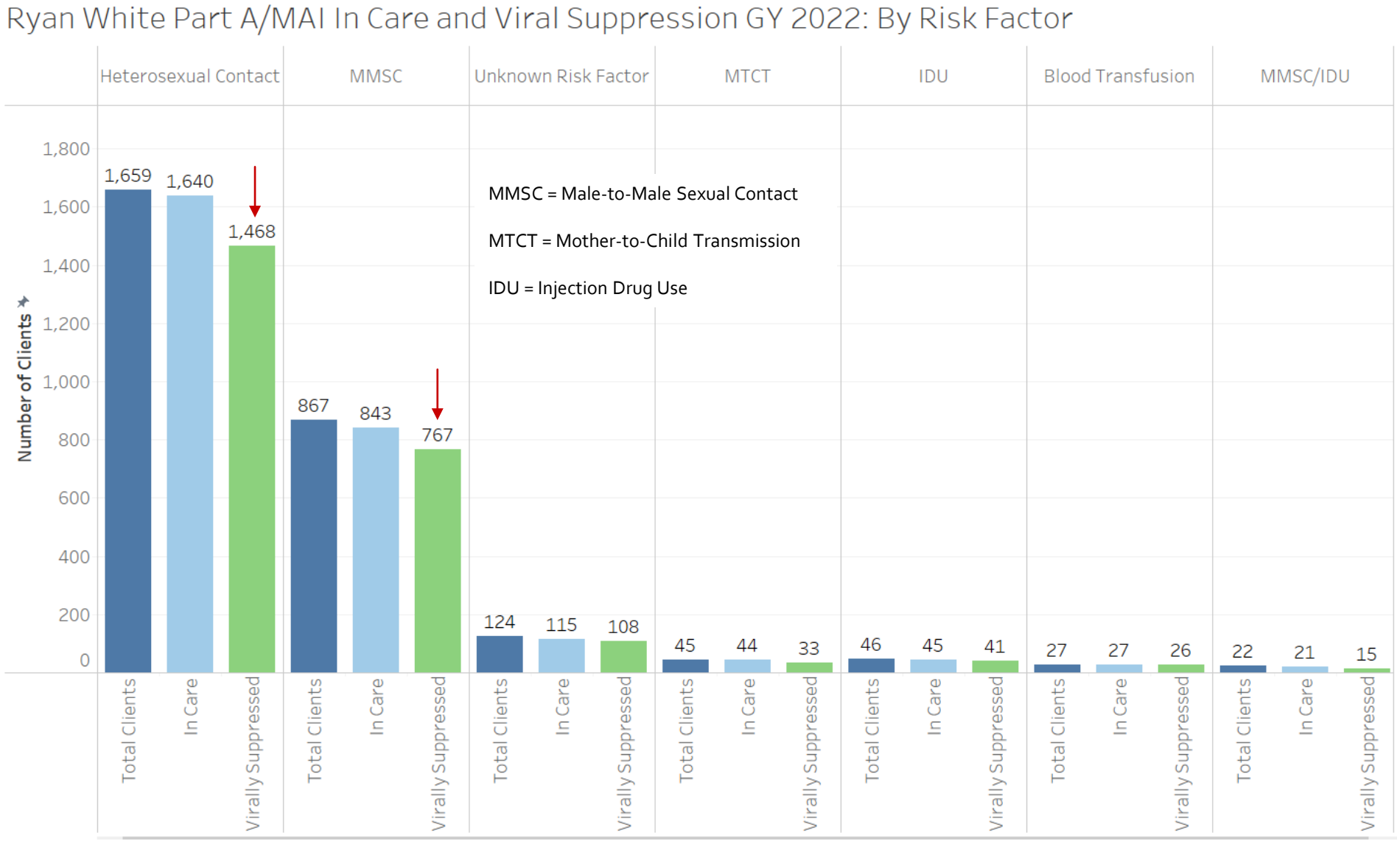


Ryan White Part A/MAI serves an **aging population**. However, the **largest group not virally suppressed is 30-39 years of age (n=86),** followed by **those 50-59 years of age (n=77),** and **60+ (n=66).**

Ryan White Part A/MAI GY 2022 Retention: By Age

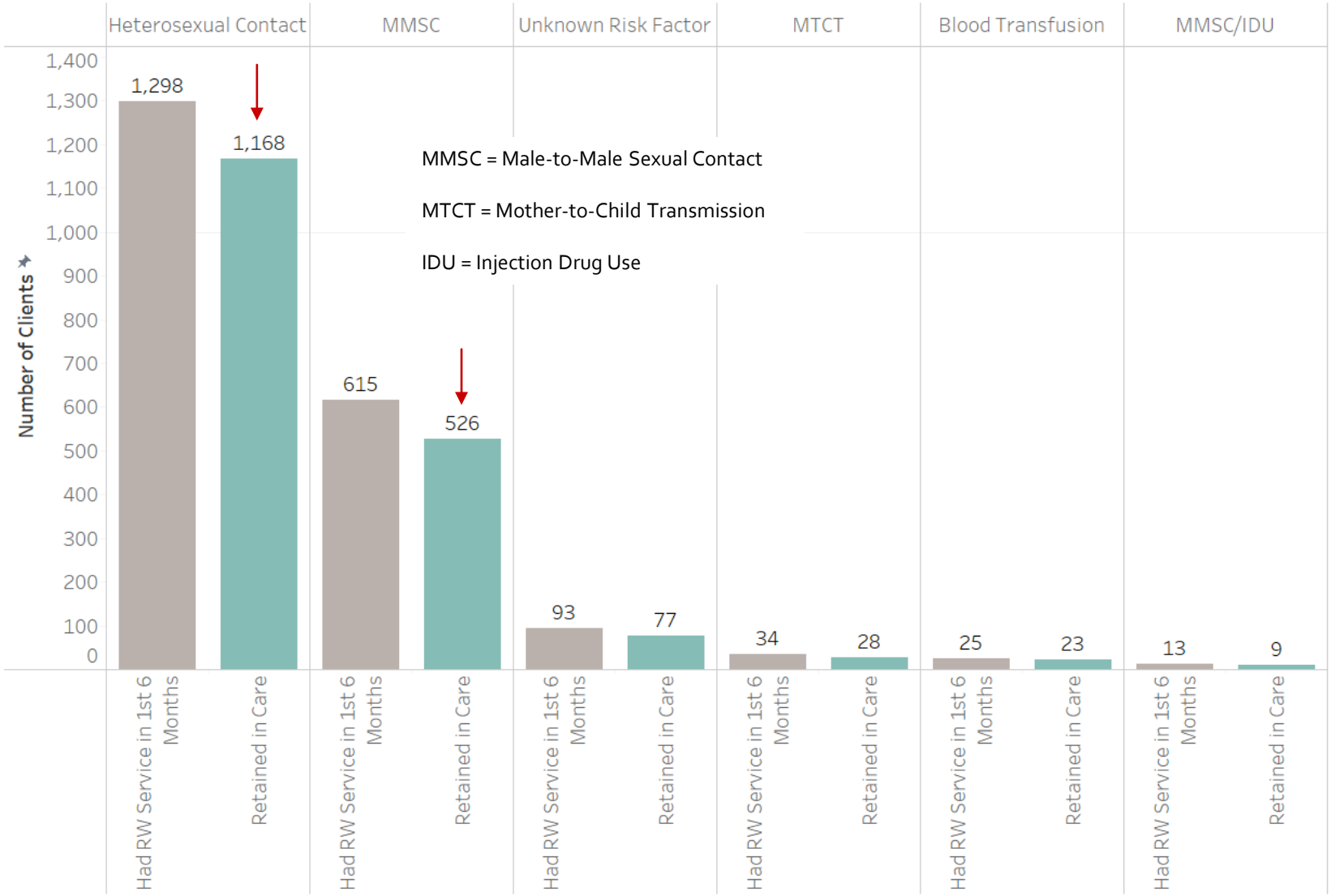


The **largest group not retained are those 50-59 years of age (n=66),** followed by **those 60+ (n=60)**



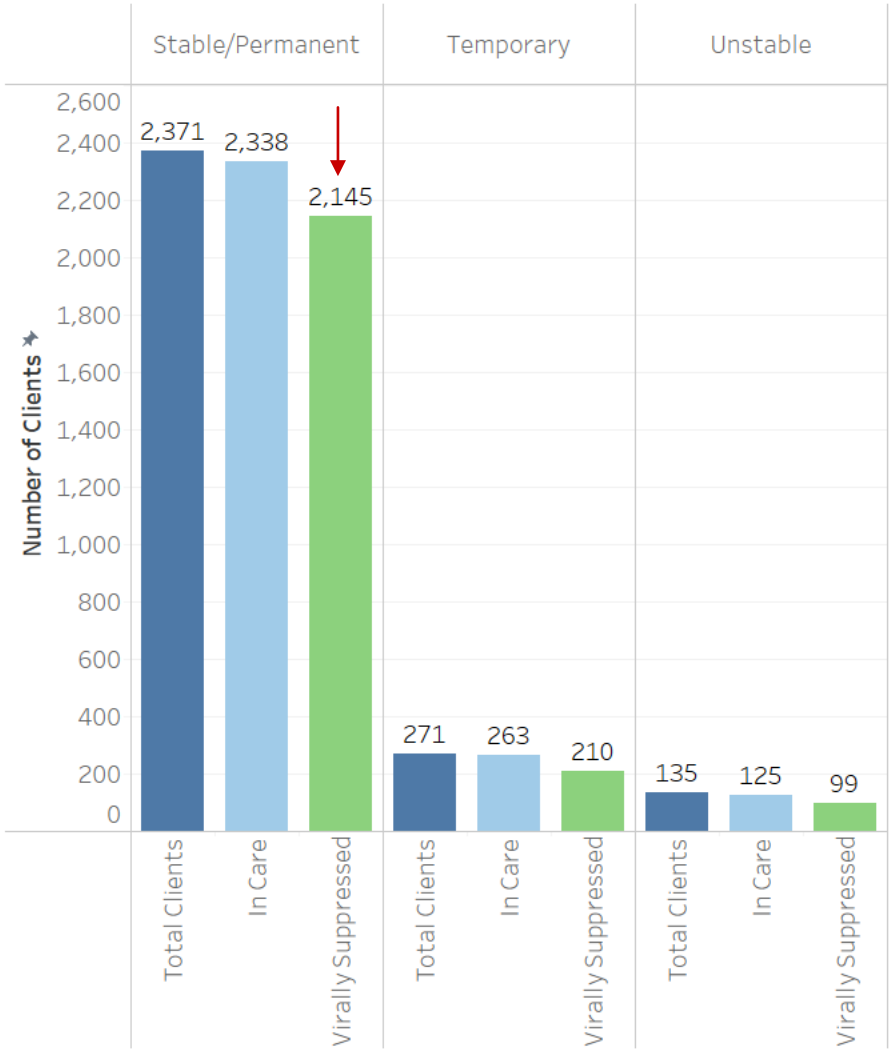
Those with heterosexual contact histories in Ryan White Part A/MAI are the largest group **who are not virally suppressed (n=191),** followed by **those with Male-to-Male Sexual Contact (MMSC) histories (n=100)**

Ryan White Part A/MAI GY 2022 Retention: By Risk Factor



Those with heterosexual contact histories in Ryan White Part A/MAI are the largest group **who are not retained in care (n=130),** followed by **those with Male-to-Male Sexual Contact (MMSC) histories (n=89)**

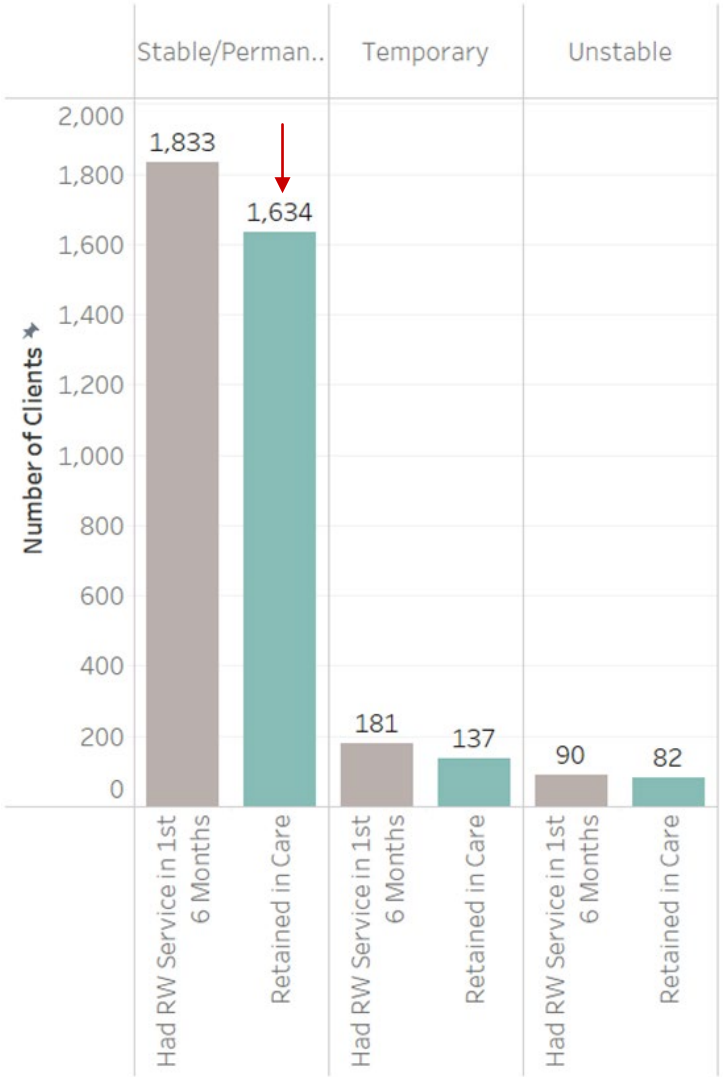
Ryan White Part A/MAI In Care and Viral Suppression GY 2022: By Housing Status



Most individuals in Ryan White Part A/MAI have **stable/permanent housing.** Those who are in **stable housing** are the **largest group** of those who are **not virally suppressed (n=226).**

However, those with **temporary or unstable housing** have **lower rates of viral suppression (76% compared to 90%** for those stably housed), which equals to **97 individuals who are not virally suppressed** who have temporary or unstable housing.

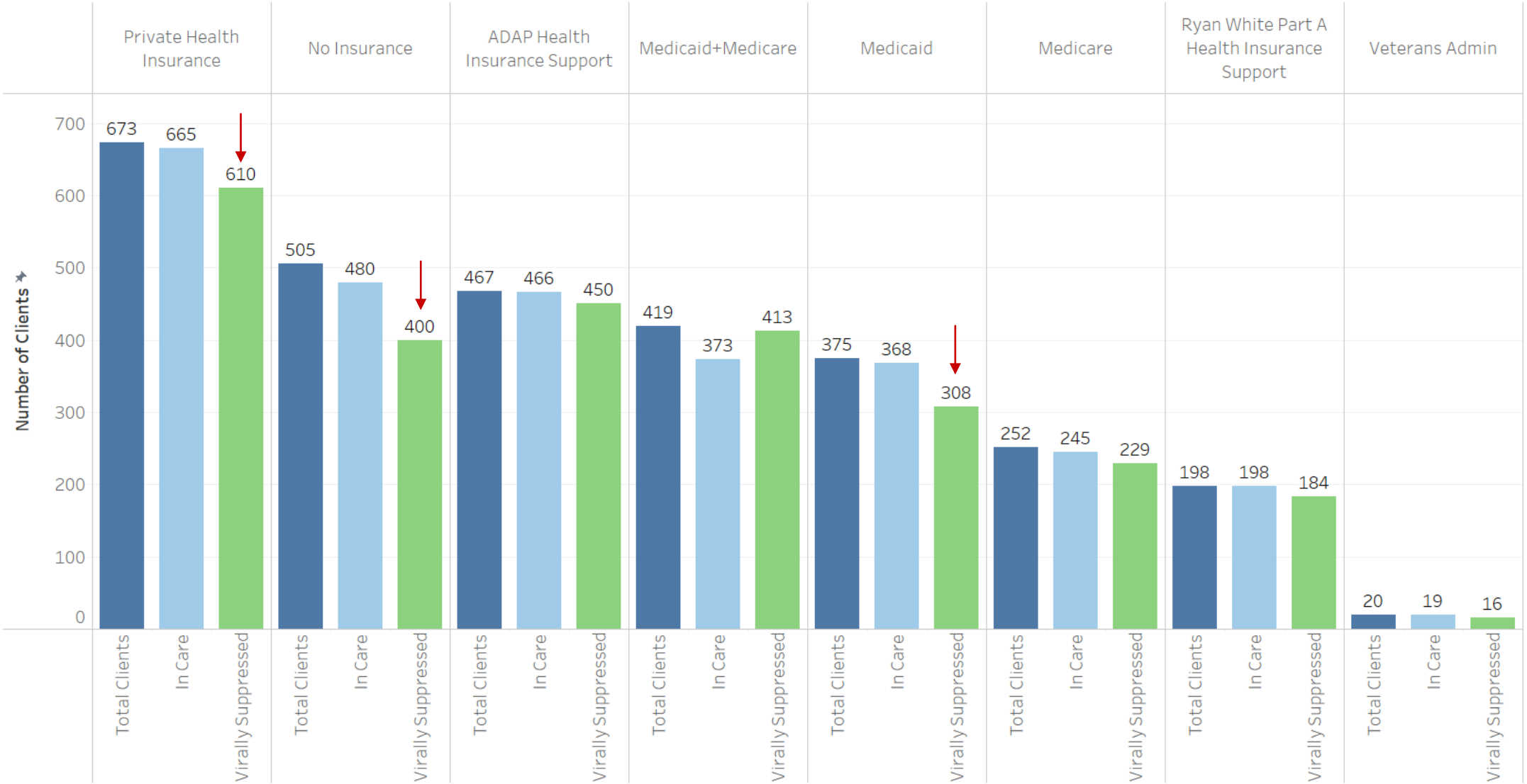
Ryan White Part A/MAI GY 2022 Retention: By Housing Status



Those who are in **stable housing** are the **largest group** of those who are **not retained in care (n=199).**

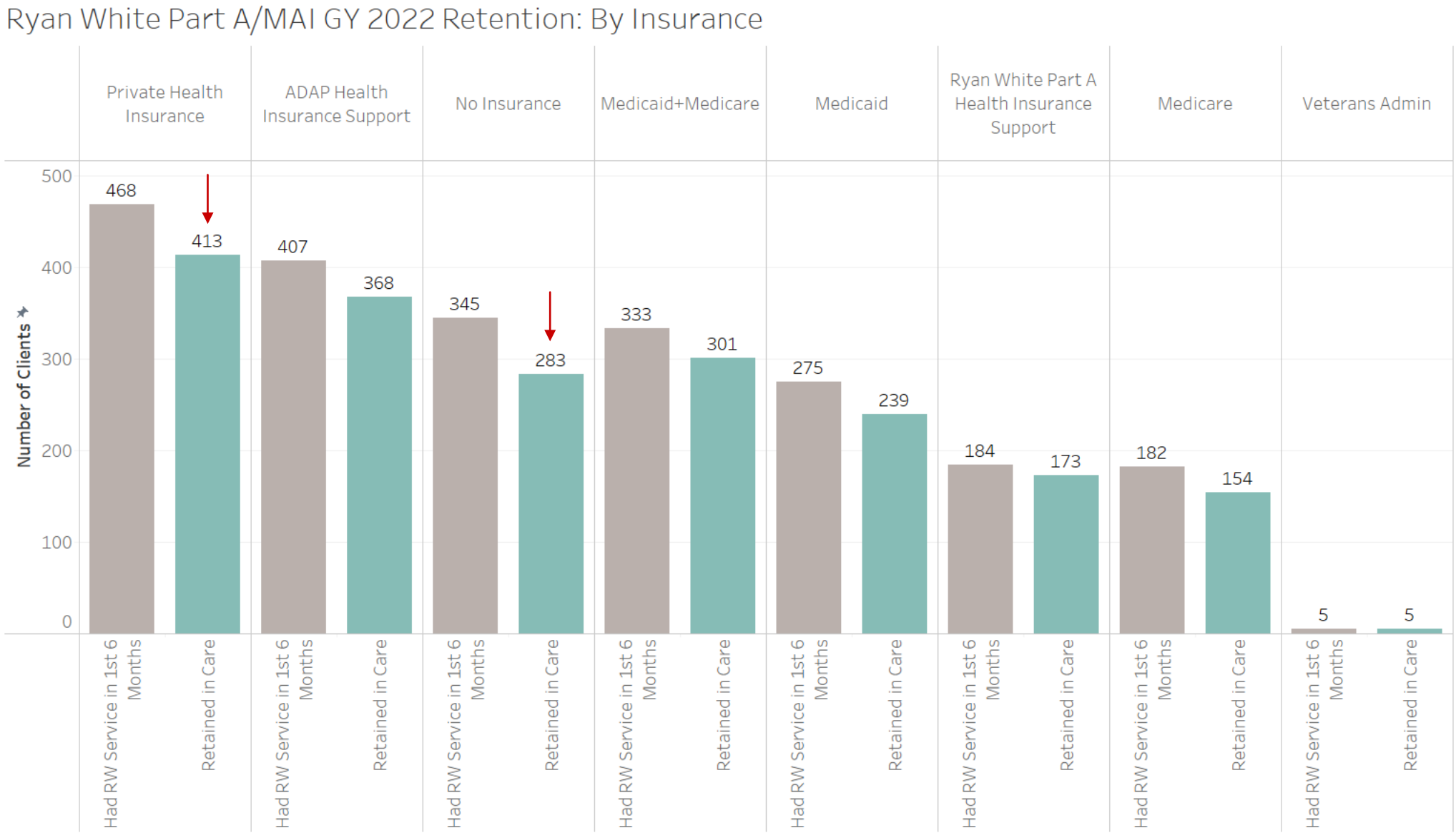
However, those with **temporary or unstable housing** have **lower rates of retention (81% compared to 89%** for those stably housed), which equals to **52 individuals who are not retained** who have temporary or unstable housing.

