The Status of HIV in Palm Beach County

2021

Presented by

Palm Beach County Ryan White
HIV/AIDS Program

&

Palm Beach County HIV CARE Council

June 24th & 25th, 2021

Palm Beach County
Ryan White HIV/AIDS Program

CDC HIV Surveillance Rates & Rankings

Juliane Tran, MPH
Quality Management Clinician
PBC Ryan White HIV/AIDS Program
jtran@pbcgov.org
(561) 355-4715

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Outline

- **Centers for Disease Control and Prevention (CDC) HIV Ranking by States**
  - Leading states with highest number of newly diagnosed HIV infection diagnoses from 2015 – 2019
  - Leading states with the highest HIV infection case rates (including District of Columbia) from 2015 – 2019

- **CDC Ranking of HIV Diagnosis rates (all ages) by Metropolitan Service Area (MSA) in 2018 vs. 2019**
  - MSAs with the highest HIV diagnoses
  - MSAs with the highest HIV diagnosis rates

Data Sources

- CDC – Centers for Disease Control and Prevention
- Published CDC data for HIV diagnoses by state and MSA (Metropolitan Statistical Areas)
- CDC HIV Ranking by States
  - U.S. data: HIV Surveillance Report, 2015 – 2019 (HIV data for all 50 states)

    http://www.cdc.gov/hiv/topics/surveillance/resources/reports/index.htm
- CDC HIV Ranking by MSAs in 2018 vs. 2019
  - [1]U.S. data: HIV Surveillance Report, 2019 Vol. 32, Table 22 (HIV data MSA)
    Data as of 12/31/2020, published 05/2021
  - [2]U.S. data: HIV Surveillance Report, 2018 Vol. 31, Table 20 (HIV data MSA)
    Data as of 12/31/2019, published 05/2020

    http://www.cdc.gov/hiv/topics/surveillance/resources/reports/index.htm

Technical Notes

- **HIV Diagnoses *(Diagnosis of HIV infections):***
  - Defined as a diagnosis of HIV infection regardless of the stage of disease and refers to all persons with a diagnosis of HIV infection (Includes adults and adolescents)
    - The data on diagnoses reflect the date of diagnosis (diagnosed by 12/31/2019, reported to CDC as of 12/31/2020), not the date of report to CDC
    - Surveillance data may not be representative of all persons infected with HIV because not all infected persons may have been tested or tested at a time when their infection could be detected and diagnosed. Due to reporting delays, the number of cases diagnosed in a given year may be lower than the numbers presented in later reports; however, fluctuations in the number of diagnoses for a calendar year typically subside after 2-3 years of reporting
- **Infection Case Rates:**
  - Rates per **100,000** population were calculated for (1) the numbers of diagnoses of HIV infection, (2) the numbers of deaths of persons with diagnosed HIV infection, and (3) the number of persons living with diagnosed HIV infection
- **Metropolitan Statistical Area (MSA):**
  - A region that consists of a city and surrounding communities that are linked by social and economic factors, as established by the U.S. Office of Management and Budget (OMB)
  - CDC: Numbers and Rates of diagnoses and prevalence, by MSA, for areas with populations of **500,000 or more**

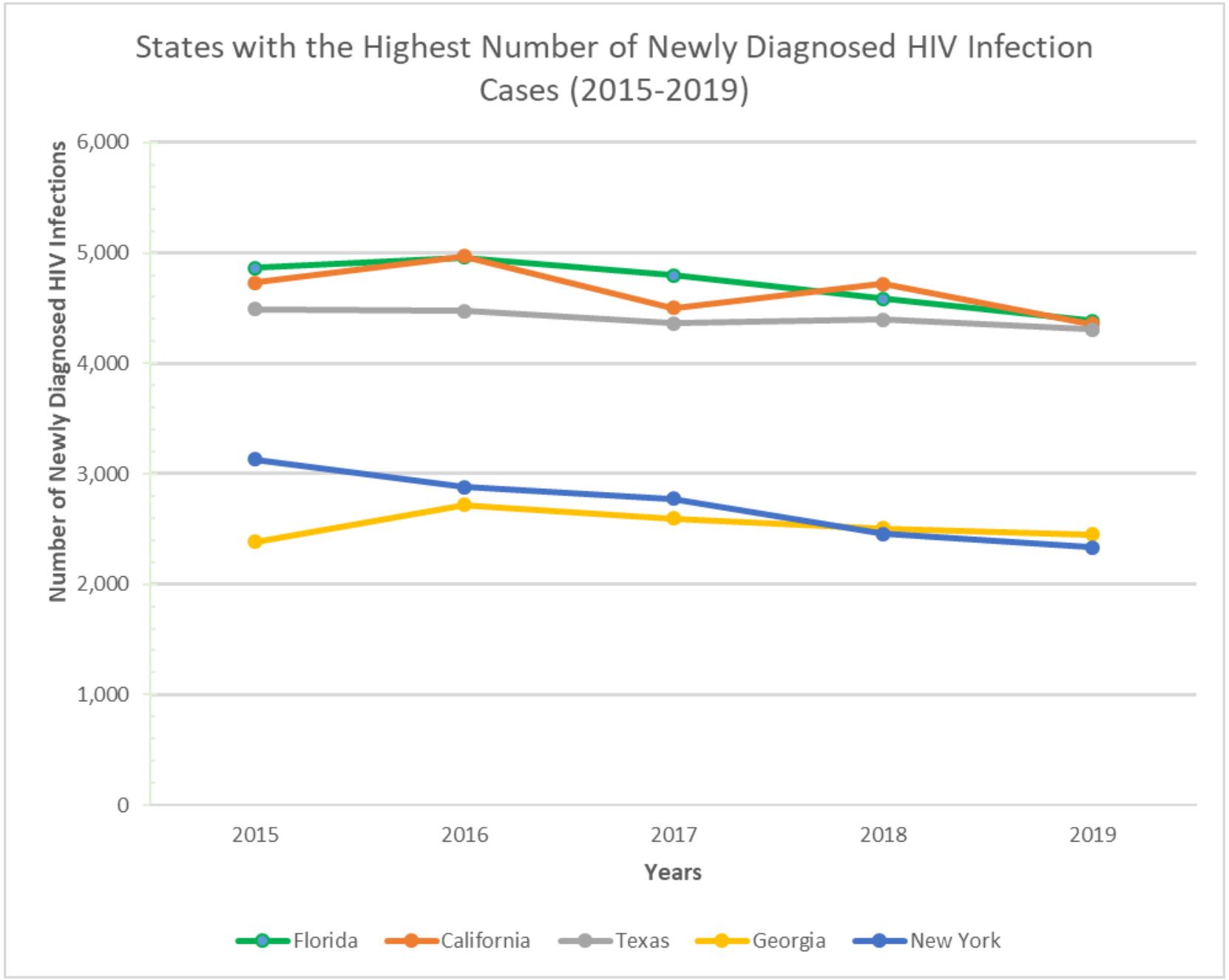
HIV in the United States of America (USA) – Top 5 Leading States

Leading States with the Highest Number of Newly Diagnosed HIV Infection Diagnoses, 2012-2019

Highest number of HIV infection diagnoses								
States	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**
Florida	5,100	5,377	5,347	4,864	4,957	4,800	4,586	4,384
California	5,814	5,334	5,551	4,728	4,972	4,500	4,717	4,358
Texas	4,690	4,854	4,833	4,491	4,472	4,364	4,394	4,308
Georgia	4,047	3,020	2,253	2,386	2,716	2,595	2,504	2,449
New York	4,175	3,803	3,825	3,128	2,877	2,772	2,458	2,334

*** Florida had the highest number of newly diagnosed HIV infection diagnoses in 2013, 2015, 2017 and 2019**

5 Year Trend: Leading states with the highest number of diagnosed HIV infection cases from 2015 - 2019



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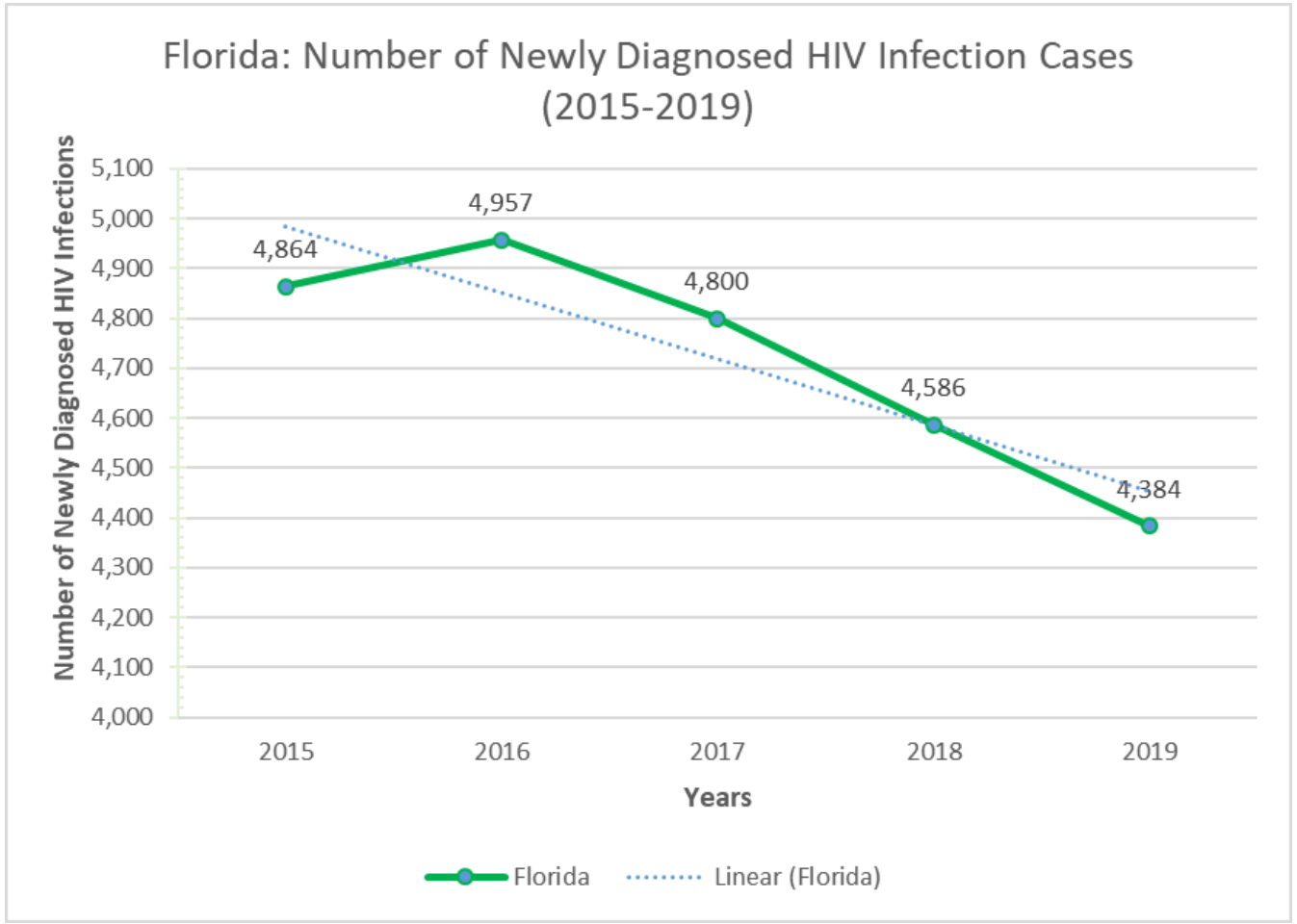
Florida: Newly Diagnosed HIV Infection Cases (2015-2019)

5 Year Trend Comparison (Florida): Decline in diagnosed HIV infection cases from 2015 (4,864) to 2019 (4,384)



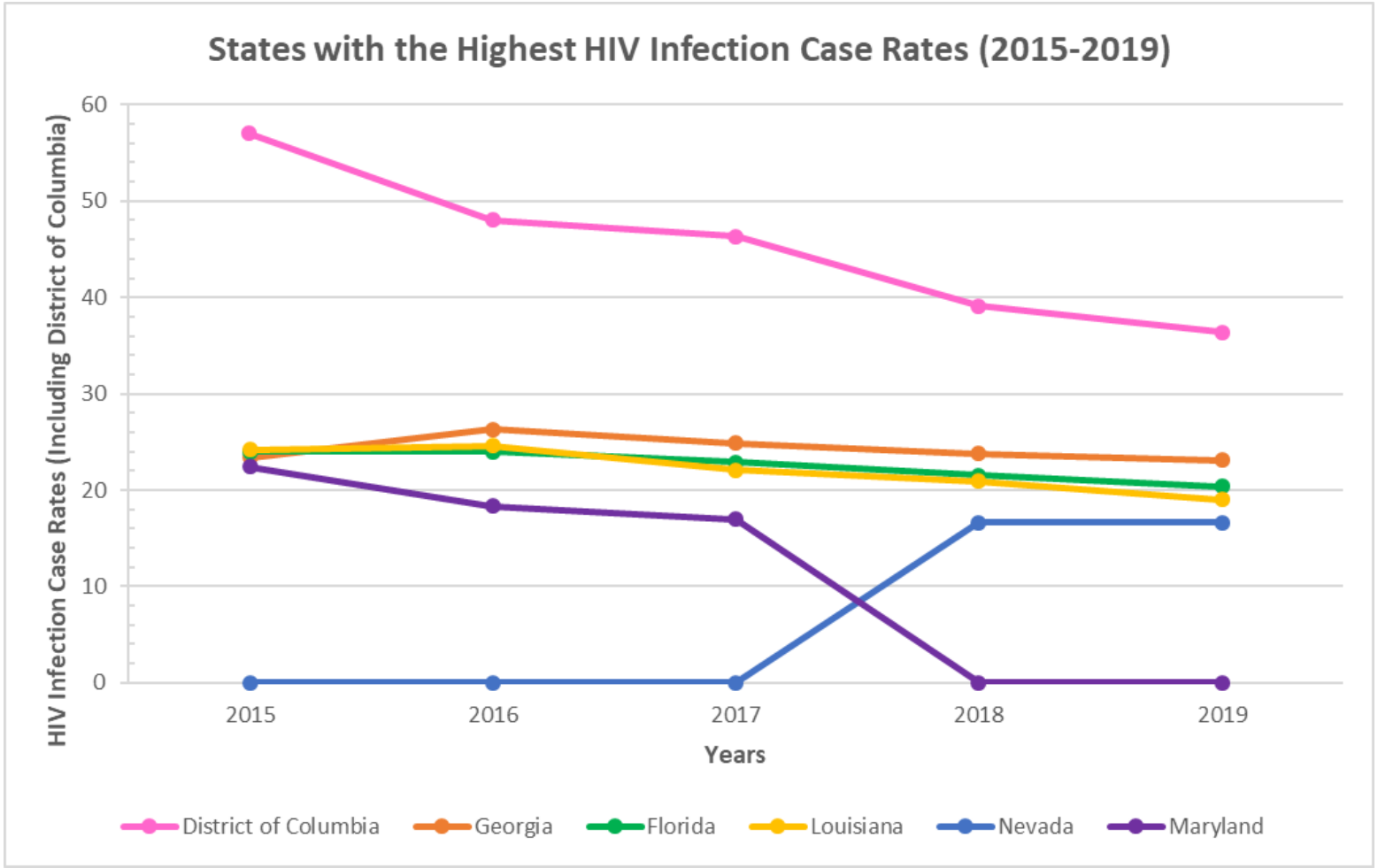
Leading States with the Highest HIV Infection Case Rates (including District of Columbia), 2012-2019

States with the Highest HIV Infection Case Rates (including District of Columbia), 2012-2019

Highest HIV infection case rates (including District of Columbia)								
States	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**
District of Columbia	140.2	94.6	57.8	57.0	48.0	46.3	39.1	36.4
Georgia	40.8	30.2	22.3	23.4	26.3	24.9	23.8	23.1
Florida	**26.4**	**27.5**	**26.9**	**24.0**	**24.0**	**22.9**	**21.5**	**20.4**
Louisiana	27.1	30.3	30.4	24.2	24.6	22.1	20.9	19.0
Nevada	–	–	–	–	–	–	16.6	16.6
Maryland	30.8	36.7	23.3	22.4	18.3	17	–	–

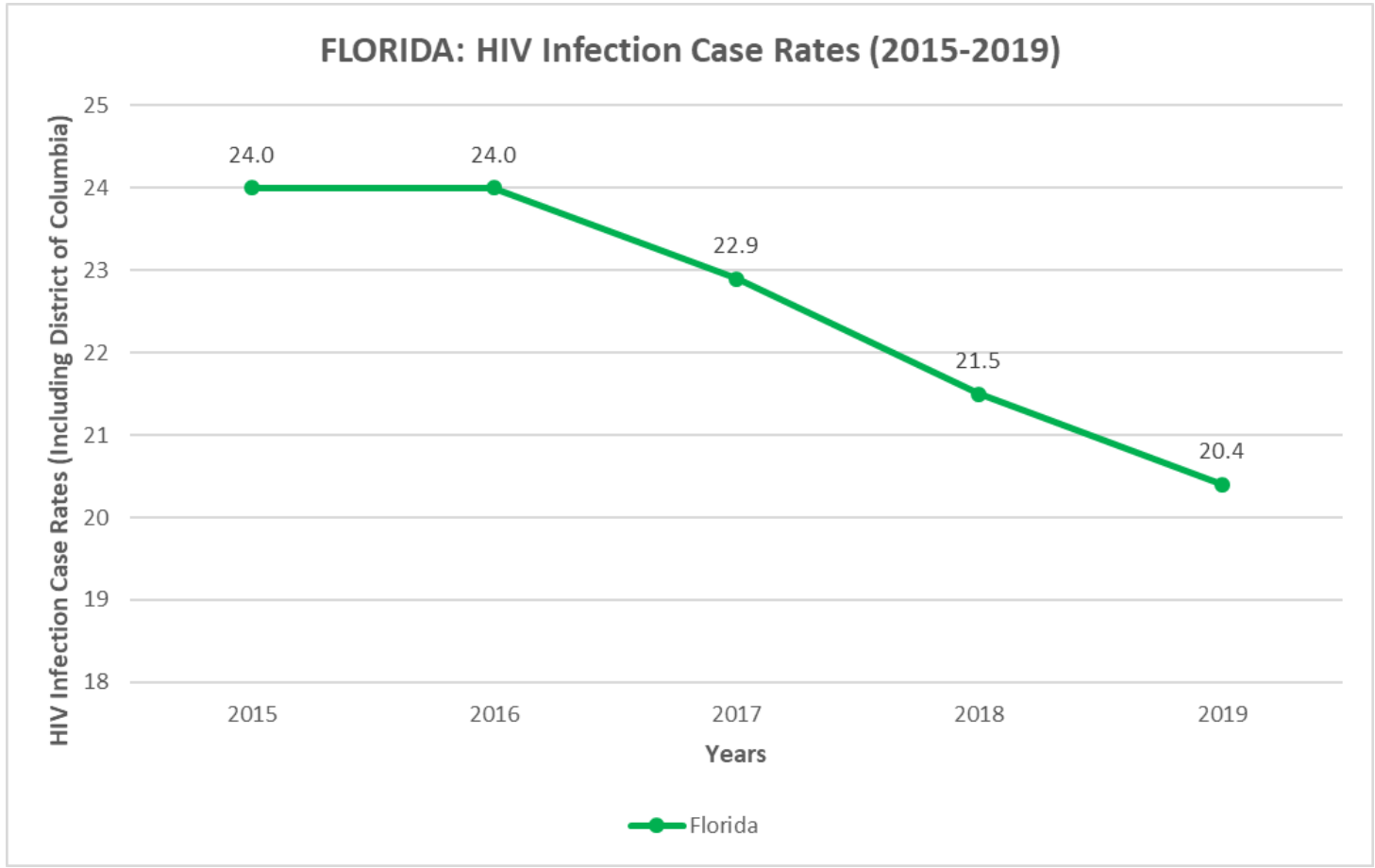
* Florida was the **3rd highest state** for HIV infection case rates for 4 of the last 5 years (4th highest in 2016).

5 Year Trend: States with the highest HIV infection case rates from 2015-2019



Florida: HIV Infection Case Rates (2015-2019)

5 Year Trend Comparison (Florida): Gradual decline of HIV infection case rates from 2015 (24.0) – 2019 (20.4) - *Decline of 3.6 from 2015-2019*



Diagnoses of HIV Infection among Adults and Adolescents in Metropolitan Statistical Areas, (MSAs) 2018 vs. 2019

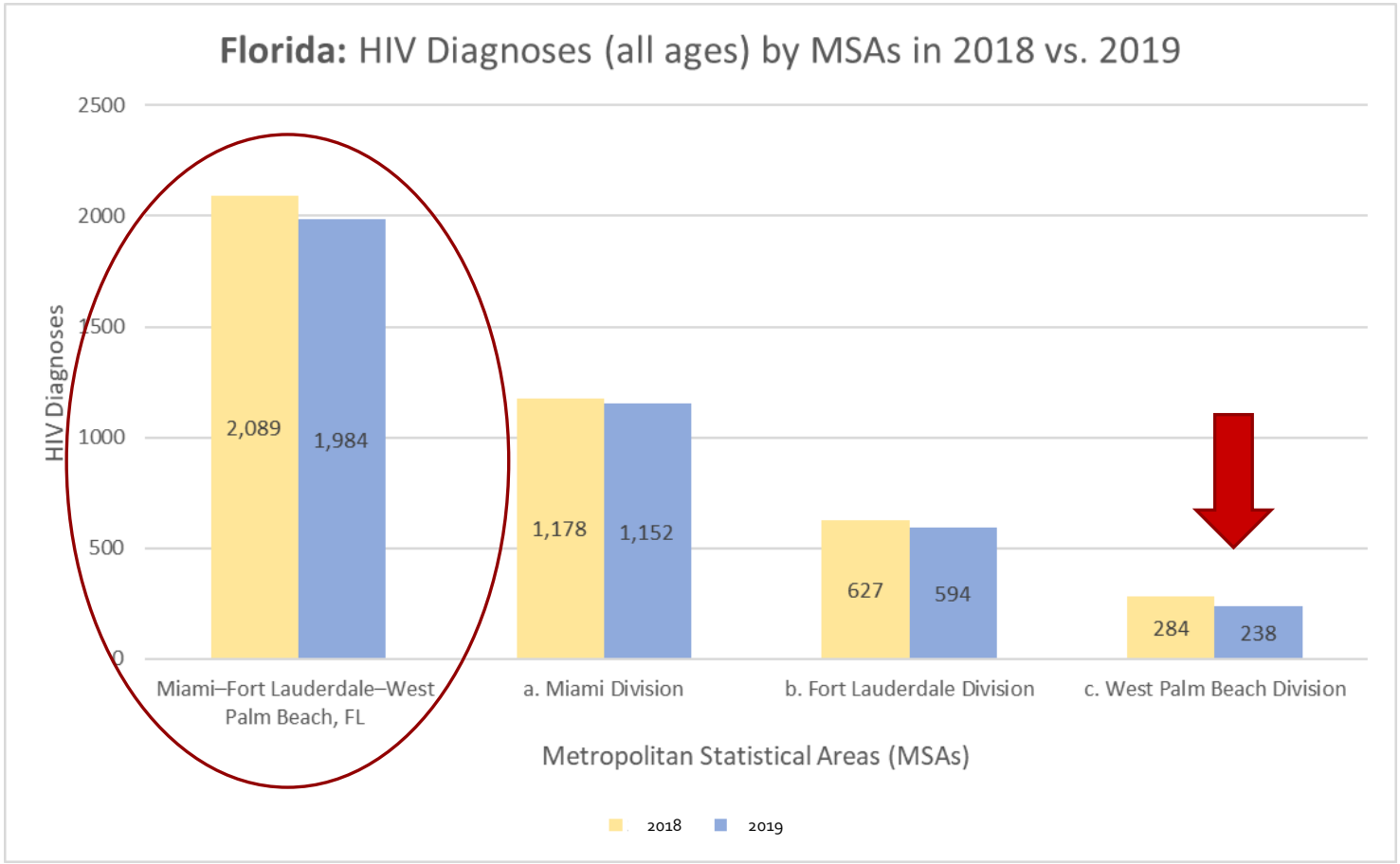
CDC's Ranking of HIV Diagnoses *(all ages)* by MSAs in 2018 vs. 2019

The ten Metropolitan Statistical Areas (MSAs) in 2018 and 2019 with the highest HIV diagnoses: *ranked #2* - **Miami-Fort Lauderdale-West Palm Beach, FL** 2018 (N=2,089) and 2019 (N=1,984)

MSAs with the highest HIV diagnoses		
MSAs	**2018**	**2019**
New York–Newark–Jersey City, NY–NJ–PA	2,981	2,820
Miami–Fort Lauderdale–West Palm Beach, FL	**2,089**	**1,984**
a. Miami Division	1,178	1,152
b. Fort Lauderdale Division	627	594
c. West Palm Beach Division	284	238
Los Angeles–Long Beach–Anaheim, CA	1,979	1,730
Atlanta–Sandy Springs–Roswell, GA	1,651	1,661
Houston – The Woodlands – Sugar Land, TX	1,427	1,436
Dallas–Fort Worth–Arlington, TX	1,309	1,259
Chicago–Naperville–Elgin, IL–IN–WI	1,212	1,118
Washington–Arlington–Alexandria, DC–VA–MD–WV	1,012	922
Philadelphia–Camden–Wilmington, PA–NJ–DE–MD	778	774
Orlando – Kissimmee – Sanford, FL	**678**	**654**

CDC's Ranking of HIV Diagnoses (all ages) by MSAs in 2018 vs. 2019

Within the **Miami-Fort Lauderdale-West Palm Beach, FL (32.2)** MSA, the West Palm Beach Division *ranked 3rd* in 2018 (N=284) and 2019 (N=238) in HIV diagnoses



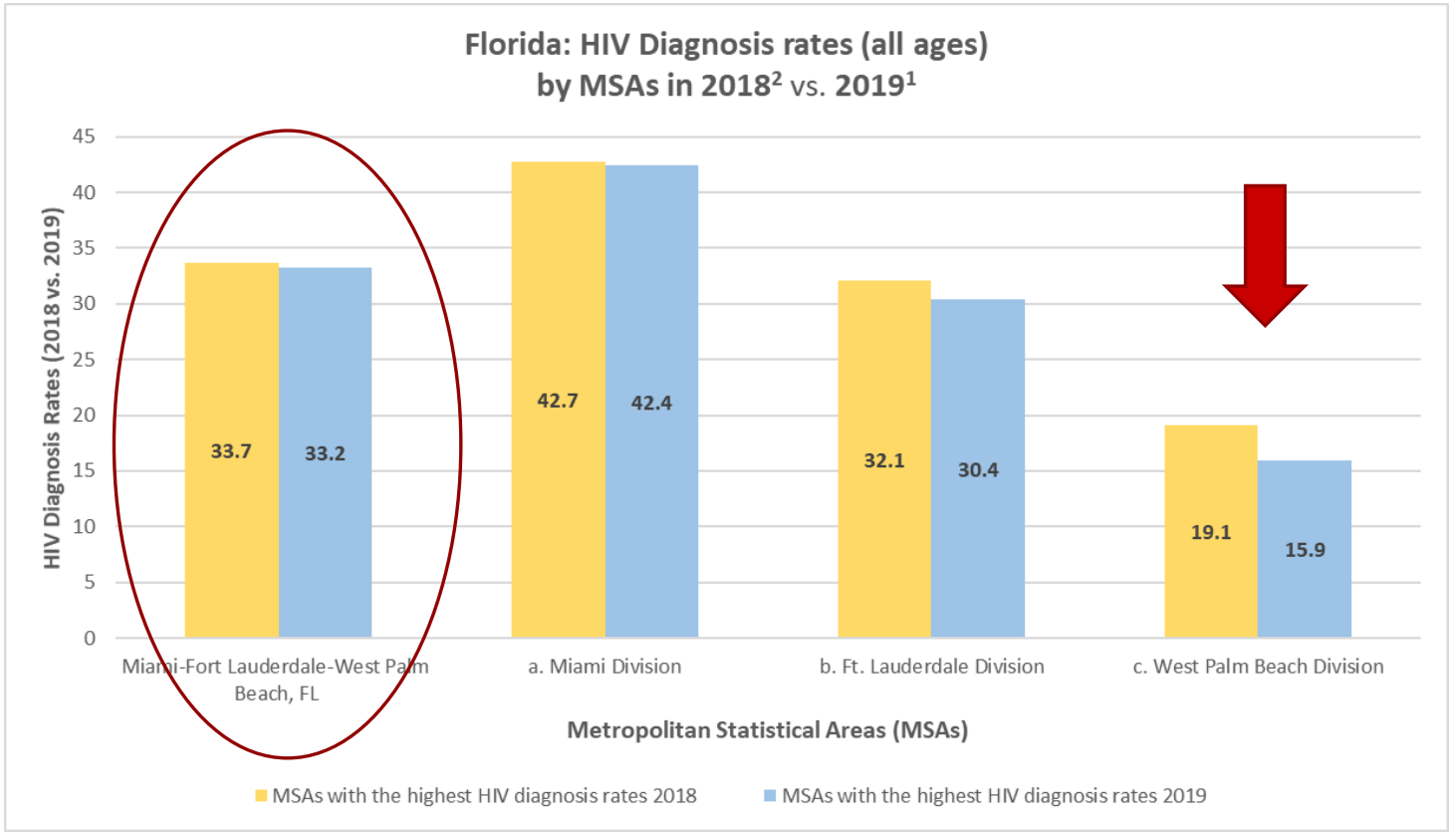
CDC's Ranking of HIV Diagnosis Rates *(all ages)* by MSAs in 2018 vs. 2019

The ten Metropolitan Statistical Areas (MSAs) in 2018 and 2019 with the highest HIV diagnosis rates: **Miami-Fort Lauderdale-West Palm Beach, FL** *ranked #1* in 2018 (33.7) and 2019 (33.2)

MSAs with the highest HIV diagnosis rates		
MSAs	**2018**	**2019**
Miami-Fort Lauderdale-West Palm Beach, FL	**33.7**	**33.2**
a. Miami Division	42.7	42.4
b. Ft. Lauderdale Division	32.1	30.4
c. West Palm Beach Division	19.1	15.9
Atlanta–Sandy Springs–Alpharetta - Roswell, GA	27.7	27.6
Orlando-Kissimmee-Sanford, FL	**26.4**	**25.1**
Baton Rouge, LA	27.3	23.5
Memphis, TN-MS-AR	27.2	23.0
New Orleans – Metairie, LA	24.2	22.2
Jackson, MS	23.6	21.0
Jacksonville, FL	**21.0**	**20.3**
Houston-The Woodlands-Sugar Land, TX	20.4	20.3
Bakersfield, CA	—	19.9

CDC's Ranking of HIV Diagnosis Rates (all ages) by MSAs in 2019 vs. 2018

- Within the **Miami-Fort Lauderdale-West Palm Beach, FL** MSA, the West Palm Beach Division *ranked 3rd* in HIV diagnosis rates in 2018 (19.1) and 2019 (15.9)
- **WPB had the greatest decline in rates from 2018-2019 (by 3.2)**



Summary

- **HIV Infection Diagnoses and Case Rates by Leading States – 5 Year Trend**
  - Florida had the highest number of newly diagnosed HIV infection diagnoses in 2015, 2017 and 2019
  - Florida was the 3rd highest state for HIV infection case rates in 2015, 2017, 2018, and 2019.
- **Metropolitan Statistical Areas (MSAs) Diagnoses and Case Rates – 2018 vs. 2019**
  - Miami-Fort Lauderdale-West Palm Beach, FL ranked 2nd highest in HIV diagnoses
    - West Palm Beach Division ranked 3rd, HIV diagnoses decreased by 46 from 2018
  - Miami-Fort Lauderdale-West Palm Beach, FL ranked 1st in HIV diagnosis case rates
    - West Palm Beach Division ranked 3rd, HIV diagnosis rate declined by 3.2 from 2018

Questions?

Palm Beach County Epidemiological Profile

Julia McGhie Harvey

Florida Department of Health in Palm Beach County

julia.mcghieharvey@flhealth.gov

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Ryan White HIV/AIDS Program

Questions?

PBC Ryan White Services Report (RSR)

Shoshana Ringer, M.Ed.
Quality Management Coordinator
PBC Ryan White HIV/AIDS Program
sringer@pbcgov.org
561-355-4788

Palm Beach County
Ryan White HIV/AIDS Program

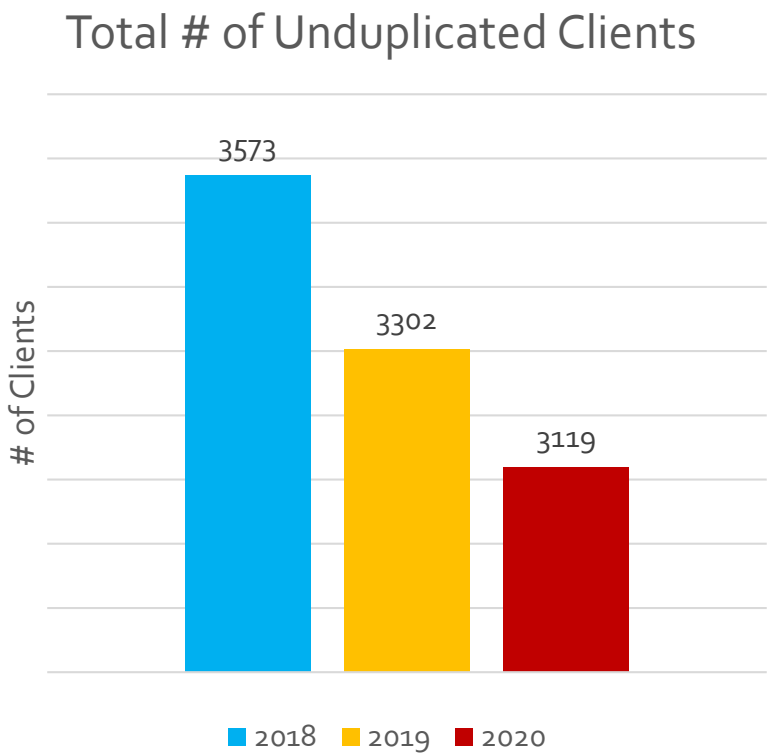
2020 Ryan White HIV/AIDS Program Service Report (RSR)

- 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.