Ryan White Part A/MAI In Care and Viral Suppression GY 2022: By Insurance



Those who have no health insurance in Ryan White Part A/MAI are the largest group **who are not virally suppressed (n=105),** followed by **with Medicaid (n=67) and private health insurance (n=63)**

Palm Beach County
Ryan White HIV/AIDS Program



Those who have no health insurance in Ryan White Part A/MAI are the largest group **who are not retained in care (n=62),** followed by **private health insurance (n=55)**

Questions?

PBC RWHAP Care Continuum Optimized Performance Measures

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Palm Beach County
Ryan White HIV/AIDS Program

HIV/AIDS Bureau (HAB) Policy

- **HRSA PCN #15-02:**

  https://hab.hrsa.gov/sites/default/files/hab/Global/HAB-PCN-15-02-CQM.pdf

  - "Performance measurement is the process of collecting, analyzing and reporting data regarding patient care, health outcomes on an individual or population level, and patient satisfaction. **In order to appropriately assess outcomes, measurement must occur.** Measures should be selected that best assess the services the recipient is funding and that reflect local HIV epidemiology and identified needs of people with HIV."

  - Recipients should analyze performance measure data to assess quality of care and health disparities and use the performance measure to inform quality improvement activities.

HIV/AIDS (HAB) Health Outcome Measures

- In the Ryan White Program, the Performance Measures are connected to each funded service category. The measures we have been tracking for client health outcomes are:
  1) **In Care**
     - Early Intervention Services (EIS)
  2) **Retention in Care**
  3) **Viral Load Suppression**
- We collect and analyze these measures to identify low performance and determine how we can improve these performance measures through quality improvement (QI) activities.

Care Continuum Optimized Report Performance Measures Definitions

- **In Care**
  - Percentage of PWH who had at least one medical care service in 90 days
  - Numerator: Number of clients who are HIV+ who had medical care within 90 days of opening a client to an agency
    a) Client has a "Kept" medical appointment within 90 days OR
    b) Client had a CD_4 or Viral Load test result within 90 days OR
    c) Client has a Payment Request "Paid" within 90 days (Co/pay or Deductible) OR
    d) Client had a prescription dispensed within 90 days
  - Denominator: HIV+ Clients

Care Continuum Optimized Report Performance Measures Definitions

- **Retention in Care:**
  - Percentage of PLWH who had two or more medical care services at least three months apart in reporting period
  - Numerator- Retention in Care Svc First 6 Mo: Number of clients that are HIV+ who had two or more HIV medical care services (with the first occurring in the first 6 months) at least 90 days apart within a 12-month measurement year.
    a) Client has a "Kept" medical appointment during the reporting period OR
    b) Client had a CD_4 or Viral Load test result during the reporting period OR
    c) Client has a Payment Request "Paid" during the reporting period (Co/pay or Deductible) OR
    d) Client had a prescription dispensed during the reporting period

    WHO ALSO RECEIVED AT LEAST ONE SERVICE FROM THE SELECTED SERVICE CATEGORY(S) IN THE FIRST 6 MONTHS OF THE REPORTING PERIOD FROM THE SELECTED AGENCY(S)
  - Denominator- Svc in First 6 Mo: Clients that are HIV+ and received at least one service from the selected service category(s) in the FIRST 6 MONTHS of the reporting period from the selected agency(s)

Care Continuum Optimized Report Performance Measures Definitions

- **Viral Load Suppression:**
  - Numerator: HIV+ clients whose most recent viral load test result record is less than 200 and the test result is from the reporting period.
  - Denominator: Clients that are HIV+ and received at least one service from the selected service category(s) in the reporting period from the selected agency(s)

Calendar Year (CY) 2022

- Annual Performance Measures (Core Measures)
  - Metrics are reported quarterly (calendar year) for each funded service category
- Report on the overall Ryan White program core measures (bold/gray):
  1. Linkage to Care (In Care)
  2. Retention in Care
  3. Viral Load Suppression
- Report on individual funded service categories that are connected to each core performance measure
  - Larger categories require 2 measurements
- **Target**: Improve all VS rates to 90%+ and RIC rates to 85%+

Palm Beach County
Ryan White HIV/AIDS Program

PBC Ryan White Program, PM Quartely Metrics	Baseline		Q1	
	Thru Date 12/31/2022		Thru Date 3/31/2023	
Service Category	N/D	Metric	N/D	Metric
In Care	**3167/3274**	**97%**	2747/2775	99%
Early Intervention Services	995/1111	90%	547/582	94%
Early Intervention Services - MAI	162/166	98%	198/207	96%
Retention in Medical Care	**1890/2148**	**88%**	1801/2096	86%
Emergency Financial Assistance	17/17	100%	19/21	90%
Food Bank - Nutritional Supplements	6/8	75%	7/7*	100%
Food Bank/Home Delivered Meals	602/629	96%	652/684	95%
Health Insurance Premium & Cost-Sharing Assistance	435/463	94%	466/493	95%
Housing	23/25	92%	21/23	91%
Legal Services	209/222	94%	217/243	89%
Medical Case Management	973/1054	92%	970/1081	90%
Medical Case Management - MAI	241/261	92%	275/289	95%
Medical Transportation	233/241	97%	256/274	93%
Mental Health Services	70/72	97%	54/56	96%
Non-Medical Case Management	1537/1712	90%	1473/1688	87%
Non-Medical Case Management - MAI	240/263	91%	269/297	91%
Oral Health Care	452/471	96%	424/453	94%
Psychosocial Support Services - MAI	609/661	92%	542/598	91%
Viral Load Suppression	**2708/3274**	**83%**	2431/2775	88%
AIDS Pharmaceutical Assistance	53/57	93%	45/48	94%
Emergency Financial Assistance - Emergency Medication	23/24	96%	28/32	88%
Laboratory Diagnostic Testing	454/497	91%	440/484	91%
Medical Case Management	1128/1223	92%	1147/1253	92%
Medical Case Management - MAI	254/298	85%	290/329	88%
Non-Medical Case Management	1945/2113	92%	1917/2112	91%
Non-Medical Case Management - MAI	266/315	84%	307/353	87%
Specialty Outpatient Medical Care	145/166	87%	133/157	85%
Outpatient/Ambulatory Health Services	641/694	92%	682/739	92%

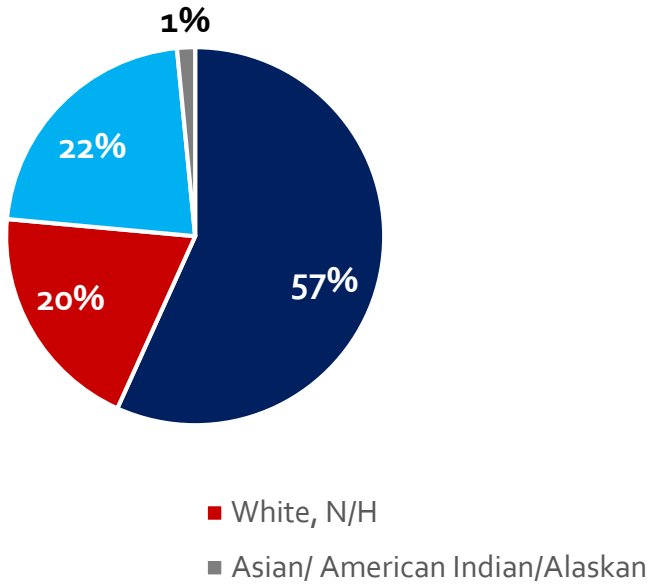
≥ 90%
80% - 89%
≤ 79%

Calendar Year (CY) 2023: Q1

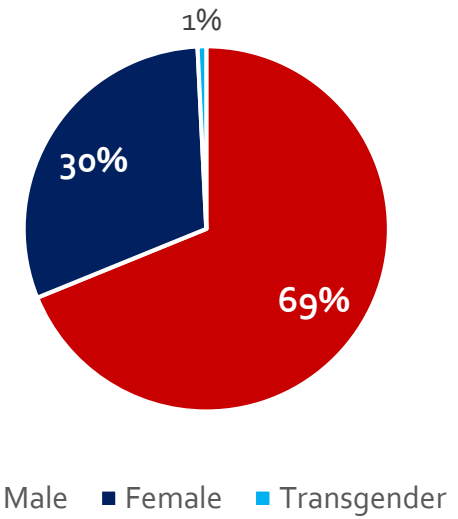
Retention in Care

N/D	%
1,801/2,096	86%

Clients Not RIC by Race/Ethnicity



Clients Not RIC by Gender

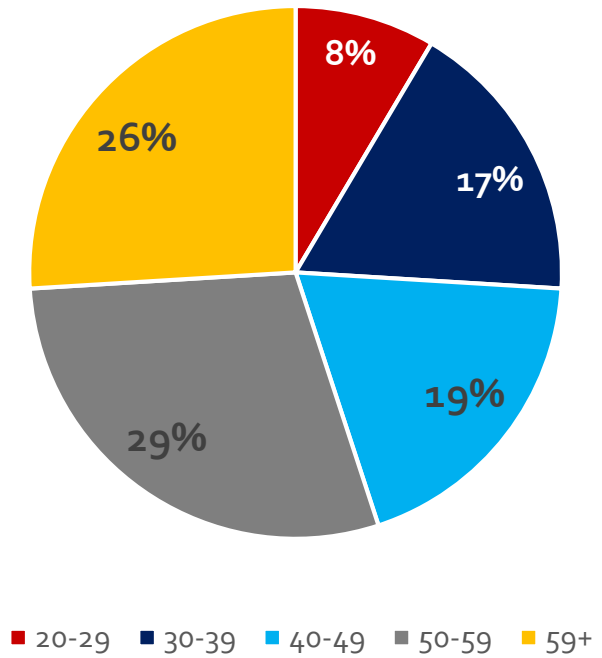


Palm Beach County
Ryan White HIV/AIDS Program

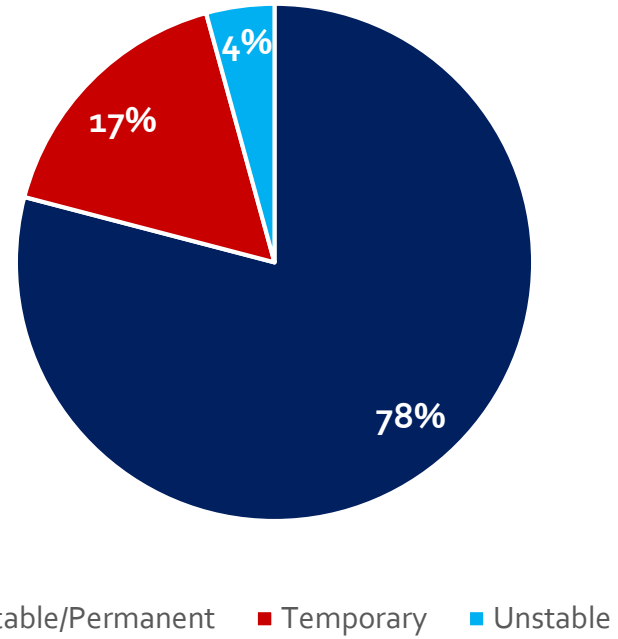
Calendar Year (CY) 2023: Q1

Retention in Care Cont.

Clients Not RIC by Age



Clients Not RIC by Housing Status

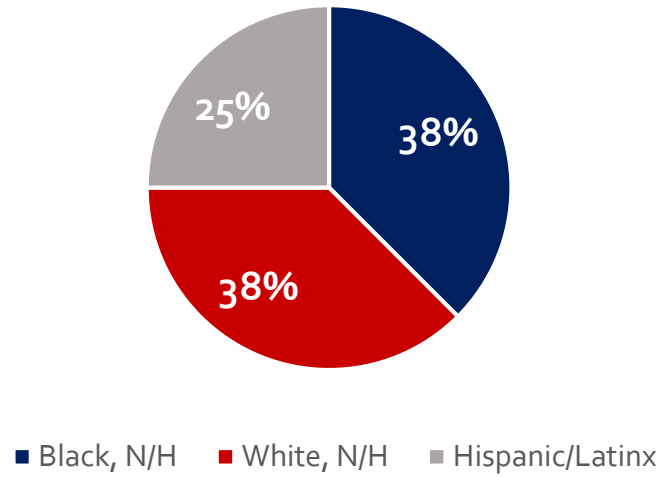


Calendar Year (CY) 2023: Q1

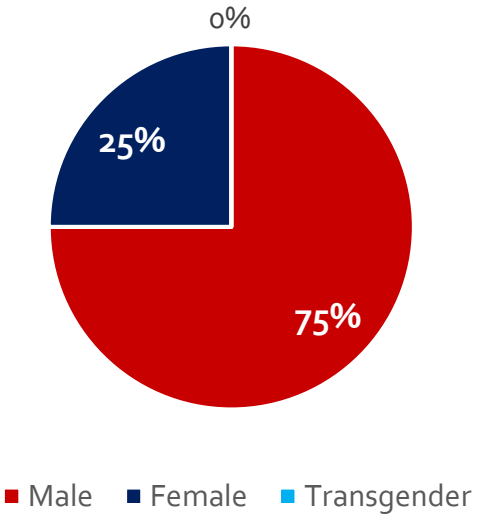
Retention in Care- Legal Services

N/D	%
218/245	89%

Clients Not VS by Race/Ethnicity

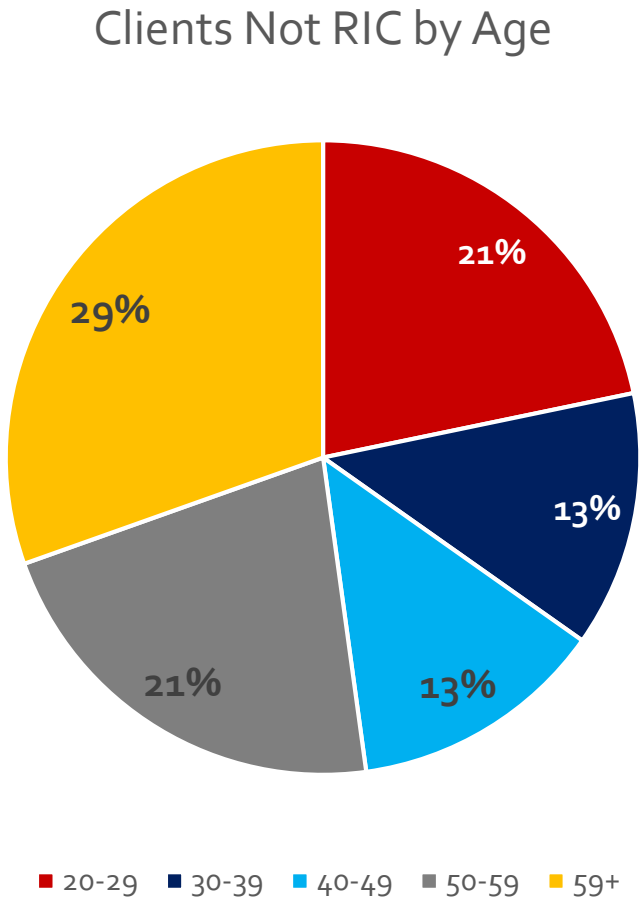


Clients Not RIC by Gender



Calendar Year (CY) 2023: Q1

Retention in Care- Legal Services Cont.

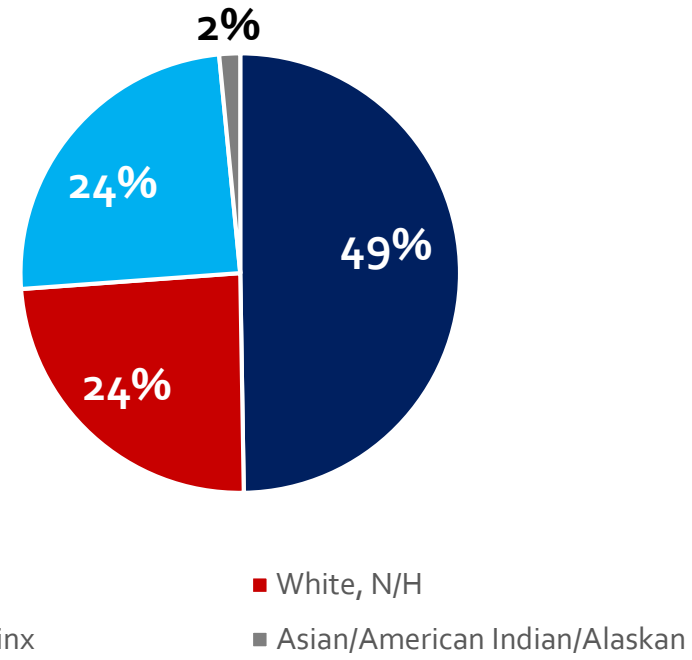


Calendar Year (CY) 2023: Q1

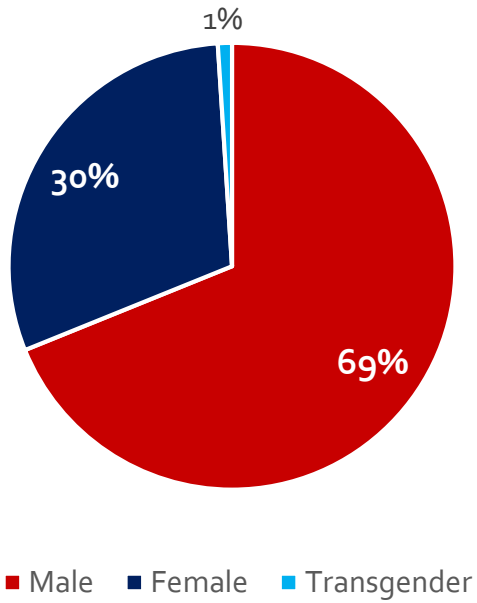
Retention in Care- Non Medical Case Management

N/D	%
1,473/1,688	87%

Clients Not RIC by Race/Ethnicity



Clients Not RIC by Gender

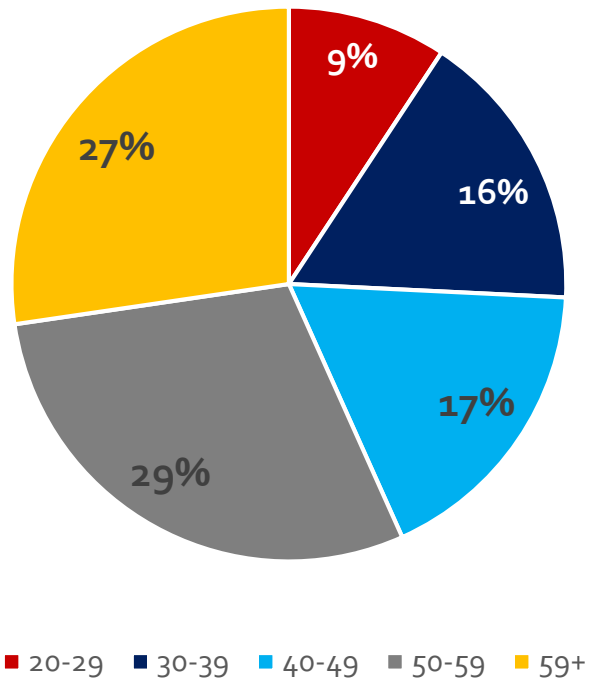


Palm Beach County
Ryan White HIV/AIDS Program

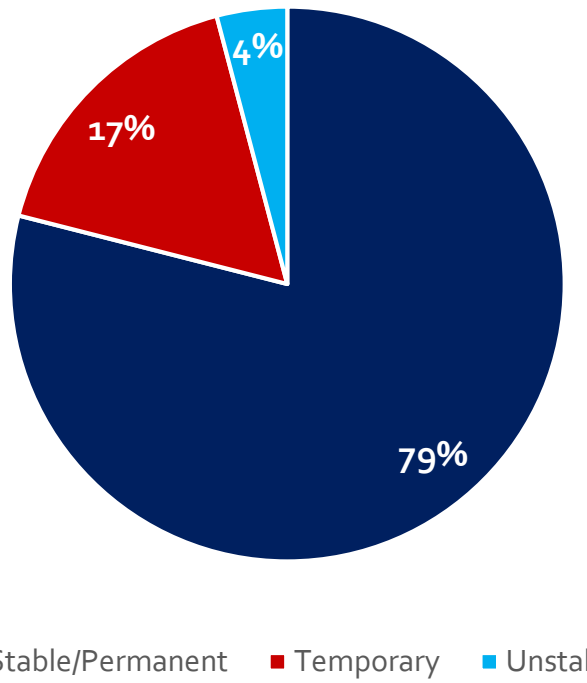
Calendar Year (CY) 2023: Q1

Retention in Care- Non Medical Case Management Cont.

Clients Not RIC by Age



Clients Not RIC by Housing Status

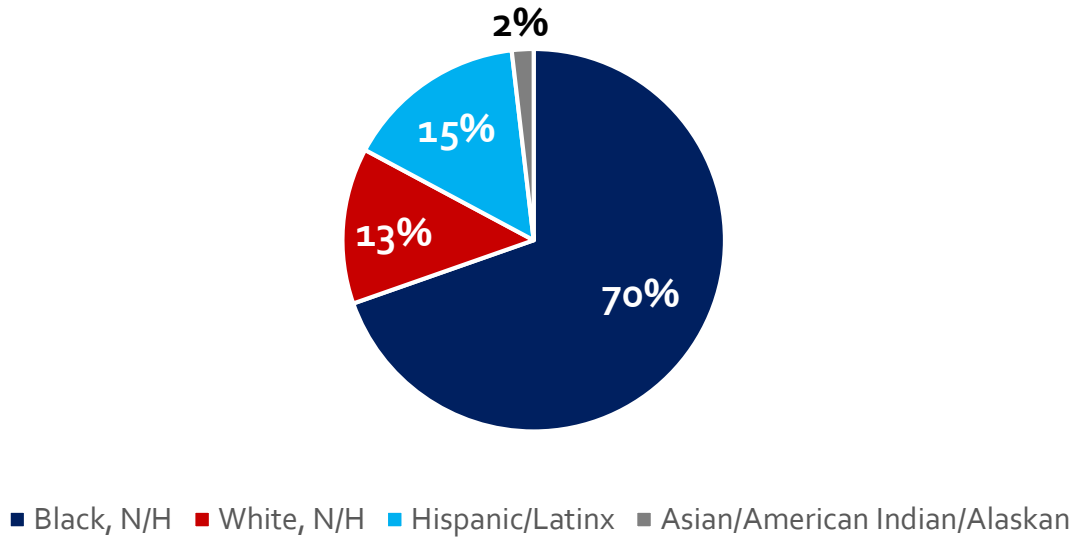


Calendar Year (CY) 2023: Q1

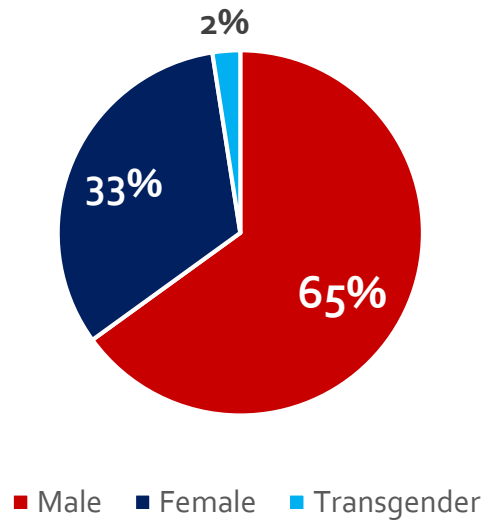
Viral Suppression

N/D	%
2,431/2,775	88%

Clients Not VS by Race/Ethnicity



Clients Not VS by Gender

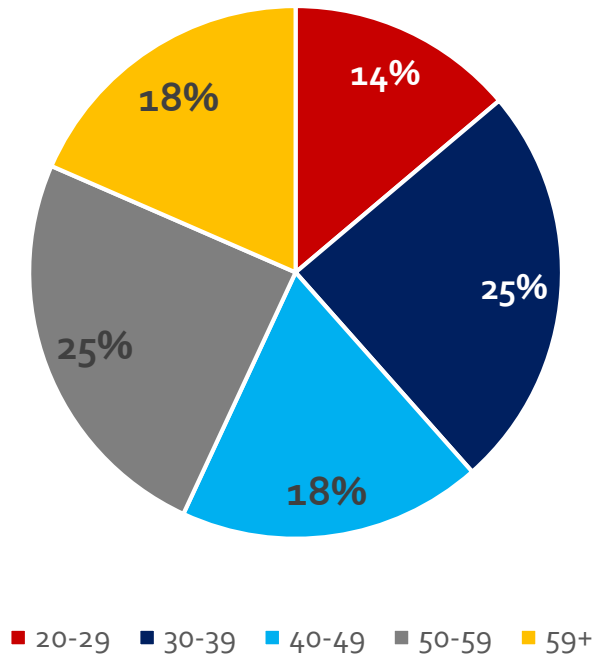


Palm Beach County
Ryan White HIV/AIDS Program

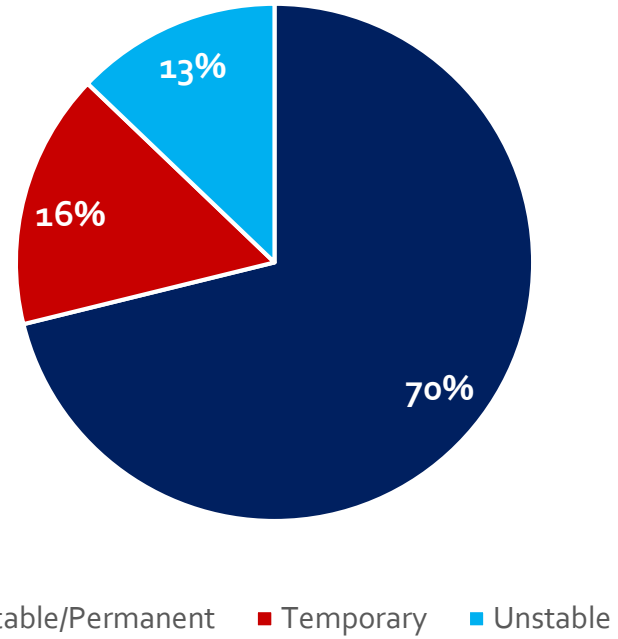
Calendar Year (CY) 2023: Q1

Viral Suppression Cont.

Clients Not VS by Age



Clients Not VS by Housing Status

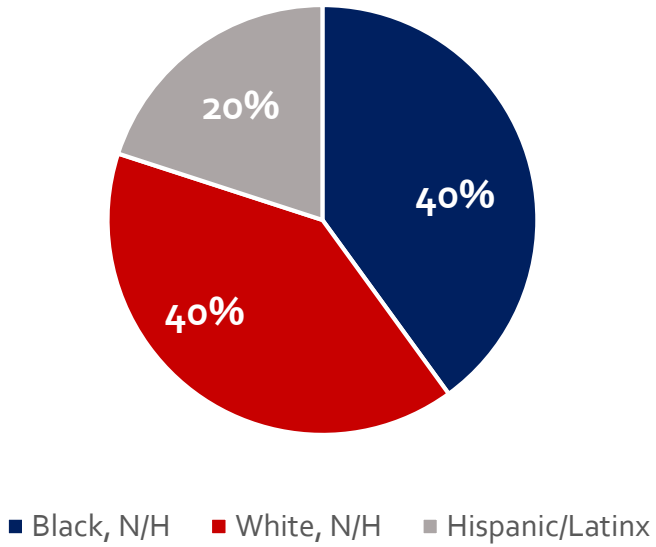


Calendar Year (CY) 2023: Q1

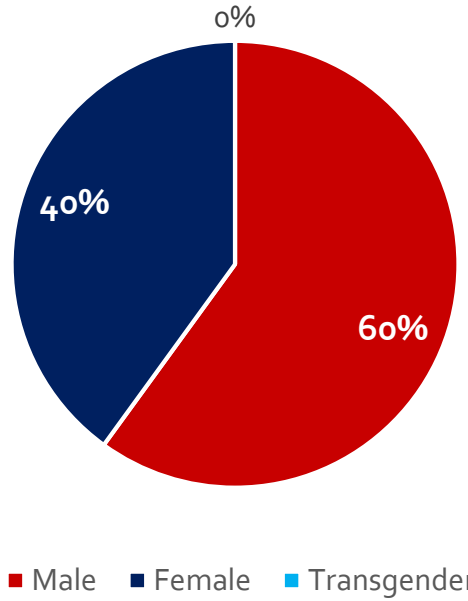
Viral Suppression- Emergency Financial Assistance- Emergency Medication

N/D	%
28/32	88%

Clients Not VS by Race/Ethnicity



Clients Not VS by Gender

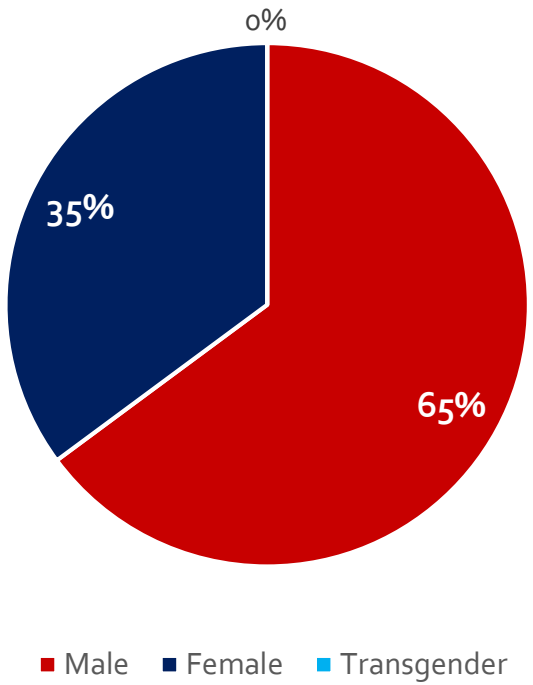


Calendar Year (CY) 2023: Q1

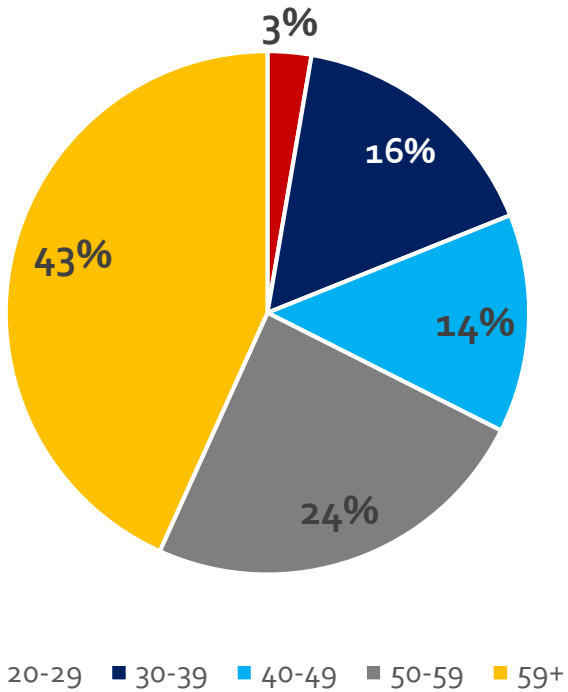
Viral Suppression- Medical Case Management MAI

N/D	%
290/329	88%

Clients Not VS by Gender



Clients Not RIC by Age

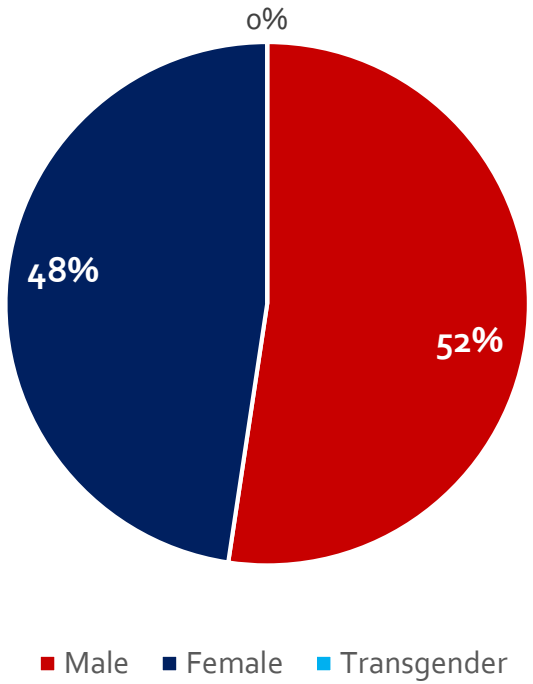


Calendar Year (CY) 2023: Q1

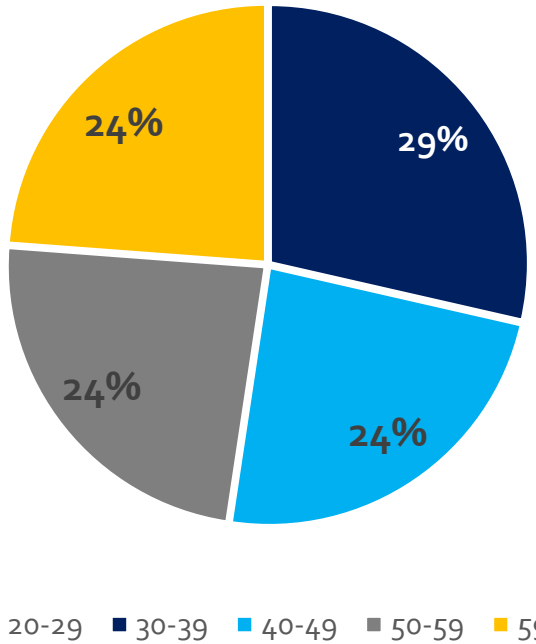
Viral Suppression- Non Medical Case Management MAI

N/D	%
307/353	87%

Clients Not RIC by Gender



Clients Not RIC by Age



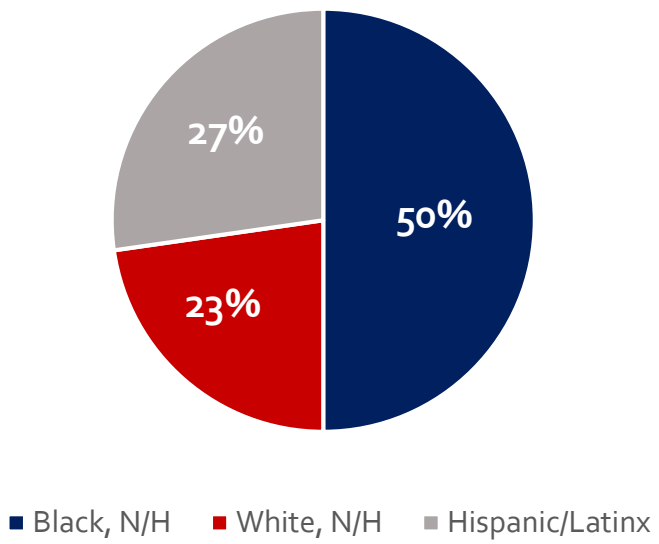
Palm Beach County
Ryan White HIV/AIDS Program

Calendar Year (CY) 2023: Q1

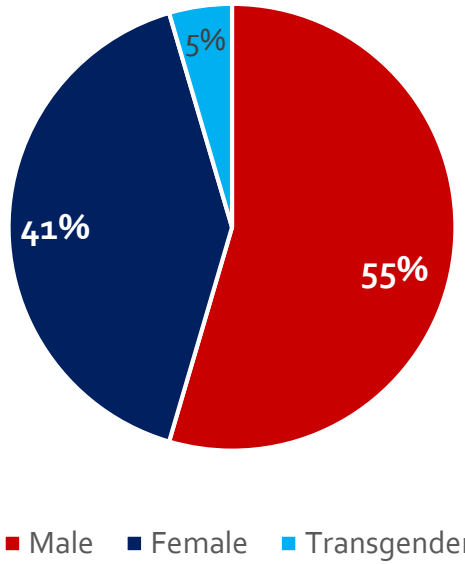
Viral Suppression- Specialty Outpatient Medical Care

N/D	%
133/157	85%

Clients Not VS by Race/Ethnicity



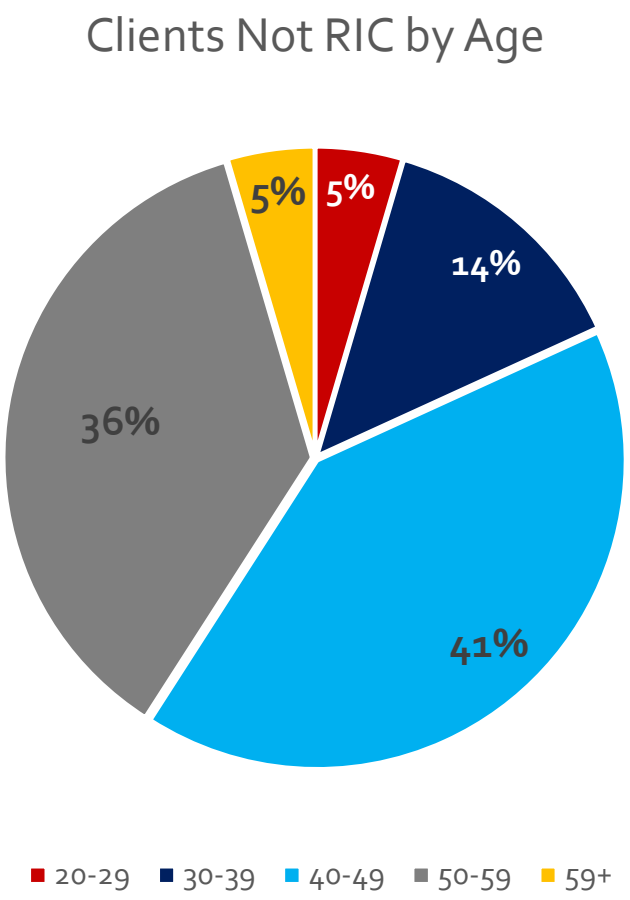
Clients Not RIC by Gender



Palm Beach County
Ryan White HIV/AIDS Program

Calendar Year (CY) 2023: Q1

Viral Suppression- Specialty Outpatient Medical Care Cont.



Questions?

PBC Ryan White Part A/MAI Clinical Quality Management & Quality Improvement Projects

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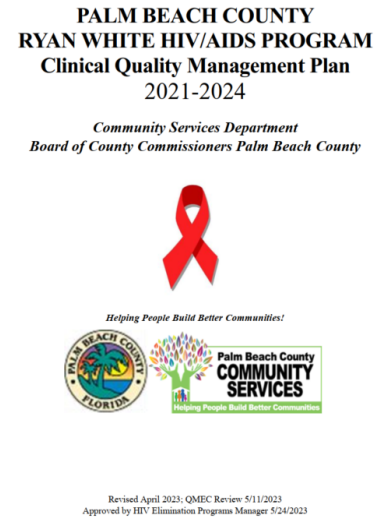
Palm Beach County
Ryan White HIV/AIDS Program

Quality Improvement Projects (QIP)

- Quality improvement involves the development and implementation of activities to make changes to the program in response to the performance data results. To do this, Recipients and Sub-recipients are required to implement quality improvement activities aimed at improving patient care, health outcomes, and patient satisfaction.
- Once QIPs are created and tested, we are then able to understand if specific changes or improvements had a positive impact on patient health outcomes or if further changes in RWHAP funded services are necessary.

Ryan White Quality Management Program

- **Recipient and Sub-Recipient Clinical Quality Management (CQM) Plans**
  - Document that includes an implementation description of the 3 items required of a CQM program:
    - Infrastructure
    - Performance Measurement
    - Quality Improvement
- **Plan, Do, Study, Act (PDSA) Template**
  - Standardized form
    - Form for recipients to track their progress
- **Monthly Quality Improvement Workgroup**
  - Agencies are required to keep track of what they are doing and report back at the workgroup
    - Challenges, feedback

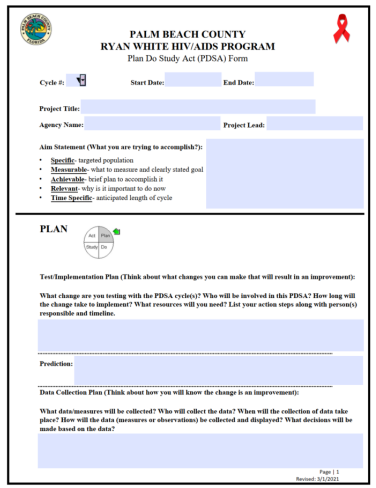

PALM BEACH COUNTY
RYAN WHITE HIV/AIDS PROGRAM
Clinical Quality Management Plan
2021-2024

Community Services Department
Board of County Commissioners Palm Beach County

Helping People Build Better Communities!

Palm Beach County COMMUNITY SERVICES
Helping People Build Better Communities

Revised April 2023; QMEC Review 5/11/2023
Approved by HIV Elimination Programs Manager 5/24/2023


PALM BEACH COUNTY
RYAN WHITE HIV/AIDS PROGRAM
Plan Do Study Act (PDSA) Form

Cycle #: Start Date: End Date:

Project Title:

Agency Name: Project Lead:

Aim Statement (What you are trying to accomplish?):

- Specific- targeted population
- Measurable- what to measure and clearly stated goal
- Achievable- brief plan to accomplish it
- Relevant- why is it important to do now
- Time Specific- anticipated length of cycle

PLAN

Test/Implementation Plan (Think about what changes you can make that will result in an improvement):

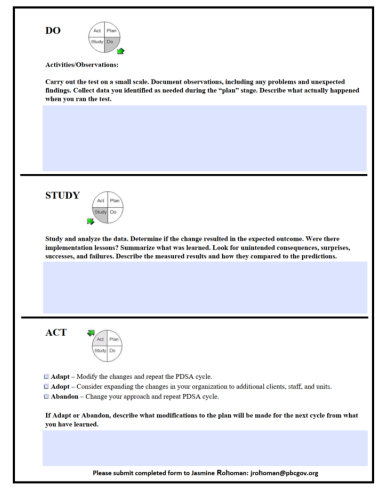
What change are you testing with the PDSA cycle(s)? Who will be involved in this PDSA? How long will the change take to implement? What resources will you need? List your action steps along with person(s) responsible and timeline.

Prediction:

Data Collection Plan (Think about how you will know the change is an improvement):

What data/measures will be collected? Who will collect the data? When will the collection of data take place? How will the data (measures or observations) be collected and displayed? What decisions will be made based on the data?

Page | 1
Revised: 3/1/2021


DO

Activities/Observations:

Carry out the test on a small scale. Document observations, including any problems and unexpected findings. Collect data you identified as needed during the "plan" stage. Describe what actually happened when you ran the test.

STUDY

Study and analyze the data. Determine if the change resulted in the expected outcome. Were there implementation lessons? Summarize what was learned. Look for unintended consequences, surprises, successes, and failures. Describe the measured results and how they compared to the predictions.

ACT

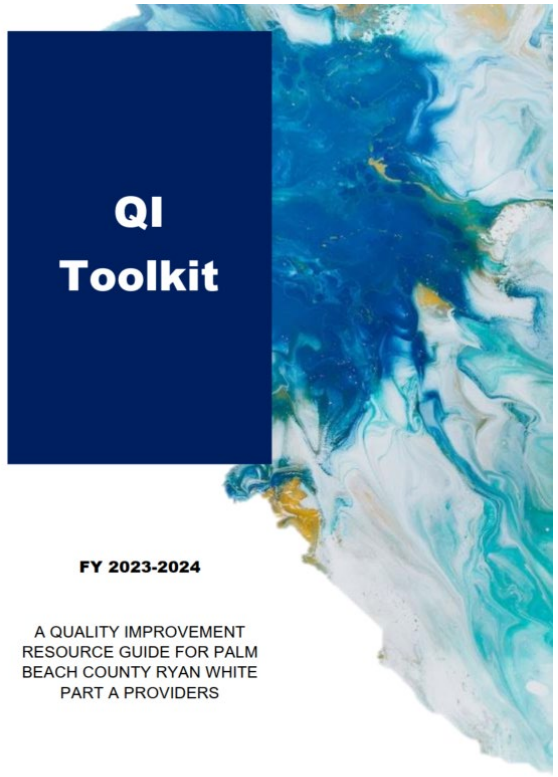
☐ **Adapt** – Modify the changes and repeat the PDSA cycle.
☐ **Adopt** – Consider expanding the changes in your organization to additional clients, staff, and units.
☐ **Abandon** – Change your approach and repeat PDSA cycle.