2020 RSR Client Summary Report Data

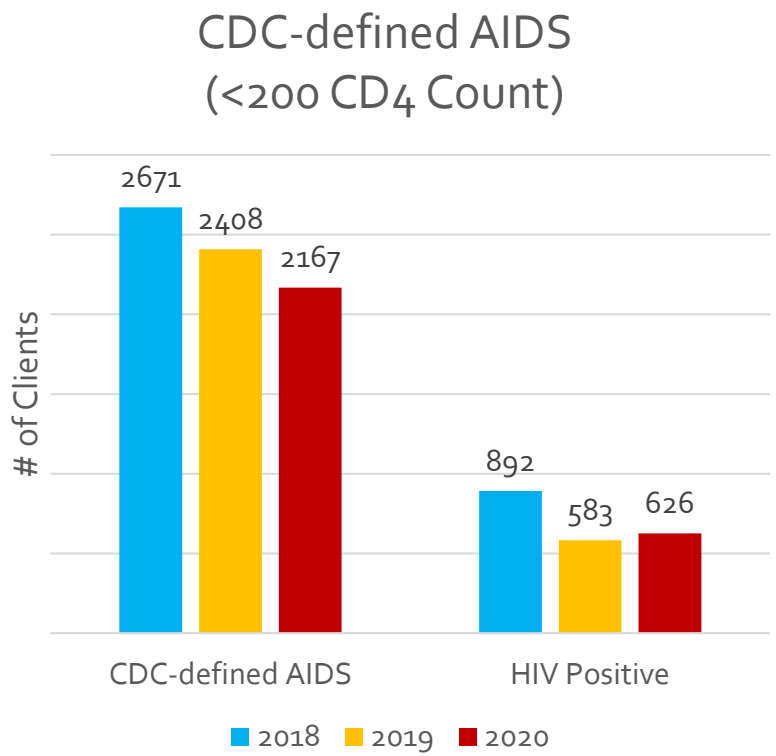
Number of Clients by HIV Status

- Reported a decrease of 183 clients



Number of Clients by HIV/AIDS Status

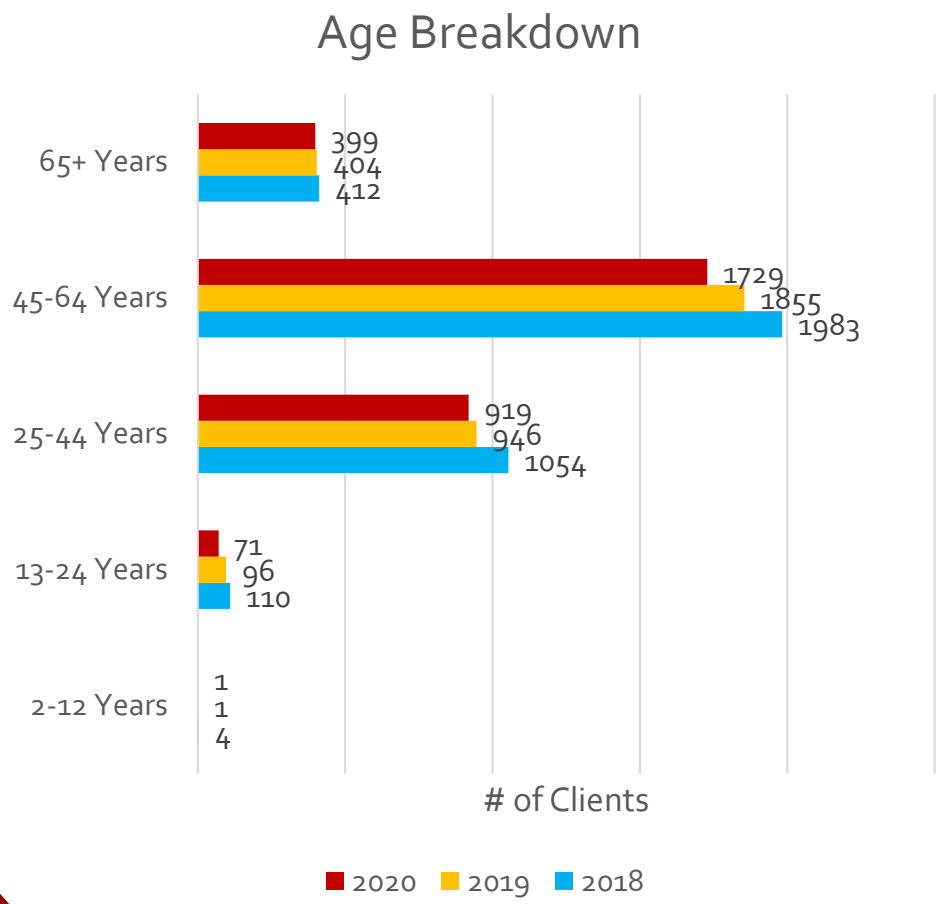
- Reported a decrease of 241 diagnosed with AIDS



2020 RSR Client Summary Report Data cont.

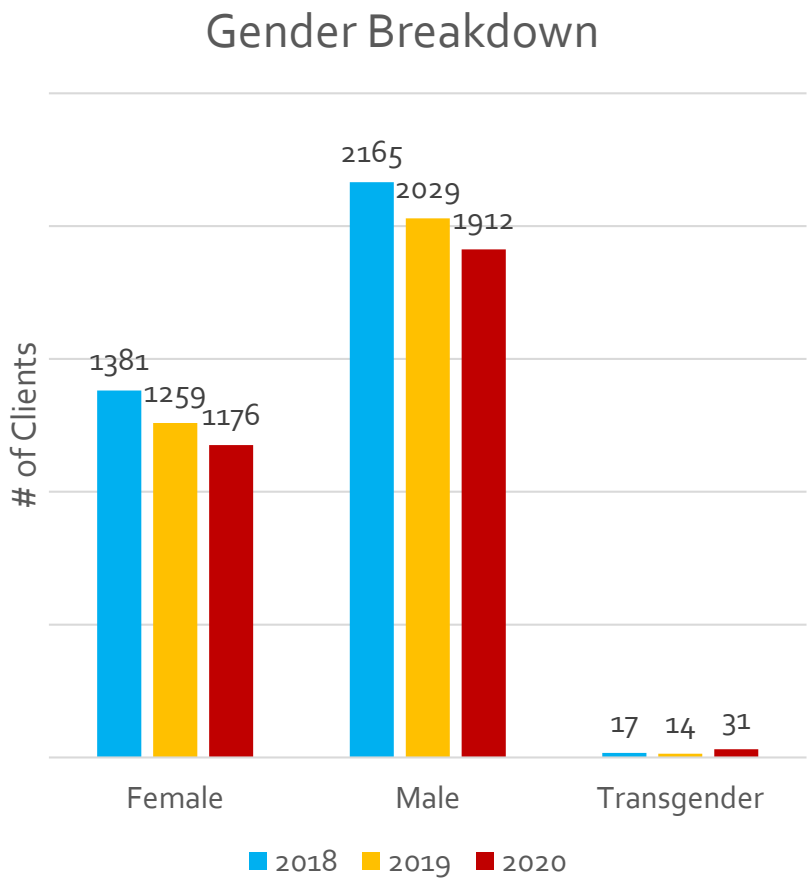
Number of Clients by Age and HIV Status

- Largest group remains 45-64 years old



Number of Clients by Gender and HIV Status

- Largest group remains Males
- Increase of 17 reported Transgender



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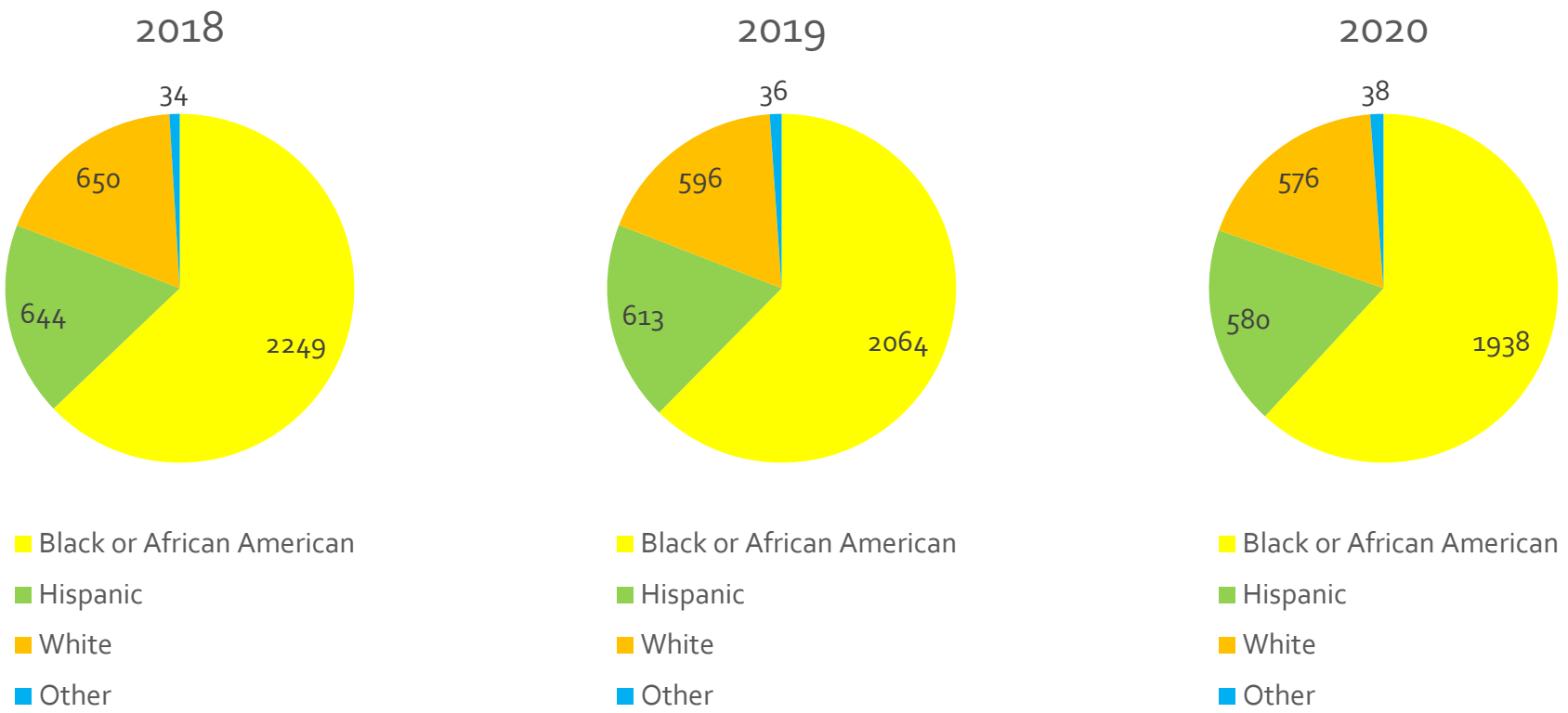
2020 RSR Client Summary Report Data cont.

Number of Clients by Race, Ethnicity and HIV Status

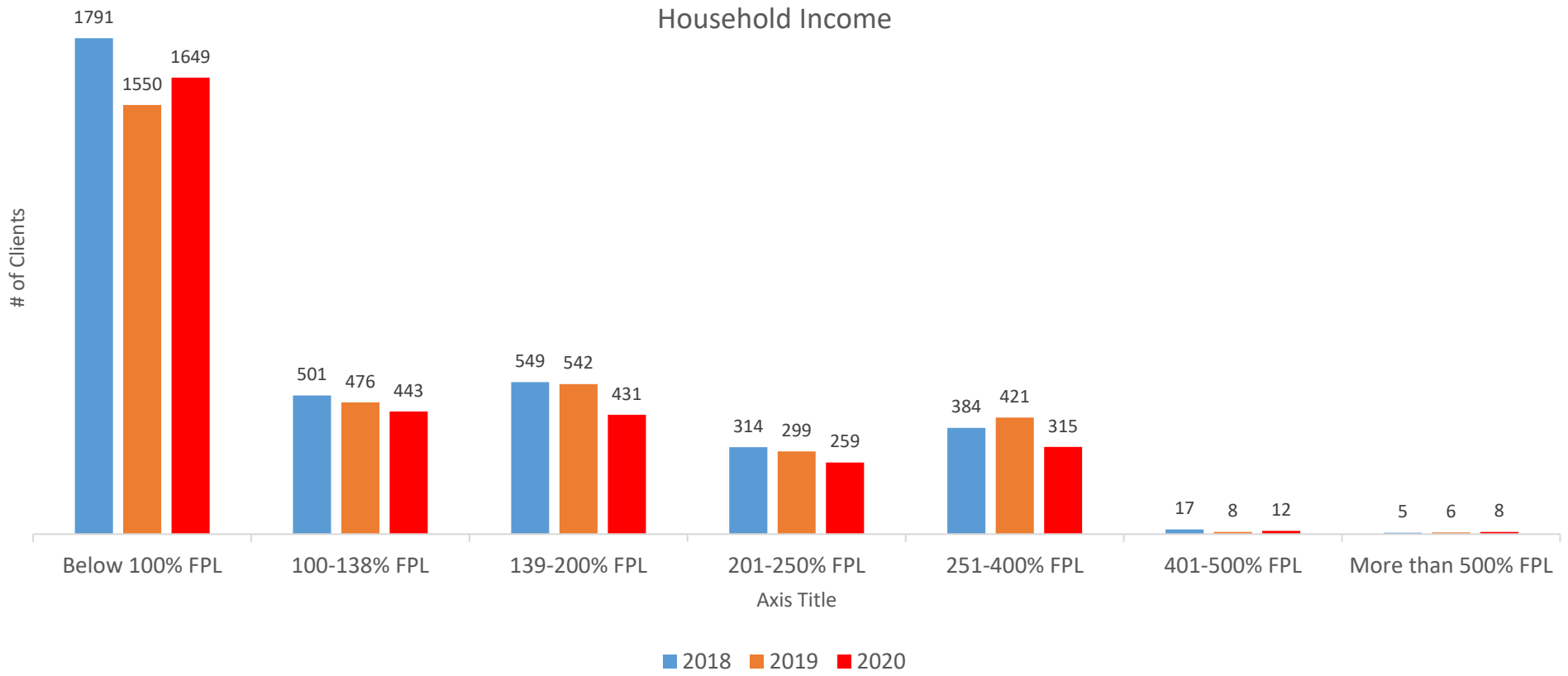
- Largest group remains Black/African American



2020 RSR Client Summary Report Data cont.

Number of Clients by Household Income and HIV Status

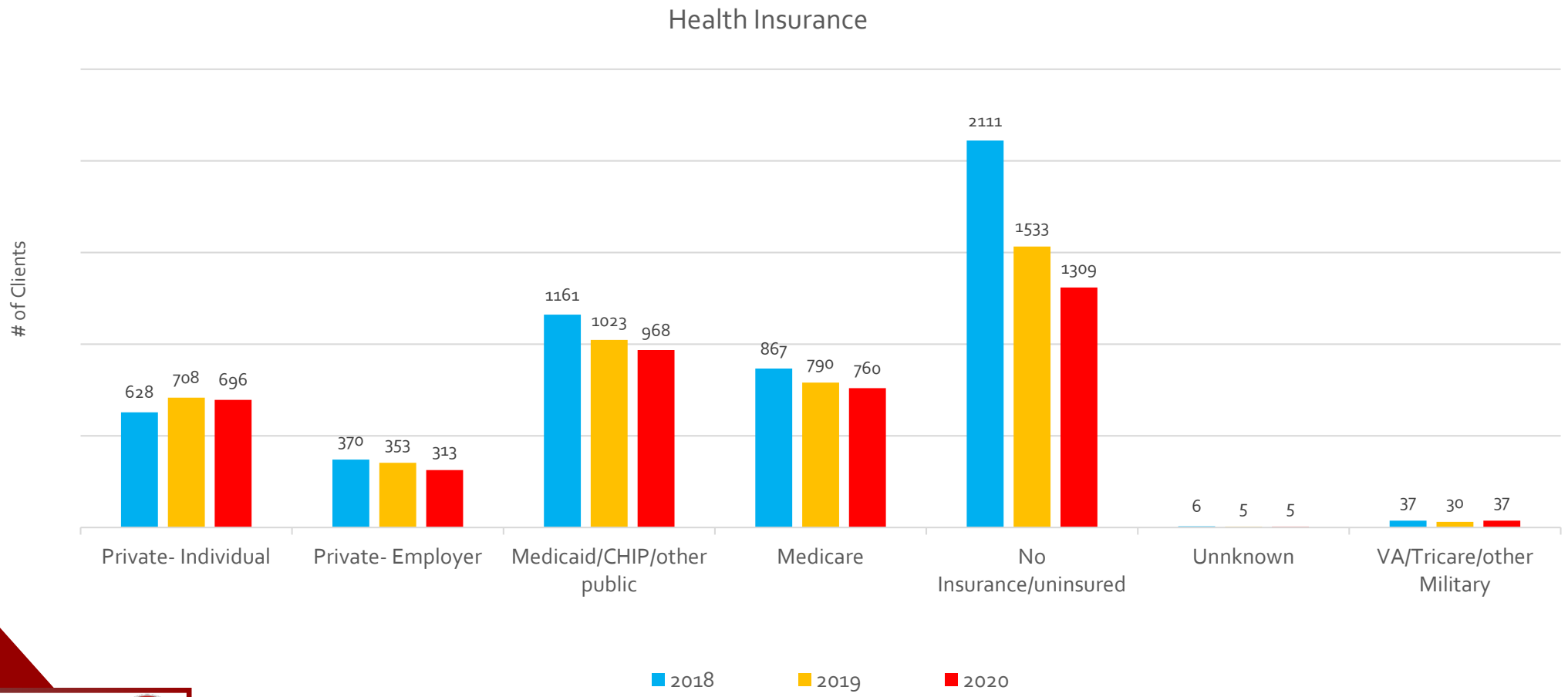
- Largest group remains Below 100% of the Federal Poverty Level (FPL)
- Number of clients below 100% FPL increased by 99



2020 RSR Client Summary Report Data cont.

Number of Clients by Medical Insurance and HIV Status

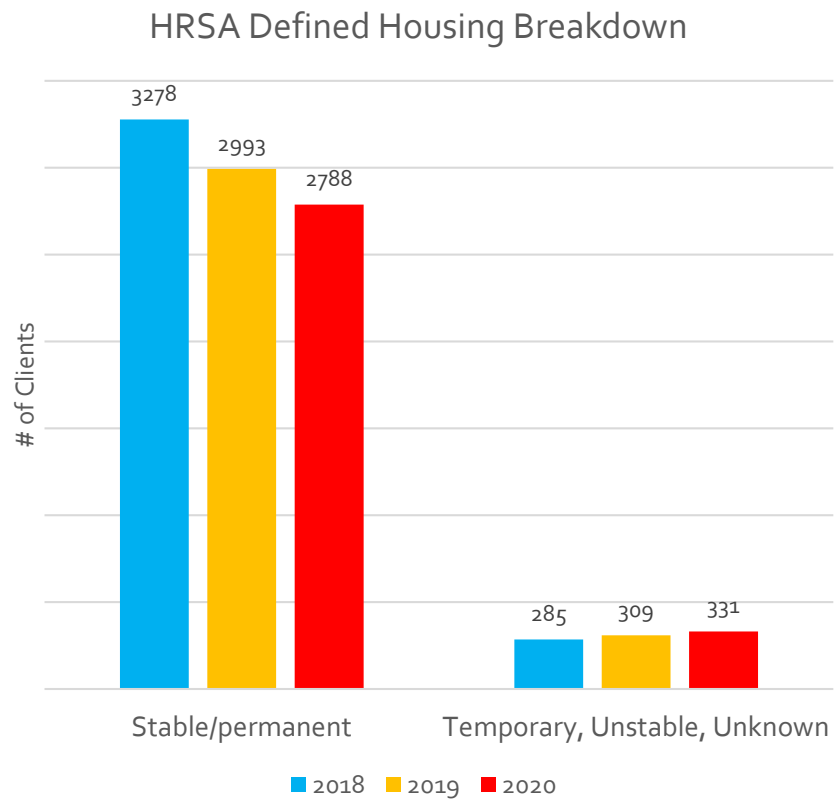
- Largest group remains No insurance/uninsured



2020 RSR Client Summary Report Data cont.

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

- Largest group remains Stable/permanent
- Temporary, Unstable, Unknown Increased by 22



Number of Clients and Service Visits by Service Category

- The 3 top services utilized remains NMCM, MCM, and EIS (change).
- The 3 lowest utilized services are HCBHS, Housing, and Mental Health (change).

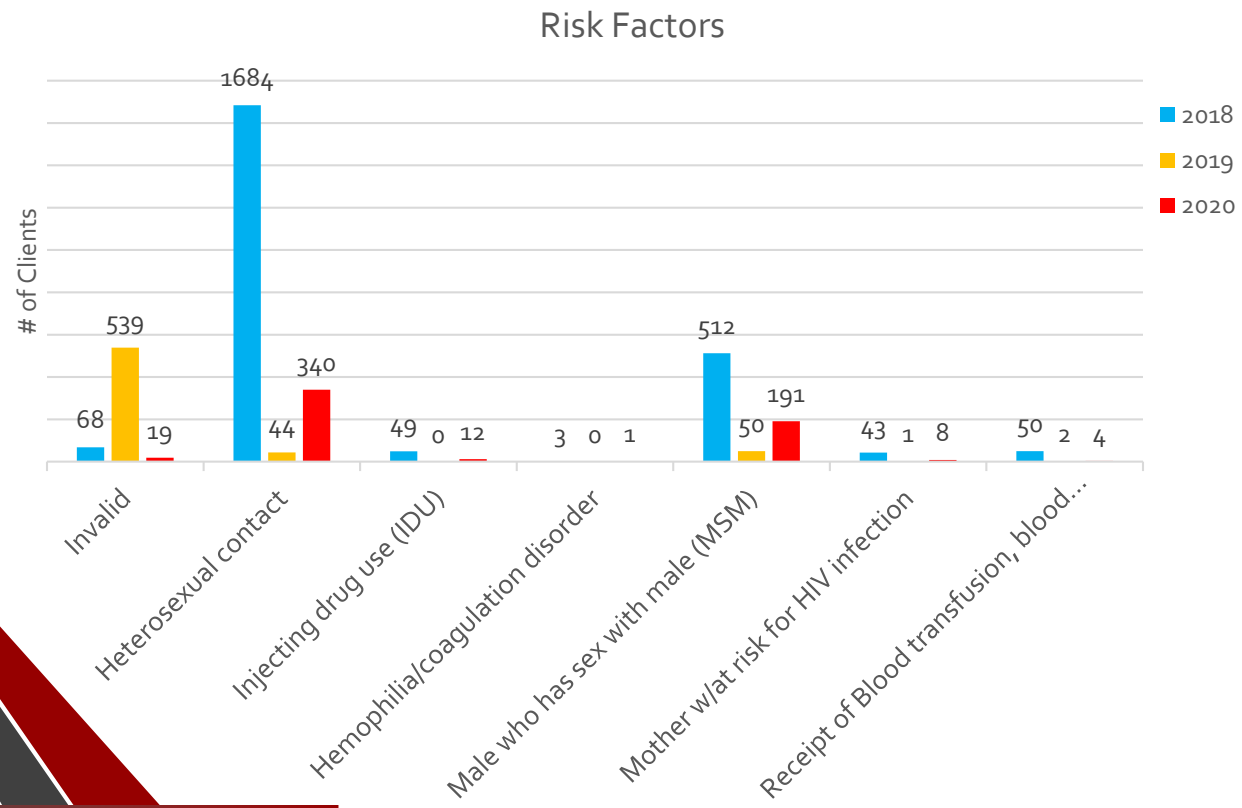
Service Category	# of Clients 2019 / 2020	# of Visits 2019 / 2020
Early Intervention Services	430 / 871	1538 / 3954
Home & Community Based Health Services	3 / 4	10 / 18
Medical Case Management	2091 / 1614	41,869 / 27,228
Medical Nutritional Therapy	16 / 260	16 / 322
Mental Health	94 / 74	847 / 737
Oral Health	725 / 450	2460 / 1099
Outpatient Ambulatory Health Services (including Specialty Medical Care and Lab services)	633 / 555	2578 / 2734
Local Pharmacy Assistance Program	165 / 144	718 / 700
Non-Medical Case Management	2919 / 1866	8886 / 12,448
Emergency Financial Assistance (including EFA-Prior Authorization)	73 / 92	84 / 120
Food Bank (including Nutritional Supplements)	571 / 635	5468 / 4166
Health Insurance Program	371 / 372	2179 / 1975
Housing	11 / 19	69 / 87
Medical Transportation	356 / 290	1573 / 1274
Other Professional Services (Legal)	150 / 186	2402 / 2180

2020 RSR Clinical Summary Report Data

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

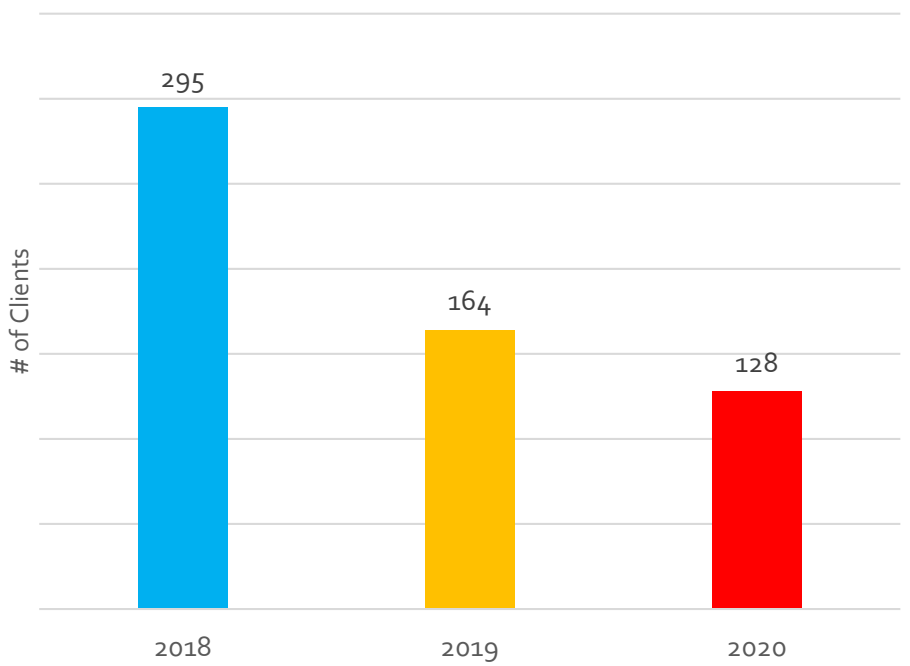
Number of Clients by Risk Factor

- Heterosexual contact remains the most common risk factor reported.
- There was a reporting issue in PE in 2019, for 539 as unknown.



Number of New Clinical Clients

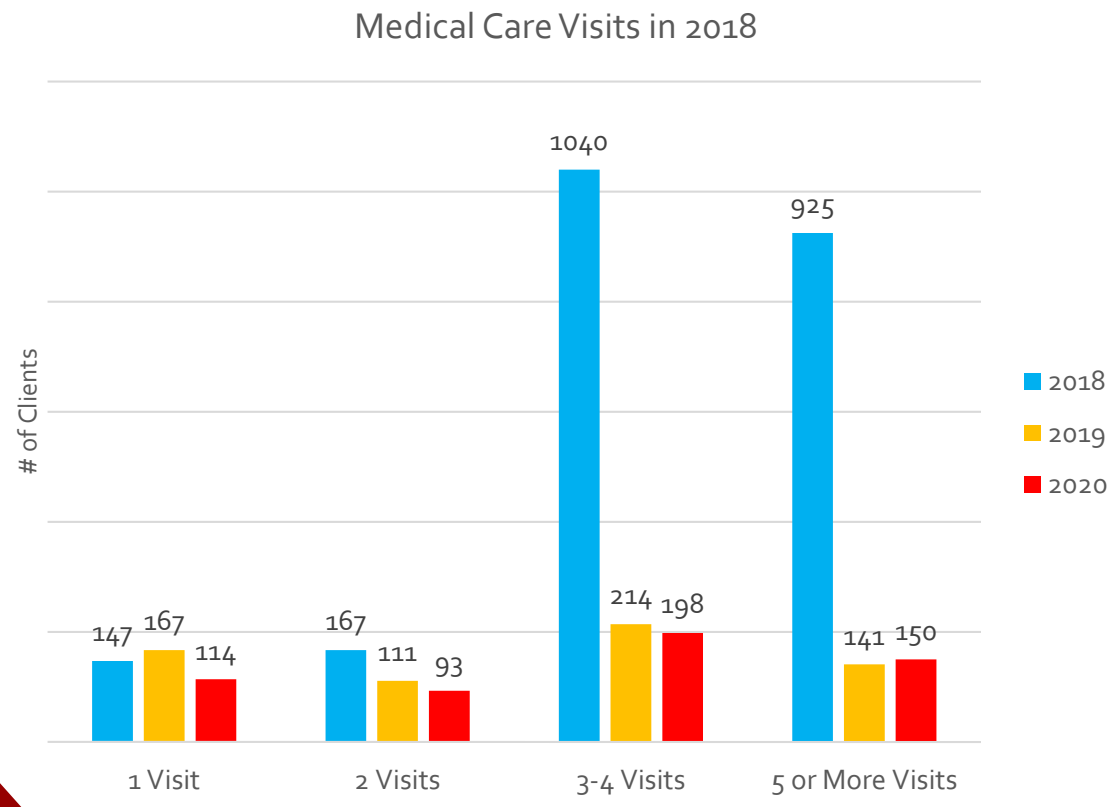
- Decreased by 36.



2020 RSR Clinical Summary Report Data cont.

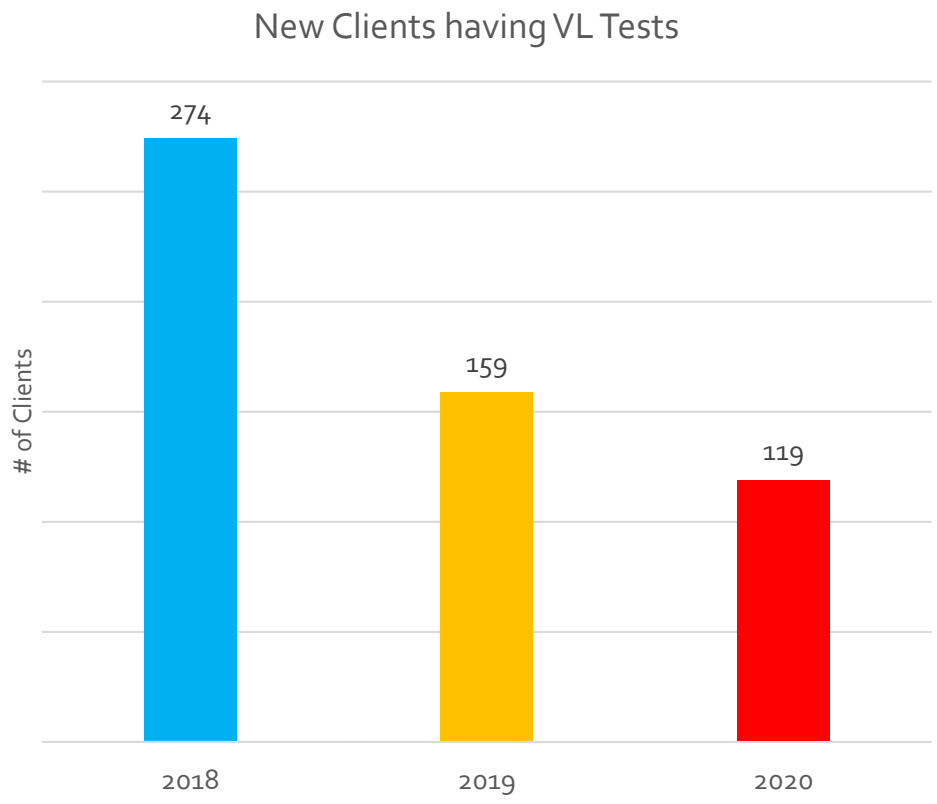
Number of Clients by Number of Medical Care Visits

- The most number of clients had 3-4 visits reported.



Number of New Clients Having Viral Load Test During Reporting Period

- Decreased by 40.



2020 RSR Total Clients Served by Zip Code Summary

- The report resulted in a total of 3,148 (down from 3,314) clients served, within 68 (up from 62) zip codes in Palm Beach County.
- 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.
- There were 31 zip codes in Palm Beach County that resulted in 10 or less clients served.

2019 Zip Code	2019 Clients Served
33407	308
33404	256
33435	207
33444	198 (179 in 2020)
33460	191

2020 Zip Code	2020 Clients Served
33407	302
33404	230
33460	198
33430	196 (189 in 2019)
33435	182

Questions?