If Adapt or Abandon, describe what modifications to the plan will be made for the next cycle from what you have learned.

Please submit completed form to Jasmine Rohoman: jrohoman@pbcgov.org

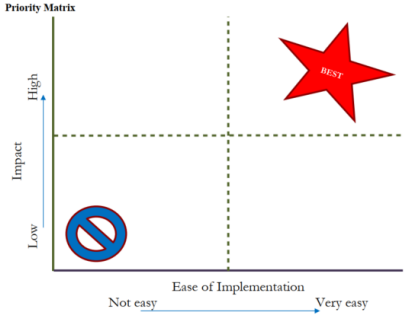
Palm Beach County
Ryan White HIV/AIDS Program

Ryan White Quality Improvement Toolkit



A Brainstorm, Priority Matrix or Force Field Analysis may be helpful in selecting a project and generating consensus among stakeholders.

Priority Matrix



The Priority Matrix helps you to:

- Evaluate the impact and ease of implementation
- Gain additional clarity on moving forward with improvements
- Take into account available resources
- Remember: It's a guide and does not take into account organizational or legislative imperatives

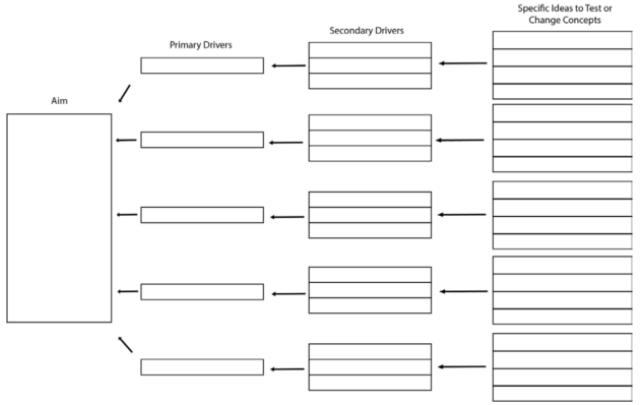
Checkpoint 1: Identify Focus Areas for Quality Improvement Projects

Quality Improvement Projects (QIPs) aim to improve the quality of care provided to consumers within the EMA. The goal for all consumers within the EMA is sustained retention in care and viral suppression. There are many issues faced by consumers that impact their ability to achieve this.

Please identify one to three areas that could be targeted with a QIP.

Issue:	
Prevalence/Frequency/Incidence:	
Population(s) Affected:	
Seriousness/Urgency:	
Available Data Sources:	
Possible Interventions:	
Current Interventions:	

Materials Adapted From:
• Schlueter, J., Washington, E., & Moore, J. (2019, November 21). *Choosing an Improvement Project.* Retrieved from Target HIV: https://targethiv.org/library/choosing-improvement-project



Checkpoint 3: Aim Statement

What are you trying to accomplish?

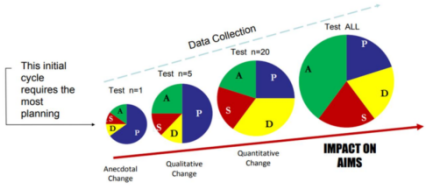
• What do you hope to accomplish with this project? Aims should be SMART, specific, clear, well defined, and at a **minimum**, describe the target population, the desired improvement, and the targeted time frame.

Use the following table to put together your aim statement.

To increase/decrease		(process/outcome)
from		(baseline %, rate, #, etc.)
to		(goal, target %, rate, #, etc.)
by		(date)
in		(group, population)

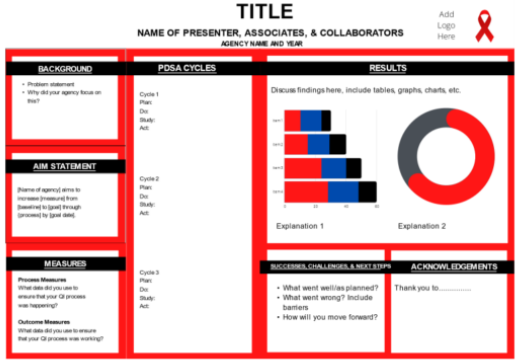
Ramping Up your PDSA Cycles:

Complete multiple rounds of PDSA cycles. After several cycles, your team should have a good idea of which ideas have the most significant impact, and which to discard. As each cycle finds, successes and limitations are accounted for, testing at grander scales become feasible.



PDSA cycles are practical and useful tools, but one difficulty is keeping the momentum. It is essential to understand that it is okay if it does not work, but rather than restarting, modifying the process is often a better alternative towards implementation at a larger scale.

Appendix D



Palm Beach County
Ryan White HIV/AIDS Program

Questions?

Identifying Disparities to Engage Action (IDEA) QIP:

Hybrid RWHAP System-level & Agency-level Project

March 2023 - February 2024

Palm Beach County
Ryan White HIV/AIDS Program

Identifying Disparities & Engaging Action (IDEA): Quality Improvement Project Charter

PURPOSE:

- The IDEA Quality Improvement Project (QIP) is a hybrid Systems-Level and Agency-Level project
- The goal is universal for all sub-recipients: to identify the largest disparities among racial/ethnic, gender and/or age groups along the continuum of care for each agency
- The quality improvement intervention will be tailored to the disparities and root causes found at each agency for an identified sub-population and will be facilitated by the Recipient's office

Identifying Disparities & Engaging Action (IDEA): Quality Improvement Project Charter

Project Rationale

- PCN 15-02 requirement
- Health outcome disparities are unjust
- In the first quarter of CY 2023, Black/African-Americans served by RWHAP in PBC had lower viral suppression rates (85%) compared to Hispanic/Latinx (91%) and Non-Hispanic White individuals (91%)
  - Which translates to 237 Black/African-American individuals who are not virally suppressed (compared to 55 Hispanic/Latinx and 43 Non-Hispanic White)
- The Continuum of Care Optimized Report in Provide Enterprise will be used for each agency by service category to identify these disparities
- The Recipient Support assigned will run the data for each agency for baseline, quarterly and at the end of the project

Identifying Disparities & Engaging Action (IDEA): Quality Improvement Project Charter

TEAM MEMBERS & ROLES:
Team Leader: Daisy Wiebe
Team Facilitator: Jasmine Rohoman
MAI Lead: Gecica Tibert

Sub-recipient Leads/Recipient Support:
AHF: Neil Walker/Jasmine Rohoman
Compass: Neka Mackay/Daisy Wiebe
FDOH: Katie Mathieu/Daisy Wiebe
FoundCare: Lilia Perez/Gecica Tibert, Jasmine Rohoman and Daisy Wiebe
HCSEF: Marsharee Chronicle/Gecica Tibert & Jasmine Rohoman
Legal Aid: Sandra Powery Moses/Daisy Wiebe
Midway: Geoff Downie/Daisy Wiebe
Monarch: Jeanice Petit-Frere/Jasmine Rohoman
Poverello: Brad Barnes/Jasmine Rohoman

Lived-experience Liaison: Cecil Smith (Member of Quality Management & Evaluation Committee of the HIV CARE Council)
Project Champion: Casey Messer

Identifying Disparities & Engaging Action (IDEA)

Activities

- The Quality Improvement Workgroup
- Quality Improvement Toolkit
  - Checkpoints and deadlines
  - Assigned Recipient support staff to run the data reports, helping understand the data, facilitating drivers diagram sessions, helping to draft aim statements and PDSA cycles
  - Together, the sub-recipients and support staff will develop or determine an intervention that would potentially address the root cause identified
  - Sub-recipients will be responsible for enacting the proposed intervention
- There will be a preliminary data review and evaluation at the end of the project with a presentation by sub-recipients to each other

Resources Needed

- Commitment from sub-recipients for meetings and enacting an intervention
  - Will include individual agency monthly meetings (2 hours) with Recipient support staff and participation in the monthly QI Workgroup (all agencies reporting progress)

Identifying Disparities & Engaging Action (IDEA)

VISION OF SUCCESS:

- The success of this QIP will rely on the identification of the largest health outcome disparities that are then acted upon with sub-recipient tailored interventions for sub-populations
- Each specific aim statement will be created by each sub-recipient with facilitation from each Recipient support staff
- These aim statements will have agency-level goals for reducing the disparity identified
- The goal of the project is to reduce disparities among those sub-populations and to elevate individual and population health

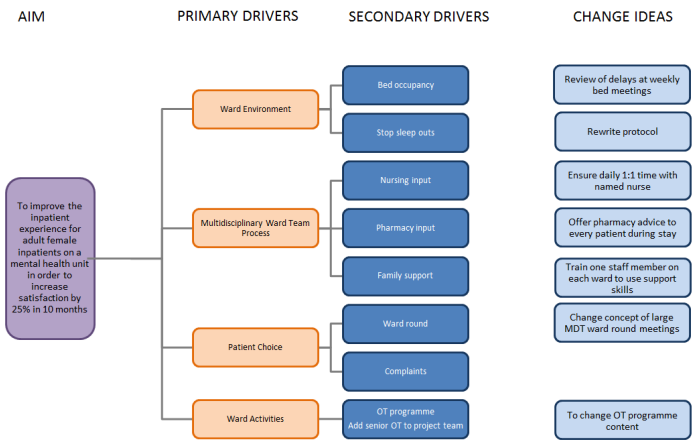
Project Milestones	Owner:	Planned Dates:	Current Status: *Working, waiting, in review, and any notes.*	Date Completed:
1. Set Overall Project Scope and Goals (Prepare Project Charter, Engage Team, Collect Data)	Champion, Team Leader, Facilitator	March-May 2023	Completed	June 2, 2023
2. Identify Focus Areas for Quality Improvement with Data (Checkpoint 1)	Recipient Support Staff & Sub-recipient	June 12, 2023 – July 7, 2023	Completed for 6/9 sub-recipients	July 7, 2023
3. Identifying the Problem with Driver Diagrams (Checkpoint 2)	Recipient Support Staff & Sub-recipient	July 10, 2023 – August 18, 2023		
4. Define Aim Statements (Checkpoint 3)	Recipient Support Staff & Sub-recipient	July 10, 2023 – August 18, 2023		
5. Drivers/Contributing Factors: Generate, Evaluate and Select Improvements (Checkpoint 4)	Recipient Support Staff & Sub-recipient	July 10, 2023 – August 18, 2023		
6. PDSA Cycle Planning Form (Checkpoint 5)	Recipient Support Staff & Sub-recipient	August 21, 2023 – December 8, 2023		
7. Implementing the Intervention	Sub-recipient	August 21, 2023 – December 8, 2023		
8. Preliminary QIP Data Review and Evaluation (Checkpoint 6)	Team Facilitator & Sub-recipient	December 11, 2023 – January 19, 2024		
9. Constructing a QIP Poster & Presentation (Checkpoint 7)	Sub-recipient	January 22, 2024 - February 26, 2024	Sub-recipient presentations at QI Workgroup February 26, 2024 from 1-3 pm	
10. Sustain Improvement	Sub-recipient	March 2024 +		

Checkpoint 1 Overview:

- Each agency has identified a service category and/or a specific subpopulation they would like to focus on based on their data. A few examples include:
  - Retention in Care of Non-Medical Case Managed Clients (Black, N/H and Hispanic/Latinx)
  - Viral Suppression in
    - Medically Case Managed Clients
    - MAI Clients, aged 59+
    - Clients receiving legal services
    - EIS Clients
    - OAHS Clients
      - Aged 20-29
      - Black/African American & Hispanic/Latinx Clients

Next Steps:

- Agencies will now begin working on the next 3 checkpoints:
  - Driver diagrams/Fish bone diagrams
  - Creation of an AIM statement
  - Identifying process and outcome measurements



Questions?

Create+Equity Collaborative

Improving Detection of Mental Health Barriers

January 2021 – June 2022

Palm Beach County
Ryan White HIV/AIDS Program

create equity collaborative

- National collaborative from Centers for Quality Improvement and Innovation (CQII)
- Approximately 100 sites, mostly Ryan White clinics
- 4 Affinity Groups: Mental Health, Substance Use, Housing and Age

HRSA Ryan White HIV/AIDS Program
CENTER FOR QUALITY IMPROVEMENT & INNOVATION

Affinity Group Data from PBC RWHAP

- Mental Health – Based on Case Management Assessment Self-Report
  - 654 Depressed
  - 63 Severe Depression
  - 78 Currently Experiencing Mental Health Problems (Not Depressed)
  - 283 Some Concerns or History of Mental Illness (Not Depressed)
- Total: 1078/3581 or 30% of All Ryan White Clients
- Total: 1078/2251 or 48% of All Ryan White Clients w/ a Case Management Assessment

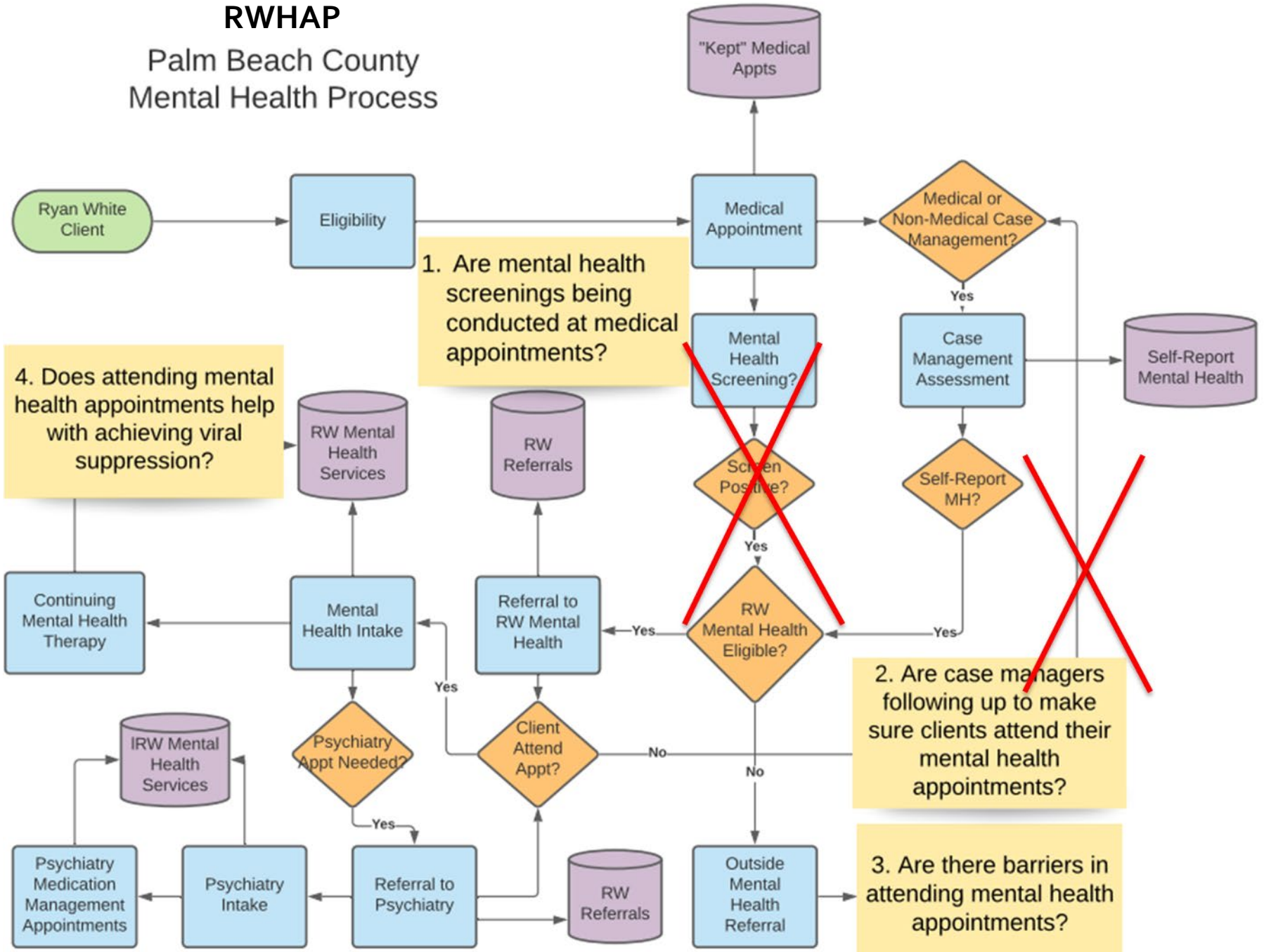
- Data from 5/11/2021 in Provide Enterprise

Collaboration in RWHAP

- 1st Provider Meeting: May 17, 2021
  - Flow Chart
- Content Expert/Community Meeting: May 26, 2021
  - Review of Flow Chart
  - Root Causes for Client Experiences – using 5 Whys Analysis
  - Review Evidence-Based Interventions and Selection
  - Aim Statements
- 2nd Provider Meeting: June 16, 2021
  - Complete Provider Processes Root Causes
  - Review of Client Experience Root Causes
  - Review and Finalize Evidence-Based Interventions
  - Review Aim Statements

RWHAP

Palm Beach County Mental Health Process



Palm Beach County
Ryan White HIV/AIDS Program

Root Causes for Lack of Mental Health Screening

- Mental health screening not conducted by Providers because of lack of time to address in 15 minute appointments & lack of mental health providers to refer to

- Mental health screening not conducted by Case Managers because they are using the Case Management Assessment, which is self-report of mental health concerns rather than a screening

Improvement Focus Areas

- **Viral Suppression:** Increases in viral suppression rates of clients with a mental health diagnosis or diagnoses (site-selected population of focus)

- **Screening:** Increases in routine mental health screening rates across all clients served by the Community Partner

Interventions

- Mental Health and Substance Abuse Screening (MHSAS) in Palm Beach County Ryan White HIV/AIDS Program (PBC RWHAP)
- Staff Training on Motivational Interviewing (MI) for PBC RWHAP
- Tele-adherence Counseling (TAC) to Improve Viral Load Suppression Among Clients Receiving Mental Health Services in PBC RWHAP

Aim Statements

- Palm Beach County RWHAP seeks to increase the viral suppression rate among clients receiving mental health services from 78% to 85% over the next 18 months (January 2021 to June 2022)

- Palm Beach County RWHAP seeks to increase the mental health screening rate among clients from 0% to 75% over the next 18 months (January 2021 to June 2022)

Mental Health Screening

- Mental Health and Substance Abuse Screening (MHSAS) in Palm Beach County Ryan White HIV/AIDS Program (PBC RWHAP)
  - Loosely based on Optimal Active Linkage and Referral (Active Referral Intervention)
- PBC RWHAP clients previously were only regularly screened for mental health or substance abuse if they attended 2 (smaller) of the 4 clinics that are a part of PBC RWHAP
- PBC RWHAP case managers were not screening for mental health or substance use even though the case management assessment asks about it (would rely on self-report)

Mental Health Screening

- Solution: PBC RWHAP case managed clients now are being screened with a PHQ-2, then PHQ-9 if warranted during their case management assessment (every 6 months)
  - If Question 9 to PHQ-9 is >0 ("Thoughts you would be better off dead or of hurting yourself in some way"), then the client is followed up with a Columbia Suicide Severity Rating Scale (C-SSRS)
- Bonus: Modified Substance Abuse and Mental Illness Symptoms Screener (SAMISS) is also being completed
  - Picks up on other mental health symptoms such as anxiety and PTSD
  - Also screening for substance use
- The PHQ and SAMISS tools were already programmed in Provide Enterprise, the database we use, so Groupware Technologies could more easily modify and "turn it on" for us rather than add a GAD-7 or other screening tools. C-SSRS is done on paper.