PBC RWHAP Care Continuum

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

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Definitions for HIV Care Continuum

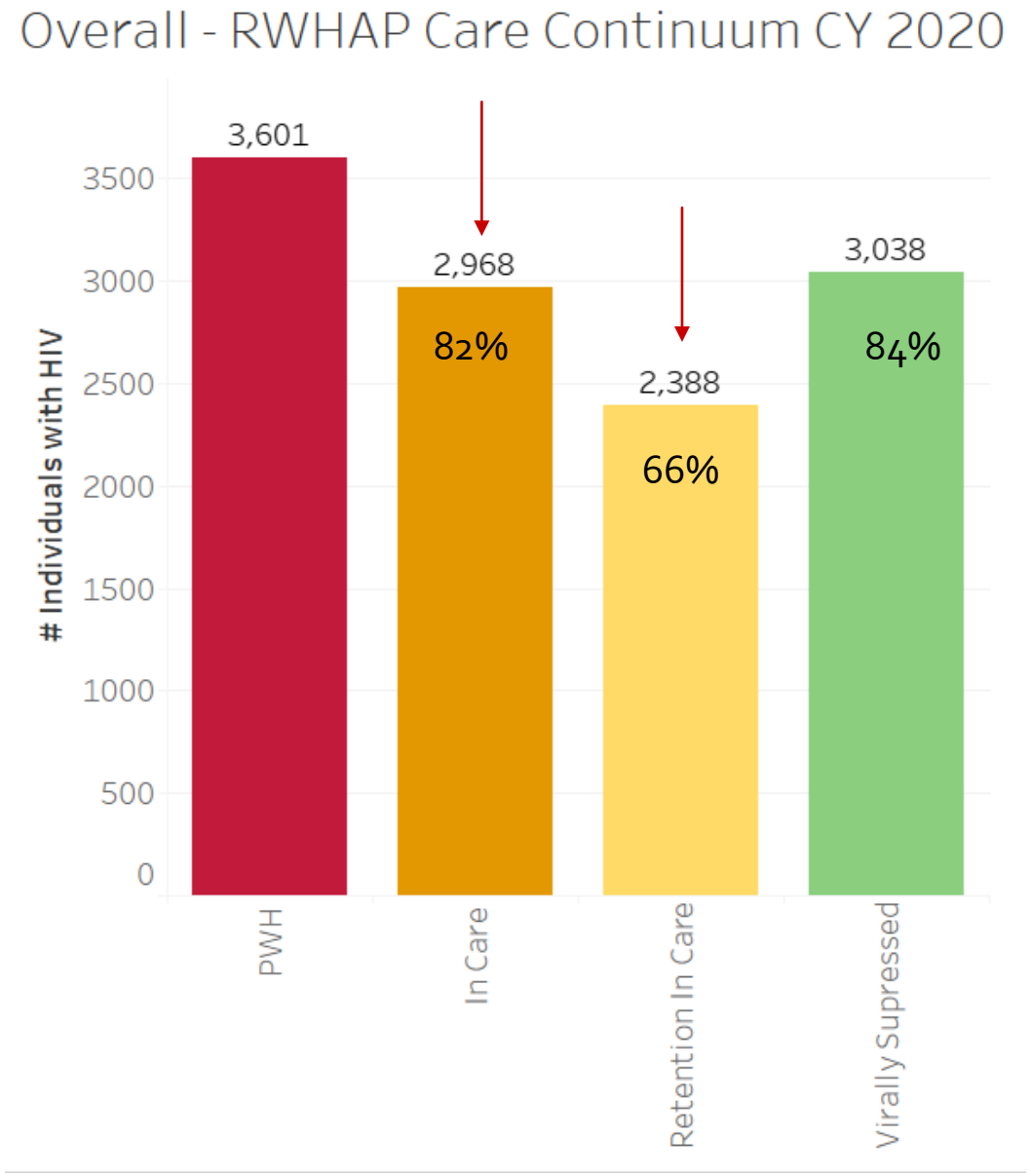
- **PWH:** Persons with HIV that received at least one service from Ryan White Part A/MAI in the reporting period, excluding EIS
- **In Care:** PWH with **at least one** documented VL or CD_4 lab, "kept" medical visit, prescription dispensed, or a payment request "paid" (co-pay or deductible) from 1/1/2020 through 12/31/2020
- **Retained in Care:** PWH with **two or more** documented VL or CD_4 labs, "kept" medical visits, prescriptions dispensed, or a payment request "paid" (co-pay or deductible) **at least three months apart** from 1/1/2020 through 12/31/2020
- **Suppressed Viral Load:** PWH with a suppressed VL (<200 copies/mL) on the last VL by 12/31/2020

The largest gaps for RWHAP are clients **who are not in care and are not retained in care.**

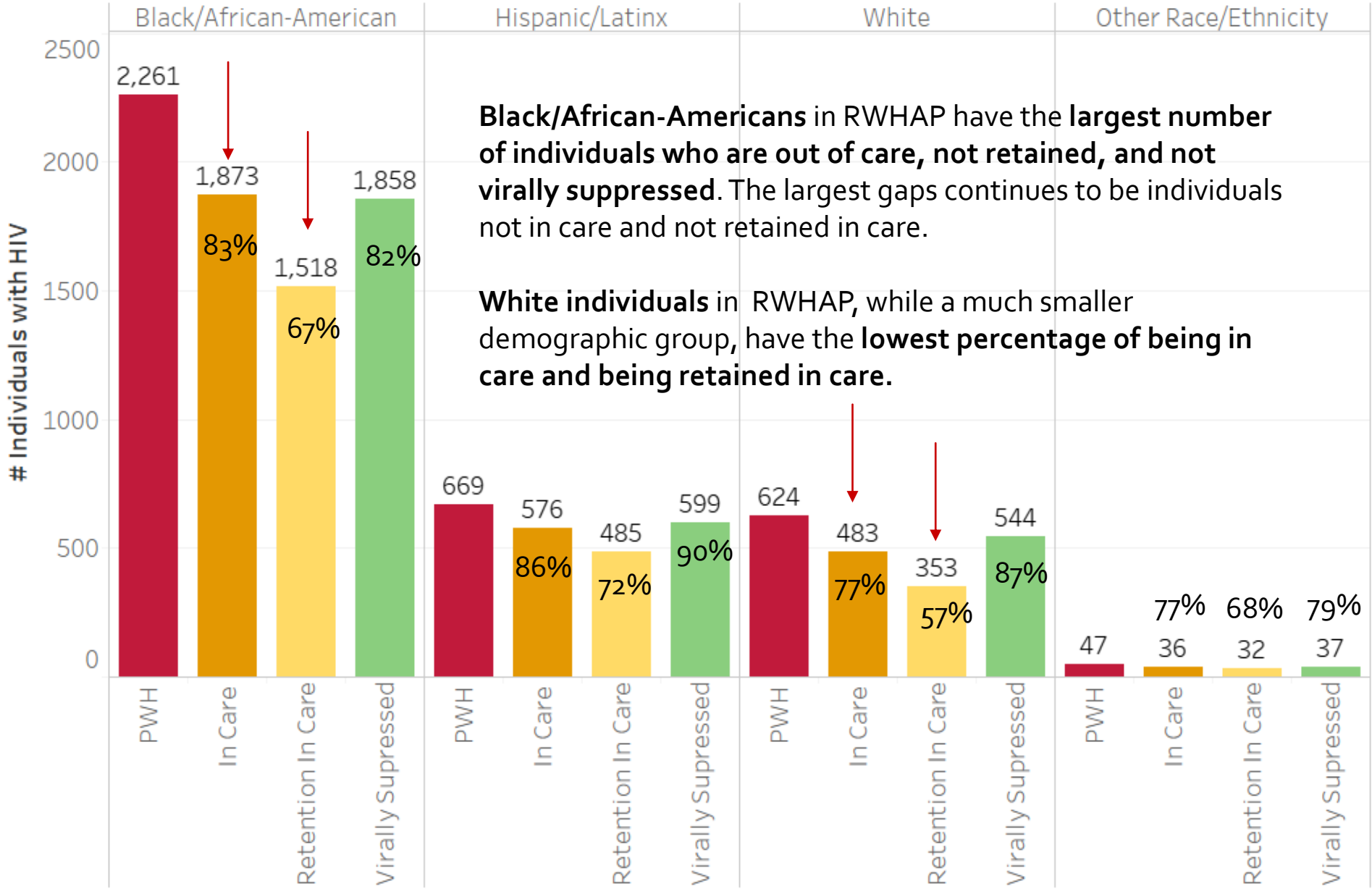
In Care has dropped from 89% in 2019 to 82% in 2020.

Retention in Care has dropped from 70% in 2019 to 66% in 2020.

The **number of individuals served increased** from 3,466 in 2018 to 3,601 in 2020.



Race/Ethnicity - RWHAP Care Continuum CY 2020



Black/African-Americans in RWHAP have the **largest number of individuals who are out of care, not retained, and not virally suppressed**. The largest gaps continues to be individuals not in care and not retained in care.

White individuals in RWHAP, while a much smaller demographic group, have the **lowest percentage of being in care and being retained in care.**

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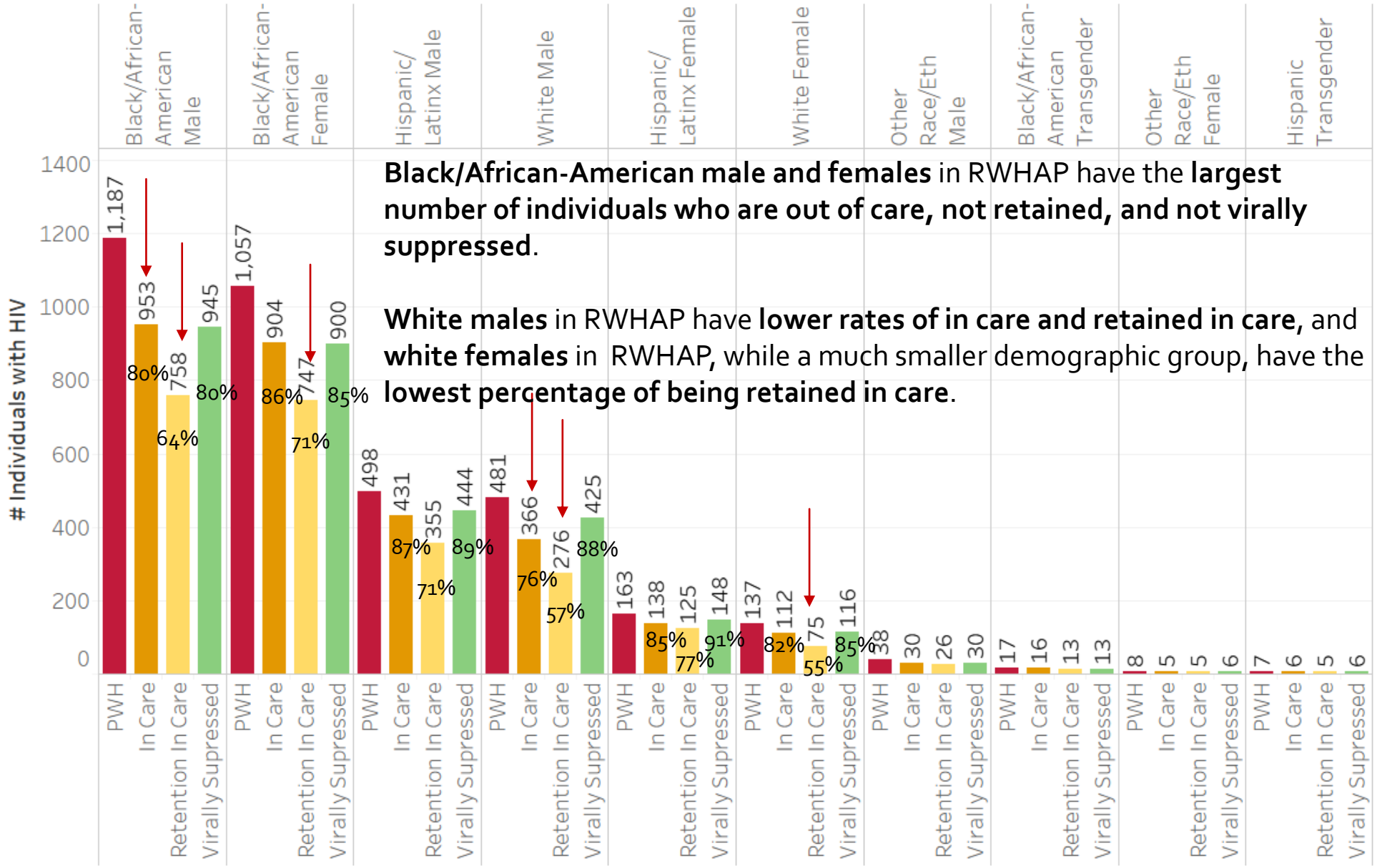
Race/Ethnicity & Gender - RWHAP Care Continuum CY 2020



Black/African-American male and females in RWHAP have the **largest number of individuals who are out of care, not retained, and not virally suppressed**.

White males in RWHAP have **lower rates of in care and retained in care,** and **white females** in RWHAP, while a much smaller demographic group, have the **lowest percentage of being retained in care**.

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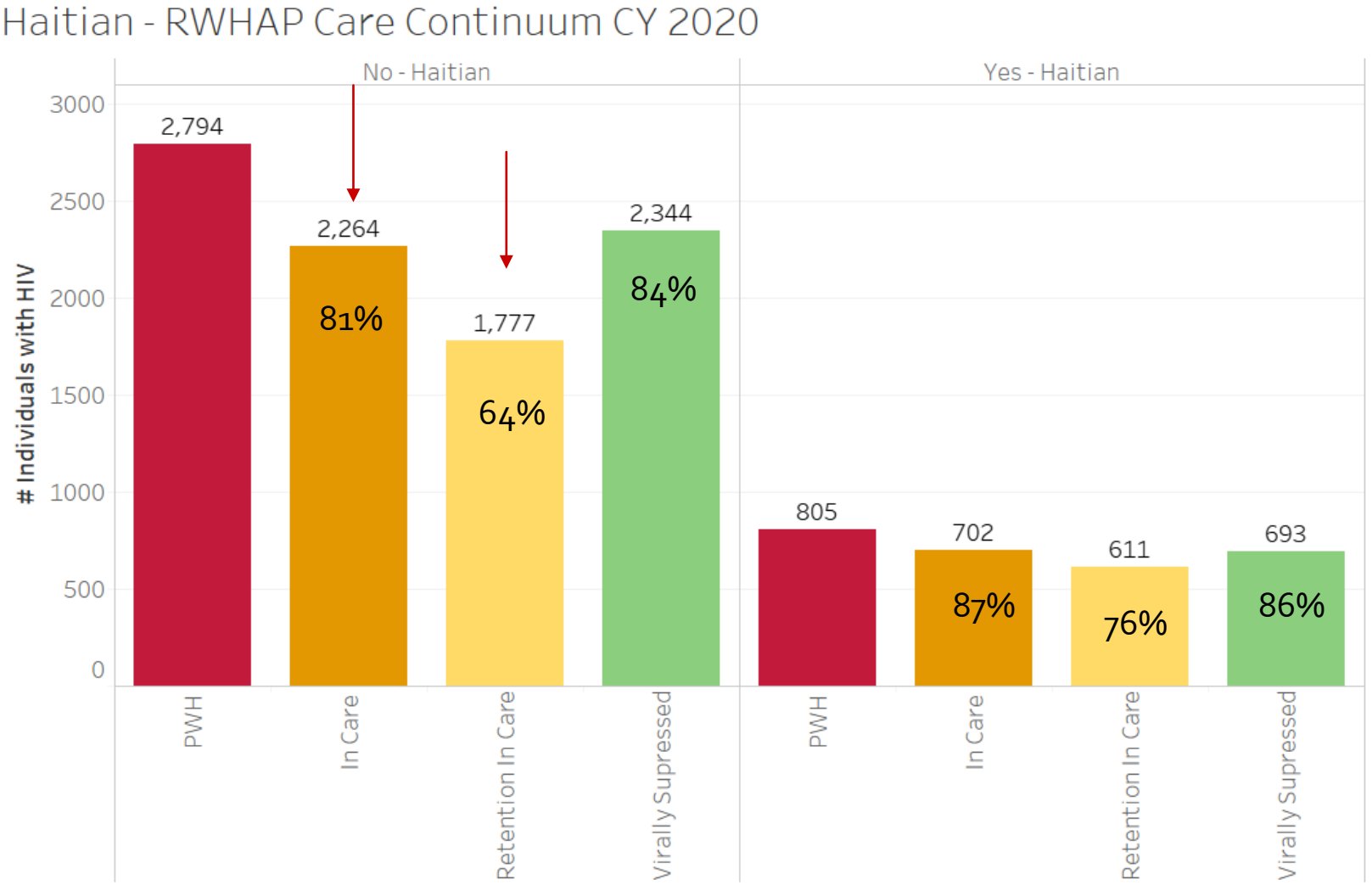
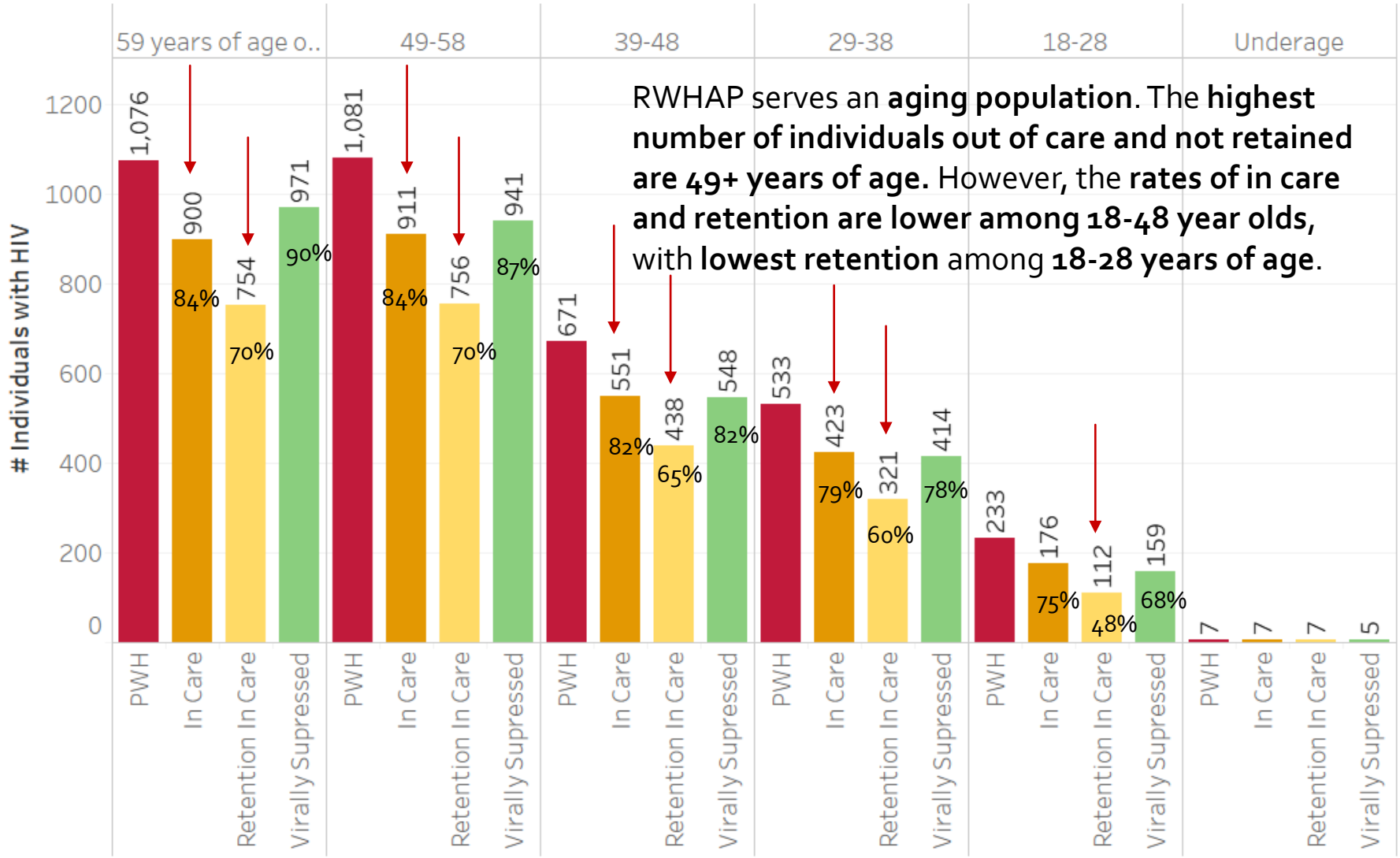
About 20% of individuals in RWHAP are **Haitian**.

However, **Haitians** in RWHAP **have higher in care and retention in care rates.**



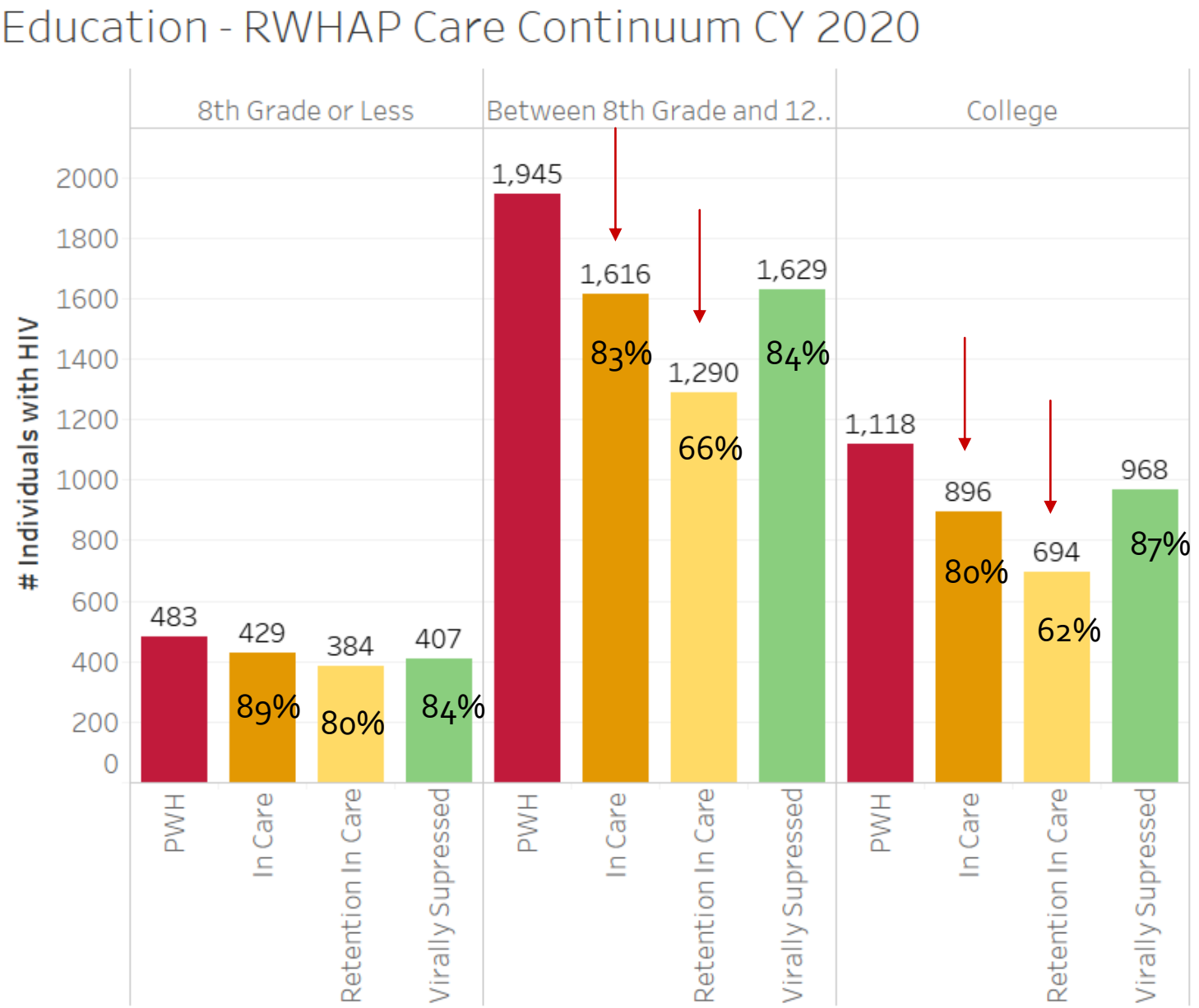
Age - RWHAP Care Continuum CY 2020



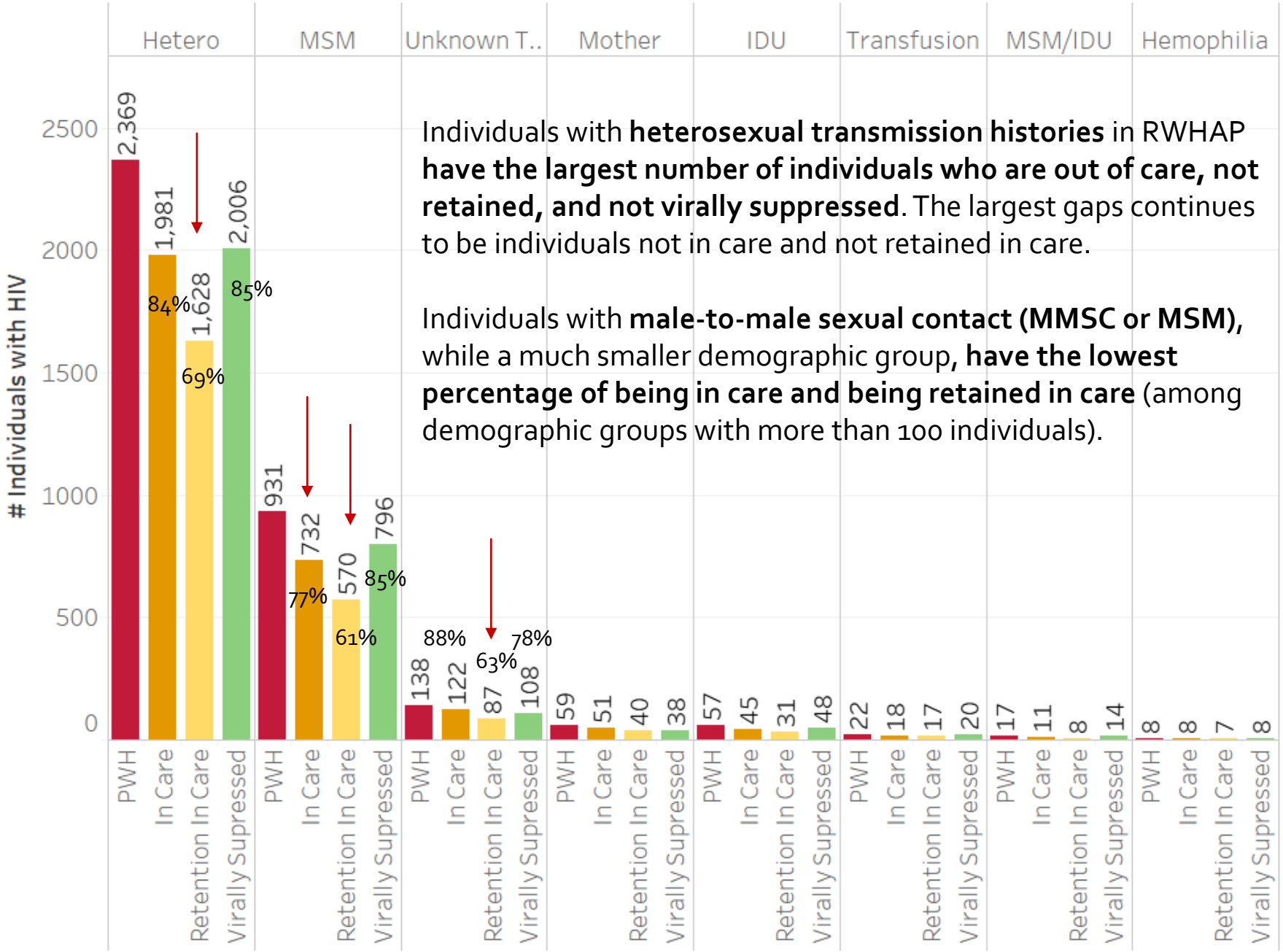
RWHAP serves an **aging population**. The **highest number of individuals out of care and not retained are 49+ years of age.** However, the **rates of in care and retention are lower among 18-48 year olds,** with **lowest retention** among **18-28 years of age**.

Most individuals in RWHAP have between an **8th-12th grade education**. **Most individuals not in care and retained in care** have this level of education.

However, the **lowest rate of in care and retention** are among those who have **at least some college education.**



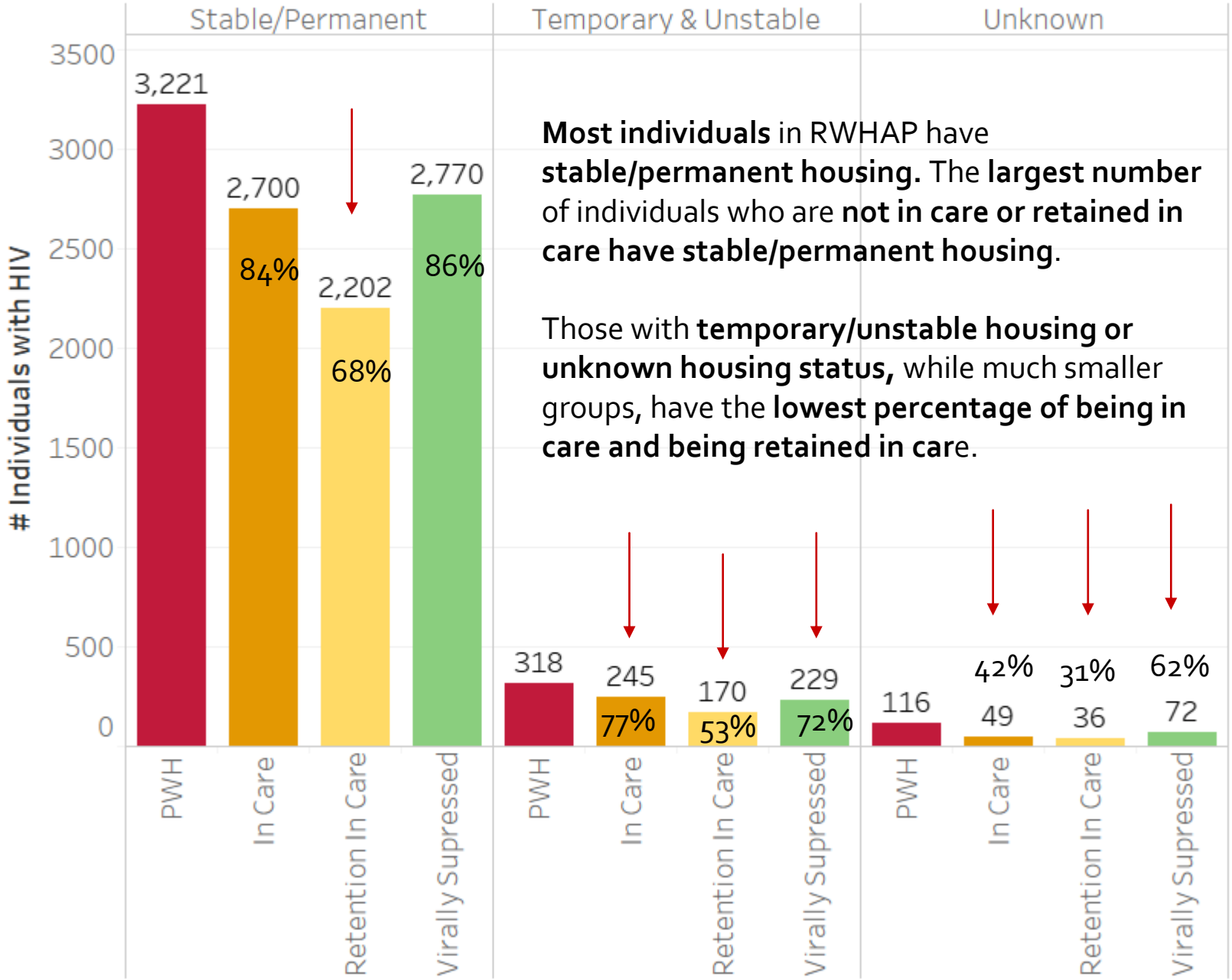
Transmission - RWHAP Care Continuum CY 2020



Individuals with **heterosexual transmission histories** in RWHAP **have the largest number of individuals who are out of care, not retained, and not virally suppressed**. The largest gaps continues to be individuals not in care and not retained in care.

Individuals with **male-to-male sexual contact (MMSC or MSM)**, while a much smaller demographic group, **have the lowest percentage of being in care and being retained in care** (among demographic groups with more than 100 individuals).

Housing Status - RWHAP Care Continuum CY 2020



Most individuals in RWHAP have **stable/permanent housing.** The **largest number** of individuals who are **not in care or retained in care have stable/permanent housing**.

Those with **temporary/unstable housing or unknown housing status,** while much smaller groups, have the **lowest percentage of being in care and being retained in care**.

Palm Beach County
Ryan White HIV/AIDS Program

Questions?

PBC RWHAP Service Utilization & Cost Analysis

Maria Corona, MBA
Financial Analyst II
PBC Ryan White HIV/AIDS Program
mcorona@pbcgov.org
561-355-4796

Palm Beach County
Ryan White HIV/AIDS Program

GY 20 Grant Award Overview

Award Information	Current GY	Carryover	Total
Part A Formula	$4,355,403	$217,944	$4,573,347
MAI	$660,793	$31,123	$691,916
Part A Supplemental	$2,442,612	-	$2,442,612
Total	$7,458,808	$249,067	$7,707,875

GY20 Grant Expenditure Overview

Expenditure Categories	Amount	Percent
Core Medical Services	$5,199,711	79.68%
Support Services	$1,325,807	20.32%
Administration	$994,012	13.22%
Total	$7,519,530	97.56%

GY20 Award & Expenditure Summary

Award Category	Award	Expenditure	Balance
Part A	$7,015,959	$6,867,228	$148,731
MAI	$691,916	$652,302	$39,614
Total	$7,707,875	$7,519,530	$188,345

GY20 Core Medical Services Expenditures by Service Category

Core Medical Service Category	Amount	Percent
AIDS Pharmaceutical Assistance (LPAP)	$13,398	0.21%
Early Intervention Services-Part A	$711,431	10.90%
Early Intervention Services-MAI	$112,135	1.72%
Health Insurance Premium & Cost Sharing Assistance	$1,553,326	23.80%
Home and Community-Based Health Services	$3,916	0.06%
Laboratory Diagnostic Testing	$168,395	2.58%

GY20 Core Medical Services Expenditures by Service Category…cont.

Core Medical Service Category	Amount	Percent
Medical Case Management-Part A	$1,210,389	18.55%
Medical Case Management-MAI	$388,697	5.96%
Medical Nutrition Therapy	$35,941	0.55%
Mental Health Services	$157,552	2.41%
Oral Health Care	$404,599	6.20%
Outpatient/Ambulatory Health Services	$160,674	2.46%
Specialty Outpatient Medical Care	$279,258	4.28%

GY20 Support Services Expenditures by Service Category

Support Service Category	Amount	Percent
Emergency Financial Assistance	$22,739	0.35%
Emergency Financial Assistance –Prior Authorizations	$4,789	0.07%
Food Bank/Home Delivered Meals	$279,372	4.28%
Food Bank/Nutritional Supplements	$5,384	0.08%
Housing Services	$141,129	2.16%
Legal Services	$280,000	4.29%

GY20 Support Services Expenditures by Service Category…cont.

Support Service Category	Amount	Percent
Medical Transportation	$50,123	0.77%
Non-Medical Case Management-Eligibility	$245,994	3.77%
Non-Medical Case Management-Supportive	$229,585	3.52%
Non-Medical Case Management- MAI	$48,689	0.74%
Psychosocial Support Services - MAI	$18,003	0.28%

Service Category Ordered by Expenditure

1. Medical Case Management (Part A & MAI)	24.5%
2. Health Insurance Premium & Cost Sharing Assistance	23.8%
3. Early Intervention Services (Part A & MAI)	12.6%
4. Non-Medical Case Management Services	8.0%
5. Oral Health Care	6.2%
6. Legal Services	4.3%
7. Food Bank/Home Delivered Meals	4.3%
8. Specialty Outpatient Medical Care	4.3%
All Other Service Categories Less than 3%	Remaining 12%

Service Category cost per unit- Part A

Core Medical Service Category	Amount	Persons Served	Units of Service	Cost/Person	Cost/Unit
AIDS Pharmaceutical Assistance (LPAP)	$13,398	118	608	$113.54	$22.03
Early Intervention Services	$711,431	686	5,853	$1,037.07	$121.55
Health Insurance	$1,553,326	362	1,998	$4,290.96	$777.44
Home and Community-based Health Services	$3,916	3	173	$1,305.33	$22.64
Laboratory Diagnostic Testing	$168,395	301	5,441	$554.45	$30.95
Medical Case Management	$1,210,389	1,183	48,246	$1,023.15	$25.09

Service Category cost per unit- Part A cont.

Core Medical Service Category	Amount	Persons Served	Units of Service	Cost/Person	Cost/Unit
Medical Nutrition Therapy	$35,941	290	320	$123.93	$112.32
Mental Health Services	$157,552	69	512	$2,283.36	$307.72
Oral Health Care	$404,599	443	1,162	$913.32	$348.19
Outpatient/Ambulatory Health Services	$160,674	407	2,209	$394.78	$72.74
Specialty Medical Care	$279,258	181	702	$1,542.86	$397.80

Service Category cost per unit- Part A cont.

Support Service Category	Amount	Persons Served	Units of Service	Cost/Person	Cost/Unit
Emergency Financial Assistance	$22,739	35	49	$649.69	$464.06
Emergency Financial Assistance - Prior Authorizations	$4,789	70	157	$68.41	$30.50
Food Bank/ Home Delivered Meals	$279,372	649	9,167	$430.47	$30.48
Food Bank/ Nutritional Supplements	$5,384	16	94	$336.50	$57.28
Legal Services	$280,000	196	2,819	$1,428.57	$99.33

Service Category cost per unit- Part A cont.

Support Service Category	Amount	Persons Served	Units of Service	Cost/Person	Cost/Unit
Housing Services	$141,129	16	1,515	$8,820.56	$93.15
Medical Transportation	$50,123	240	2,188	$208.85	$22.91
Non-Medical Case Management-Eligibility	$245,994	1,717	16,303	$143.27	$15.09
Non-Medical Case Management-Supportive	$229,585	813	16,450	$282.39	$13.96

Service Category cost per unit - MAI

Core Medical Service Category	Amount	Persons Served	Units of Service	Cost/Person	Cost/Unit
Early Intervention Services	$112,135	178	956	$629.97	$117.30
Medical Case Management	$388,697	629	24,298	$617.96	$15.99

Support Service Category	Amount	Persons Served	Units of Service	Cost/Person	Cost/Unit
Non-Medical Case Management	$48,689	69	832	$705.64	$58.52
Psychosocial Support	$18,003	12	60	$1,500.25	$300.05

Service Category Ordered by Persons Served – Top Ten

	Persons Served
1. Non-Medical Case Mgt. Eligibility	1,717
2. Medical Case Management	1,183
3. Non-Medical Case Management-Supportive	813
4. Early Intervention Services	686
5. Food/Bank Home Delivered Meals	649
6. Medical Case Management-MAI	629
7. Oral Health	443
8. Outpatient/Ambulatory	407
9. Health Insurance Premium	362
10. Medical Nutrition Therapy	290

Service Category Ordered by Cost/Person – Top Five

	Cost/Person
1. Housing Services	$8,820.56
2. Health Insurance	$4,290.96
3. Mental Health	$2,283.36
4. Psychosocial Support	$1,500.25
5. Legal Services	$1,428.57

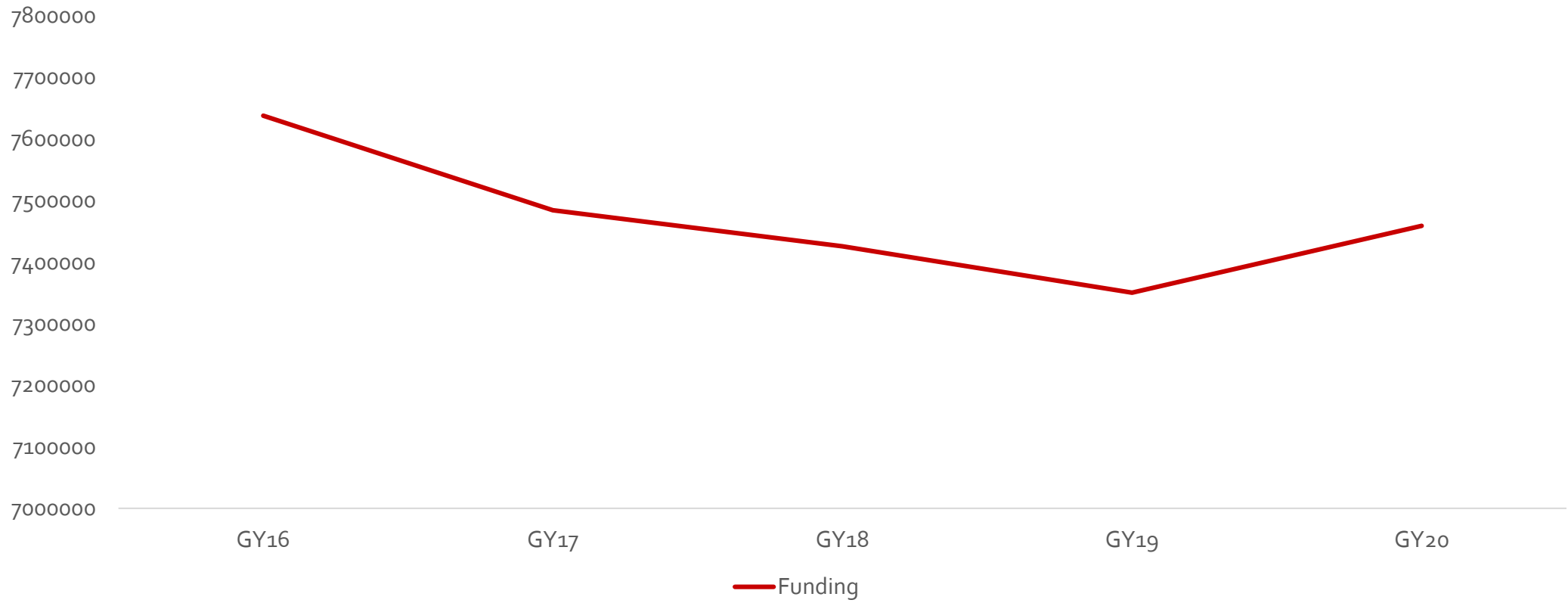
Service Category Ordered by Cost/Unit – Top Five

	Cost/Unit
1. Health Insurance	$777.44
2. Emergency Financial Assistance	$464.06
3. Specialty Medical Services	$397.80
4. Oral Health Services	$348.19
5. Mental Health	$307.72

5 Year Trend Analysis

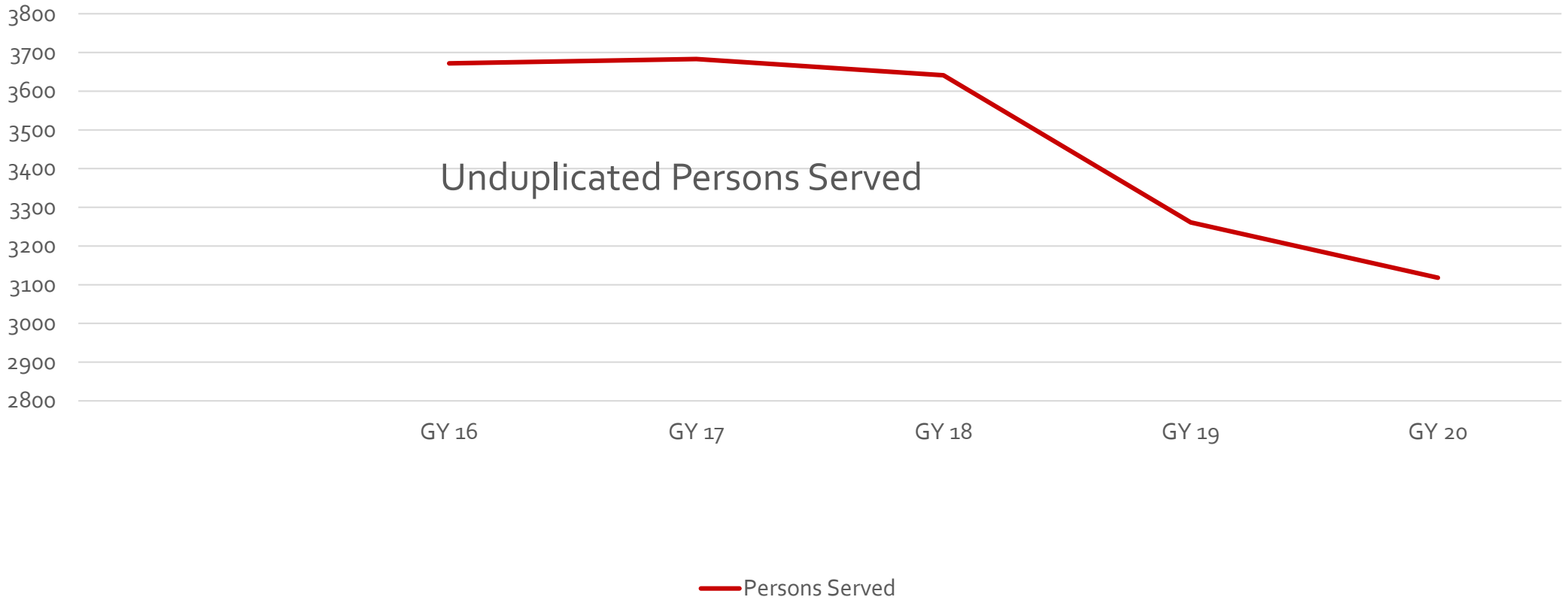
GY 16 – GY 20

5 Year Trends-RW Funding



- 2.34% Funding from GY16 to GY20

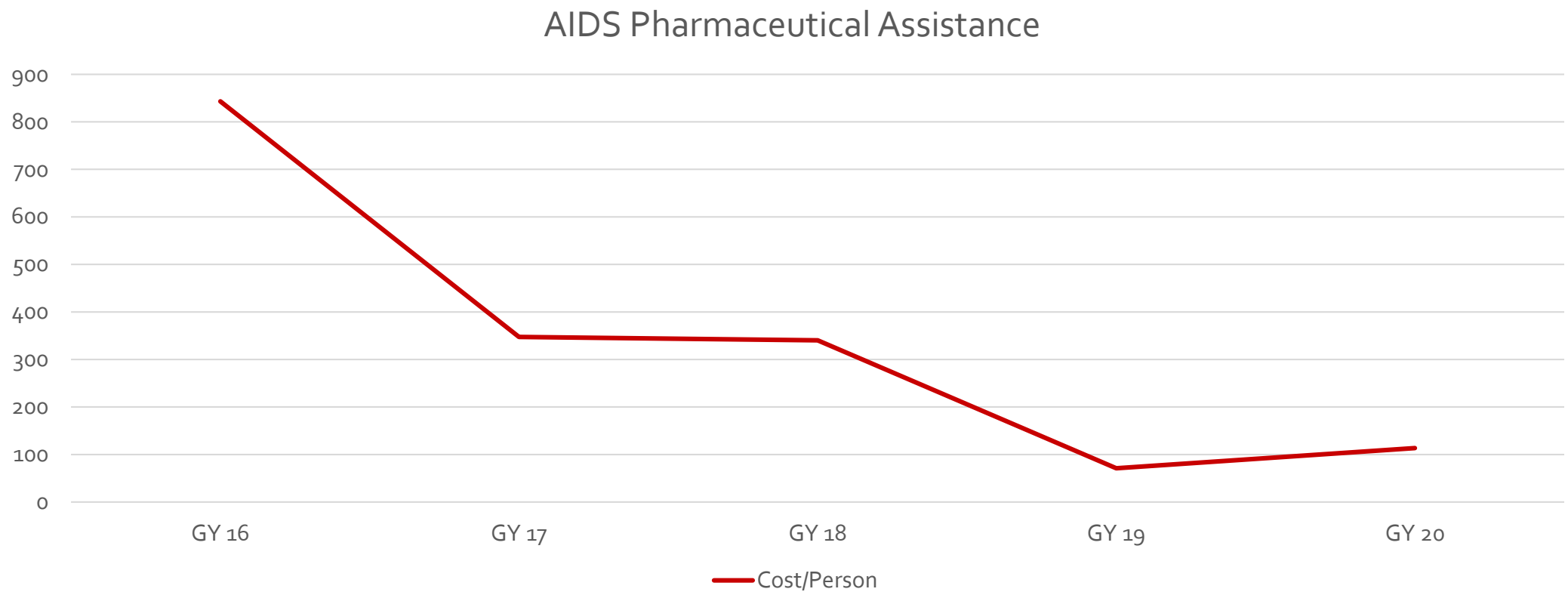
5 Year Trend-Persons Served



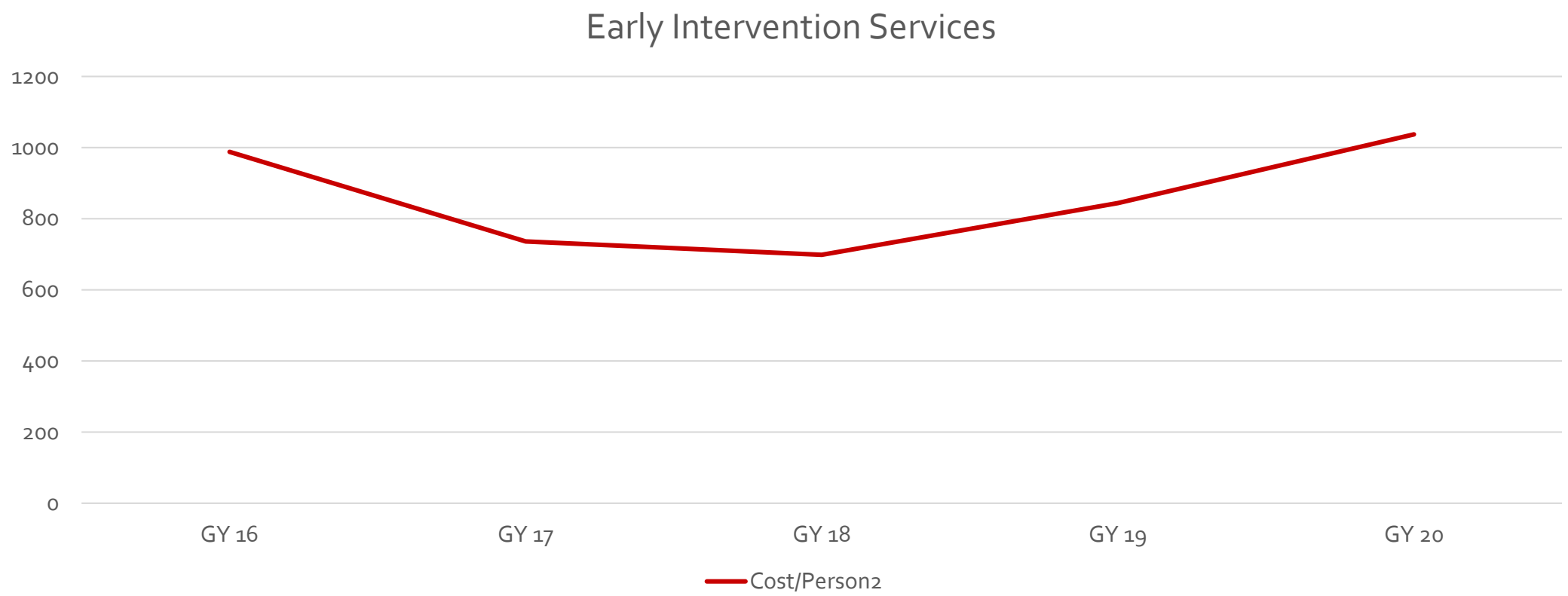
-15.08 % Persons Served from GY 16 - GY 20

Palm Beach County
Ryan White HIV/AIDS Program

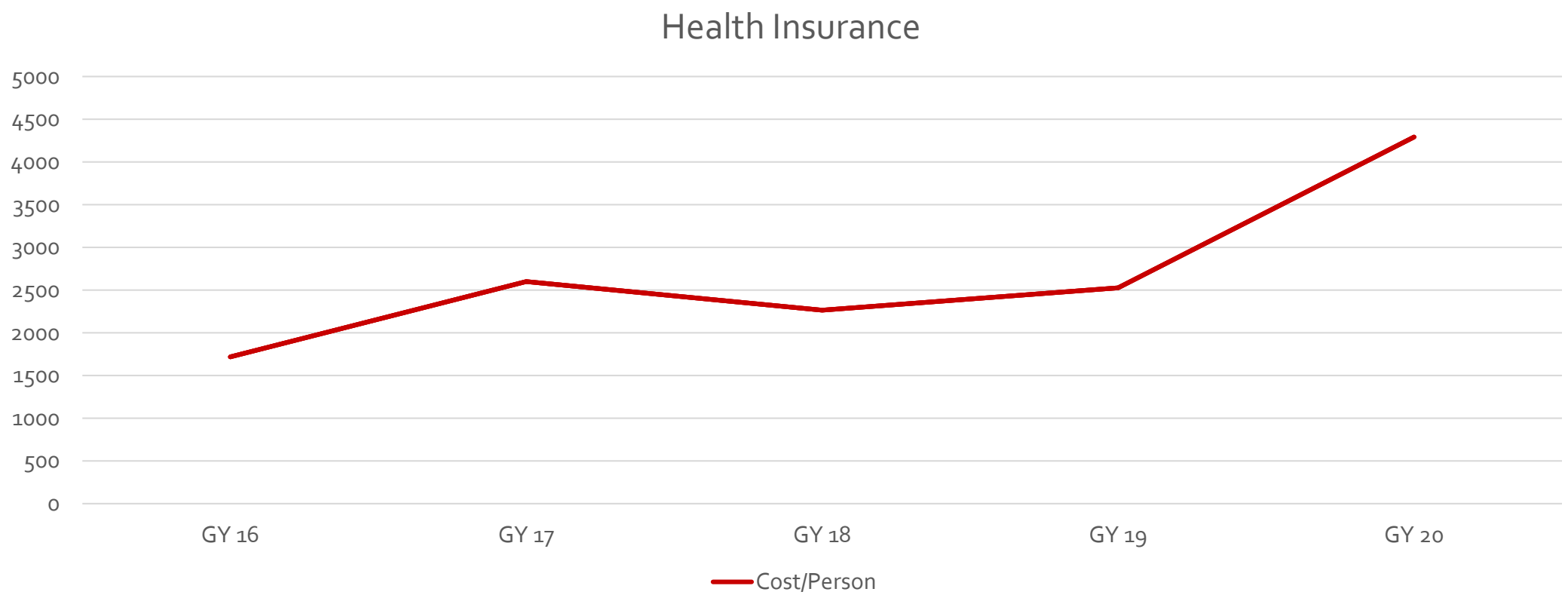
5 Year Trends-Cost/Person by Service Category



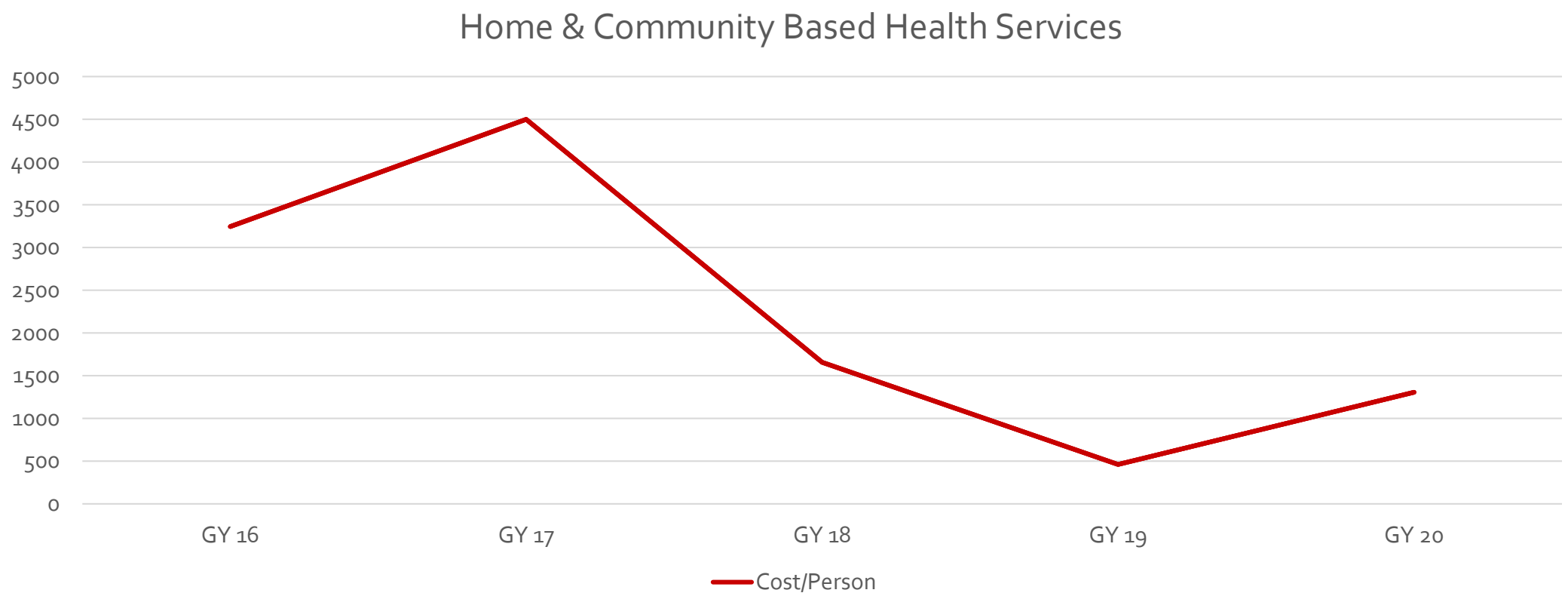
5 Year Trends-Cost/Person by Service Category



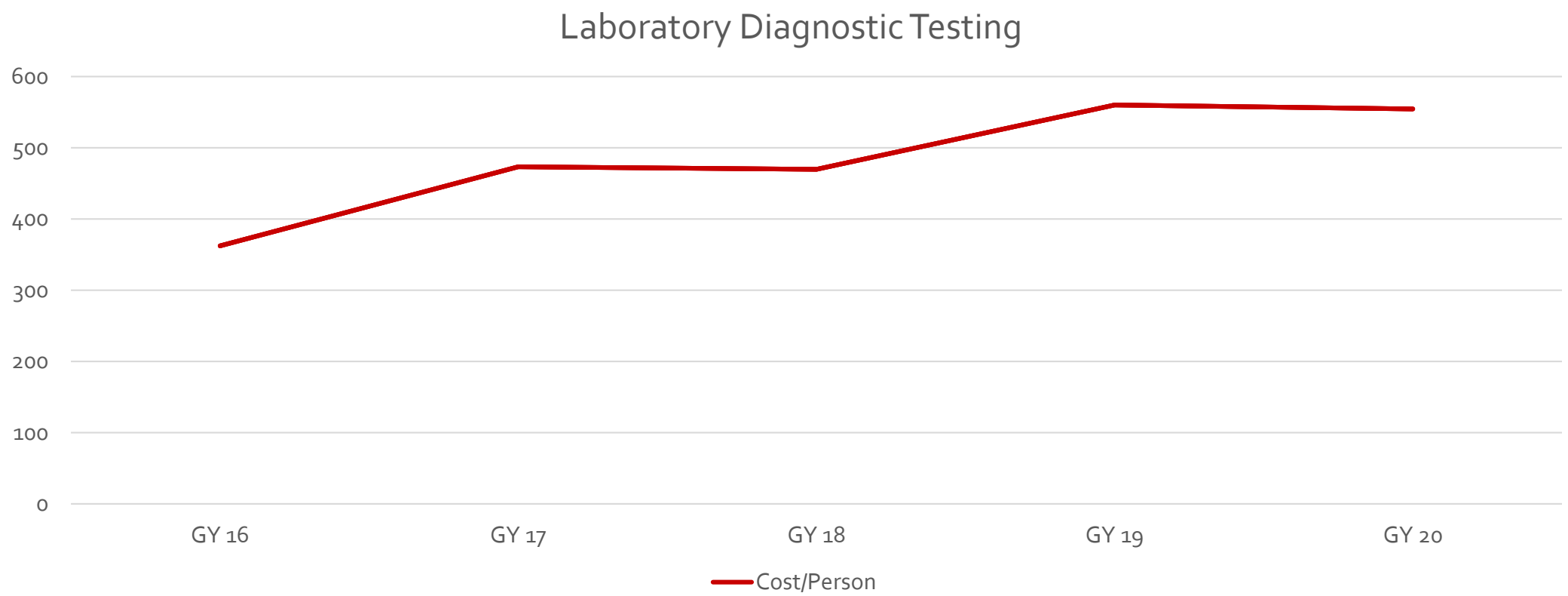
5 Year Trends-Cost/Person by Service Category



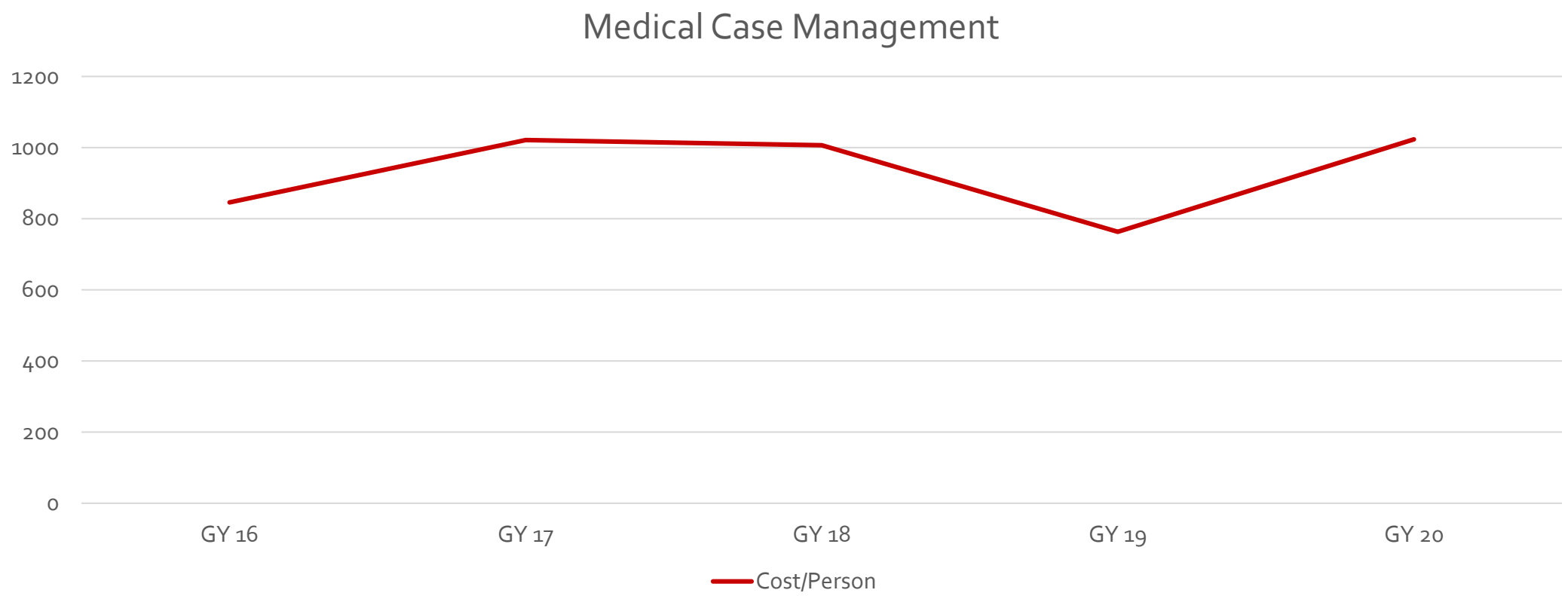
5 Year Trends-Cost/Person by Service Category