PHQ-9

Over the last 2 *weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

COLUMBIA-SUICIDE SEVERITY RATING SCALE (C-SSRS)

Screen Version - Recent

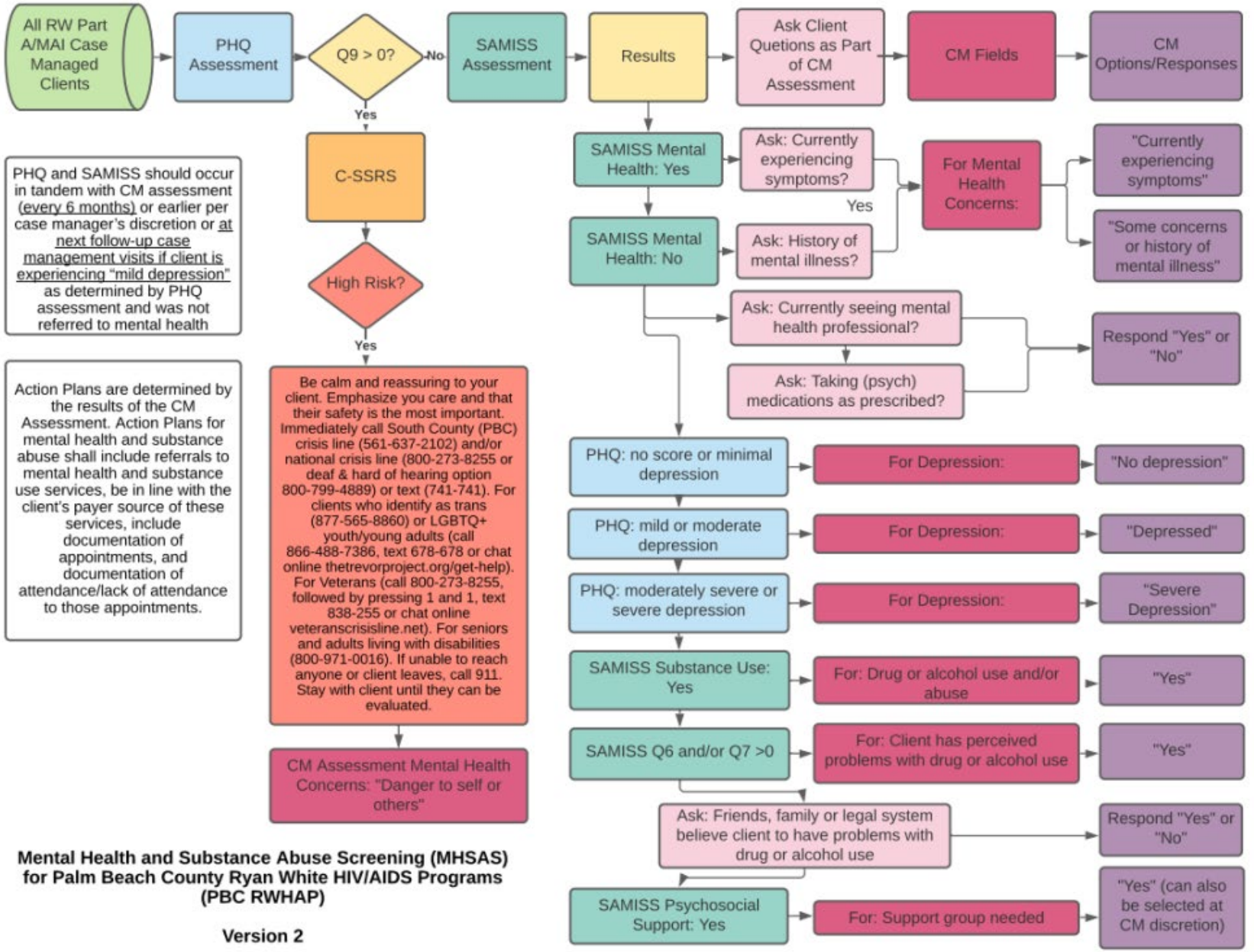
	Past month	
Ask questions that are underlined.	**YES**	**NO**
Ask Questions 1 and 2		
1) ***Have you wished you were dead or wished you could go to sleep and not wake up?***		
2) ***Have you actually had any thoughts of killing yourself?***		
If YES to question 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) ***Have you been thinking about how you might do this?***		
4) ***Have you had these thoughts and had some intention of acting on them?***		
5) ***Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan?***		

	YES	NO
6) ***Have you ever done anything, started to do anything, or prepared to do anything to end your life?***		
Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.		
If YES, ask: *Was this within the past three months?*		

- Low Risk
- Moderate Risk
- High Risk

Any YES indicates that someone should seek mental health/behavioral healthcare.

If High Risk: Be calm and reassuring to your client. Emphasize you care and that their safety is the most important. Immediately call South County (PBC) crisis line (561-637-2102) and/or national crisis line (800-273-8255 or deaf & hard of hearing option 800-799-4889) or text (741-741). For clients who identify as trans (877-565-8860) or LGBTQ+ youth/young adults (call 866-488-7386, text 678-678 or online chat thetrevorproject.org/get-help). For Veterans (call 800-273-8255, followed by pressing 1 and 1, text 838-255 or chat online veteranscrisisline.net). For seniors and adults living with disabilities (800-971-0016). If unable to reach anyone or client leaves, call 911. Stay with client until they can be evaluated.

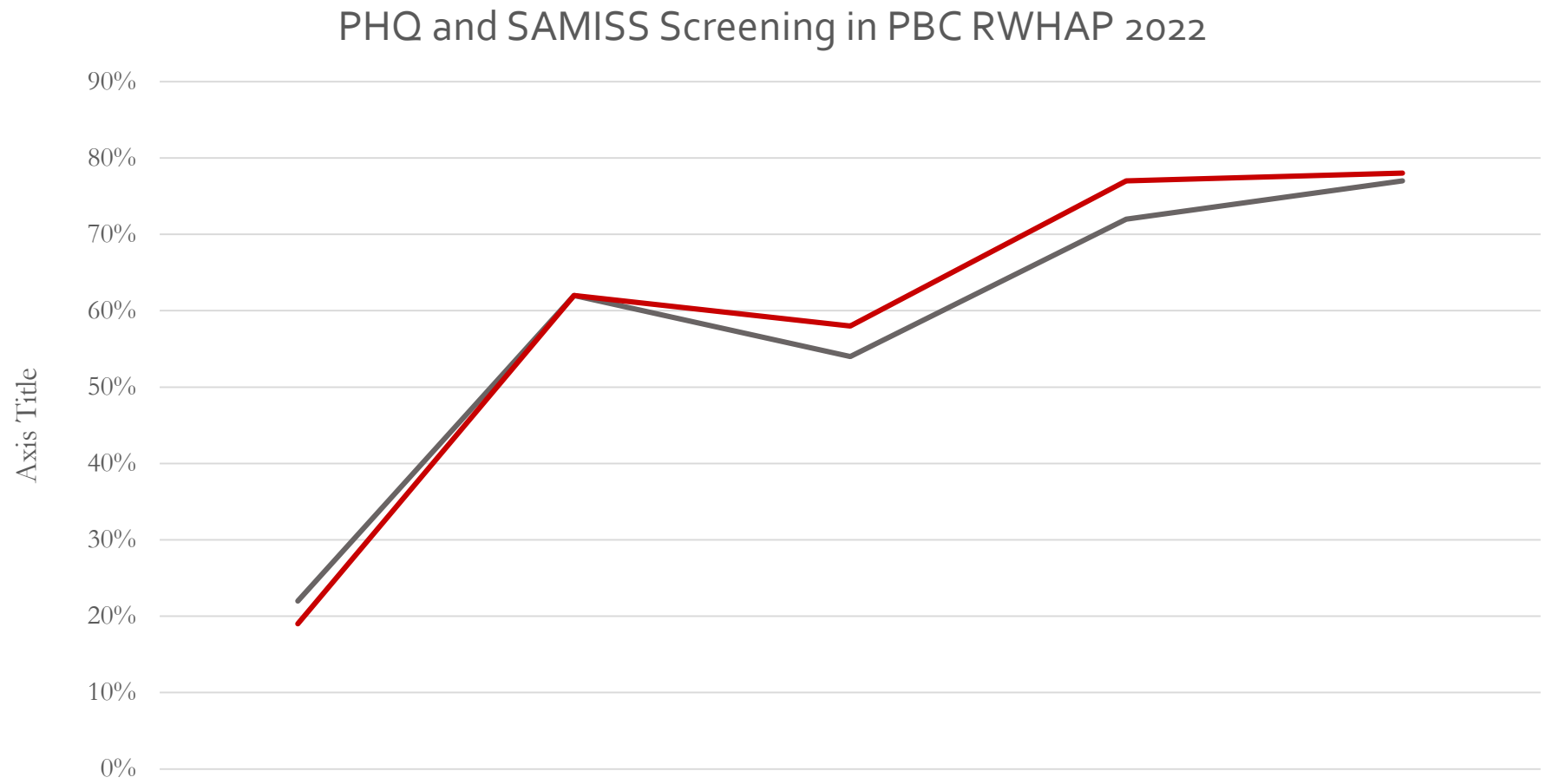


Mental Health and Substance Abuse Screening (MHSAS) for Palm Beach County Ryan White HIV/AIDS Programs (PBC RWHAP)

Version 2

Motivational Interviewing

- Staff Training on Motivational Interviewing (MI) for PBC RWHAP
  - Based on Staff Training on Motivational Interviewing Skills, Strategies and Tools
- Conducted by South Florida AIDS Education & Training Center
- Two-hour training conducted virtually in July 2021, with more than 20 case managers attending
- Now offered regularly with our Case Management Training series twice a year

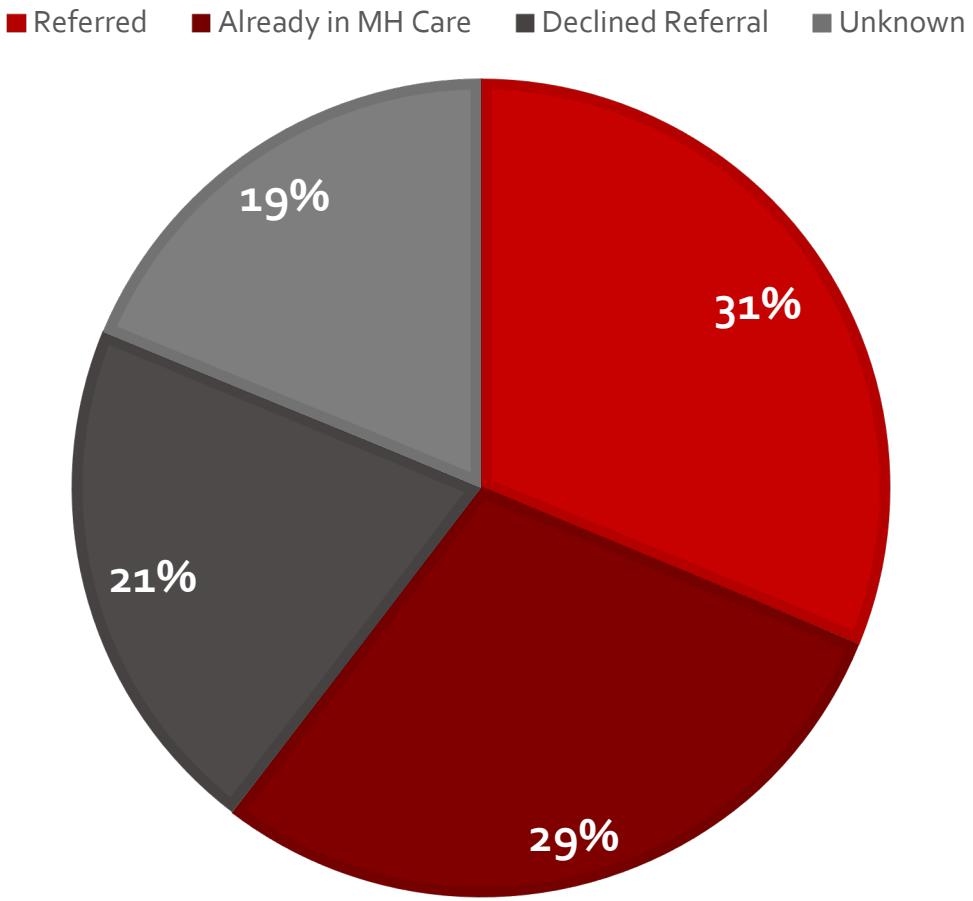


	Jan-22	Feb-22	Mar-22	Apr-22	May-22
PHQ	22%	62%	54%	72%	77%
SAMISS	19%	62%	58%	77%	78%

Total of 490 individuals screened

Palm Beach County
Ryan White HIV/AIDS Program

MODERATE-SEVERE DEPRESSION



Tele-adherence Counseling (TAC)

- Tele-adherence Counseling (TAC) to Improve Viral Load Suppression Among Clients Receiving Mental Health Services in PBC RWHAP
  - Loosely based on Tele-health to Increase ART Adherence

- PositiveLinks® from Warm Health Technology
- Adapted for Palm Beach County for use with Ending the HIV Epidemic (EHE)
- Daily mood and stress check-ins, daily medication reminders, anonymous community message board, tracking of viral load/CD_4 data, local resources, private messaging and sessions with tele-adherence counselor
- Smartphone if client does not have one, data plan support if client achieves a set goal for participation in daily check-ins

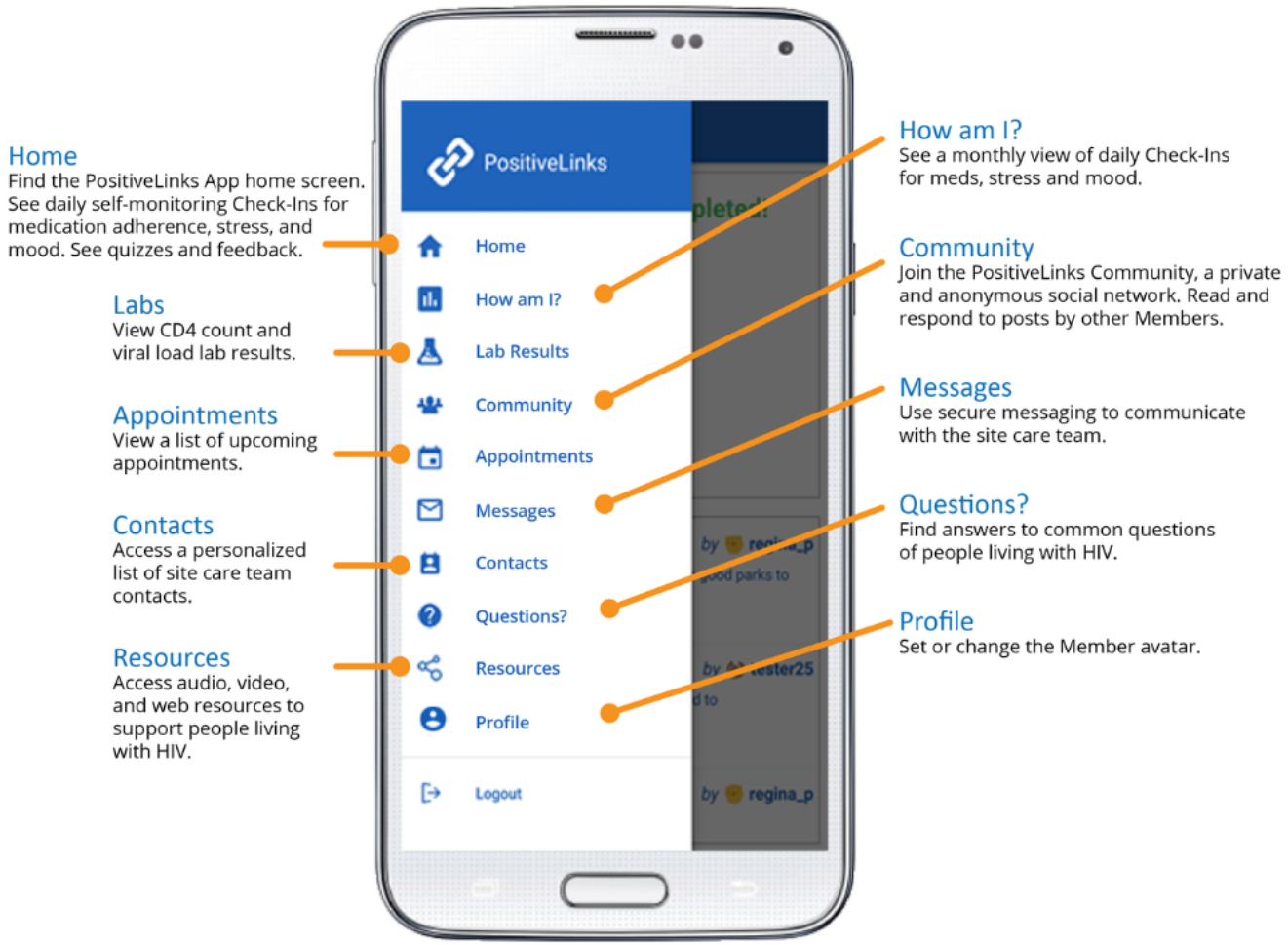
PositiveLinks: A Mobile Health Intervention for Retention in HIV Care and Clinical Outcomes with 12-Month Follow-Up

Rebecca Dillingham, MD, MPH,[1] Karen Ingersoll, PhD,[2] Tabor E. Flickinger, MD, MPH,[1] Ava Lena Waldman, MHS, CHES, CCRP,[1] Marika Grabowski, MPH,[1] Colleen Laurence, MPH,[1] Erin Wispelwey, MSC,[1] George Reynolds, BA,[3] Mark Conaway, PhD,[4] and Wendy F. Cohn, PhD[4]

Abstract

Mobile health interventions may help People Living with HIV (PLWH) improve engagement in care. We designed and piloted PositiveLinks, a clinic-affiliated mobile intervention for PLWH, and assessed longitudinal impact on retention in care and viral suppression. The program was based at an academic Ryan White Clinic serving a nonurban population in Central Virginia. The PL intervention included a smartphone app that connected participants to clinic staff and provided educational resources, daily queries of stress, mood and medication adherence, weekly quizzes, appointment reminders, and a virtual support group. Outcomes were analyzed using McNemar's tests for HRSA-1, visit constancy, and viral suppression and nonparametric Wilcoxon signed-rank tests for CD4 counts and viral loads. Of 77 participants, 63% were male, 49% black non-Hispanic, and 72% below the federal poverty level. Participants' achievement of a retention in care benchmark (HRSA-1) increased from 51% at baseline to 88% at 6 months ($p<0.0001$) and 81% at 12 months ($p=0.0003$). Visit constancy improved from baseline to 6 months ($p=0.016$) and 12 months ($p=0.0004$). Participants' mean CD4 counts increased from baseline to 6 months ($p=0.0007$) and 12 months ($p=0.0005$). The percentage of participants with suppressed viral loads increased from 47% at baseline to 87% at 6 months ($p<0.0001$) and 79% at 12 months ($p=0.0007$). This study is one of the first to demonstrate that a mobile health intervention can have a positive impact on retention in care and clinical outcomes for vulnerable PLWH. Next steps include integration with clinical practice and dissemination.

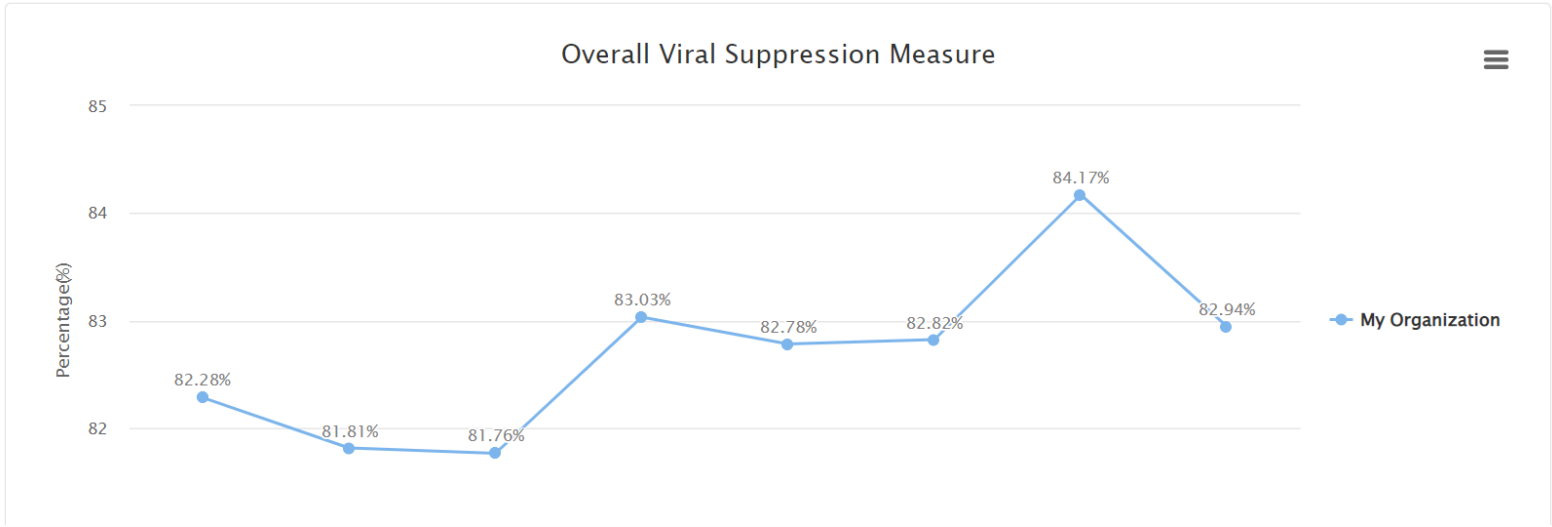
Keywords: mobile health, smartphone app, retention in care, HIV/AIDS, positive links

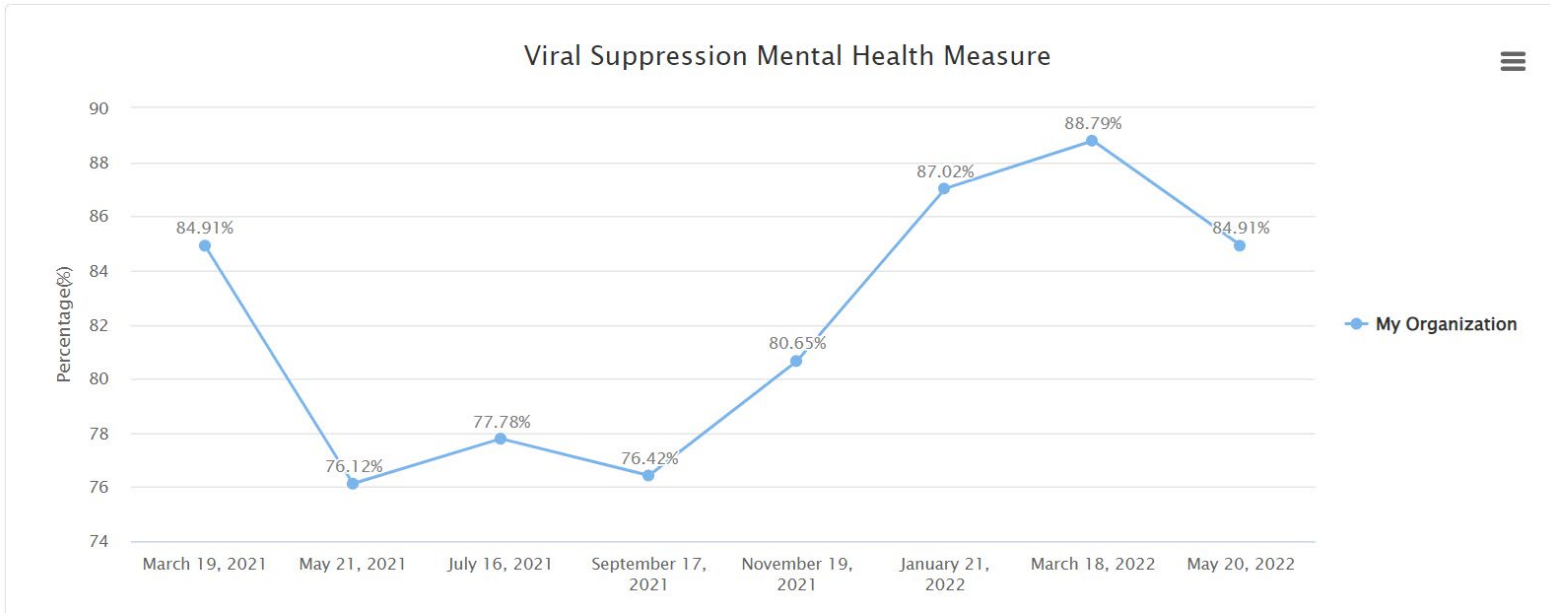

Home
Find the PositiveLinks App home screen. See daily self-monitoring Check-Ins for medication adherence, stress, and mood. See quizzes and feedback.
Labs
View CD4 count and viral load lab results.
Appointments
View a list of upcoming appointments.
Contacts
Access a personalized list of site care team contacts.
Resources
Access audio, video, and web resources to support people living with HIV.
PositiveLinks
Home
How am I?
Lab Results
Community
Appointments
Messages
Contacts
Questions?
Resources
Profile
Logout
How am I?
See a monthly view of daily Check-Ins for meds, stress and mood.
Community
Join the PositiveLinks Community, a private and anonymous social network. Read and respond to posts by other Members.
Messages
Use secure messaging to communicate with the site care team.
Questions?
Find answers to common questions of people living with HIV.
Profile
Set or change the Member avatar.