5 Year Trends-Cost/Person by Service Category



5 Year Trends-Cost/Person by Service Category



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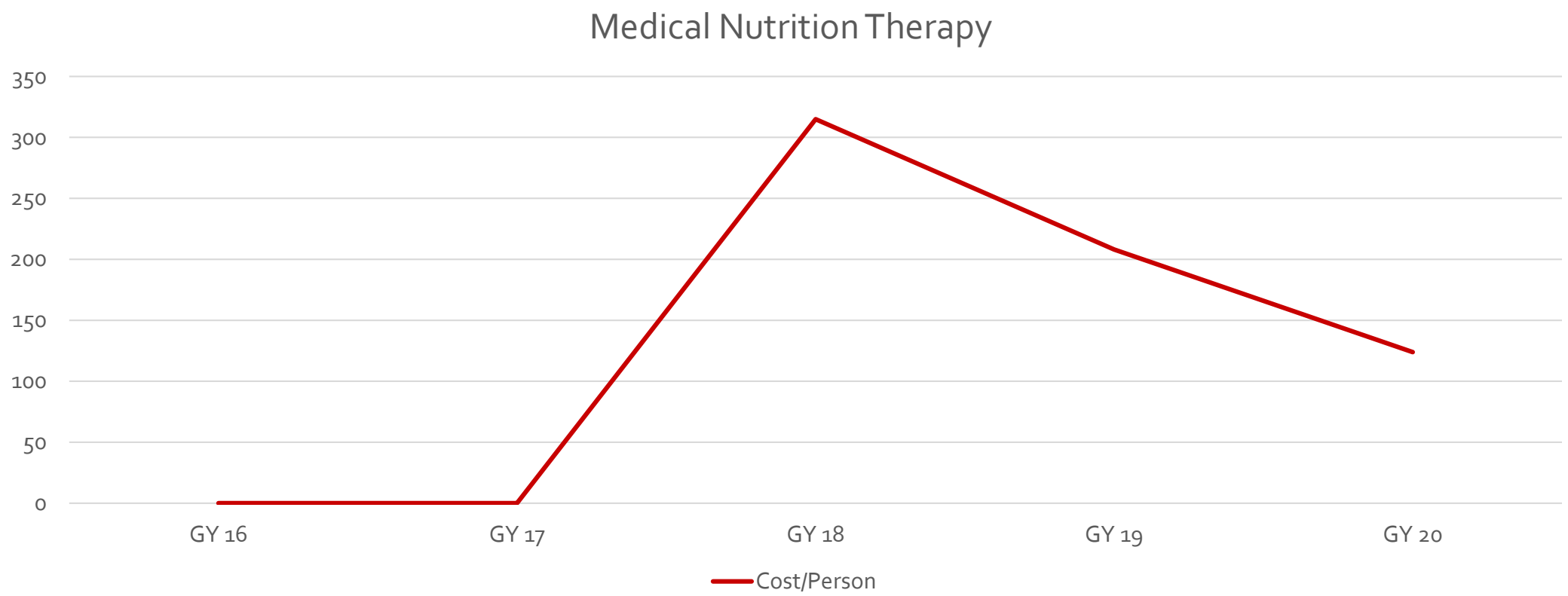
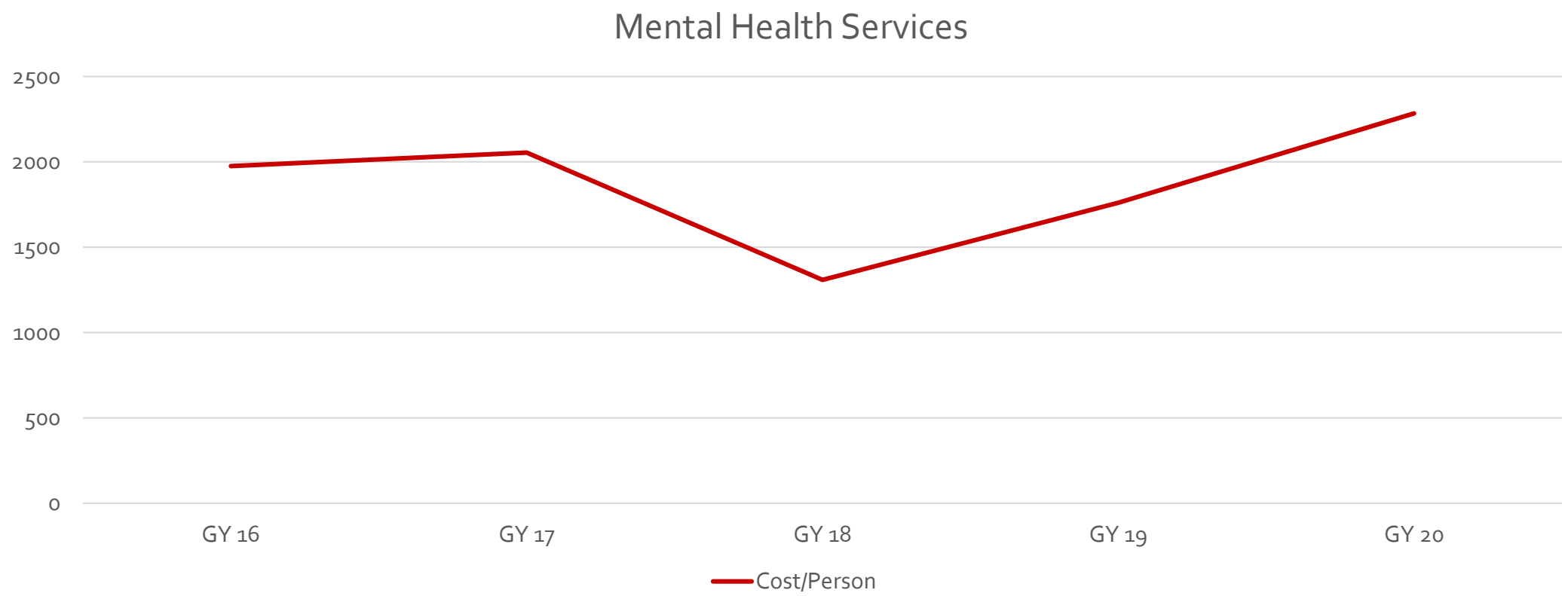
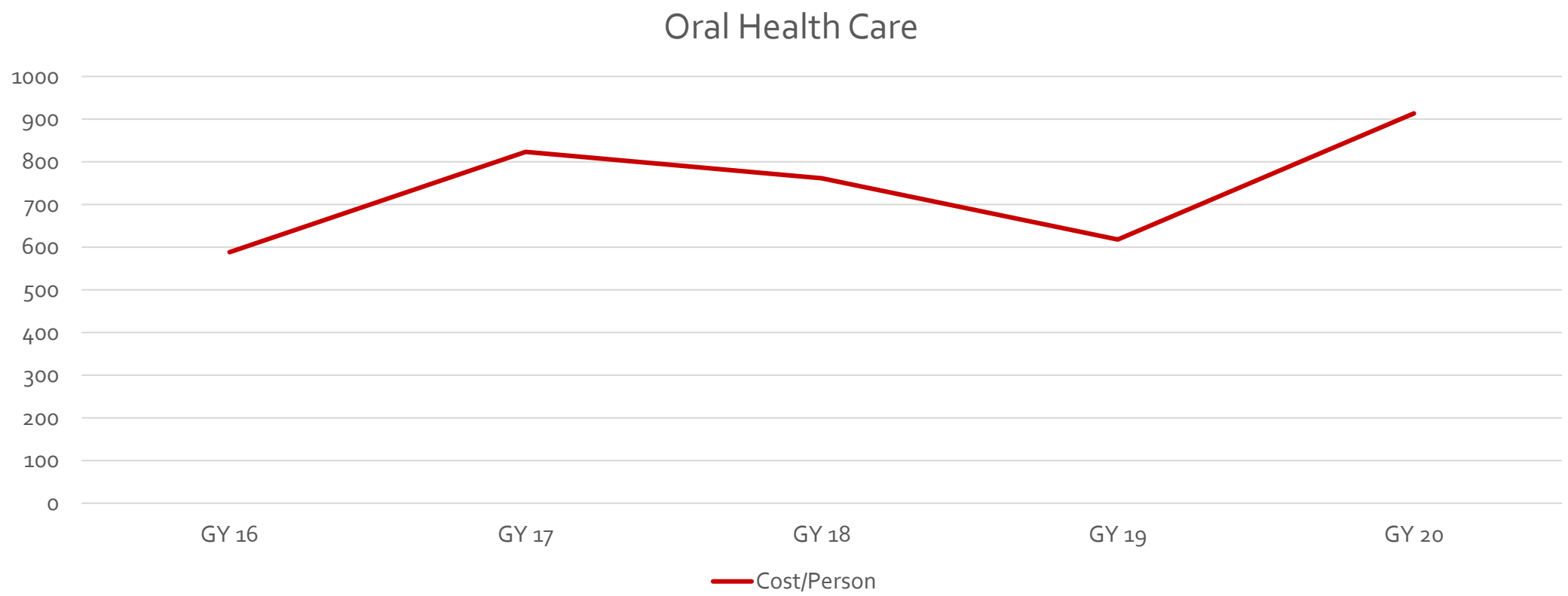


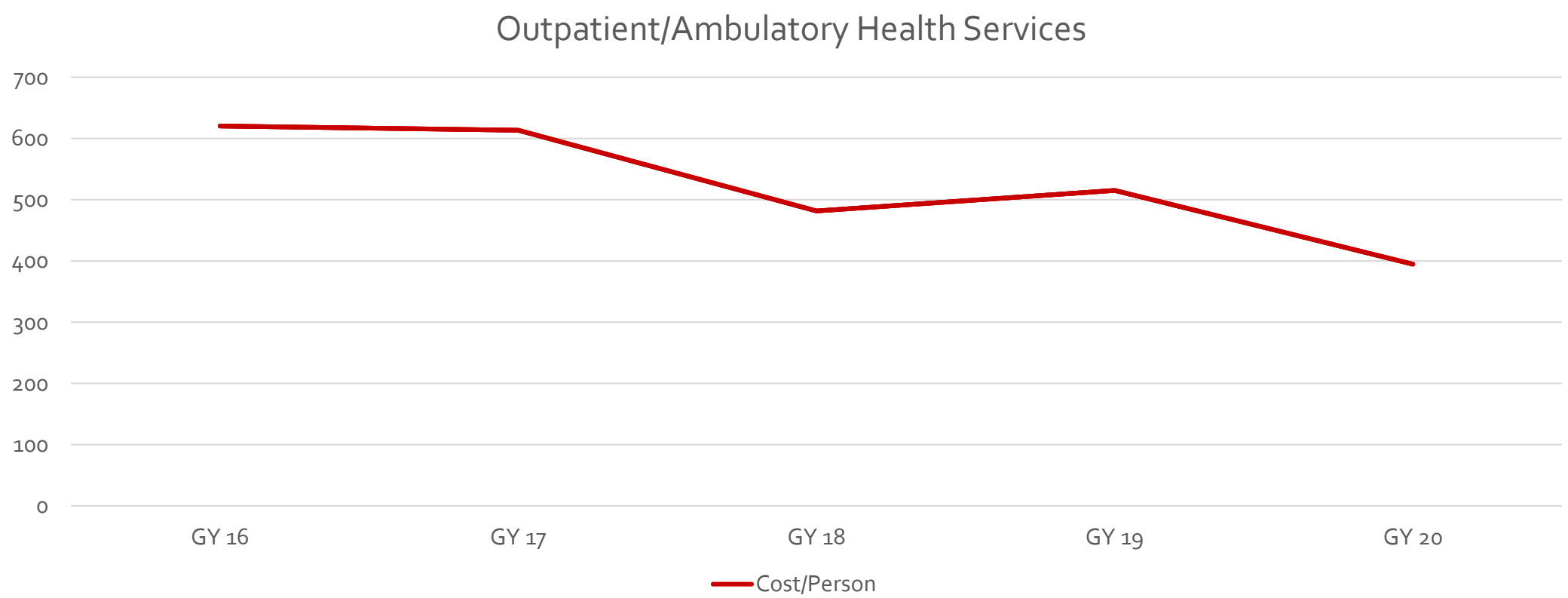
5 Year Trends-Cost/Person by Service Category



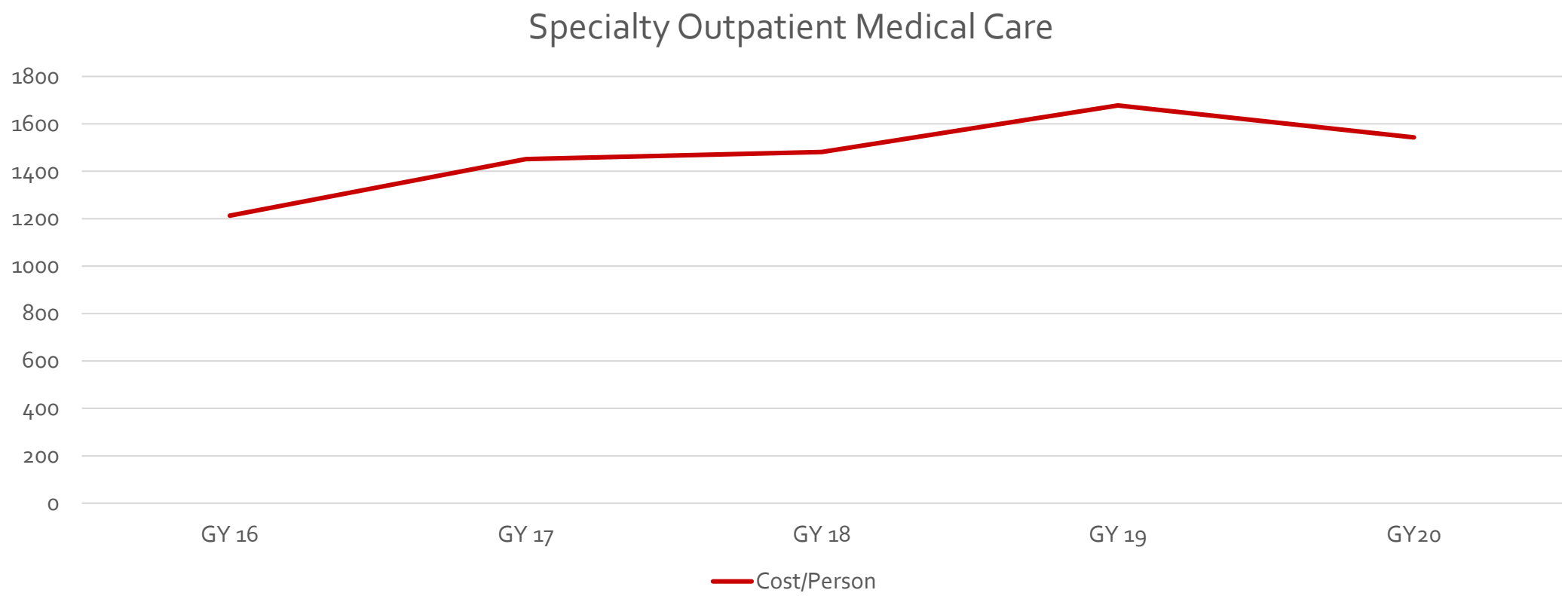
5 Year Trends-Cost/Person by Service Category



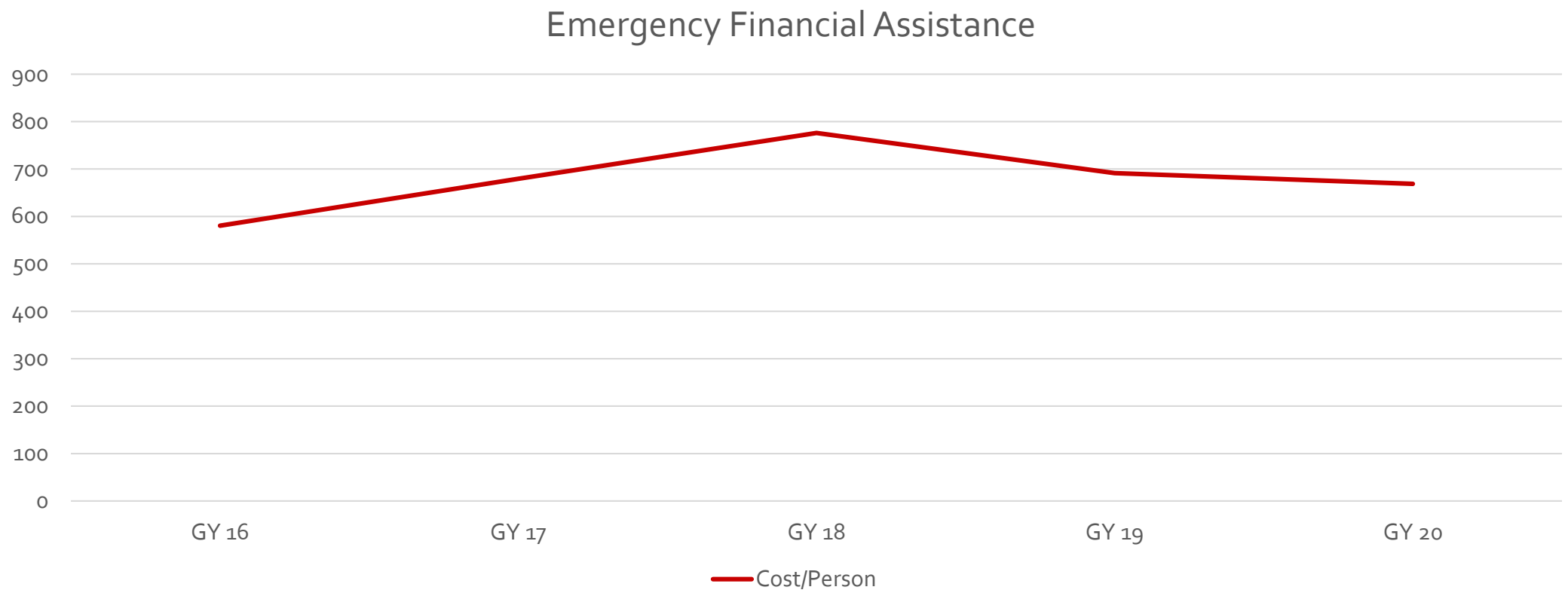
5 Year Trends-Cost/Person by Service Category



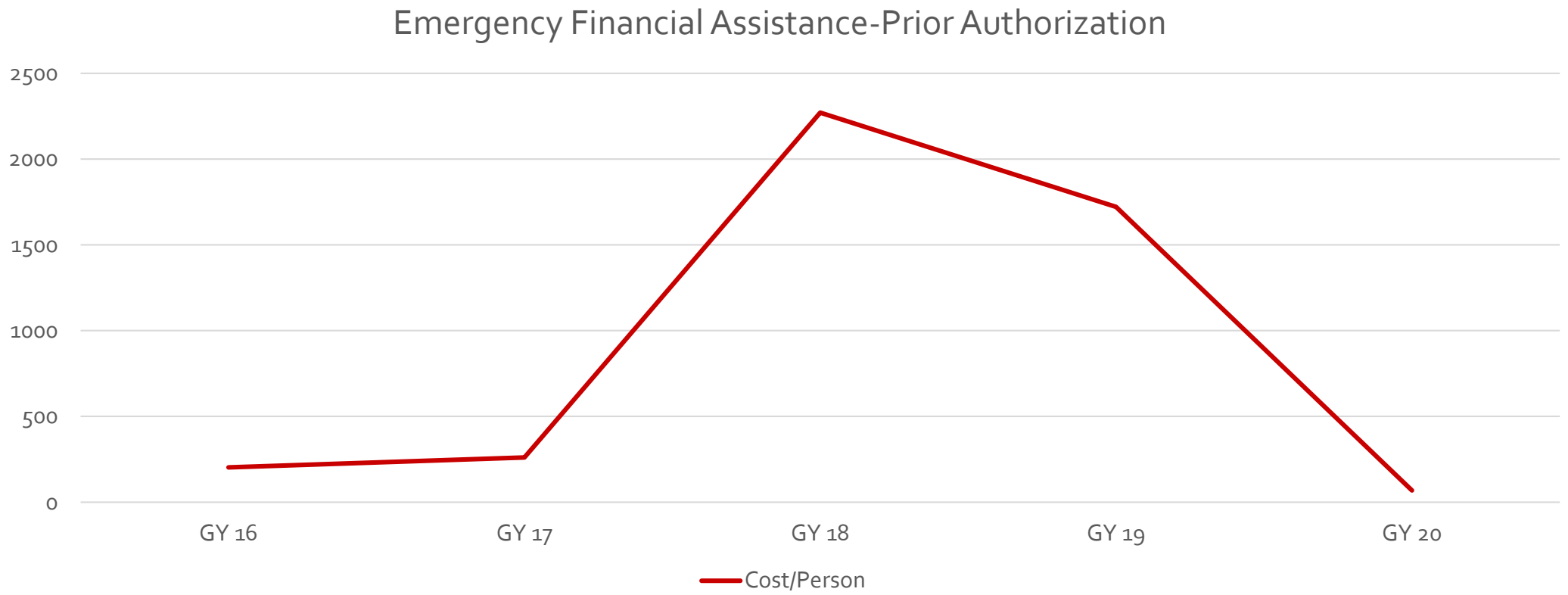
5 Year Trends-Cost/Person by Service Category



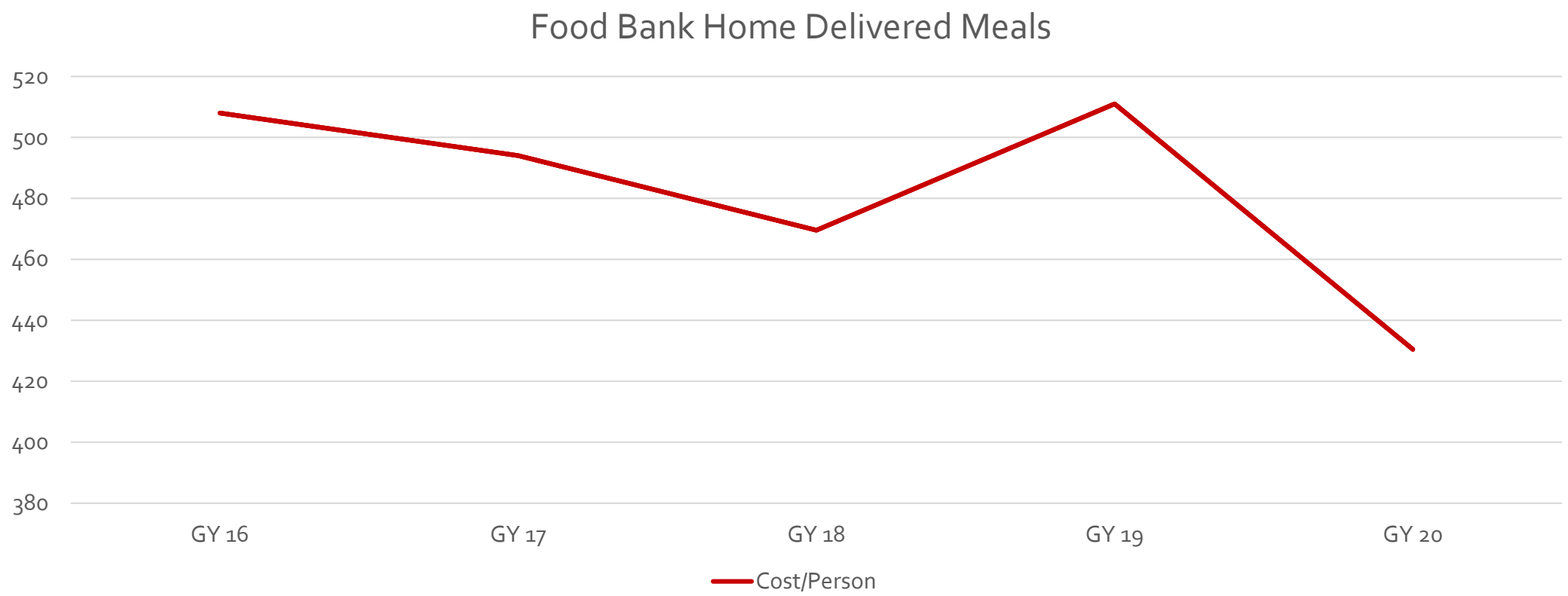
5 Year Trends-Cost/Person by Service Category



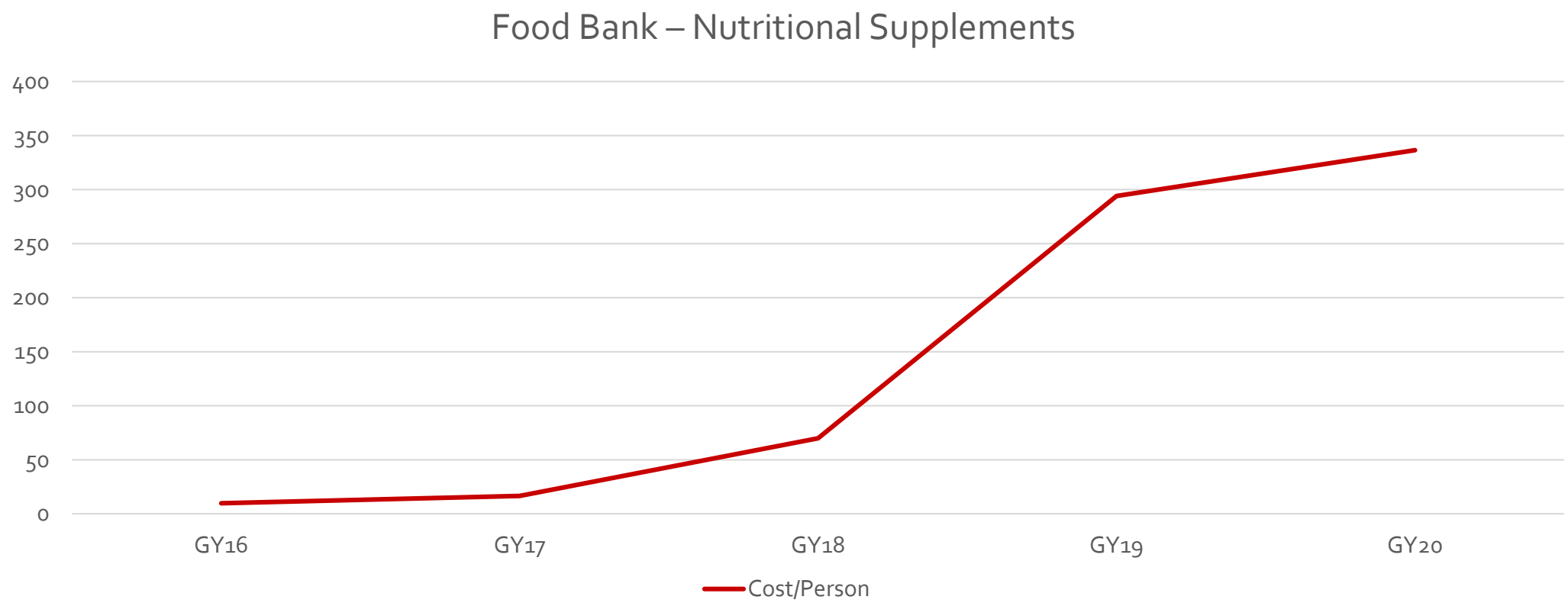
5 Year Trends-Cost/Person by Service Category



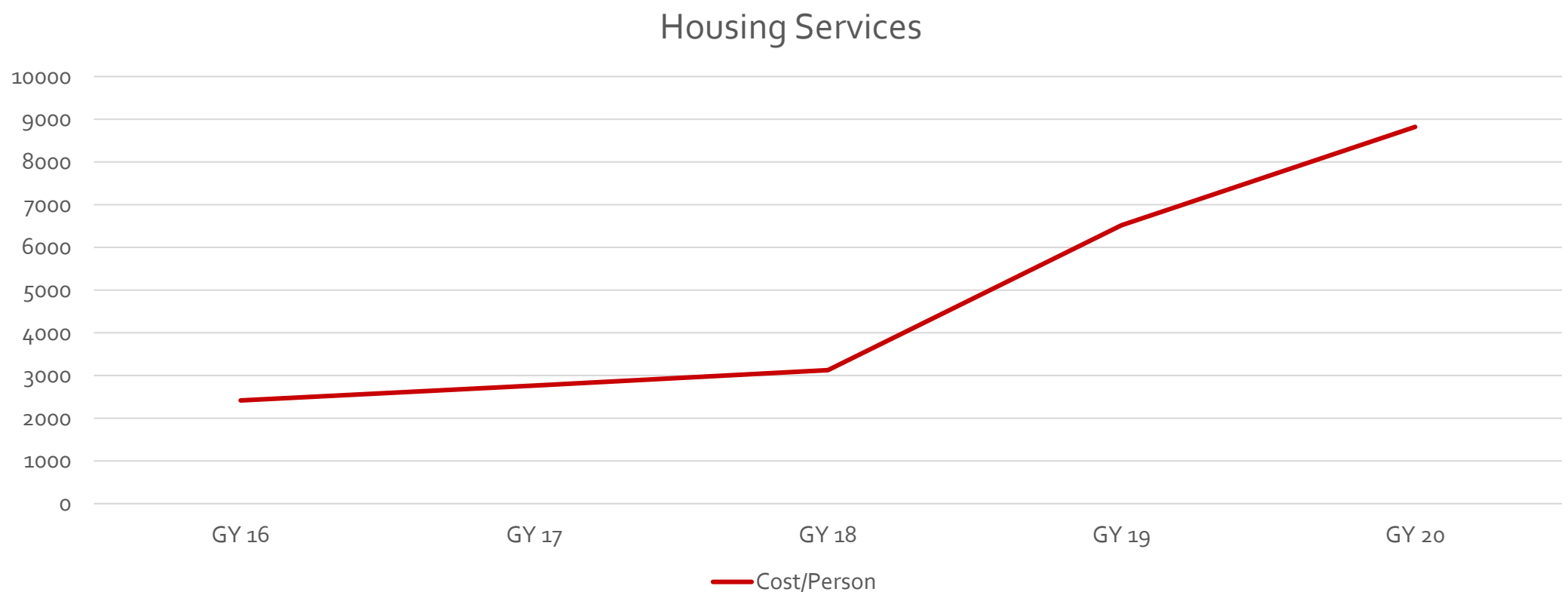
5 Year Trends-Cost/Person by Service Category



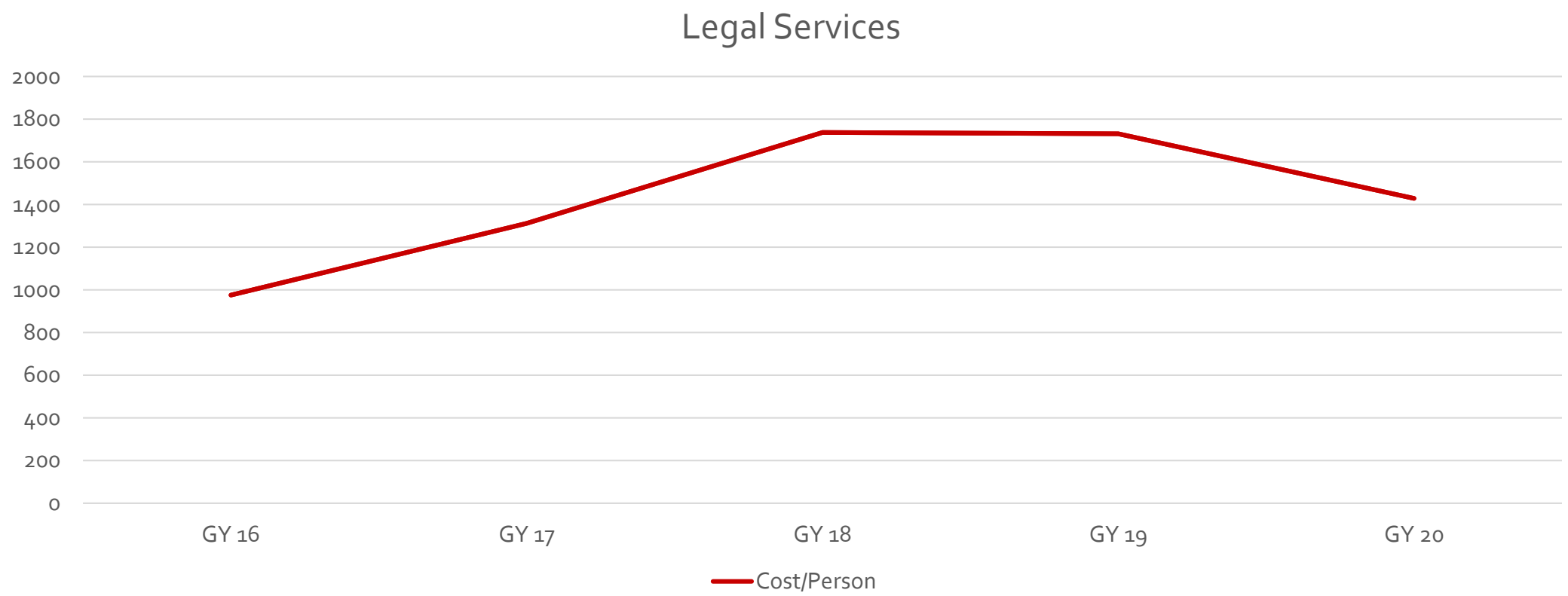
5 Year Trends-Cost/Person by Service Category



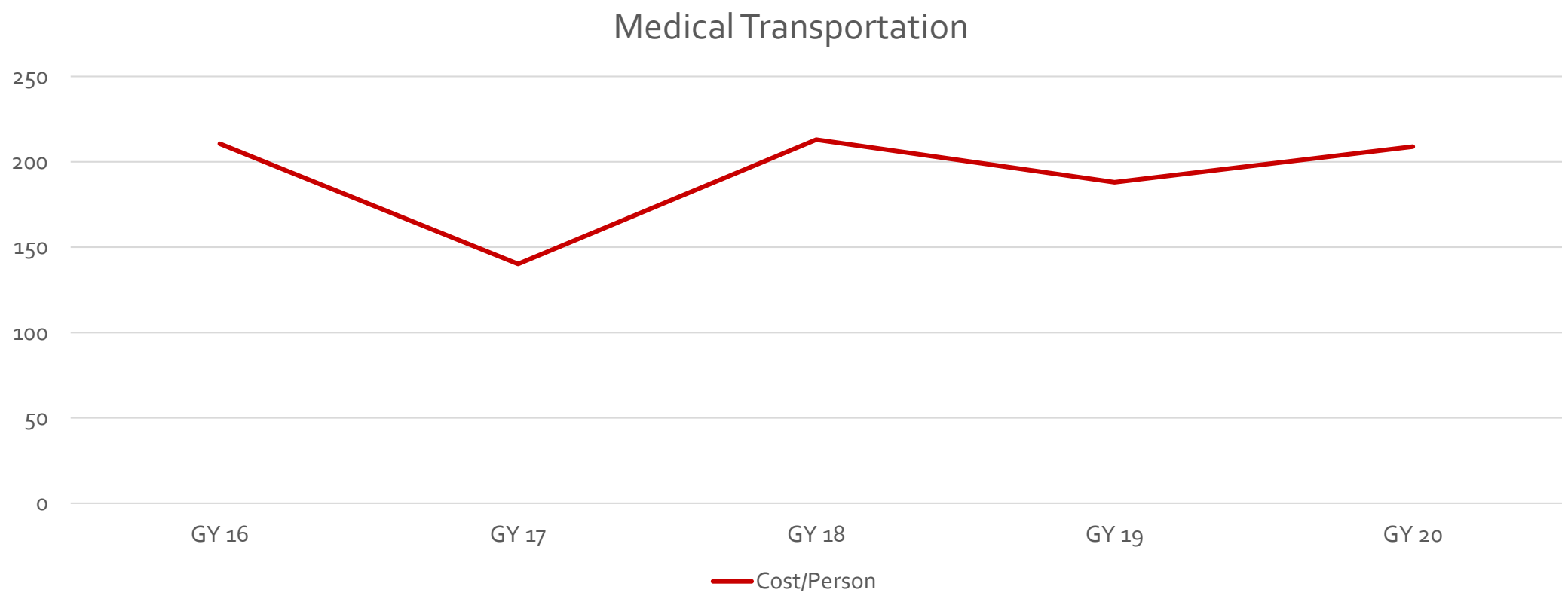
5 Year Trends-Cost/Person by Service Category



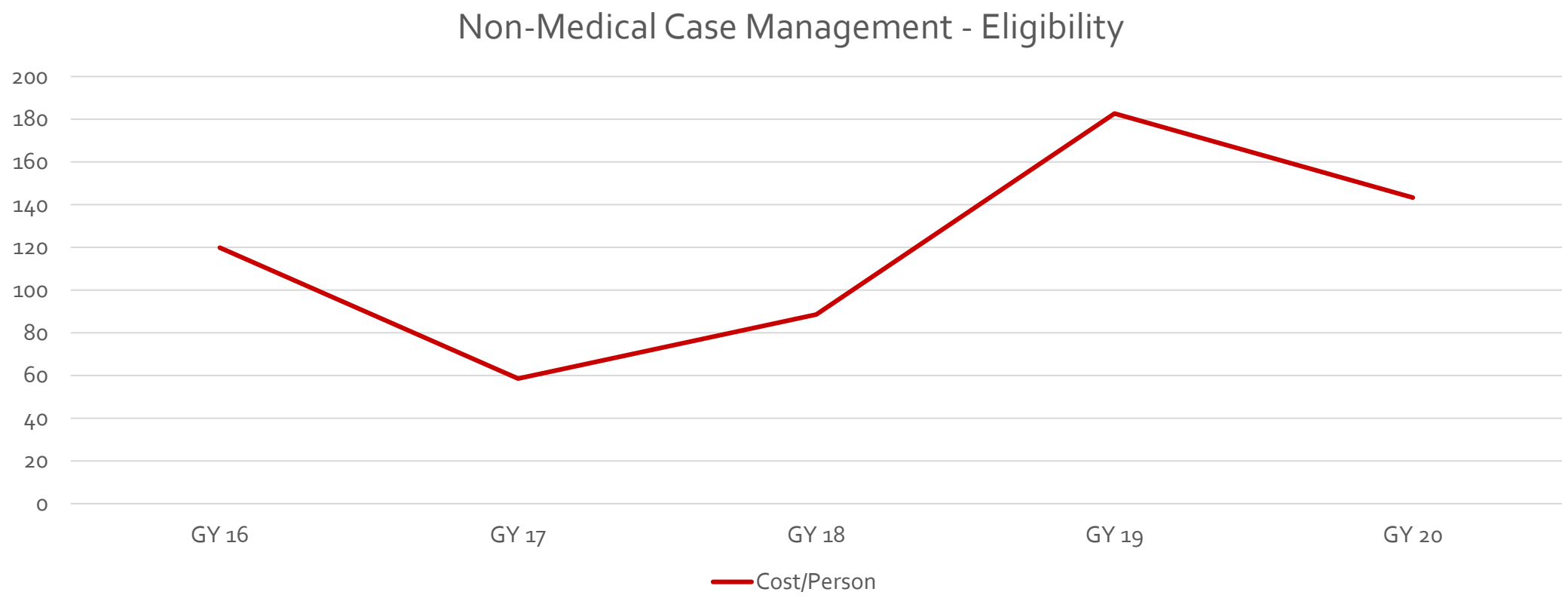
5 Year Trends-Cost/Person by Service Category



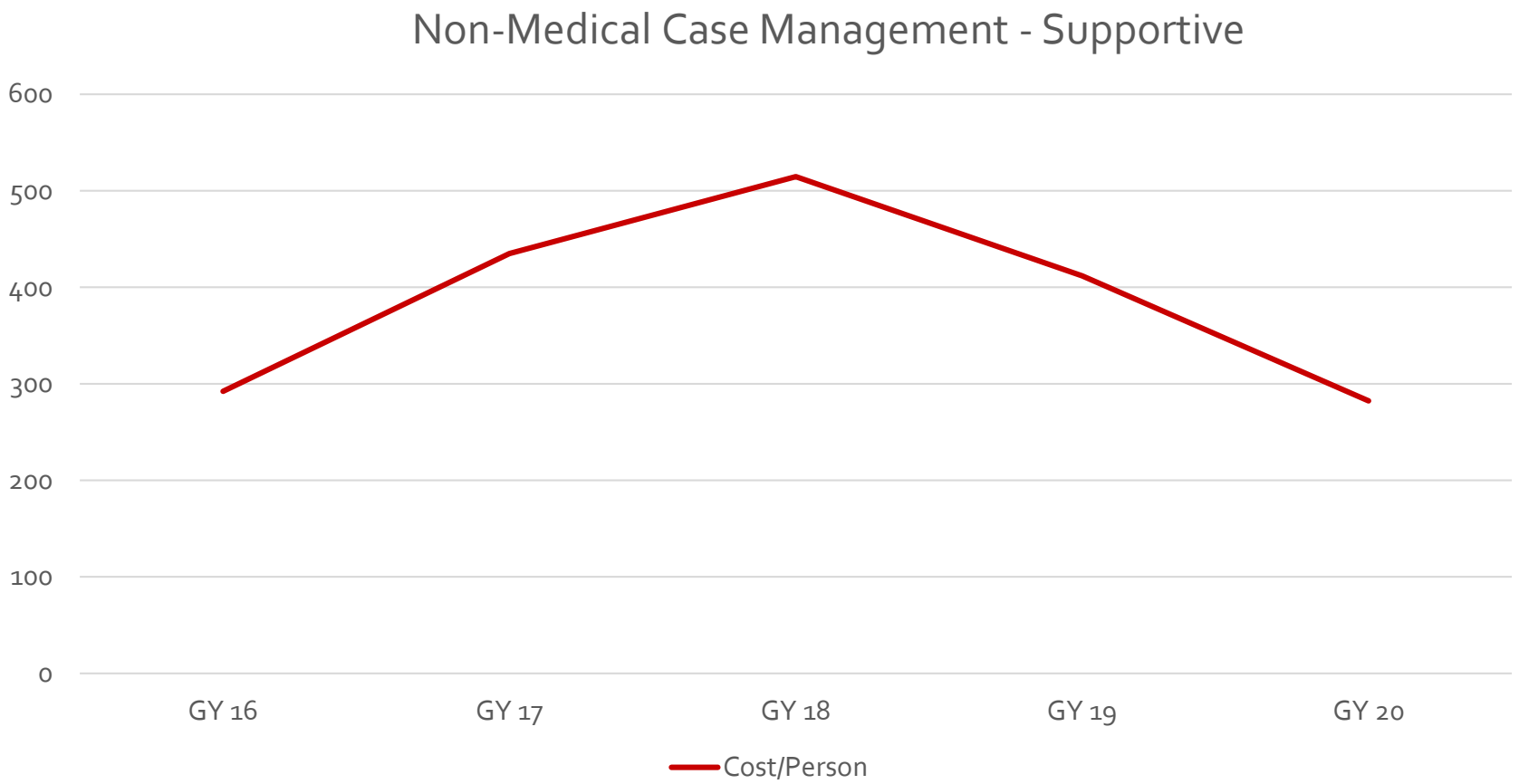
5 Year Trends-Cost/Person by Service Category



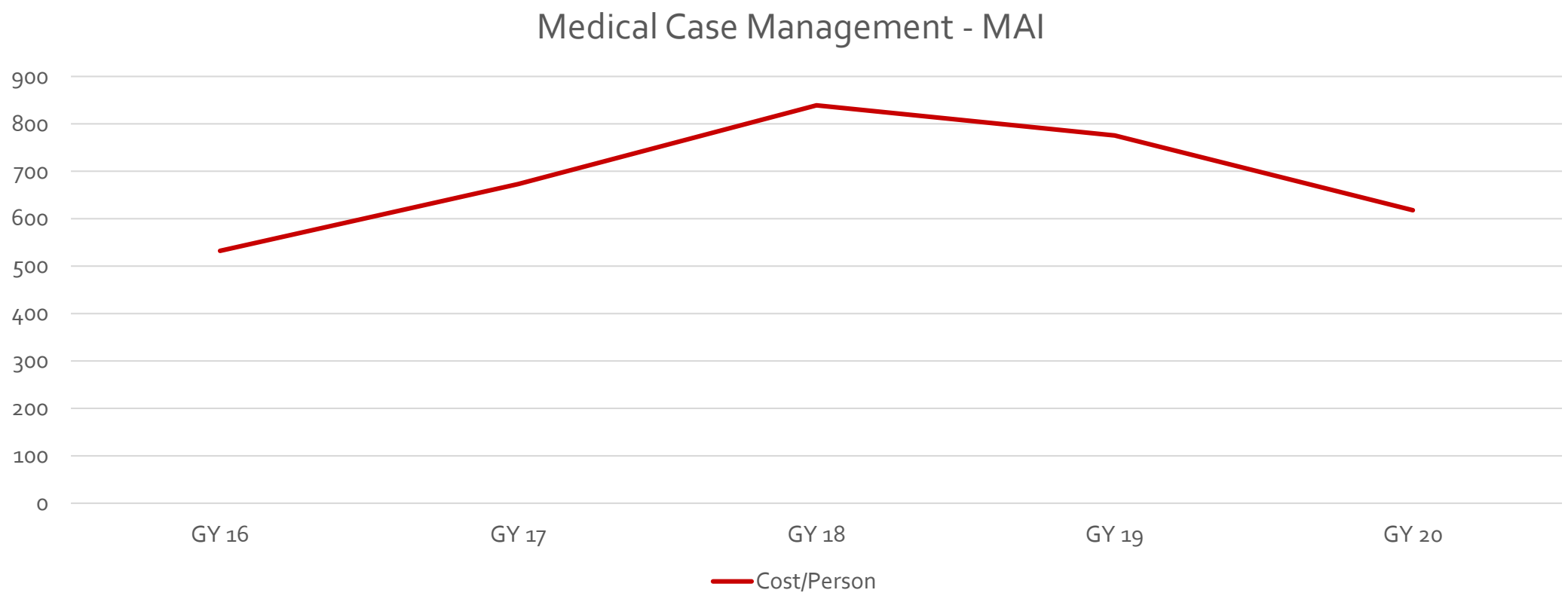
5 Year Trends-Cost/Person by Service Category



5 Year Trends-Cost/Person by Service Category



5 Year Trends-Cost/Person by Service Category



5 Year Trends-Cost/Person by Service Category Summary

Core Medical Service Category	5 Year Trend-Cost/Person
AIDS Pharmaceutical Assistance (LPAP)	-87%
Early Intervention Services	5%
Health Insurance	150%
Home and Community-based Health Services	-60%
Laboratory Diagnostic Testing	53%
Medical Case Management	21%

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

Core Medical Service Category	5 Year Trend-Cost/Person
Medical Nutrition Therapy	-61%
Mental Health Services	16%
Oral Health Care	55%
Outpatient/Ambulatory Health Services	-36%
Specialty Outpatient Medical Care	27%

5 Year Trends-Cost/Person by Service Category Summary

Support Service Category	5 Year Trend-Cost/Person
Emergency Financial Assistance	12%
Emergency Financial Assistance-Prior Auth.	-66%
Food Bank/Home Delivered Meals	-15%
Food Bank-Nutritional Supplements	3327%
Housing	265%

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

Support Service Category	5 Year Trend-Cost/Person
Legal Services	46%
Medical Transportation	-1%
Non-Medical Case Management-Eligibility	20%
Non-Medical Case Management-Supportive	-3%

5 Year Trends-Cost/Person by Service Category Summary - MAI

Core Medical Service Category	5 Year Trend-Cost/Person
Medical Case Management	16%

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

1.	Home & Community Based Health Care	183%	$844	
2.	Health Insurance Premium & Cost Sharing	70%	$1765	*
3.	AIDS Pharmaceutical Assistance	60%	$43	
4.	Oral Health	48%	$296	
5.	Housing	35%	$2303	*
6.	Medical Case Management	34%	$260	
7.	Mental Health	30%	$523	*
8.	Early Intervention Services	23%	$193	
9.	Food Bank-Nutritional Supplements	14%	$42	
10.	Medical Transportation	11%	$21	

Green = Salary-funded Blue = Direct assistance to clients Purple = Not funded in 2021 *Largest increase by $$$

Questions?

FDOH PBC Part B Service Utilization

Brittany McClure

Patient Care Contract Manager

Florida Department of Health in Palm Beach County

brittany.mcclure@flhealth.gov

(561) 804-7946

Palm Beach County
Ryan White HIV/AIDS Program

Palm Beach County Ryan White Part B

GY20 Service Utilization and Cost Summary

Brittany McClure
Patient Care Contract Manager
June 24, 2021

Important Information:

- Part B services are decided based off 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 PBC
- Not all services were provided for all 12 months of the GY
- Services provided were impacted by the beginning of the COVID-19 pandemic
- GY20 timelines:
  - Patient Care Consortia - 4/1/2019 to 3/31/2020
  - Patient Care Network - 7/1/2019 to 6/30/2020
  - Patient Care General Revenue - 7/1/2019 to 6/30/2020

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 reimbursement rate ($169.57)
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 Clinic
    2. Reimbursed at Medicaid rate ($169.57)
    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

1. Non-Medical Case Management
    1. Eligibility Services
2. AIDS Pharmaceutical Assistance (Bulk Drugs)
    1. Bulk vaccines, medications for other diagnosis
3. Medical Transportation Services (Oral Health)
    1. Transportation provided to patients utilizing oral health services
    2. Belle Glade Health Center or Delray Beach Health Center to Northeast Clinic
4. Food Bank
    1. Food Pantry (up to $35/mo)
    2. Food recommended by nutritionists
    3. No NOE required

GY20 Grant Award Overview

Award Information	GY20	GY19 Cash Balance	Total
Part B Consortia 4/1/2019 – 3/31/2020	$773,137	N/A	$773,137
Patient Care Network 7/1/2019 – 6/30/2020	$616,647	$4,863	$621,510
General Revenue 7/1/2019 – 6/30/2020	$770,000	$172,870	$942,870
Total	$2,159,784	$177,733	$2,337,517

GY20 Grant Expenditure Overview
Part B Consortia

Expenditure Categories	Amount Budgeted	Amount Spent	Percent
Core Medical Services	$688,137	$671,627	98%
QI/P&E	$50,000	$50,000	100%
Administration	$35,000	$35,117	100%
Total	$773,137	$756,744	98%

GY20 Grant Expenditure Overview Part B
Patient Care Network

Expenditure Categories	Amount Budgeted	Amount Spent	Percent
Core Medical Services	$413,150	$413,150	100%
Support Services	$188,339	$156,294	82%
Administration	$15,156	$10,409	69%
Total	$616,645	$579,852	98%

GY20 Grant Expenditure Overview Part B Patient Care General Revenue

Expenditure Categories	Amount Budgeted	Amount Spent	Percent Spent
Core Medical Services	$394,332	$316,259	80%
Support Services	$166,749	$130,041	78%
QI/P&E	$42,389	$36,403	86%
Administration	$166,530	$94,020	56%
Total	$770,000	$576,723	75%

GY20 Award & Expenditure Summary

Award Category	Amount Awarded	Amount Spent	Balance
Part B Consortia 4/1/2019 – 3/31/2020	$773,137	$756,744	$16,393
Patient Care Network 7/1/2019 – 6/30/2020	$616,647	$579,852	$36,795*
General Revenue 7/1/2019 – 6/30/2020	$770,000	$577,739	$192,261**
Total	$2,159,784	$1,892,762	$267,022

*Total balance carried over to GY 21

**10% of balance carried over to GY21 ($77,000.00)

GY20 Patient Care Consortia
Core Medical Services Expenditures by service category

Core Medical Service Category	Amount Budgeted	Amount Spent	Percent
Outpatient/Ambulatory Health Services (Lab - NOE)	$475,000	**$475,000**	100%
Medical Nutrition Therapy	$151,077	**$151,016**	100%
Oral Health Care	$62,060	**$45,611**	73%

GY20 Patient Care Network
Core Medical & Support Services Expenditures by service category

Core Medical Service Category	Amount Budgeted	Amount Spent	Percent
Oral Health Care	$15,000	**$15,000**	100%
Outpatient Ambulatory Health Services (Medical Care)	$398,150	**$398,150**	100%

Support Services Category	Amount Budgeted	Amount Spent	Percent
Medical Transportation	$9,174	**$5,694**	62%
Referral for Health Care/Support Services (Care Coordination)	$179,165	**$150,560**	84%

GY20 Patient Care General Revenue
Core Medical & Support Services Expenditures by service category

Core Medical Service Category	Amount Budgeted	Amount Spent	Percent
AIDS Pharmaceutical Assistance (Bulk Drugs)	$7,500	**$6,449**	86%
Treatment Adherence	$90,859	**$67,840**	75%
Mental Health Services	$113,238	**$94,477**	83%
Oral Health Care	$51,000	**$42,769**	84%
Outpatient Amb Health Services (Lab- No NOE)	$131,735	**$104,724**	79%

Support Service Category	Amount Budgeted	Amount Spent	Percent
Food Bank/Home Delivered Meals (Food Pantry)	$60,000	**$30,702**	51%
Refer for HC/Support Services (Care Coordination)	$61,749	**$54,339**	88%
Non-Medical Case Management (Eligibility)	$45,000	**$45,000**	100%

Service Category Ordered by Expenditure

1.	Outpatient Ambulatory Health Services (Lab w/NOE)	22%
2.	Outpatient Ambulatory Health Services (Medical)	18%
3.	Referral For Health Care/Support Services	10%
4.	Medical Nutrition Therapy	7%
5.	Outpatient Ambulatory Health Services (Lab No NOE)	5%
6.	Oral Health	5%
7.	Mental Health Services	4%
8.	Treatment Adherence Counseling	3%
9.	Non-Medical Case Management	2%
10.	Food Bank	1.4%
11.	AIDS Pharmaceutical Assistance (Bulk Drugs)	<1%
12.	Medical Transportation Services (Oral Health)	<1%

Service Category cost per unit

Core Medical Service Category	Amount	Persons Served	Units of Service	Cost/Person	Cost/Unit
Outpatient Ambulatory Health Services (Lab w/NOE)	$475,000.00	727	14,455	$653.37	$32.86
Outpatient Ambulatory Health Services (Medical)	$398,150.00	738	2,065	$539.49	$192.81
Referral For Health Care/Support Services	$204,899.00	1,225	2,654	$167.26	$77.20
Medical Nutrition Therapy	$151,016.00	607	4,146	$248.79	$36.42
Outpatient Ambulatory Health Services (Lab No NOE)	$104,724.00	181	1,596	$578.59	$65.62
Oral Health *December 2019 – June 2020	$103,380.00	437	1200*	$236.57	$86.15**

*Number of Visits
**Cost/Visit

109

Service Category cost per unit…cont.

Core Medical Service Category	Amount	Persons Served	Units of Service	Cost/Person	Cost/Unit
Mental Health Services	$94,477.00	471	1366	$200.06	$69.16
Treatment Adherence Counseling	$67,840.00	379	1472	$178.99	$46.09
Non-Medical Case Management (Eligibility) *March 2020 – June 2020	$45,000.00	610	790	$73.77	$56.96
Food Bank	$30,702.00	495	1090	$62.02	$28.17
AIDS Pharmaceutical Assistance (Bulk Drugs)	$6,449.00	217	235	$29.72	$27.44
Medical Transportation Services (Oral Health) *Services stopped March 2020	$5,694.00	37	110	$153.89	$51.76

Service Category Ordered by Unit

1.	Outpatient Ambulatory Health Services (Lab w/ NOE)	14,455
2.	Medical Nutrition Therapy	4,146
3.	Referral For Health Care/Support Services	2,654
4.	Outpatient Ambulatory Health Services (Medical)	2,065
5.	Outpatient Ambulatory Health Services (Lab No NOE)	1,596
6.	Treatment Adherence Counseling	1,472
7.	Mental Health Services	1,366
8.	Oral Health	1,200
9.	Food Bank	1,090
10.	Non-Medical Case Management	790
11.	AIDS Pharmaceutical Assistance (Bulk Drugs)	235
12.	Medical Transportation Services (Oral Health)	110

Service Category Ordered by Persons

1.	Referral For Health Care/Support Services	1225
2.	Outpatient Ambulatory Health Services (Medical)	738
3.	Outpatient Ambulatory Health Services (Lab w/ NOE)	727
4.	Non-Medical Case Management	610
5.	Medical Nutrition Therapy	607
6.	Food Bank	495
7.	Mental Health Services	471
8.	Oral Health	437
9.	Treatment Adherence Counseling	379
10.	AIDS Pharmaceutical Assistance (Bulk Drugs)	217
11.	Outpatient Ambulatory Health Services (Lab No NOE)	181
12.	Medical Transportation Services (Oral Health)	37

Service Category Ordered by Cost/Person

Cost/Person	
1. Lab w/ NOE	$653.37
2. Lab No NOE	$578.59
3. Medical Services	$539.49
4. Medical Nutrition Therapy	$248.79
5. Oral Health	$236.57

Service Category Ordered by Cost/Unit

Cost/Unit

1.	Medical	$192.81
2.	Oral Health	$86.15
3.	Referral for Health Care/Support Services	$77.20
4.	Mental Health	$69.16
5.	Food Bank	$68.17

THANK YOU

Patient Care Contract Manager
HIV/AIDS Contract Manager
Work: (561) 804-7946
Mobile: (561) 446-5551
brittany.mcclure@flhealth.gov

Questions?

The Status of HIV in Palm Beach County

2021

Day 2

Palm Beach County
Ryan White HIV/AIDS Program

PBC RWHAP HRSA/HAB Performance Measures

Juliane Tran, MPH

Quality Management Clinician

PBC Ryan White HIV/AIDS Program

jtran@pbcgov.org

(561) 355-4715

Palm Beach County
Ryan White HIV/AIDS Program

HIV/AIDS (HAB) Health Outcome Measures

- **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 from the **Implementation Plan**. The measures we have been tracking for client health outcomes are:
  1) **Linkage to Care**
     - Early Intervention Services (EIS)
       - HIV Epi Profile - '% In Care'
     - Currently used as an annual metric
       - New metric, TBD
  2) **Annual Retention in Care**
  3) **HIV Viral Load Suppression**
  4) **Prescription to Antiretroviral Therapy**
     - Ambulatory Outpatient Medical Care
- We collect and analyze these measures to identify low performance and determine how we can improve the low performance measures through quality improvement (QI) activities.

HAB Performance Measures Definitions

- **Linkage to Care**
  - Continuum of HIV Care Definitions, Department of Health, HIV Epidemiological Profile
    - **% In Care**: PWH with at least one documented VL or CD4 lab, medical visit, or prescription from January 1 of the year specified through March 31 of the following year
- **Prescription to HIV Antiretroviral Therapy**:
  - Numerator: Number of patients from the denominator
  - Denominator: Number of patients from the denominator prescribed HIV antiretroviral during the measurement year

HAB Performance Measures Definitions

- **Annual Retention in Care:**
  - Numerator: Number of patients in the denominator who had at least two HIV medical care encounters at least 90 days apart within a 12-month measurement year. At least one of the two HIV medical care encounters needs to be a medical visit with a provider with prescribing privileges.
  - Denominator: Number of patients, regardless of age, with a diagnosis of HIV who had at least one HIV medical encounter within the 12-month measurement year. An HIV medical care encounter is a medical visit with a provider with prescribing privileges or an HIV viral load test.
- **Viral Load Suppression:**
  - Numerator: Number of persons with an HIV diagnosis with a viral load <200 copies/mL at last HIV viral load test during the measurement year.
  - Denominator: Number of patients, regardless of age, with a diagnosis of HIV with at least one medical visit in the measurement year.

Calendar Year (CY) 2020

- 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. Annual Retention in Care
  3. Prescription to Antiretroviral Therapy
  4. Viral Load Suppression

- Report on individual funded service categories that are connected to each core performance measure

- **Target**: Improve +5% above baseline

PBC Ryan White Program, QI Quartely Metrics	Calendar Year 2020 Thru Date 12/31/2020	
Service Category	N/D	Metric
In Care (Jurisdictional)	**6053/8259**	**73%**
Early Intervention Services	TBD	TBD
Early Intervention Services - MAI	N/A	N/A
Retention in Medical Care	**2269/2688**	**84%**
Emergency Financial Assistance	42/55	76%
Food Bank - Nutritional Supplements	23/24	96%
Food Bank/Home Delivered Meals	568/651	87%
Health Insurance Premium & Cost-Sharing Assistance	317/381	83%
Housing	16/20	80%
Legal Services	209/235	89%
Medical Nutritional Therapy	240/264	91%
Medical Transportation	375/422	89%
Mental Health Services	112/123	91%
Non-Medical Case Management	829/1000	83%
Non-Medical Case Management - MAI	N/A	N/A
Oral Health Care	624/694	90%
Psychosocial Support Services - MAI	N/A	N/A
Prescription to Antiretroviral Therapy	**2488/2688**	**93%**
Outpatient/Ambulatory Health Services	573/622	92%
Viral Load Suppression	**2226/2688**	**83%**
AIDS Pharmaceutical Assistance	210/261	80%
Emergency Financial Assistance - Prior Authorizations	65/83	78%
Laboratory Diagnostic Testing	680/810	84%
Medical Case Management	1643/1987	83%
Medical Case Management - MAI	N/A	NA
Specialty Outpatient Medical Care	N/A	N/A

≥ 90%	
80% - 89%	
≤ 79%	

Questions?

PBC RWHAP Quality Improvement Project Updates

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

Juliane Tran, MPH
Quality Management Clinician
PBC Ryan White HIV/AIDS Program
jtran@pbcgov.org
(561) 355-4715

Palm Beach County
Ryan White HIV/AIDS Program

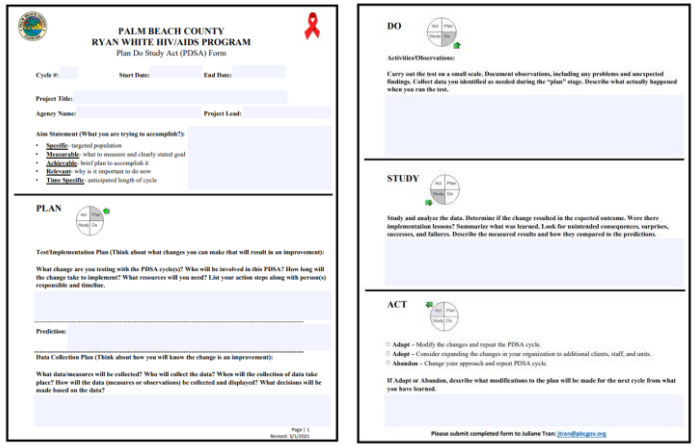
Quality Improvement Projects (QIP)

- 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

- **Sub-Recipient CQM Plan**
  - 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 (GY2021)**
  - Standardized form
    - Form for recipients to track their progress
- **Monthly QM Workgroup**
  - Agencies are required to keep track of what they are doing and report back at the workgroup
    - Challenges, feedback


West Palm Beach Eligible Metropolitan Area
Quality Management Plan
2018-2021


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?

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 Juliane Tran: jtran@pbcgov.org

Optimal Retention in Care (RiC)

Quality Improvement Projects (QIP)

Improving clients' health outcomes and reduce health disparities through optimal <u>retention in care</u>

Quality Improvement Initiative: Optimal Retention in Care (RiC)

Project Objective

- Successful implementation of a RiC quality improvement project (QIP), by enhancing the current system of care and utilizing data sources to monitor retention and reduce health disparities
- Goal to increase the overall program retention from 59% (baseline) to 70% by project completion

Team

- Each sub-recipient selected QIP Team members and team coordinator (Juliane Tran)

Performance Measure

- Continuum of Care Measures - **Retention in Care**

  Definition: HIV+ clients that had ***two or more medical care services*** at least 3 months apart in the reporting period (CY2020)

  - Client has a "Kept" Medical Appointment during the reporting period. *Or*
  - Client had a CD4 or Viral Load test result during the reporting period. *Or*
  - Client has a Payment Request "Paid" during the reporting period (Co/Pay or Deductible). *Or*
  - Client had a Prescription dispensed during the reporting period.

Quality Improvement Initiative: Optimal Retention in Care (RiC)

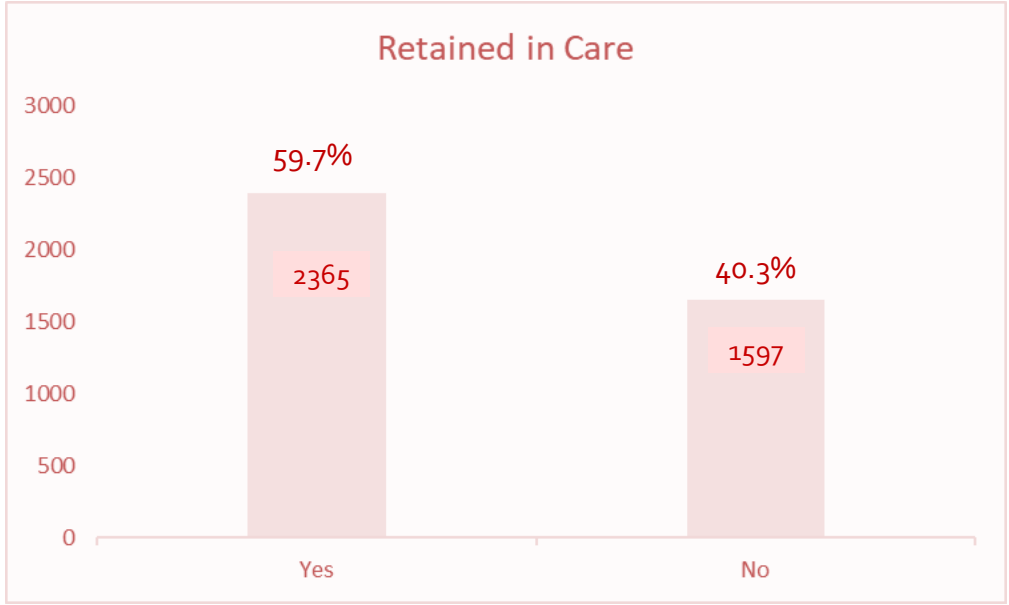
- **Data Collection:**
  - **Data Source:** Provide Enterprise (PE)
  - **Data Abstraction: (Baseline Data)**
    - **'Continuum of Care' Client Level Data:** January 1, 2020 – December 31, 2020
  - **Data Exclusions:**
    - *Clients were excluded from the QIP cohort if they were deceased, incarcerated, had relocated or were deemed no longer eligible during the measurement period.*
    - *Does not exclude patients newly enrolled in care during last six months of the measurement year*
  - **Total Eligible clients:** 3,962

Quality Improvement Initiative: Optimal Retention in Care (RiC)

- **Baseline Data**

This retention in care metric includes all exclusions <u>except individuals newly enrolled in the last 6 months of the reporting period</u>.

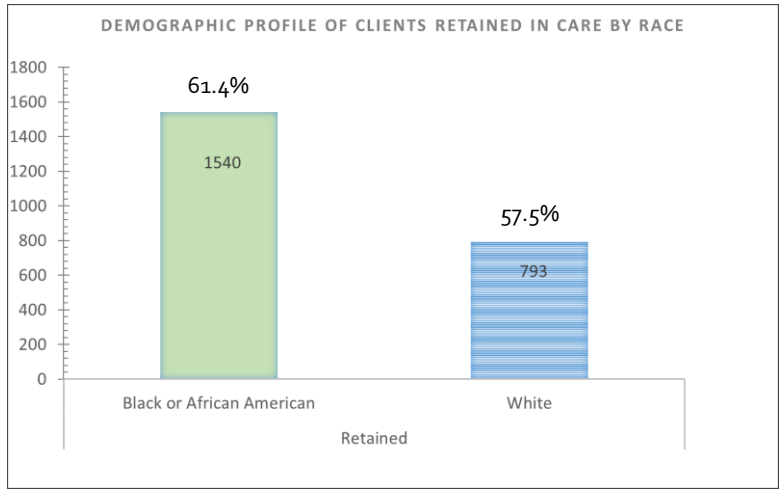
  - Baseline Data
    - Retained: 59.7%
    - Not Retained: 40.3%
  - **Exclusions:** Relocated, Deceased, No Longer Eligible, Incarcerated
  - Total After Exclusions: 3,962 eligible clients



Demographics	Total Retained	% Retained
Retained	2365	59.7%
Not Retained	1597	40.3%
Grand Total	**3962**	**100.0%**

Quality Improvement Initiative: Optimal Retention in Care (RiC)

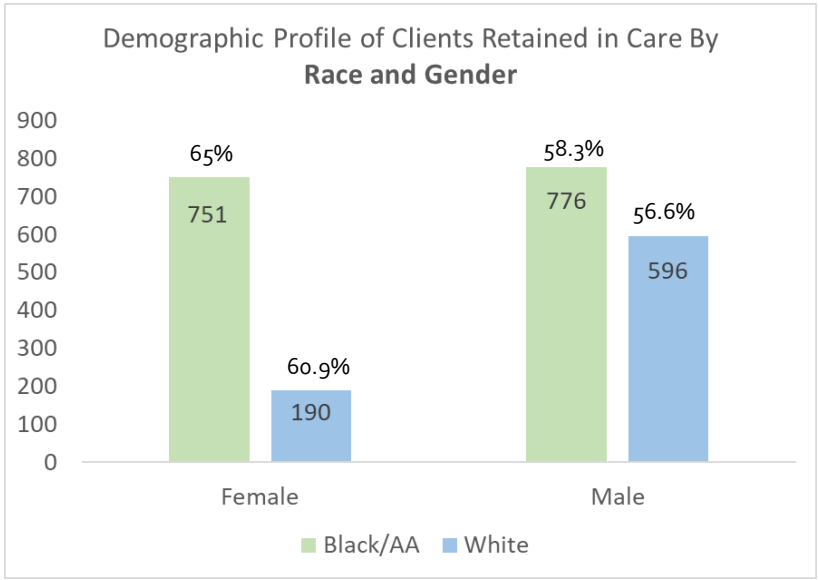
- Demographic Profile of Clients Retained in Care by **Race and Gender**



Retained in Care: 59.7% (N=2,365)

Does not include Asian, American Indian/Alaskan Native, Native Hawaiian/Pacific Islander or Unknown

- Black/AA were retained at a rate of 61.4% compared to White at 57.5%



Does not include Transgender Male to Female

- Black AA: 65% Female; 58.3% Male
- White: 60.9% Female; 56.6% Male

- ✓ **In the Ryan White Program, the majority of the population that we serve are Black/AA**
- ✓ **The highest Retention in Care Rates was among Black/AA (61.4%)**
- ✓ **The highest Retention in Care Rates was among Black/AA Females (65%)**

Quality Improvement Initiative: Optimal Retention in Care (RiC)

Summary

- Successful implementation of a RiC quality improvement project (QIP), by enhancing current system of care and utilizing data sources to monitor retention and reduce health disparities
- Goal to increase the overall program retention from 59% (baseline) to 70% by project completion
- **Metric**: Continuum of Care – Retention in Care measure
- Baseline Data:
  - ***This retention in care metric includes all exclusions except individuals newly enrolled in the last 6 months of the reporting period.***
    - Retained: 59.7%
    - Not Retained: 40.3%

Quality Improvement Initiative: Optimal Retention in Care (RiC)

Summary

- After exclusions *(Relocated, Deceased, Incarcerated, No longer eligible)*
  - 3,962 eligible clients in cohort
    - 59.7% Retained (N=2,365)
    - 40.3% Not Retained (N=1,597)
- Comparison of Demographic Profile of Clients Retained in Care by Race and Gender
  - Black AA were retained at a rate of 61.4% compared to Whites at 57.5%
    - Black AA: 58.3% Males; 65% Females
    - White: 56.6% Males; 60.9% Females
- Key Points:
  - The majority of the population that we serve in the Ryan White Program are Black/AA
  - The highest retention in care rates was among Black/AA (61.4%) and Black/AA Females (65%)

Quality Improvement Initiative: Optimal Retention in Care (RiC)

Next Steps:

- Investigate Baseline Data (all sub-recipients)
- Root-Cause Analysis
  - Fishbone Diagram
  - 5 Why's
- Model for Improvement
  - What are we trying to accomplish?
  - How will be know that a change is an improvement?
  - What change can we make that will result in improvement?
- Begin Plan, Do, Study, Act (PDSA) Cycle

Create+Equity Collaborative

Mental Health Quality Improvement Project

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
- January 2021 to June 2022