Tele-adherence Counseling (TAC)

- Pulled list of clients receiving mental health services and not virally suppressed to enroll
  - Trouble with data in that a client might have had mental health sessions a year ago, but is no longer receiving mental health services or client had missing viral loads in their client profile
  - Focused on existing clients or new clients to mental health not virally suppressed

- Pulled a general list of clients not virally suppressed to enroll
  - Forming a new system-wide Quality Improvement Project on improving our overall enrollment numbers


Overall Viral Suppression Measure
Percentage(%)
85
84
83
82
82.28%
81.81%
81.76%
83.03%
82.78%
82.82%
84.17%
82.94%
My Organization


Viral Suppression Mental Health Measure
Percentage(%)
90
88
86
84
82
80
78
76
74
84.91%
76.12%
77.78%
76.42%
80.65%
87.02%
88.79%
84.91%
March 19, 2021
May 21, 2021
July 16, 2021
September 17, 2021
November 19, 2021
January 21, 2022
March 18, 2022
May 20, 2022
My Organization

Lessons Learned

- Implementation worked and uptake was high for case managers and clients
- Having a manual and recorded training facilitated uptake of this new procedure by case managers
- Case managers requested more training on how to encourage clients to begin mental health treatment/therapy (which we provided subsequently)

Challenges and Understanding

- Database challenges: no automatic way to track declined referrals, already seeing mental health providers, and referrals outside our Ryan White system
- Mental health stigma and competing priorities: clients declining referrals
- Would like to gain a deeper understanding of the community's value of mental health treatment and therapy, especially when so many other crises are impacting many in the community (i.e. housing instability, financial insecurity, etc.)

Involvement and Sustainability

- Clients were involved in the review of process flow mapping, root cause analysis (5 whys), and intervention selection
- Case managers were provided training on all three interventions, with an additional mental health informational session provided by our mental health providers about mental health stigma, encouraging referrals, types of services provided, etc.
- Sustainability involves programming our mental health and substance use tools into the new cloud-based version of Provide, and will auto-fill and populate assessments and care plans, be linked to referrals, and follow-up
- Planning to launch an HIV System of Care Collaborative (HIV SOCC) for direct service staff that will be held quarterly for training, direct collaboration and continued guidance/support from the Recipient's Office

Questions?

Improving Viral Load Suppression through Active Linkage & Referral to Tele-adherence Counseling (PL Cares®)

Ryan White Part A/MAI & Ending the HIV Epidemic
Joint Quality Improvement Project (QIP)

April 1, 2022 - June 7, 2022

Palm Beach County
Ryan White HIV/AIDS Program

Background

- Ryan White HIV/AIDS Programs in Palm Beach County (RWHAP PBC) Provide Enterprise database
  - 210 persons with HIV who were not virally suppressed as evidenced by elevated lab results (>200 copies/mL) from June 1, 2021 to March 10, 2022

- Ending the HIV Epidemic program in Palm Beach County designed for improving viral load suppression among clients through a smartphone app called PL Cares®
  - Has relied on passive referrals from agencies for clients who are not virally suppressed

Project Description

- The Team Coordinator pulled clients who are not virally suppressed in RWHAP PBC from the Provide Enterprise Database
- Program contacts and supervisors at each agency were sent the list of clients respective to their agencies to review and delegate active referral and linkage
- Active referral and linkage included case managers discussing PL Cares® including its benefits with their clients, encouraging clients to accept a referral, sending a referral in Provide Enterprise to the Tele-adherence Counselor (TAC) and letting them know to expect a contact from the TAC
- If the TAC encountered any issues with reaching the client, then the TAC communicated with the case manager
- The Team Coordinator reviewed viral load lab results at 3-month intervals among clients successfully enrolled into the program and share results at the QI workgroup

Rationale

- Pulling clients who are not virally suppressed from the Provide Enterprise database will focus efforts on a client-level rather than relying on passive messages to refer any non-virally suppressed clients to the PL Cares® Program
- The formation of a Quality Improvement Project will lead to better communication and cooperation on actively referring clients to the program

Aim Statement

- Seventy percent of individuals in the non-virally suppressed lists will be referred to PL Cares®
- Of those referred, seventy percent will be successfully enrolled into the program within 3 months
- Of those enrolled, seventy percent will become virally suppressed within 6 months of being in the program

Barriers & Boundaries

- Barriers to Project
  - Case manager competing priorities have posed a barrier in speaking with their clients about the program
  - In addition, clients competing priorities have also posed a barrier in being referred and enrolled into the program
  - Some clients become overwhelmed with the process of enrollment and changed their minds
- Boundaries of Project
  - The scope of this project is to refer and enroll non-virally suppressed clients into PL Cares®; however, this program is not meant to supplant case management or existing efforts and interventions

Baseline with Phase I & Phase II

- Baseline
  - Pulled data for non-virally suppressed clients in Provide Enterprise with elevated lab results (>200 copies/mL) from June 1, 2021 - March 10, 2022; worked April – October 2022
- Phase I
  - March 11, 2022 to May 31, 2022 viral load data added; worked June - October 2021
- Phase II
  - March 1, 2022 to October 31, 2022 viral load data; worked November - March 2021

Baseline Results

- 56 of 210 clients (27%) were referred to TAC in Provide
- Of those, 25 enrolled (45%), 17 are in the process of enrolling (30%), and 14 declined (25%)

Phase I Results

- 209 clients not virally suppressed in the initial list
  - 37 clients were no longer eligible (became virally suppressed) (18%)
- 36 of 172 of still eligible clients (21%) were referred to TAC
  - Of those, 22 enrolled (61%). Of those enrolled, 13 have reached viral load suppression by 4 months (end of Feb '22) (59%)
  - 43 (21%) of clients agencies lost contact/client was closed (n=129 still had contact with), 29 clients had an unknown status (14%), 29 clients were offered PL Cares and declined (14%), 14 clients were referred to TAC but not successfully enrolled (8%), 11 clients were not offered yet (4%), 10 clients were assigned the wrong agency or were in historic view (4%).
- Need to improve the referral rate: share more recent results with agencies on a more frequent basis to minimize lost to follow-up (refer to CORE when LTFU), improve messaging about PL Cares, and conduct three-way meetings/calls and warm hand-offs with all-in-one enrollment visits

Phase II Results

- 227 persons with HIV who were not virally suppressed
- Of those, 22 were referred from sub-recipients to PL Cares (9.7% referral rate)
  - Notably, 3 subrecipients did not provide updates to their Phase II Lists that were sent out
  - In addition, there were many clients who were not reached or have a status update on the lists sent back.
- Of the 22 clients, only 4 were successfully enrolled into the platform (18.2%)

Lessons Learned & Next Steps

- The use of a static list with viral load information that can be outdated shortly is not optimal and also is a time-intensive way to review clients for potential referral and linkage to PL Cares
- Furthermore, more work needs to be done to understand and mitigate the gap between referral and successful enrollment.
- Recipient to work with GTI to add automated prompt when someone is newly diagnosed, out of care coming into care or in care not virally suppressed in Provide to discuss PL Cares and referral if client agrees (i.e. EIS Episode of Care and CM Assessment for Action Plan Prompt)

Questions?

Health Insurance Cost Benefit Analysis

Alejandro Arrieta, PhD

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Florida International University

Department of Health Policy and Management

Email: alejarri@fiu.edu

Palm Beach County
Ryan White HIV/AIDS Program

Background

The Palm Beach County (PBC) Department of Community Services established an Intergovernmental Agreement with Florida International University to evaluate Ryan White Part A HIV Health Support Services in PBC. For the third year of this agreement, the evaluation has focused on identifying the potential savings associated to providing health insurance to clients, compared to continue paying providers directly for clients' medical services. This report describes the findings of this cost-benefit evaluation of health insurance investment, and it provides recommendations to identify sub-populations of clients where savings could be maximized.

This cost-benefit evaluation is performed from the perspective of the PBC Ryan White program, and it only focuses on dollar savings to the program associated to payments for clients' medical care. The evaluation does not include other potential source of benefits including reduced administrative costs, savings to the state of Florida through its ADAP Health Insurance Program, and non-monetary benefits for clients associated to more and better services provided by the health insurance networks, and potentially better health outcomes.

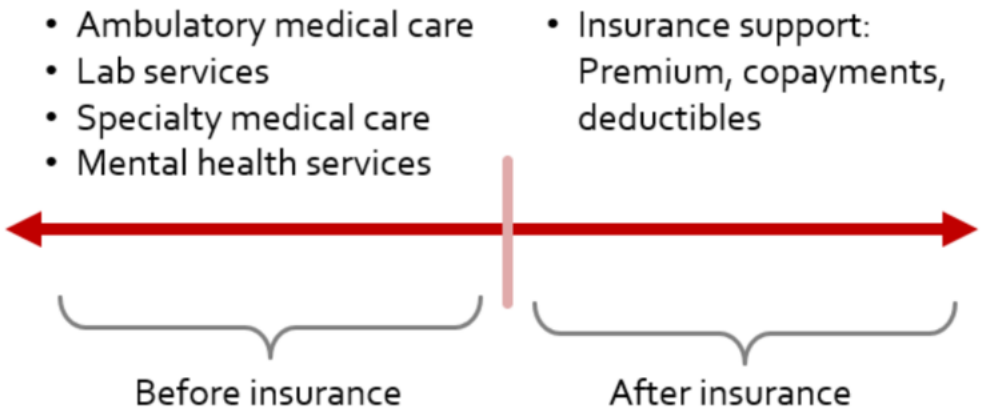
Methods

We use administrative data provided by PBC on different service categories, including AIDS pharmaceutical assistance, emergency financial assistance, laboratory services, specialty medical care, mental health services, food bank nutritional supplements, and ambulatory outpatient medical care. Cost data was included in all service categories except for most laboratory services and ambulatory outpatient medical care. In those cases, we obtain the average costs per service, provided by PBC, and use those estimates to calculate the total cost per service per year adjusted by medical inflation.

Cost of insurance included cost-sharing (copayments and deductibles) as well as premium paid to eligible clients who received insured in previous years. The data used in this study ranged from 2017 to 2021 (5 years), and all clients were fully de-identified to protect identities. This study received IRB approval by FIU, #IRB-19-0036-AM01.

Our methodological approach followed up clients from 2017 to 2021 and assessed the change in medical and insurance costs before and after they got health insurance support from the PBC Ryan White program. Only eligible clients were included, defined as those who were below the poverty line of 100% and did not have Medicaid, Medicare or employed based insurance at the time of enrollment. As illustrated in figure 1, before getting insurance support, the program paid directly to providers for clients' medical care. After getting insurance, the program paid insurance companies premiums and deductibles to cover for clients' medical care. Our method compares the cost before and after using a panel data Generalized Linear Model with random effects, to capture the skewed distribution of cost data, and the heterogeneity of the PBC Ryan White program population.

Figure 1: Cost to the program before and after health insurance investment



Results

Table 1 presents the estimated change in costs associated to health insurance investment. The average medical care cost per client per month that the PBC Ryan White program pays is reduced by $35.1 after providing health insurance. However, these savings are not big enough to compensate for the average cost of monthly premium and cost-sharing paid by the program when providing health insurance, estimated at $289.9. As a result, the net costs associated to the health insurance investment is positive, indicating that on average, the PBC Ryan White program increases its cost by $254.8 per client per month.

Table 1. Change in costs after health insurance investment (per client per month)

Service Categories	Change in Cost
AIDS Pharmaceutical Assistance	-$0.15
Emergency Financial Assistance - Med	-$3.20*
Lab Services	-$17.26*
Specialty Medical Care	-$4.75*
Mental Health Services	-$0.21
Food Bank Nutritional Supplements	$0.03
Ambulatory Outpatient Medical Care	-$12.00*
Medical care savings	**-$35.09***
Insurance support payments	$289.87*
Total Net Cost (Saving)	**$254.78***

Negative cost represents saving.
* Statistically significant at 1%

Figure 1 shows the annual trend in costs. After a decline in insurance cost in 2017, the average premium and cost-sharing paid by the PBC Ryan White program ranged from $257 to $303 per client per month, implying a net cost (insurance cost net of medical care savings) of $224 to $242 per client per month between years 2019 and 2021.

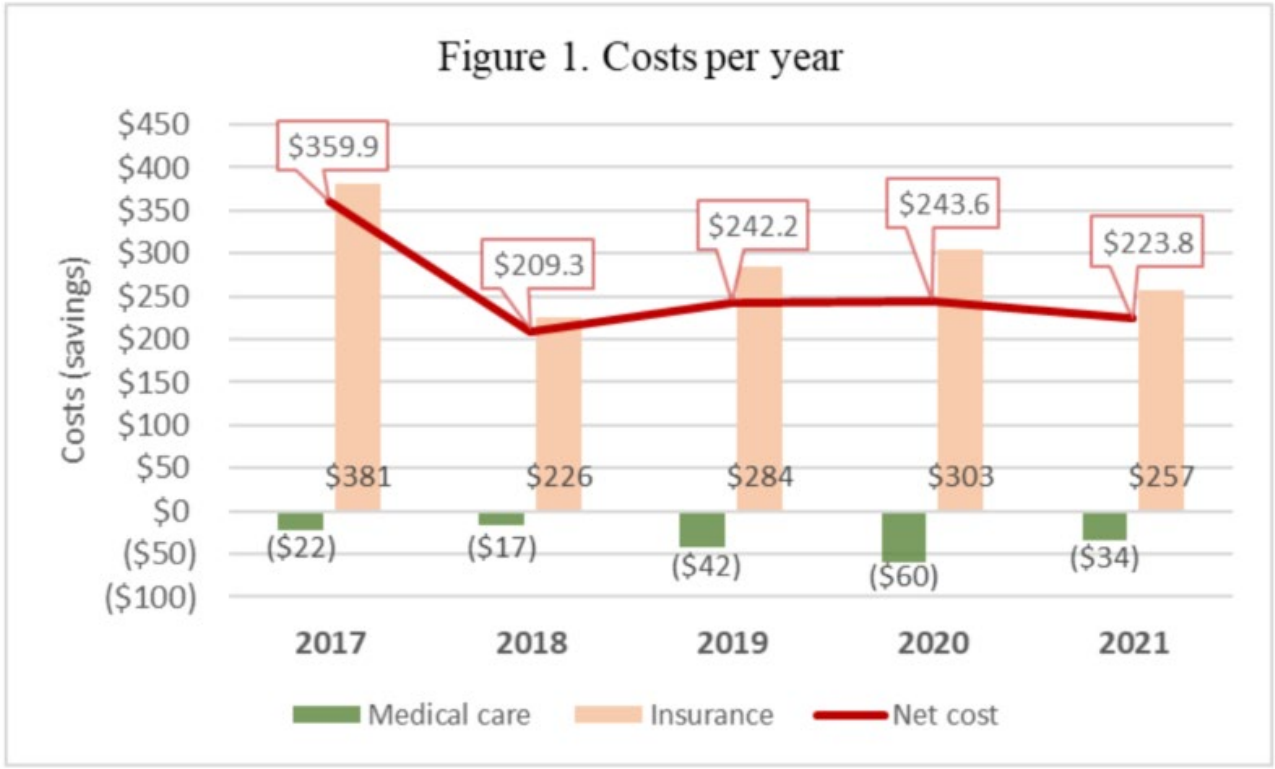


Table 2 presents the total net cost of sub-populations of clients according to total cost, number of ambulatory outpatient care visits and laboratory visits before insurance enrollment. It presents the breakeven point where the impact of health insurance investment on total net cost is budget neutral (cost is statistically zero). We found that providing health insurance to clients who on average spent $120 or more per month before enrollment, is budget neutral. However, providing insurance to those who spent less than $120 increases the total cost to the program by $325. Providing insurance to clients who had 3 or more outpatient visits per year before enrollment is also budget neutral, as well as providing insurance to clients who had 4 or more laboratory visits per year. Our results indicate that health insurance investment could potentially save money if it targets high utilizers (spending more than $120 per month, using more than 3 outpatient visits per year, and/or using more than 3 laboratory visits per year).

Table 2. Sub-populations and budget impact

Total cost (before enrollment)	Total net cost
Cost < $120/month (N=1,006)	$324.92
Cost ≥ $120/month (N=282)	$20.90†
Number of outpatient visits (before enrollment)	
Outpatient visits < 3/year (N=1,029)	$325.69
Outpatient visits ≥ 3/year (N=259)	$30.51†
Number of laboratory visits (before enrollment)	
Lab visits < 4/year (N=999)	$335.11
Lab visits ≥ 4/year (N=289)	$41.16†

† Non statistically significant (statistically equivalent to zero)

Recommendations

Our results and recommendations should be read with caution. We are conditional to the quality and scope of the administrative data provided by the PBC Ryan White program. Because this cost-benefit evaluation is from the PBC Ryan White program perspective, we only include services paid by the program. Important drivers of medical costs, such as utilization of hospital or emergency services, are not paid by the program and therefore are not included in this study. Other important monetary and non-monetary benefits are not included, such as program administrative costs and clients' satisfaction and health outcomes.

Our results show that on average, providing health insurance to clients increases the cost to the PBC Ryan White program by $255 per client per month. However, we identify sub-populations where this increment in cost could be statistically zero. Enrolling those sub-populations could result on either a neutral impact on the budget or even a potential saving. Based on our results, we recommend an algorithm that target clients by utilization observed in the last 12 months before enrollment. Given the lack of accurate cost data per client, we recommend focusing on visits using the algorithm described in figure 2.