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
  - Flow Chart
- Content Expert/Community Meeting: May 26
  - 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
  - Complete Provider Processes Root Causes
  - Review of Client Experience Root Causes
  - Review and Finalize Evidence-Based Interventions
  - Review Aim Statements

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

Overall Viral Suppression

- Of 2652 clients with at least one medical appointment, 2182 had a suppressed viral load (February 1, 2020 to January 31, 2021)

Actual: 2182/2652 = 82%

Goal: 85%

Mental Health Viral Suppression

- Of 125 clients with at least one medical appointment and at least one Ryan White mental health visit, 98 had a suppressed viral load (February 1, 2020 to January 31, 2021)

Actual: 98/125 = 78%

Goal: 85%

Mental Health Screening

- Of 2652 clients with at least one medical appointment, 0 had a mental health screening through RW case management (February 1, 2020 to January 31, 2021)

Actual: 0/2652 = 0%

Goal: 75%

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

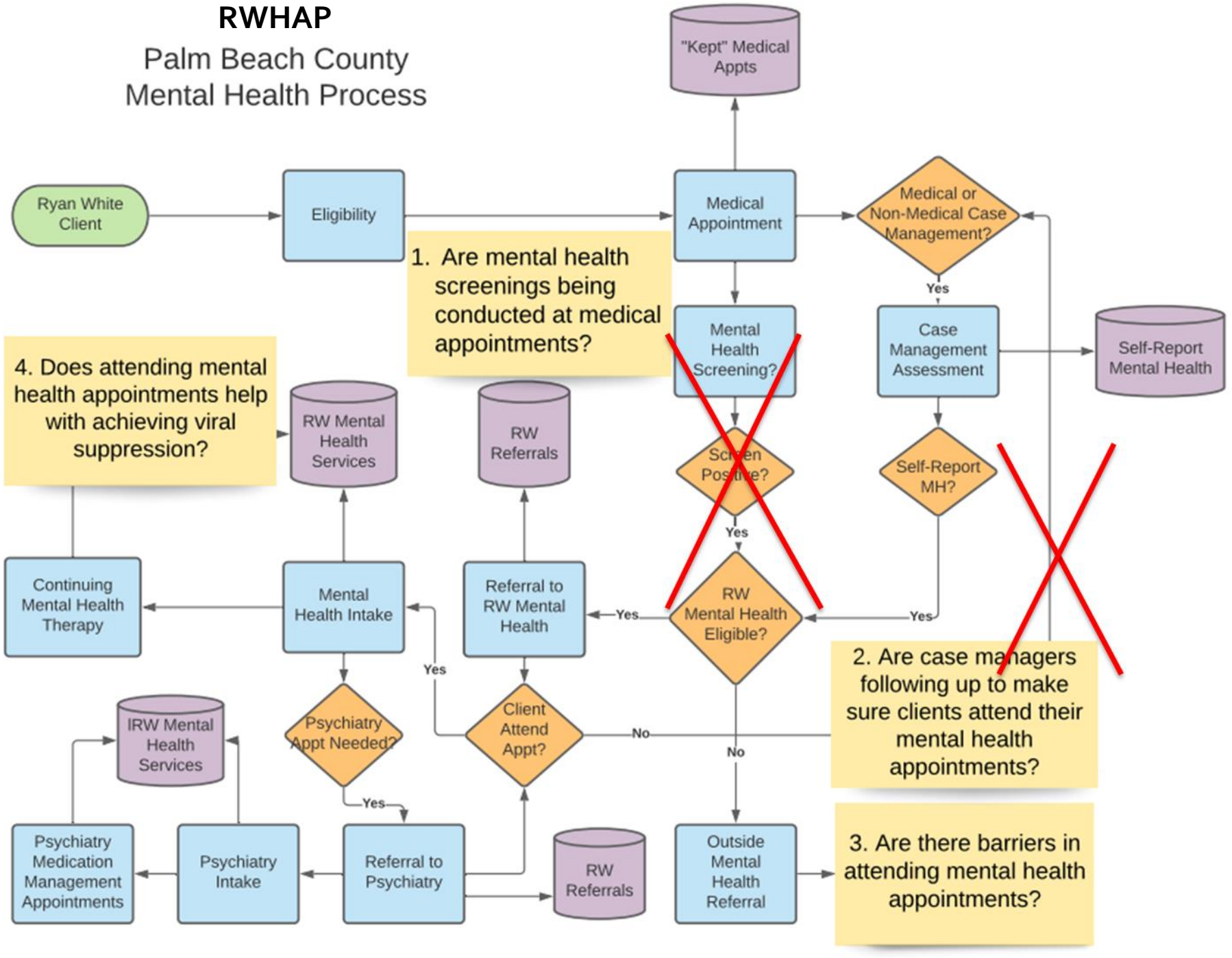
Aim Statements

- 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)

RWHAP

Palm Beach County Mental Health Process



Palm Beach County
Ryan White HIV/AIDS Program

Problem: Many More Clients Self-Reporting Mental Health Issues than are Receiving Mental Health Services

Root cause	Case management staff turnover and burnout

Solutions: Higher Standards and Salaries for Case Managers and/or Supportive Team Building?; Staff Training on Motivational Interviewing Skills, Strategies, and Tools

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

Root Causes for Clients Not Actively Referred to Mental Health

- Case manager turnover and burnout, training not adequate to address clients struggling with mental health issues

- Clients were signed up for new health insurance and are experiencing trouble linking to needed mental health services (waitlists, not accepting new patients, don't know who is in network, etc.)

Interventions

- Mental Health Screening with Optimal Linkage and Referral (Active Referral Intervention) in Case Management – Fall 2021
  - iCARE Tool being implemented in Provide Enterprise, includes comprehensive mental health screening
  - Building relationships to form a network of mental health providers
- Support Case Management with Training and Additional Resources – Summer 2021 onward
  - Staff Training on Motivational Interviewing Skills, Strategies, and Tools
  - Case Management Group every two months for support, collaboration and self-care
  - Develop ways to retain staff, including increased salary support, manageable caseloads, and spreading high acuity cases among staff

Engaging Out-of-Care Clients into Care

Early Intervention Services Initiative

Background on Out of Care PWH in PBC

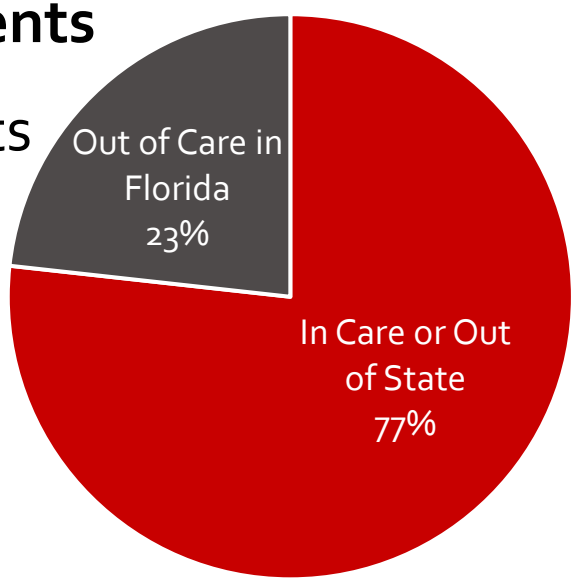
- According to the Florida Department of Health Epidemiological Profile, there were **2,594** previously diagnosed individuals living with HIV who were **out of care in Palm Beach County in 2018**
- Currently, there is no data sharing agreement in place for the Florida Department of Health at the state-level to share the client-level data directly to Ryan White Part A in Palm Beach County

Using RWHAP Data for Data-to-Care

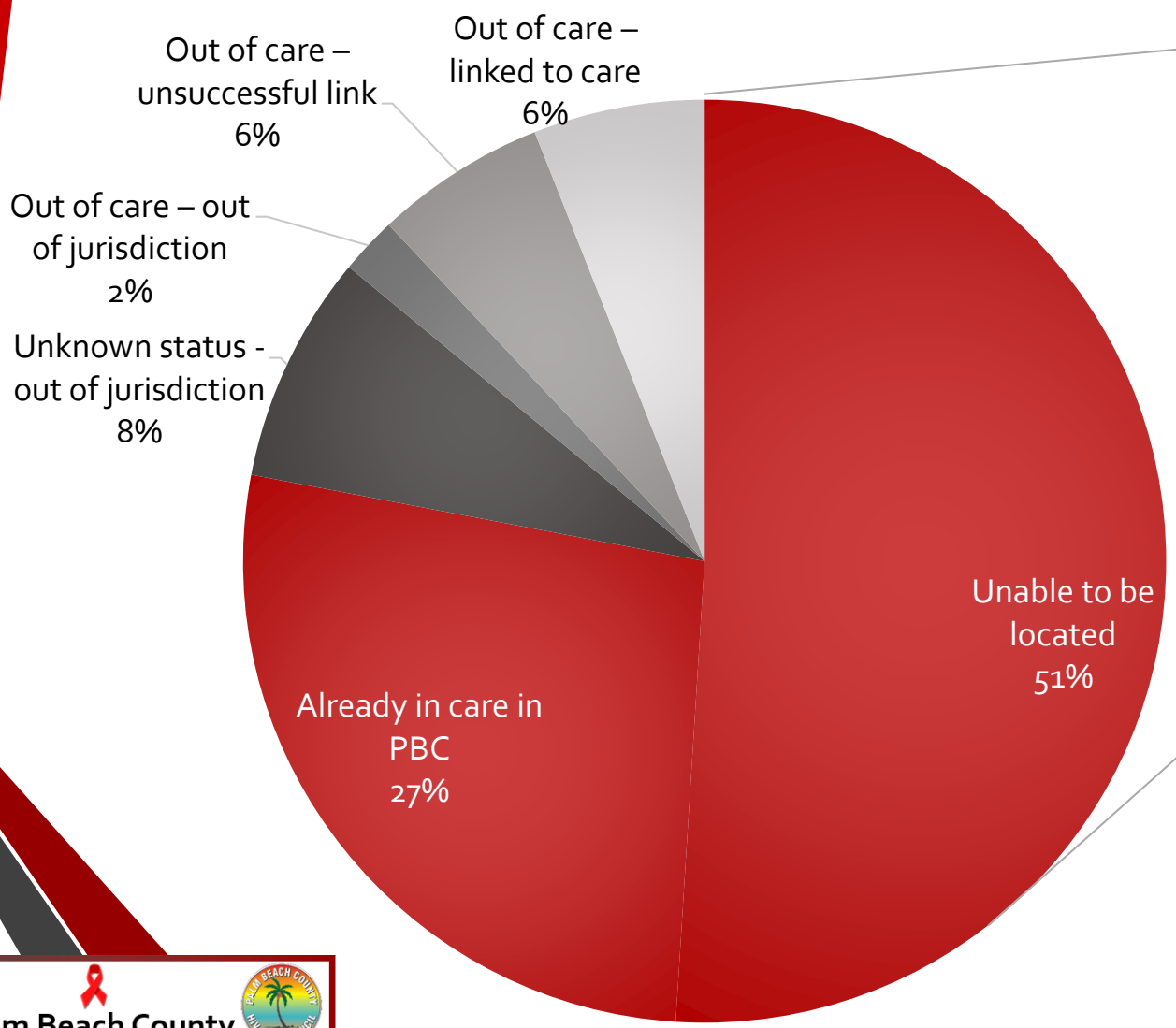
- In Provide Enterprise, there were **4,571 inactive clients** and 3,373 active clients (data as of July 1, 2020)
- **The vast majority (n=4,180)** of inactive clients **do not have a reason for being inactive** as indicated reason for closure of a client to a subrecipient in the "Effective Reason" field
- Some are listed as **agency lost contact or unknown (n=81)**, but the majority of those without a reason for closure are **auto-closed by the system (n=4,099)**, which occurs after 365 days without a service being provided and have not had updates to their Client Service Profile in 60 days (both conditions have to be met)

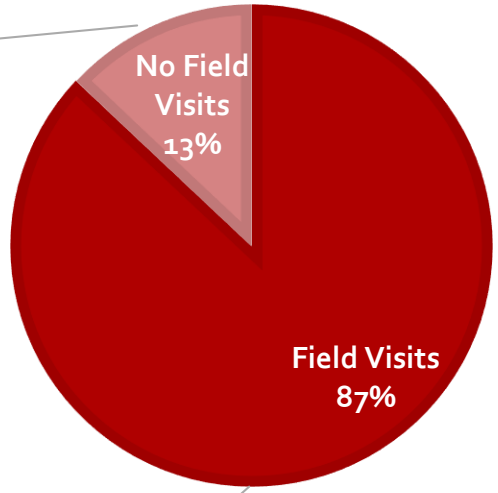
Inactive Client Match to Out of Care – Department of Health

- **499 former (inactive) Ryan White clients** who had an **active Coordinated Services Network (CSN) form** (which had expired after 3 years) were sent to **Department of Health in Tallahassee for matching in March 2020**
- **116** were determined to be on the **Out of Care list** at the State
- Ryan White HIV/AIDS Programs has information on **107 clients**
- Local Florida Department of Health EIS worked these clients



Out of Care State Results





Status	Number	Percent
Unable to be located (48 had field visits)	55	51%
Already in care in PBC	29	27%
Unknown status - out of jurisdiction	9	8%
Out of care – out of jurisdiction	2	2%
Out of care – unsuccessful link	6	6%
Out of care – linked to care	6	6%

Summary on Data Match with State

- **Half of individuals** have an **unknown care status**, with **vast majority** having had **field visits** to attempt to contact the client
- Nearly a **third of individuals were in care**
- **A tenth were out of jurisdiction**

- **12 individuals** were found to be **out of care**, but only **half of those clients were successfully linked**

Inactive Client Project – All Other EIS

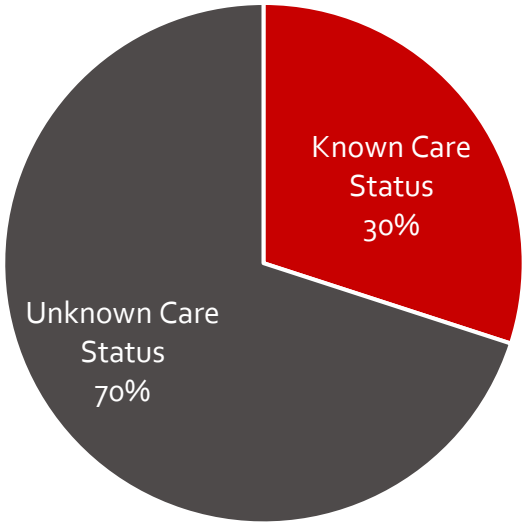
- **Inactive clients in Ryan White** who had not been sent to Department of Health were sent to the **last Ryan White EIS agency** who had contact with the client

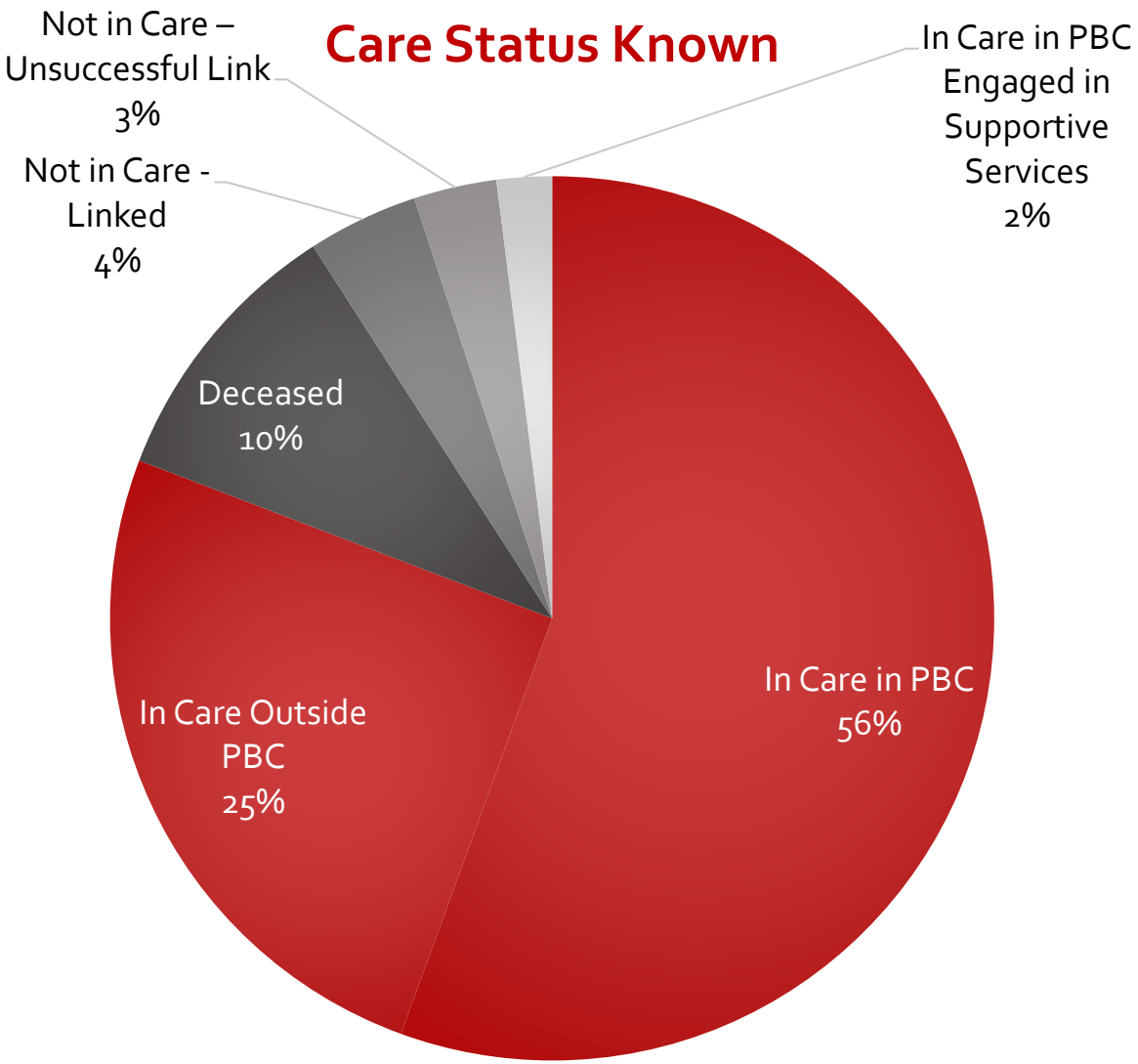
- EIS Specialists called clients with the Provide contact information on file

Phase I

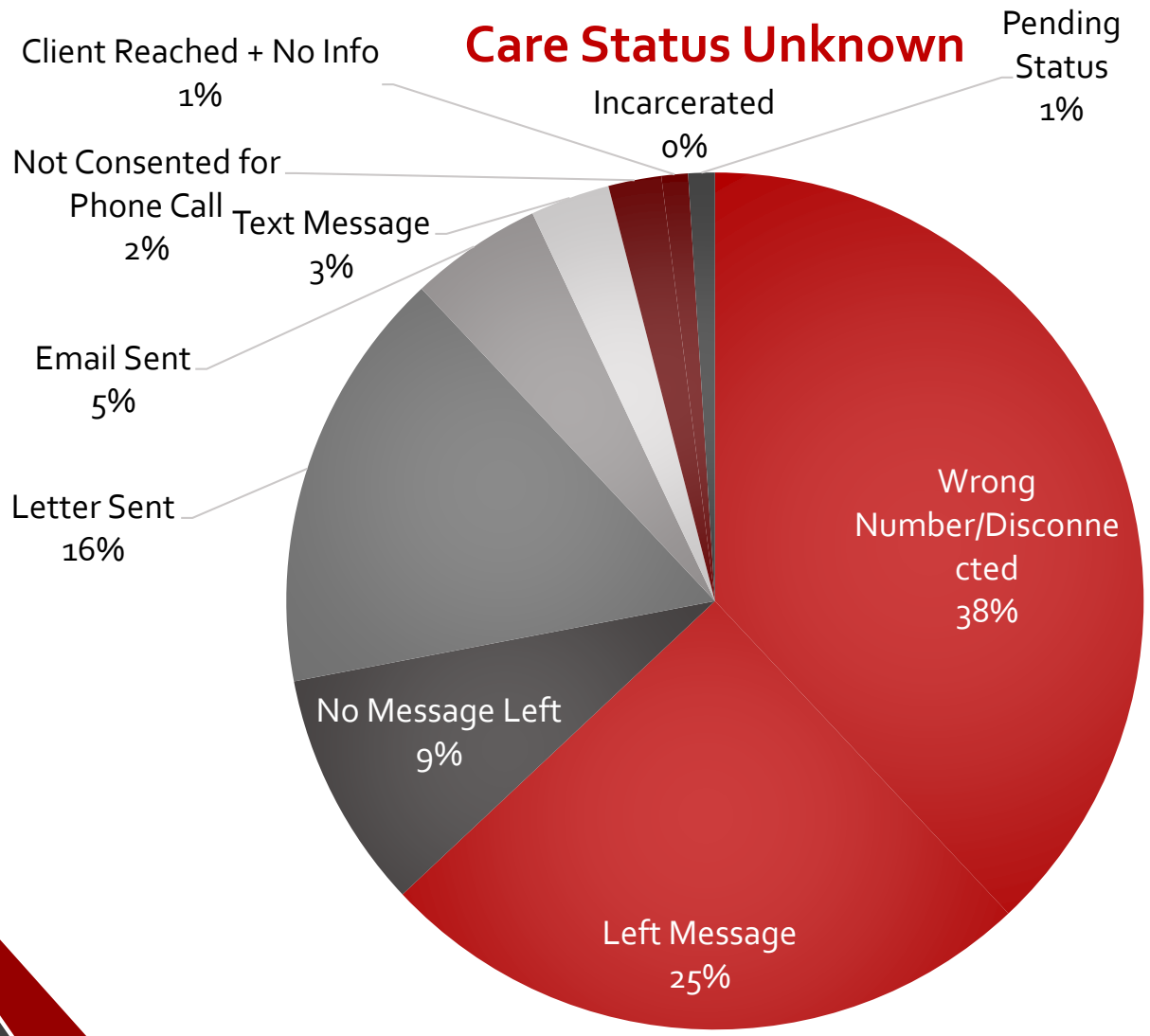
- Phase I included **415 clients** who had an active CSN form from **March 1, 2016 to March 31, 2017**

- In total, **30% of clients have a known care status (n=126)** and **70% have an unknown care status (n=289)**





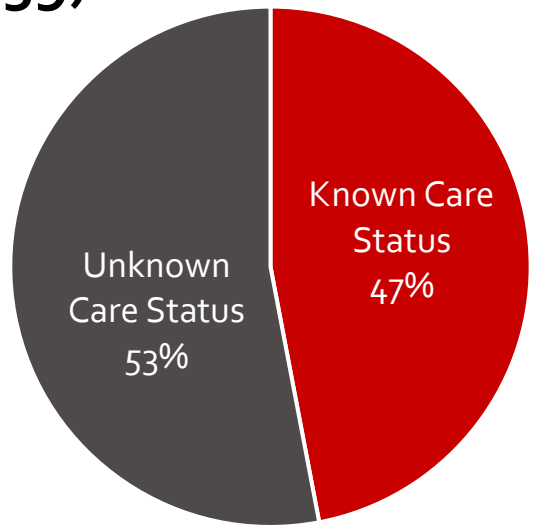
Care Status Known	Number	Percent
In Care in PBC	69	55%
In Care in PBC Engaged in Supportive Services	3	2%
In Care Outside PBC	32	25%
Deceased	13	10%
Not in Care - Linked	5	4%
Not in Care – Unsuccessful Link	4	3%
TOTAL	126	100%

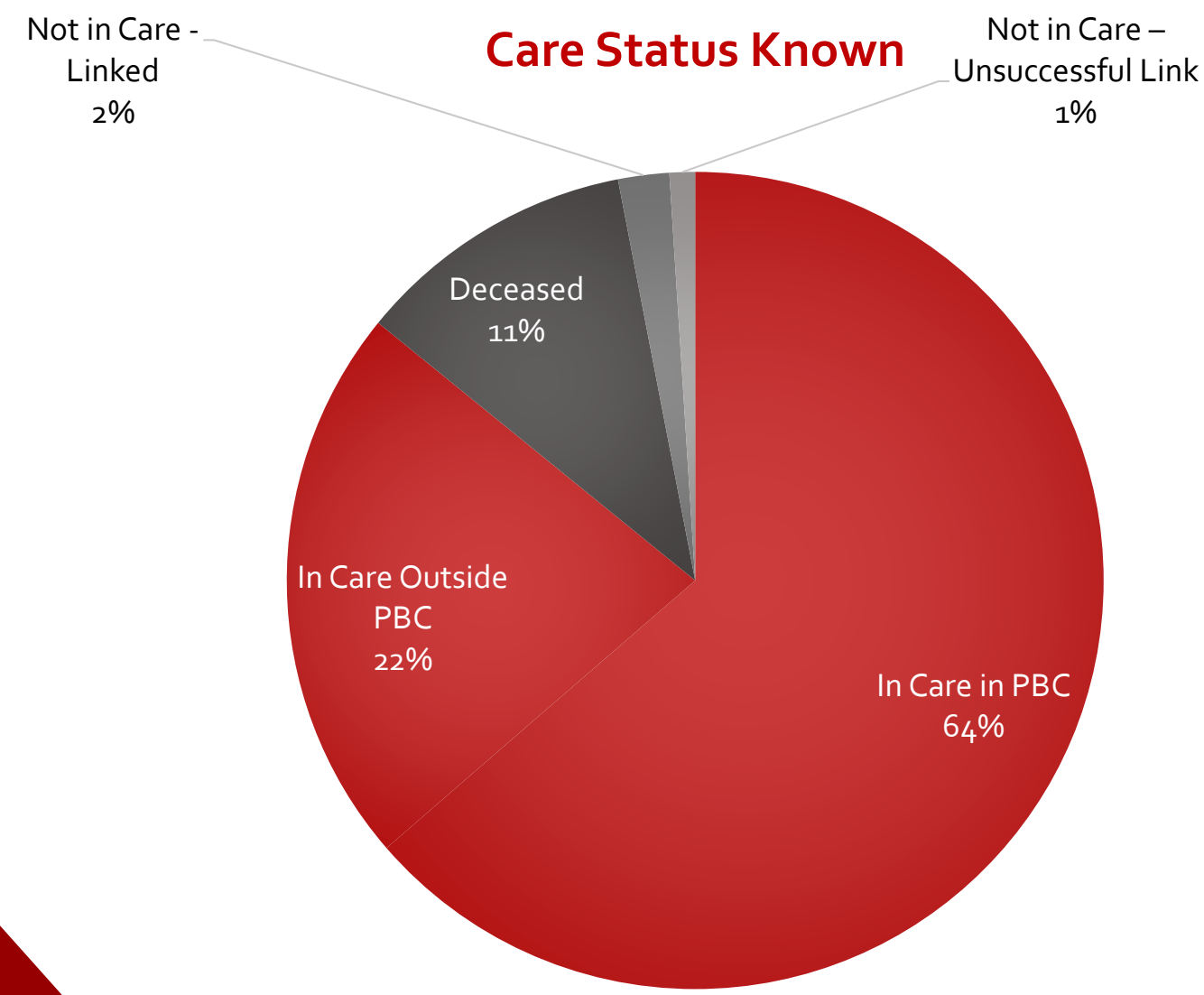


Care Status Unknown	Number	Percent
Wrong Number/Disconnected	110	38%
Left Message	71	25%
No Message Left	26	9%
Letter Sent	47	16%
Email Sent	14	5%
Text Message	9	3%
Not Consented for Phone Call	5	2%
Client Reached + No Info	3	1%
Incarcerated	1	<1%
Pending Status	3	1%
TOTAL	289	100%

Phase II+

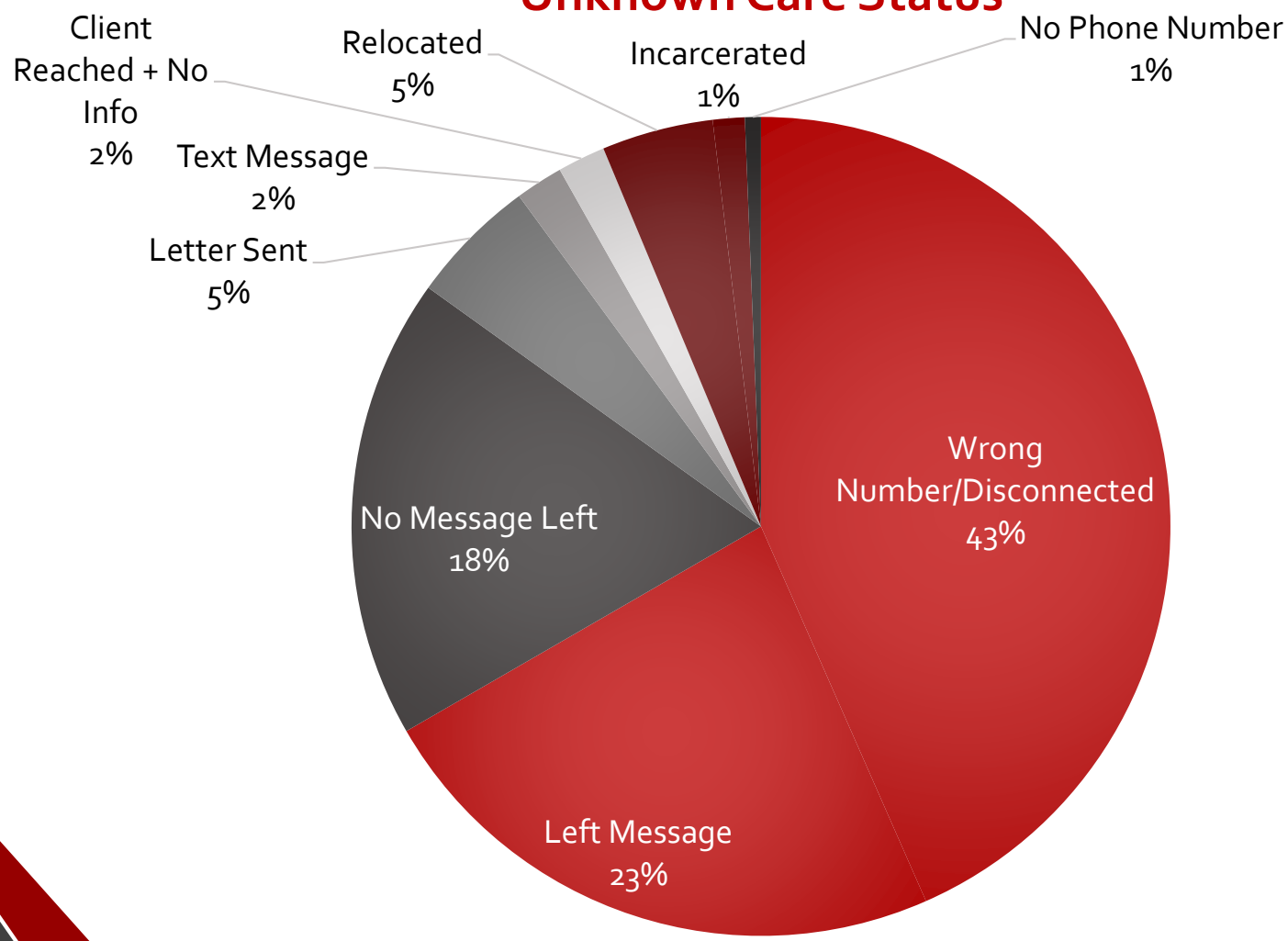
- Phase II+ included **130 clients** who had **become inactive since March 2020-August 2020** and **had an active CSN form from April 1, 2017 to September 1, 2020** were pulled for AHF, Compass, FoundCare and DOH
- Phase II+ also included **170 clients** who had a care episode with **DOH with an active CSN form from March 1, 2013 to February 28, 2017**
- In total, **47% of clients have a known care status (n=141)** and **53% have an unknown care status (n=159)**





Care Status Known	Number	Percent
In Care in PBC	89	63%
In Care Outside PBC	31	22%
Deceased	16	11%
Not in Care - Linked	3	2%
Not in Care – Unsuccessful Link	2	1%
TOTAL	141	100%

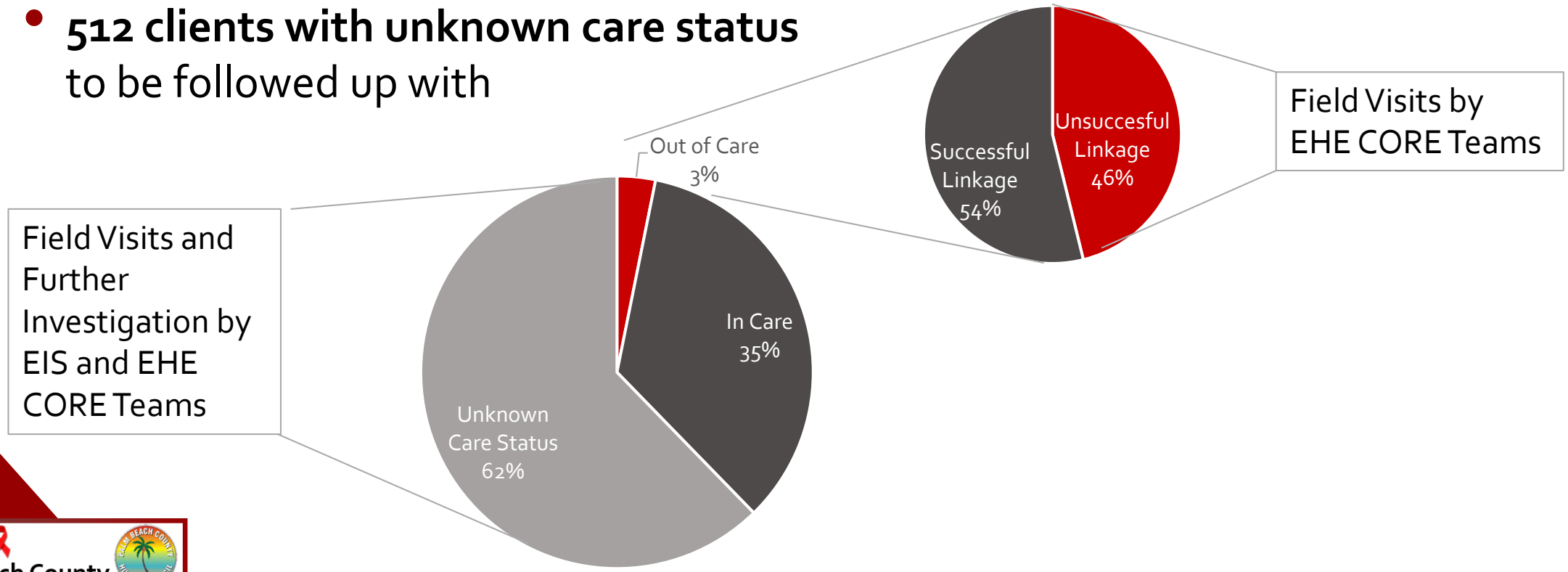
Unknown Care Status



Unknown Care Status	Number	Percent
Wrong Number/Disconnected	69	43%
Left Message	37	23%
No Message Left	29	18%
Letter Sent	8	5%
Text Message	3	2%
Client Reached + No Info	3	2%
Relocated	7	4%
Incarcerated	2	1%
No Phone Number	1	<1%
TOTAL	159	100%

RWHAP Inactive Project Summary in Total

- Out of 822 clients, **26 clients were found to be out of care**
  - **14** were **successfully linked** back into care
  - **12** were **unsuccessful in linkage**
- **512 clients with unknown care status** to be followed up with



Field Visit Training

- The South Florida Chapter of the South East AIDS Education Training Center (SEATC) conducted a field visit training for EIS on June 9, 2021
- Topics included:
  - How to conduct a field visit/outreach safely and effectively
  - How to engage with a client successfully (Motivational Interviewing)
  - Other methods of contacting a client
- Discussion on non-traditional hours (late afternoon/early evening) and weekends
- Motivational Interviewing will be offered as a more in-depth training in July/August 2021

Phase III

- All remaining Inactive clients with an active CSN from the beginning in Provide (2010) to February 28, 2016: 1193 clients left
- These have been de-duplicated across agencies and only if the client did not have a valid reason listed in any of their service categories
- EIS will began working on these clients at the end of Grant Year 2020 and will be completed with the project by the end of Grant Year 2021

Questions?