Figure 2: Health Insurance Enrollment Algorithm

Recipient Notes

- Important to note that we have not implemented the suggested algorithm for enrolling clients
- We could focus enrollment of clients who have 3 or more outpatient visits a year or 4 or more laboratory visits for cost-benefit purposes, but all clients who are eligible based on FPL can be enrolled into Ryan White Health Insurance Premium Support and Cost-Sharing Assistance
- Also, clients should be encouraged to utilize their insurance to address all health issues and concerns as they have access to more health services than Ryan White alone can provide or pay for directly without insurance

100 Day Challenge: Housing is Healthcare

October 2022-January 2023

Palm Beach County
Ryan White HIV/AIDS Program

About the 100 Day Challenge

- Partnered with RE-INSTITUTE
- Ryan White Part A/MAI Providers and Recipient's Office worked with Community Service's Human Services and Housing Providers
- Created a By Name List of clients who were unsheltered in Provide Enterprise matched with information from ClientTrack/HMIS data from Human Services (added a few clients who attested to HIV status who were not in Ryan White)
- Goal was to get clients STABLY housed and IN care (i.e. shelter does not count toward success)
- Met weekly for case conferencing with a team of providers and data support to work through a list of 300+ clients

100 Day Challenge Goal

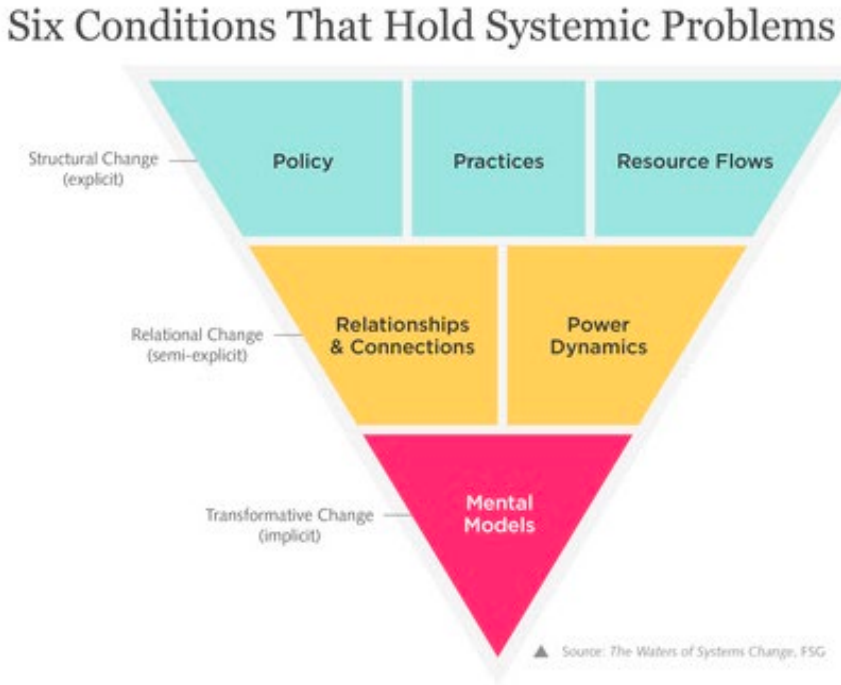
- Our Goal: In 100 Days, 60 individuals living with HIV and experiencing homelessness will be safely and stably housed and linked to care, with equitable exits based on Gender, Race, Ethnicity, Age, and Household type.
- The Result: 28 people connected to safe and stable housing and linked to care
  - Over 90% of people housed identify as Black, Indigenous, or Persons of Color (BIPOC)

Accomplishments

- More than doubled our housing baseline
  - Previous 100 Days: 13 clients were stably housed, 100 Day Challenge: 28 clients were stably housed AND linked to care
- Met our equity goal
- Established a dual system case conferencing model

Barriers/Gaps Identified

- Identified areas of opportunity in data tracking
- Identified need for community wide trainings
- Effective case conferencing is needed
- Need an easier way to pull accurate data
- Need for better communication about what services exist



Systems Leader Ask: Cross System Case Conferencing

Policy: Creation of Prioritization mechanism for conferencing taking in a client centered and circles of support approach

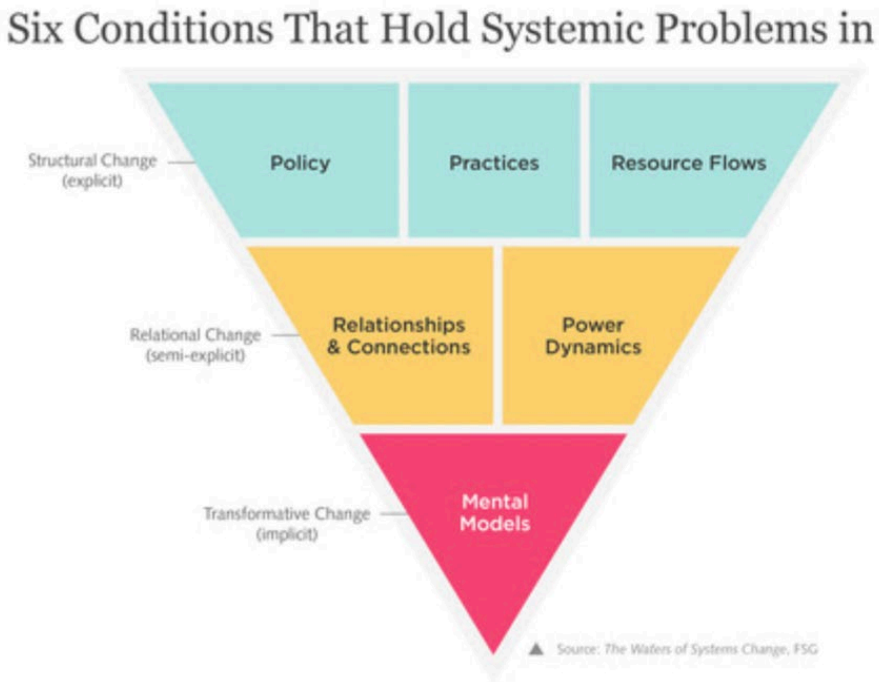
Practice: Development and implementation of Standardized Multi-System ROI to include mainstream resources

Resources: commitment to entering and updating data into PBC resource Portal

Relationships and Connections: Creation of data superuser across both healthcare and homeless response

Power Dynamics: Funding for Lived Expertise to Attend Meetings

Mental Model: shift from organizational or system to community approach



Systems Leader Ask: Multi System Training

Policy: Training every 6 months with a certain threshold of understanding

Practice: Development of On Demand Training as well as required in person

Resources: Develop Community Experts

Relationships and connections: Explore additional
Programs who can provide training outside of housing and health (mainstream, prevention)

Power Dynamics: How to make mandatory and check and what models to use

Mental Model: Commitment to the training

Ending the HIV Epidemic

Sean Conklin, MNM (He/Him/His)

Ending the HIV Epidemic Program Evaluator

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Palm Beach County
Ryan White HIV/AIDS Program

Ending the HIV Epidemic Program Overview

Palm Beach County
Ryan White HIV/AIDS Program

Vision & Philosophy

- **Vision:** The vision of the Palm Beach County EHE is to end the HIV epidemic through innovative services and strategies, new dynamic relationships and collaborations with community stakeholders, and input and involvement from the greater community.
- **Philosophy:** PBC EHE's philosophy is that the gaps that exist in the current system of care are not able to be addressed by current resources, strategies, and activities, so new and innovative strategies must be developed for and led by persons with HIV.

EHE Programs and Activities Overview

- PBC EHE Active Services:
  - Community Outreach, Response & Engagement (CORE)
  - Tele-adherence Counseling (TAC)
  - Rapid Entry to Care (REC)
  - Vocational Rehabilitation
  - Housing & Healthcare Opportunities (H2O)
  - Harm Reduction Intervention Services (HRIS)
- PBC EHE Community Engagement Activities
  - Community Engagement Series
  - EHE Marketing Campaign
  - Social Media Marketing
  - Quarterly Newsletter

EHE Programs and Activities Overview

- PBC EHE is planning the following programs/activities:
  - Transportation Assistance
  - Jail Linkage
  - Case Management System Improvements

Community Outreach, Response and Engagement (CORE)

- CORE services identify PWH who care currently out of care and rapidly reengage them into care
- CORE staff:
  - Locate and reengage PWH who are out of care in our jurisdiction
  - Assist PWH in addressing any barriers to care they may face
- CORE is provided by a CORE Specialist (Case Manager) and a Peer in a CORE Team
- CORE services look different for each client receiving them based on client needs

Community Outreach, Response and Engagement (CORE)

- CORE Specialists and Teams are able to:
  - Provide transportation for clients to medical appointments
  - Meet clients wherever they need
  - Keep non-standard hours
  - Provide intensive, strengths-based case management for clients to address their barriers
  - Be dispatched by the EHE Registration clerk to assist clients when needed
  - Refer clients to other services, both HIV and not HIV related
  - Develop relationships with local service providers
  - Respond to HIV clusters and outbreaks to provide these services in coordination with prevention partners

Who Should be Referred to CORE?

- Clients who have disengaged from or fallen out of care
- Clients who are not reached by EIS, DIS or Partner Services
  - These clients should be referred even if no contact was made, instead of closing out
- Clients who receive a positive HIV test and are not linked to care successfully
- Clients who have been out of care and are interested in returning to care

What to Expect from CORE

- Improved coordination with local service coordinators
- Regular communication between CORE teams and provider staff
- Regular in-person visits from CORE staff
- Increased number of linkages to care
- Increase in total clients served
- Increased access to other available services
- Support for capacity building activities
- Support for adherence to care plan
- Improved access to clients

Rapid Entry to Care (REC)

- Rapid Entry to Care (REC) will be a service that guarantees access to an introductory healthcare appointment for any HIV+ client regardless of income or residency status
- REC is a Clinical Service
- REC guarantees an appointment within 3 days of referral
- REC guarantees clients are seen at their appointment time without a long wait
- REC provides rapid ART initiation for clients
- REC can be used for clients who are returning to care or who are newly diagnosed

Tele-Adherence Counseling (TAC)

- Tele-Adherence Counseling (TAC) will be provided directly by county staff
- Clients are enrolled in an online platform called PL Cares which helps to develop self monitoring skills and improve adherence to care
- Clients have daily check-ins to keep track of:
  - Medication Adherence
  - Stress Level
  - Mood
- Clients may also input their medical appointments
- Tele-Adherence counselor may enter client CD_4 and Viral Load lab results so client may track their progress
- Tele-Adherence counselor will reach out to clients who indicate missing appointments or medication to develop a strategy to improve adherence
- Tele-Adherence Counseling works in tandem with non-medical and medical case management service and does not replace them

Tele-Adherence Counseling

- Clients have access to an anonymous community message board to ask questions and have conversations with other affected community members without fear of disclosing their identity
- The message boards are in English, Spanish and Creole
- Tele-Adherence Counselor (English, Creole) and Registration Clerk (Spanish) monitor message boards to remove any inappropriate or personally identifying posts
- Clients may request a Tele-Adherence session with Tele-Adherence Counselor through a HIPPA-compliant virtual call or in person
- Clients may privately message with the Tele-Adherence Counselor, but not other members
- Providers and other case managers are not invited to participate on the platform in the implementation phase

Which clients should be referred to TAC services?

- Newly Diagnosed Clients
- Clients who are returning to care or who have recently returned to care (within 6 months)
- Clients who are in care but not virally suppressed or struggling to adhere to a care plan

TAC by the Numbers

- Clients Active: 84
  - Viral suppression Rate: 72%
  - Undetectable Rate: 60%
  - Average Response Rate: 80%
  - Average Mood (1-5, low to high): 3.4
  - Average Stress (1 – 10, low to high): 2.5

Assessments & Projects

- Three projects and assessments are ongoing:
  - Jail Linkage Project
  - Case Management Assessment
  - Transportation Assessment

Jail Linkage Project

- Jail Linkage Project began in September of 2021
- Over the course of 2022, our Technical Assistance Provider CAI conducted interviews with 6 different stakeholders who all currently have or previously had involvement in the county jails
  - FDOH
  - Rebel Recovery
  - Palm Beach County Reentry Program
  - Palm Beach Sheriffs Office Reentry Unit
  - Wellpath (Jail healthcare provider)
  - The Lords Place

Main Findings

- The average daily population (ADP) across both jail locations is approximately 3000 people
  - 20% are sentenced
  - 50 PWH are in jail between the two locations
  - PWH make up 1.6% of the ADP
  - 8-16 PWH are released from county jail per month
  - Without specific intervention, an average of 1 person is released from the jail every other day without HIV-specific linkage and supportive services

Identified Gaps and Opportunities

- Gaps
  - Current reentry assessment does not include medical considerations
  - Wellpath no longer schedules appointments for clients post-release due to now-shows
    - Clients did not keep their scheduled appointments
  - Some clients leave with only as 14 day supply or a 30 day prescription for medication.
  - No collaboration between Wellpath medical discharge and in-jail discharge planners
- Opportunities
  - Jail-based reentry providers express desire to develop a comprehensive linkage process for PWH
  - Reentry providers are able to provide in-person work with the clients in the jail
  - Space for programming in the jail is available
  - Video visitation is available in the jail

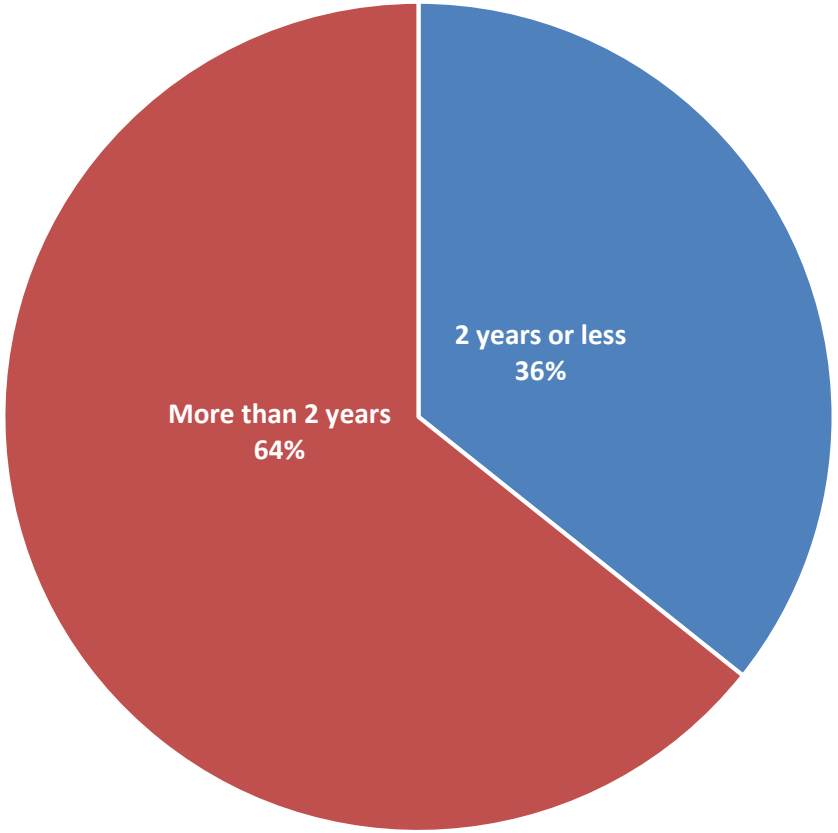
Next steps

- Convening a workgroup of community stakeholders to review linkage models and identify how best to address them with current resources.
- Developing a program proposal to submit to the jail for approval

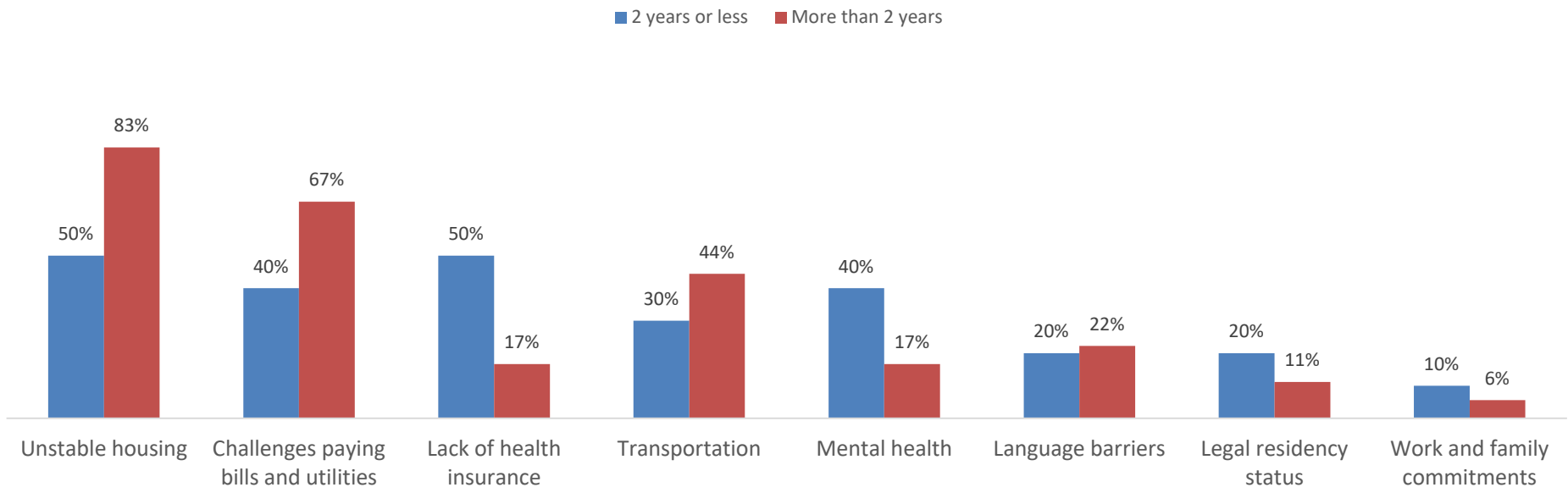
Case Management Assessment

- Case Management Assessment began in March of 2022
- Three stages of the project:
  - Survey with Case Management and EIS Staff
  - Interviews with Case Management and EIS staff
  - Interviews with clients who received Case Management or EIS services within the last 12 months
- CAI compiled aggregate descriptive data from the surveys conducted

How long have you been providing case management / EIS services?

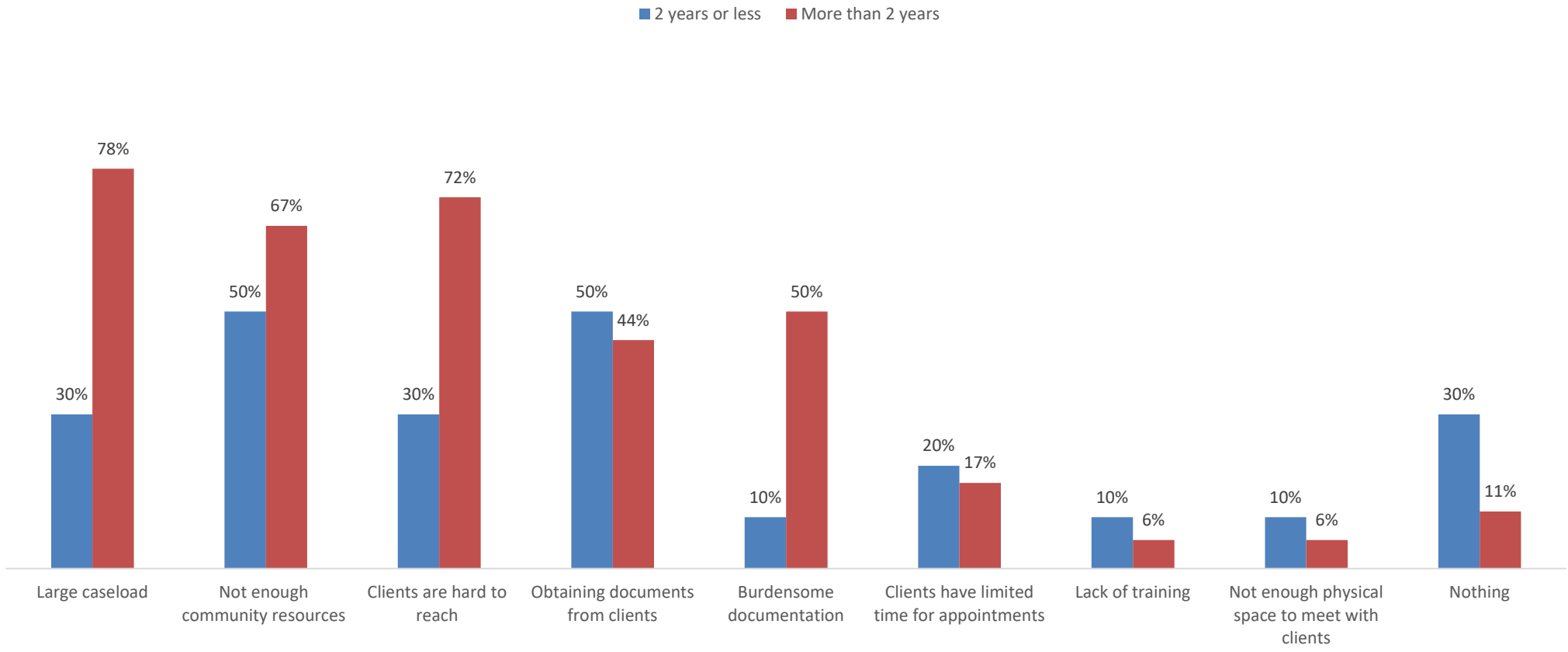


What are the three most dominant challenges clients express while engaging in HIV care?

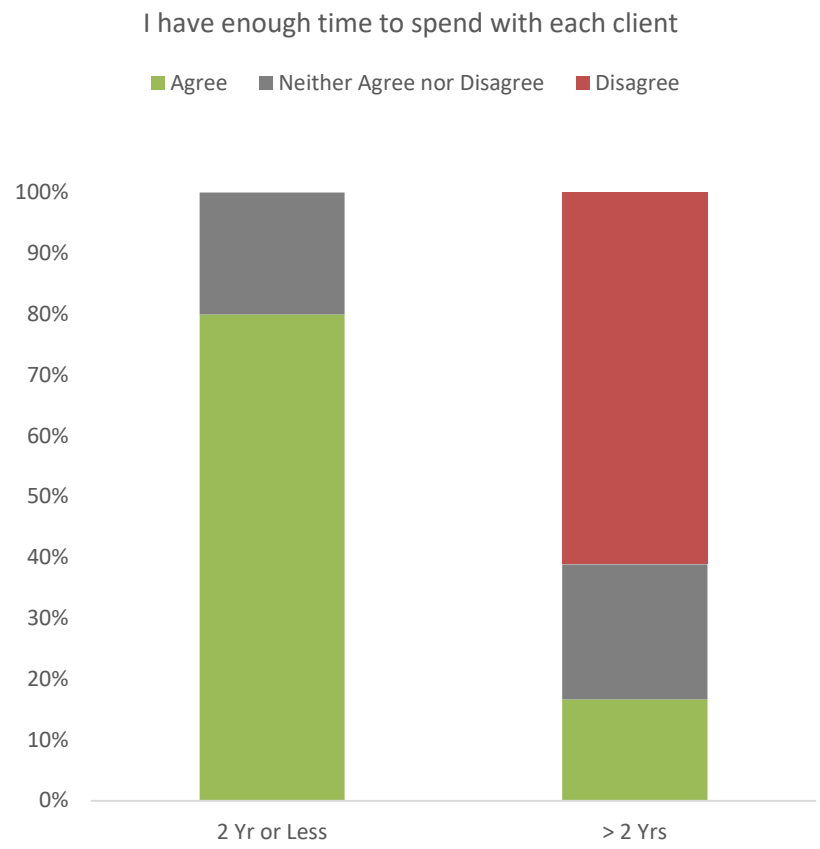


Palm Beach County
Ryan White HIV/AIDS Program

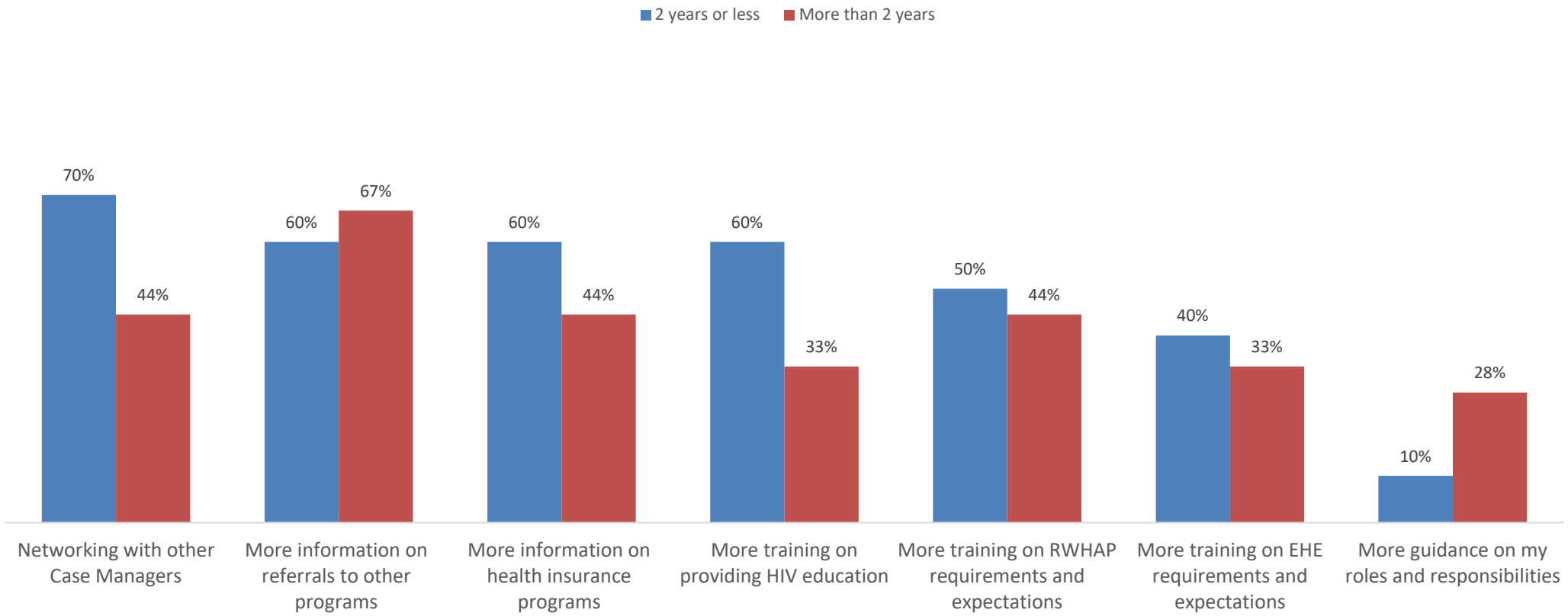
What prevents you from supporting clients?



Feedback on Time with Clients and Caseload



What would better support you in your job?



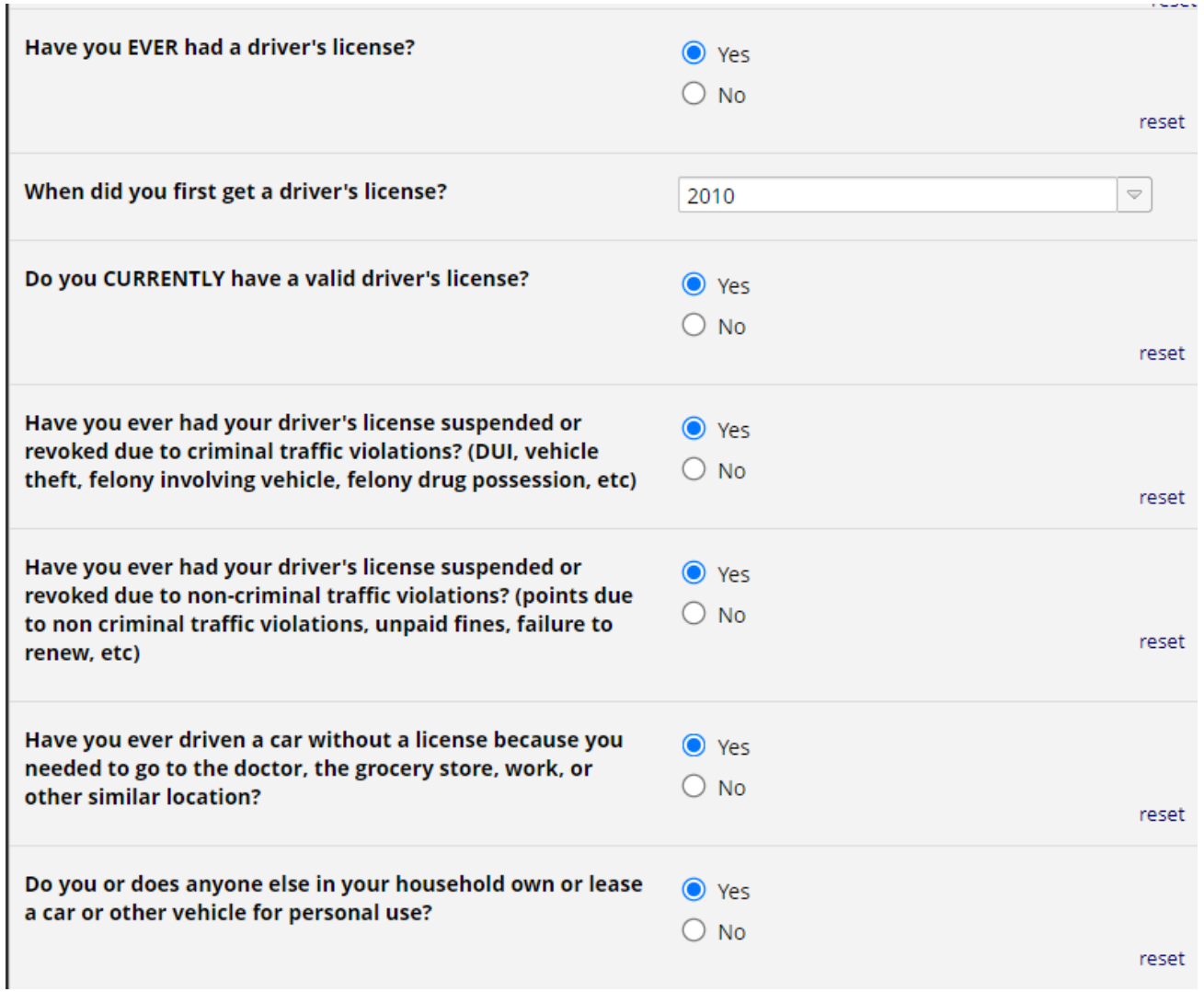
Next Steps

- Clients were randomly selected for interviews
- Interviews are currently ongoing
- After interviews are completed, a comprehensive data analysis will occur
- The analysis will be presented to the community after it is completed and reviewed

Transportation Needs Assessment

- Transportation was identified as an issue for clients
- EHE is interested in identifying root causes in order to develop an intervention that can provide long term improvement
- Identified the TSI-16, a validated tool used to identify levels of "transportation insecurity"
- PBC EHE developed questions to identify specific factors that may be contributing to the transportation insecurity and which factors have the largest influence in transportation insecurity

Sample of Transportation Assessment data



Have you EVER had a driver's license?	(•) Yes ( ) No reset
When did you first get a driver's license?	2010
Do you CURRENTLY have a valid driver's license?	(•) Yes ( ) No reset
Have you ever had your driver's license suspended or revoked due to criminal traffic violations? (DUI, vehicle theft, felony involving vehicle, felony drug possession, etc)	(•) Yes ( ) No reset
Have you ever had your driver's license suspended or revoked due to non-criminal traffic violations? (points due to non criminal traffic violations, unpaid fines, failure to renew, etc)	(•) Yes ( ) No reset
Have you ever driven a car without a license because you needed to go to the doctor, the grocery store, work, or other similar location?	(•) Yes ( ) No reset
Do you or does anyone else in your household own or lease a car or other vehicle for personal use?	(•) Yes ( ) No reset

Next Steps

- A randomized list of PWH stratified by zip code has been created
  - Zip codes were selected based on HIV prevalence
- Clients will be contacted to complete the survey either over the phone or in person
- Clients will receive a $25 gift card for participating

Vocational Rehabilitation

- EHE partnered with the Palm Beach County Community Action Partnership (CAP) to provide Vocational Rehabilitation services for PWH
- Eligible clients are able to access CAP programs through EHE, rather than using the standard process to access CAP
- Available services include:
  - Vocational Training
  - Debt management planning
  - Financial Literacy
  - GED Classes
  - ESL Classes
  - Interview Preparation
  - Resume Building
  - And more

Vocational Rehabilitation

- To Date, 62 clients have been referred for Vocational Rehabilitation Services
- To date, 1 client has completed their training program
- 45 have not begun the process due to trouble contacting them
- 15 are in some stage of the process for getting training or other services

Community Engagement and Marketing

- A large component of Ending the HIV Epidemic is community engagement and marketing
- Palm Beach County Community Services has retained 3 marketing firms to perform marketing activities for the department
- A formal marketing strategy is being developed by one of the agencies

Community Engagement

- EHE is conducting multiple community engagement activities
  - Community Engagement Series
  - Quarterly Newsletter
  - Social Media

Community Engagement Series

- February 7, 2023: HIV in Black Communities: Addressing Racial Disparities in Healthcare
- June 1, 2023: Empowering Resilience: HIC Long-Term Survivor's Day
- July 20, 2023: Breaking the Silence: A Conversation on Overcoming HIV Stigma
- October 17, 2023: Latinx HIV Awareness Day – TBD
- December 1, 2023: World AIDS Day – TBD

HIV In Black Communities

- Partnered with AETC for an event honoring Black HIV/AIDS Awareness Day
- A panel of three speakers presented on their topics and then had a roundtable discussion

Palm Beach County
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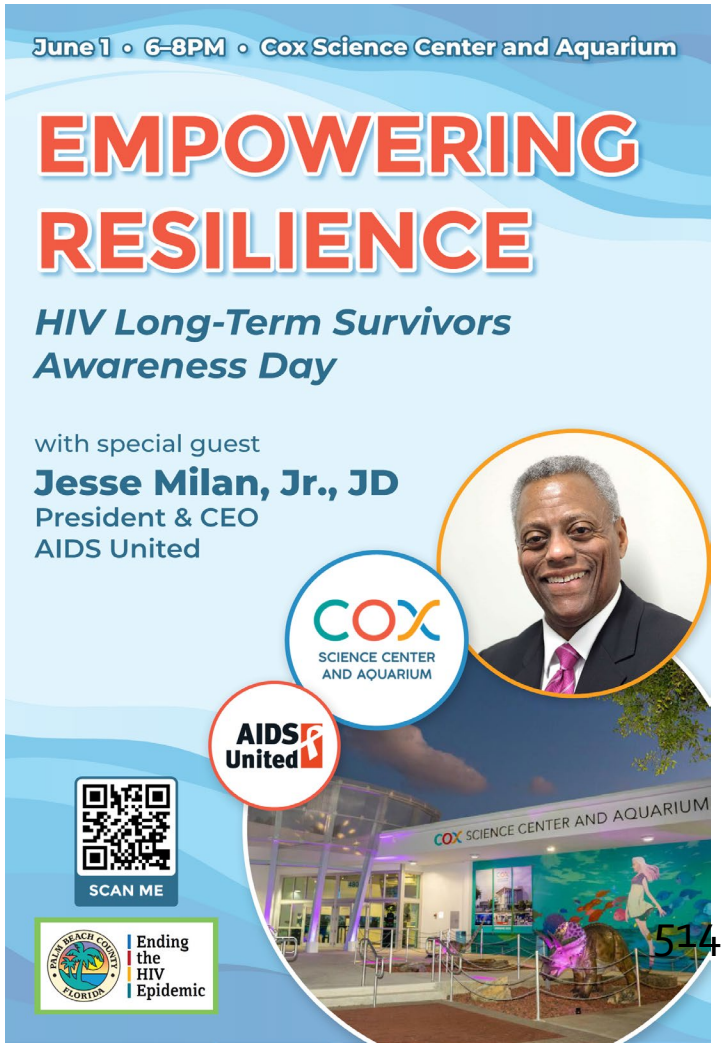
Empowering Resilience: HIV Long-Term Survivor Awareness Day

June 1st Celebrated HIV Long Term survivor Awareness Day by bringing Jesse Milan Jr, President and CEO of AIDS United and 40 year survivor of HIV to talk about his experience.



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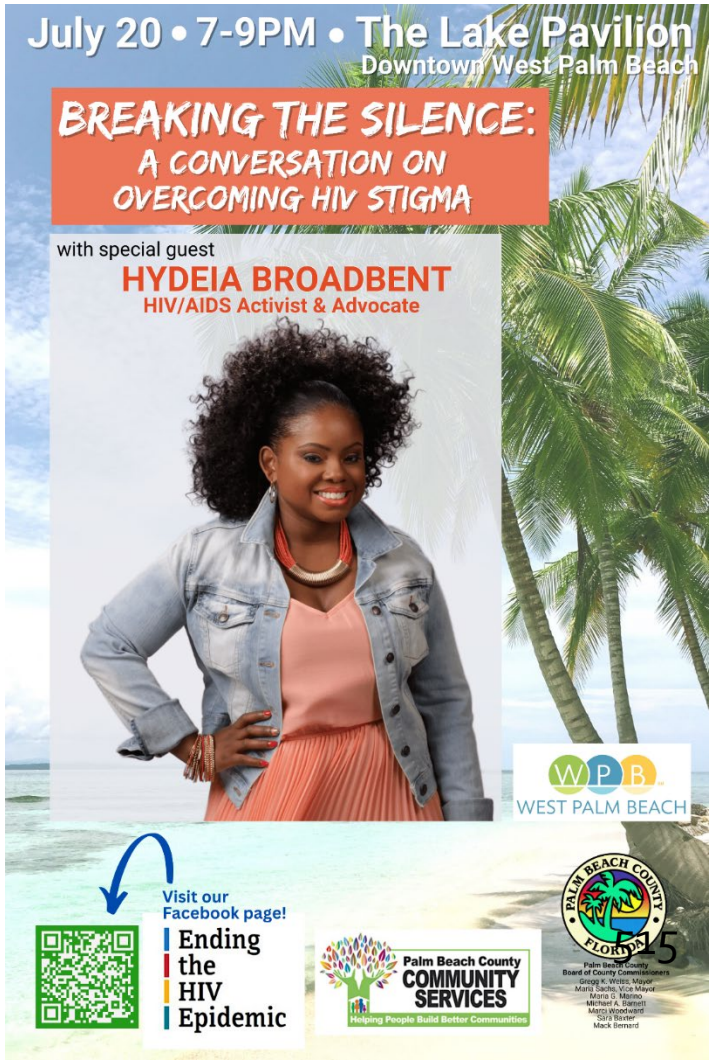
Breaking the Silence: A Conversation on Overcoming HIV Stigma

- July 20th, 2023
- Hydeia Broadbent, HIV/AIDS Activist and speaker, will be our keynote speaker
- Hydeia was the fist black child to go public about being born with and living with HIV/AIDS and was on many TV programs including Oprah and Nickelodeon, CBS, etc



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Syringe Services

- The Syringe Services Program is NOT an Ending the HIV Epidemic Initiative service
- The Syringe Services program does not receive funding from the County at all, though is contractually obligated to the county on legal precedent
- Ending the HIV Epidemic manages the data for the Syringe Services Program

Syringe Services

- The FLASH Syringe Services program is run and Operated by Rebel Recovery, a recovery community organization in palm beach county specializing in peer support, harm reduction, and medication assisted treatment
- FLASH offers 1 to 1 needle exchange, safe injection supplies, opioid overdose reversal (Narcan/Noloxone), linkage to treatment, HIV and HPV Testing, and a wound care clinic

Flash by the Numbers

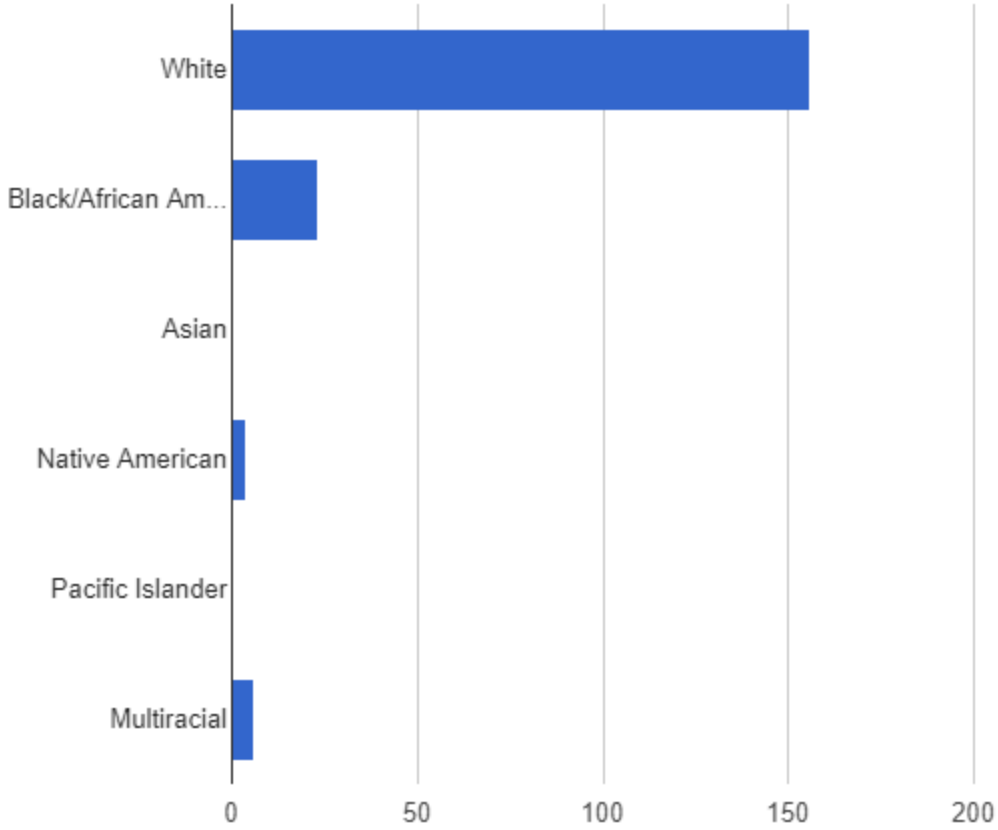
- Total Enrolled Clients – 481
- April 2022 – May 2023
  - Clients using exchange - 265
  - Total Needles In – 76,732
  - Total Needles Out – 70,976
  - Average needles in/visit – 54.3
  - Average Needles out/visit – 50.3
  - Average Needles in /client – 289.6
  - Average Needles Out/ client – 267.83
- Cases of Narcan Given – 1,302
- Number of overdose reversals – 204
  - 17 reversals/month

Demographics

- Enrolled from May 1 2022 – April 30 2023 - 189
- Average Age – 40 years old
- Average # of visits per client – 5.3
- Number of clients who never received a HIV Test – 48
- Number of clients who were tested within the last 90 days (Excluding those never tested) – 67
- Total HIV Tests Performed - 62

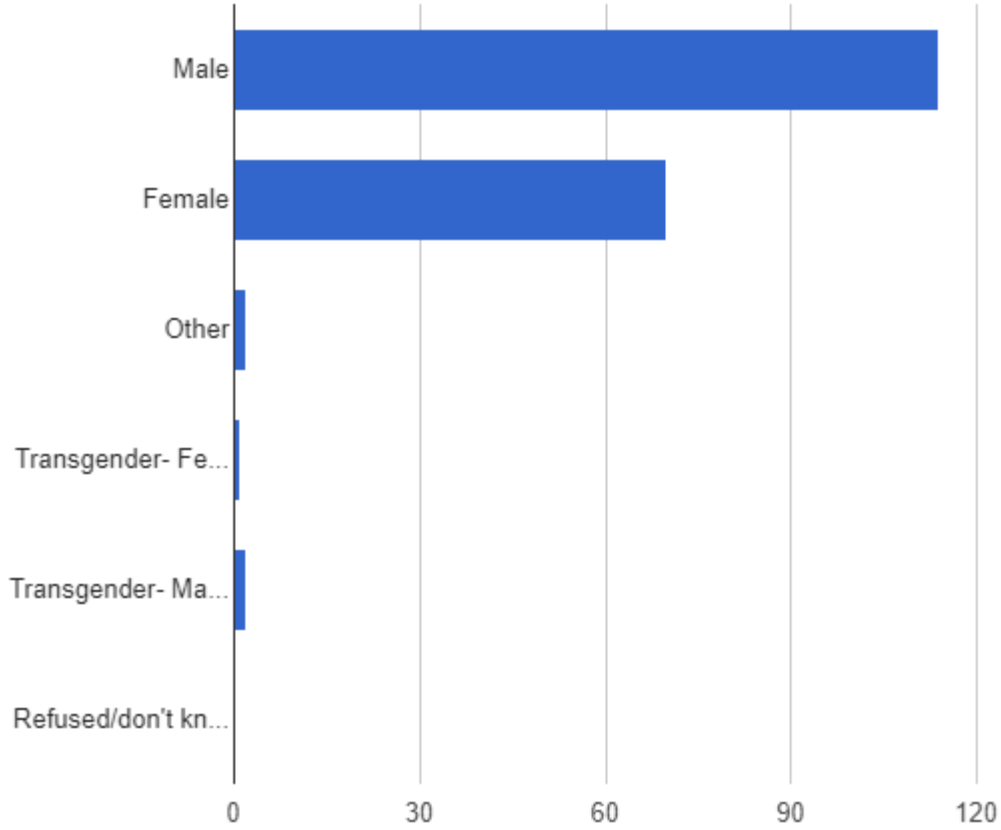
Race Breakdown

- Race Breakdown
  - White - 156 (82.5%)
  - Black/African American – 23 (12.2 %)
  - Native American – 4 (2.1%)
  - Multiracial – 6 (3.2%)



Gender Breakdown

- Men – 114 (60.3%)
- Women – 70 (37%)
- Transgender – Female to Male – 1 (.5%)
- Transgender – Male to Female – 2 (1.1%)
- Other – 2 (1.1%)



Harm Reduction Intervention Services

- New EHE Funded Service Starting with FLASH to improve testing and linkage to care for PWH who inject drugs
- Service will provide targeting testing and counseling to clients
- Contract expected to be executed on August 22, 2023

Questions?

Palm Beach County HIV CARE Council Administrative Assessment Report 2022-2023

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Palm Beach County
Ryan White HIV/AIDS Program

Palm Beach County HIV CARE Council Administrative Assessment Report

https://redcap.pbcgov.org/redcap/redcap_v13.4.12/DataExport/index.php?pid=52&report_id=321&stats_charts=1

Questions?