PBC RWHAP Cost-Effectiveness of Health Insurance Investment

Alejandro Arrieta, PhD

Associate Professor

Department of Health Policy and Management

Florida International University

Palm Beach County
Ryan White HIV/AIDS Program

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Pay for insurance to cover same+ services
Pay providers directly for medical visits, labs, etc.

Several implications…

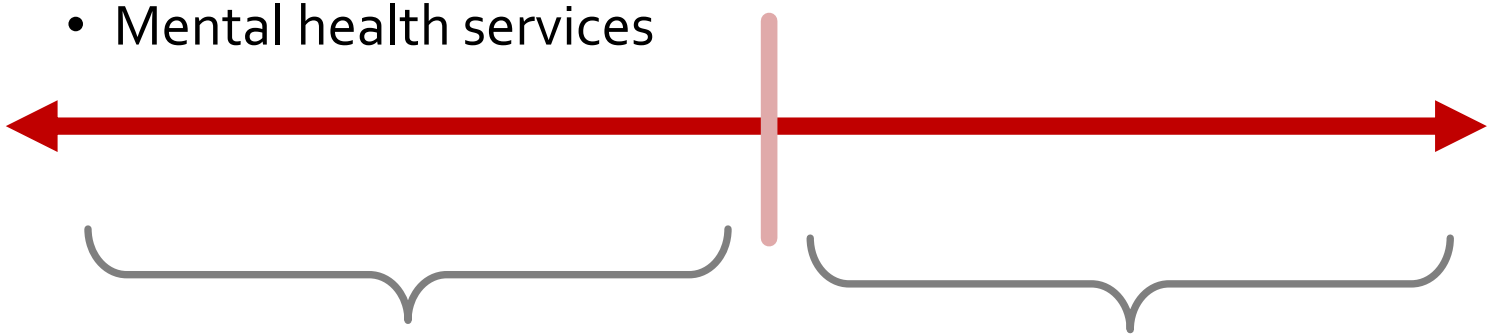
- Clients can get more and better services.
- Ryan White program can save money for each client.
- Ryan White program administrative costs can be reduced.
- The state of Florida could save money by insuring clients below 100% FPL, through its ADAP Health Insurance Program.

Can the Ryan White program save money by purchasing insurance?

- Look at data from 2017 to 2020
- Compare clients before and after they get insurance

- Ambulatory medical care
- Lab services
- Specialty medical care
- Mental health services

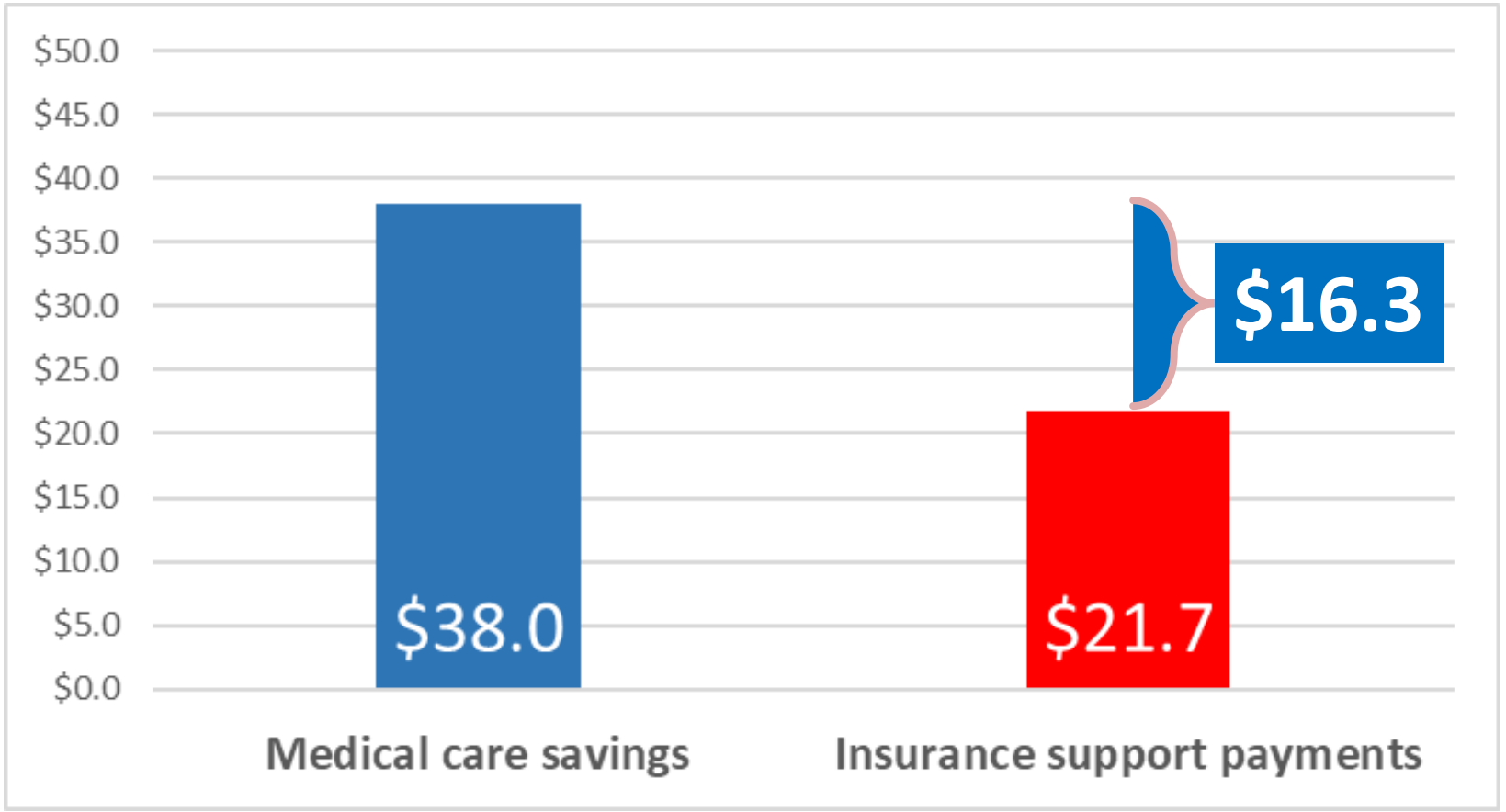
- Insurance support: Premium, copayments, deductibles



Preliminary results

Service Categories	Savings
AIDS Pharmaceutical Assistance	-$1.2*
Emergency Financial Assistance - Med	-$0.3
Lab Services	-$14.3*
Specialty Medical Care	-$5.7*
Mental Health Services	-$1.4*
Food Bank Nutritional Supplements	$0.1
Ambulatory Outpatient Medical Care	-$15.2

Preliminary results



Purchase insurance saves money to the Ryan White program and could add value to clients

Questions?

PBC Minority AIDS Initiative (MAI) Updates

Shoshana Ringer, M.Ed.

Quality Management Coordinator

PBC Ryan White HIV/AIDS Program

sringer@pbcgov.org

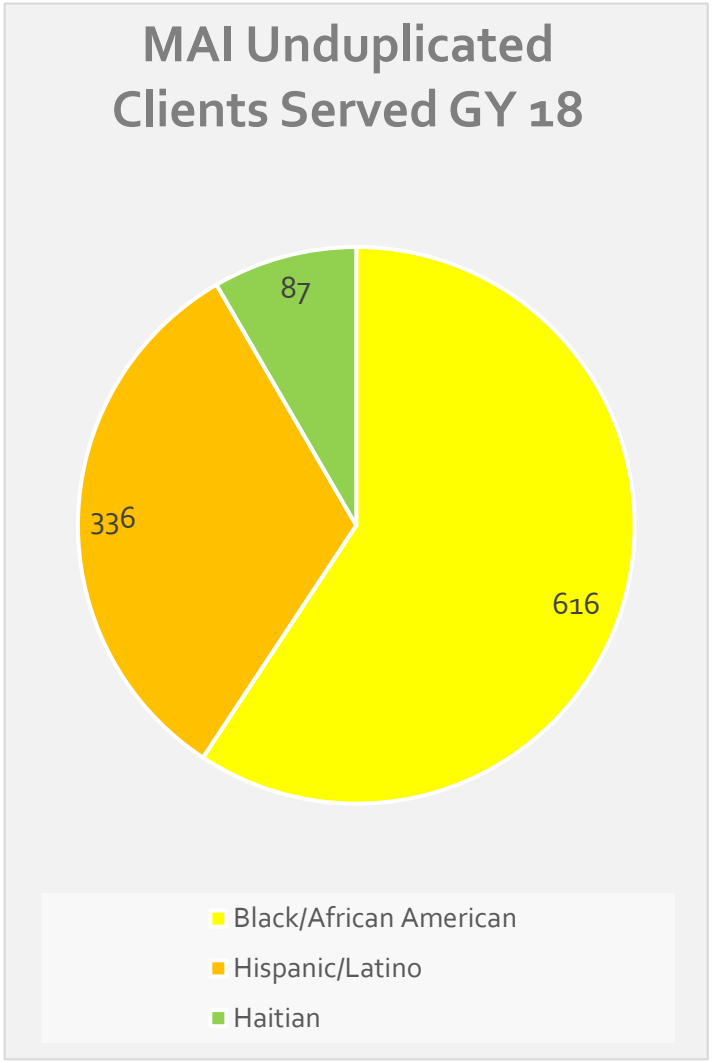
561-355-4788

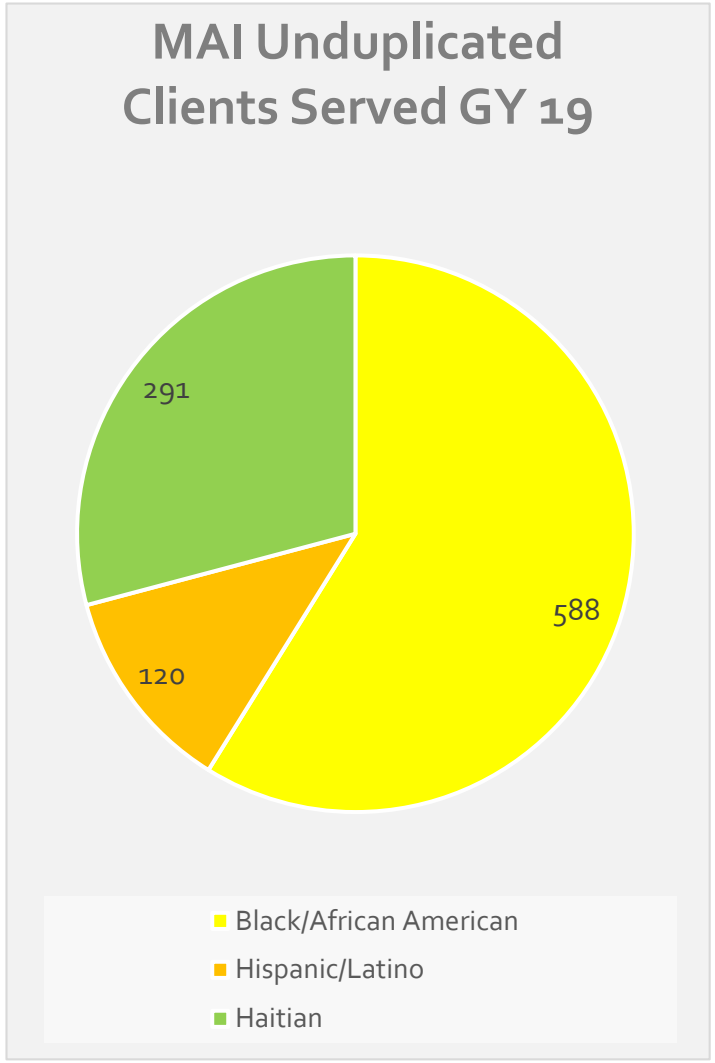
Palm Beach County
Ryan White HIV/AIDS Program

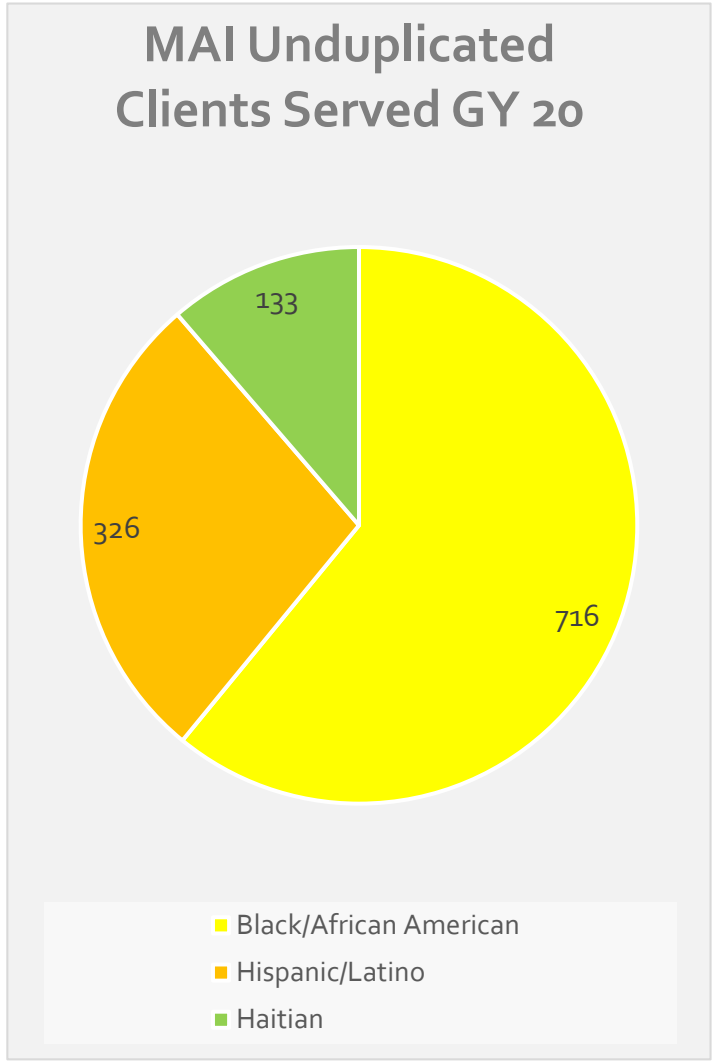
Minority AIDS Initiative (MAI)

- 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.
- In GY20, 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 2 populations, who have 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.
- GY20 was the first year that MCM was not the only funded MAI service in PBC. The CARE Council also allocated MAI funding to Early Intervention Services (EIS), Non-Medical Case Management (NMCM) and Psychosocial Support Services (PSS). In addition, it was the first year that PSS were provided in PBC RWHAP.

MAI Utilization Data Comparison







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

HAB Performance Measure Health Outcome Definitions

Viral Suppression:

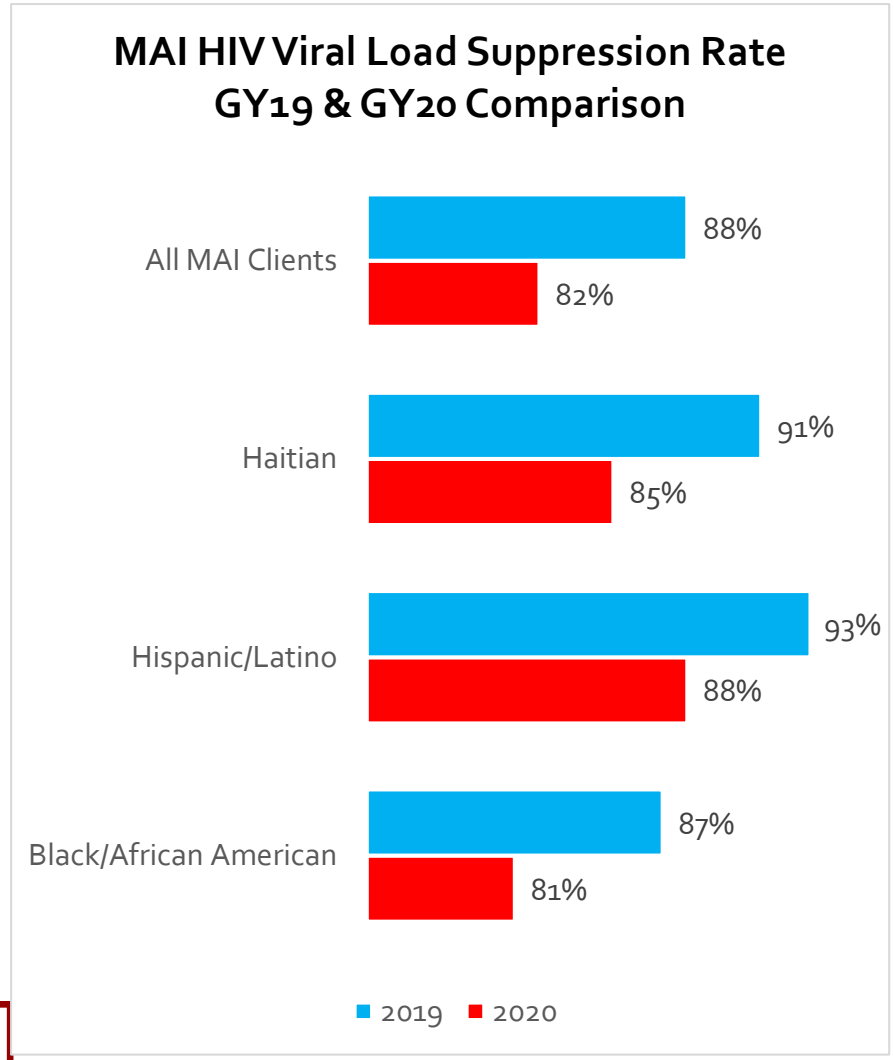
- Denominator: Number of patients with a diagnosis of HIV with at least one medical visit in the measurement year.
- Numerator: Number of patients in the denominator with a HIV viral load less than 200 copies/ml at last HIV viral load test during the measurement year.

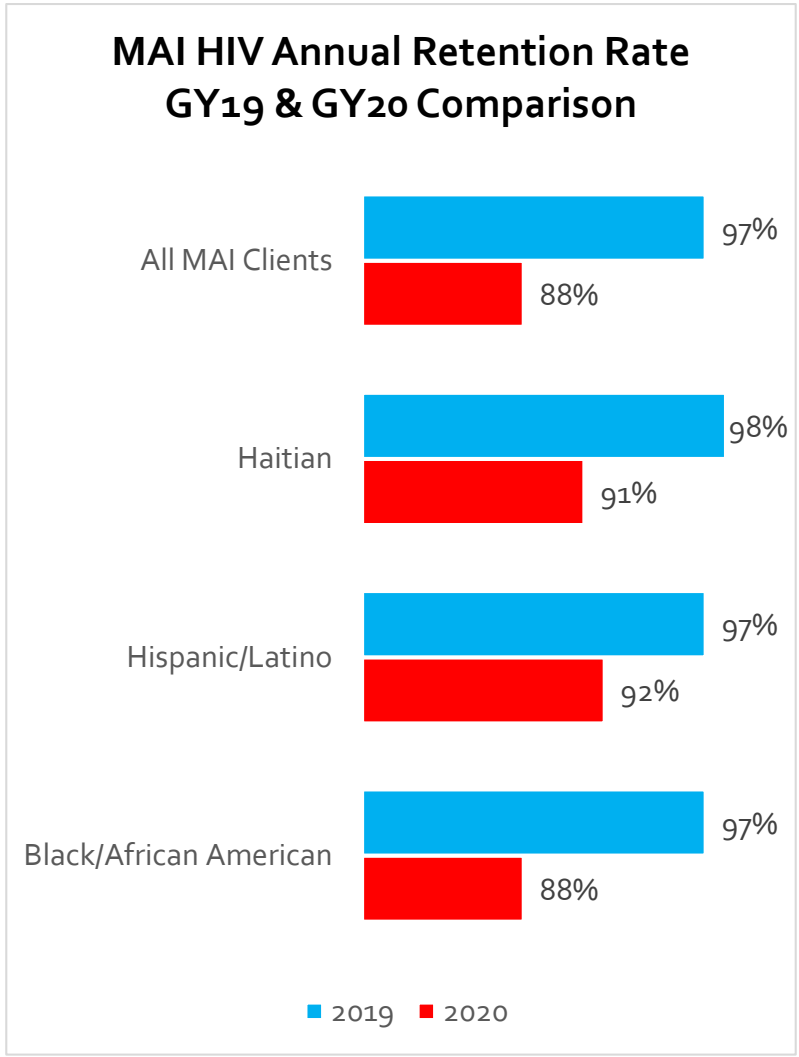
Annual Retention in Care:

- Denominator: Number of patients with a diagnosis of HIV who had at least one HIV medical encounter within the 12-month measurement year.
- Numerator: Number of patients in the denominator who had at least two HIV medical care encounters at least 90 days apart within a 12-month measurement year. At least one of the two HIV medical care encounters needs to be a medical visit with a provider with prescribing privileges.
  - 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 GY19 & GY20

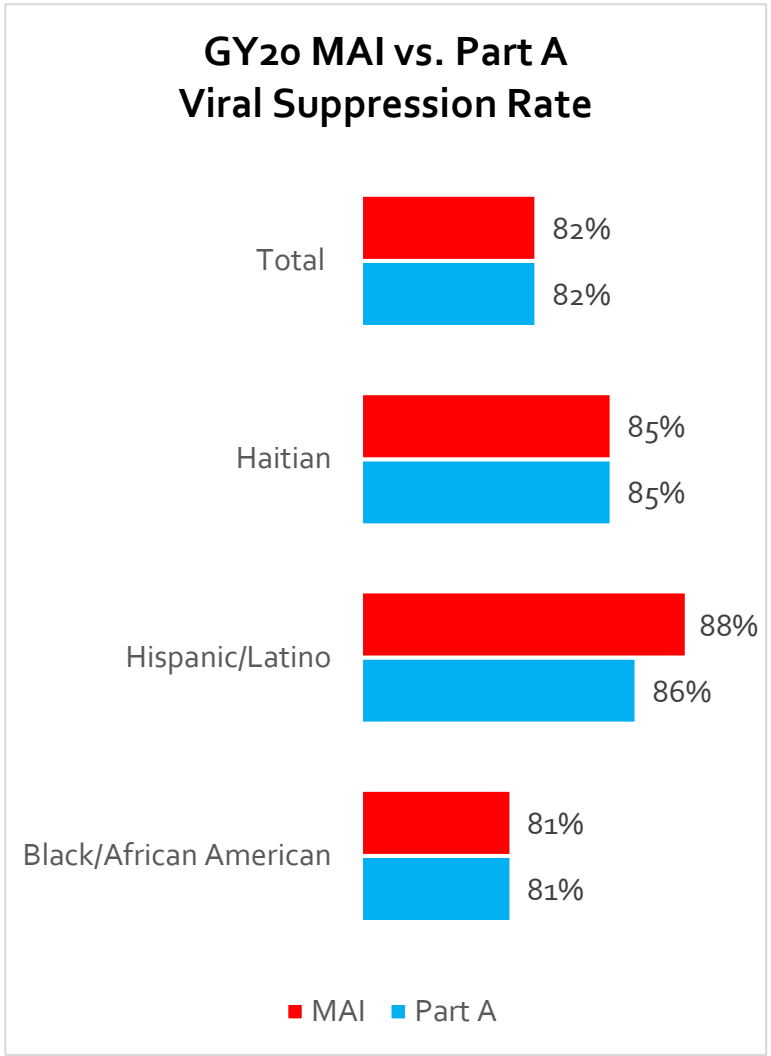
- Decrease in rates for both Viral Suppression and Annual Retention in GY20.

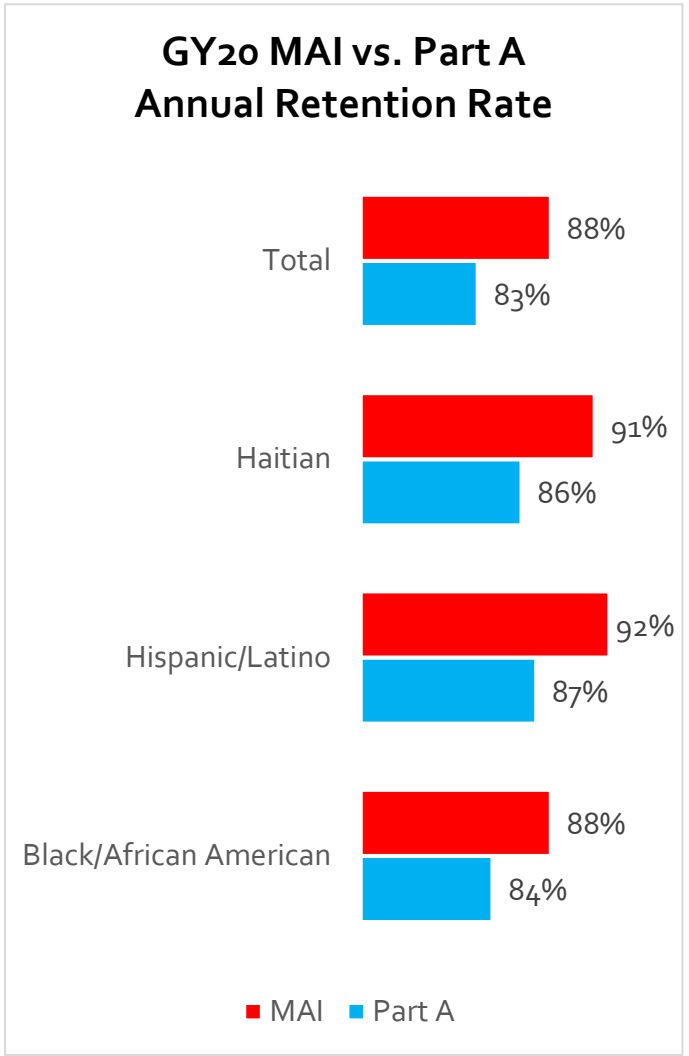




MAI Health Outcomes Comparison
MAI vs. Part A

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





Questions?

PBC Ending the HIV Epidemic Initiative Updates

Sean Conklin, MNM

Program Evaluator

PBC Ryan White HIV/AIDS Program

sconklin@pbcgov.org

(561) 355-4737

Palm Beach County
Ryan White HIV/AIDS Program

What is Ending the HIV Epidemic (EHE)?

- Ending the HIV Epidemic is a national strategy that aims to end the HIV Epidemic in the United states by 2030.
- The initiative aims to reduced new HIV infections by 75% in five years, and 90% by 2030.
- The first five years of EHE, called Phase 1, will focus on 57 priority jurisdictions (including Palm Beach County) where more than 50% of the nation's new HIV infections occurred in 2016 and 2017

The Four Pillars of Ending the HIV Epidemic

- **Diagnose** all people with HIV as early as possible
- **Treat** people with HIV rapidly and effectively to reach sustained viral suppression.
- **Prevent** new HIV transmissions by using proven interventions, including pre-exposure prophylaxis (PrEP) and syringe services programs (SSPs).
- **Respond** quickly to potential HIV outbreaks to get needed prevention and treatment services to people who need them.

Palm Beach County EHE Goals for Phase 1

- Goal 1: By End of GY2024, increase percentage of newly diagnosed Persons with HIV linked to care within 30 days to 95%
  - 77% in 2019
- Goal 2: By the end of GY2024, increase percentage of PWH who are retained in care to 91%
  - 73% in 2019
- Goal 3: By the end of GY2024, increase viral suppression rate among persons with HIV to 90%
  - 73% in 2019

Palm Beach County's EHE Activities

- Activity 1: C.O.R.E. Teams
- Activity 2: Rapid Entry to Care
- Activity 3: Teleadherence Counseling

Activity 1: C.O.R.E. Teams

- Community Outreach, Response & Engagement (C.O.R.E) Teams
  - Community-based teams consisting of one community health worker and one peer
  - Primarily responsible for locating out of care clients and reengaging them in care
  - Use strengths-based case management strategies to help clients address barriers to care
  - 3 CORE Teams for GY21
  - Objective Measure: 270 people linked/re-engaged per year
  - Associated with PBC EHE Goal 1 & 2

Activity 2: Rapid Entry to Care

- Rapid Entry to Care (REC)
  - Sites providing medical visit, labs, and 30 days of ART to clients newly diagnosed or re-engaging in care
  - Guaranteed medical appointment available within 3 days of referral
  - Provide referral/linkage to support services
  - Services provided prior to RW eligibility; only requires proof of HIV positive status
  - Objective Measure: 270 people who are newly diagnosed/out of care will initiate/restart ART
  - Objective Measure: Link 60% of newly diagnosed PWH to care within 72 hours and an additional 25% within 30 days
  - Associated with PBC EHE Goal 1 & 2

Activity 3: Teleadherence Counseling

- Teleadherence Counseling
  - Clients provided access to a mobile health engagement platform (PL Cares)
  - Clients provided a mobile phone (as needed) and phone credits to participate in the platform
  - Clients track their stress level, mood, and if they took their medication in daily check-ins
  - Anonymous community message board where clients can ask questions and have discussions with other users
  - Teleadherence Counselor assists clients with barriers and strategies to help them remain adherent to medication
  - Objective Measure: 40 people become virally suppressed this year
  - Associated with PBC EHE Goal 3

EHE Activities for Next Year

- Syringe Services Program
- Health Insurance Continuation
- Justice Involved Program
- Mobile Health Unit

Syringe Services Program

- Syringe Services Programs (SSPs) provide a range of services for Intravenous Drug Users (IDU)
- In 2019, 21 new HIV diagnoses were attributed to IDU
  - HIV is most commonly spread by people who inject drugs (PID) when sharing needles or reusing dirty needles
- Currently one operator provides SSP in Palm Beach County (Rebel Recovery FL, Inc)
- SSP provides:
  - 1-to-1 needle exchange and safe injection equipment
  - Narcan (naloxone)
  - HIV/HCV Testing and Linkage
  - Referrals to recovery services
- Objective Measure: Increasing linkage to care to 85% within 72 hours, 95% within 30 days
- Objective Measure: PWH who inject drugs engaged in care at 82%
- Associated with PBC EHE Goal 1 & 2.

Health Insurance Continuation

- EHE funds will be used to help enroll Palm Beach county residents with HIV in extended healthcare coverage
- Associated with PBC EHE Goal 2 & 3

Justice Involved Program

- Once EHE infrastructure is in place, we will prioritize PWH who are justice involved, particularly those who have been incarcerated
- Justice involved individuals will be invited to participate in the teleadherence platform
- CORE Teams will meet with clients prior to release to help arrange for housing, medical care, and other needs

Mobile Health Unit

- EHE funding will be used to purchase and outfit a mobile health unit that will act as a REC site
  - HIV Counseling & Testing
  - Rapid Entry to Care
  - Labs
  - Medications
  - Vaccinations
  - Support Services

PBC EHE Budget

- GY20 Grant Award: $850,000
  - Expenses: $88,087
  - Carryforward: $761,912
- GY21 Grant Award: $1,396,646

Questions?

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

Jacqueline Taylor

Casework Supervisor

PBC Ryan White HIV/AIDS Program

jtaylor4@pbcgov.org

(561) 355-4700

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 AWARDS

- City of West Palm Beach - CORONAVIRUS AID, RELIEF, AND ECONOMIC SECURITY (CARES) ACT – April 30, 2023 -$440.000
- Florida Department of Health – June 30, 2022 - $1,900,000

HOPWA Goals

The HOPWA Program has 3 primary goals.

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

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.

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 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.

HOPWA Program Activities

Supportive Services:

Activities include, but are not limited to, health, mental health, assessment, permanent housing placement, drug and alcohol abuse treatment and counseling, nutritional services, and assistance in gaining access to local, state and federal government benefits and services, except that health services may only be provided to individuals with acquired immunodeficiency syndrome or related diseases and not to family members of these individuals.

REFERRALS

- Ryan White Case Managers may refer through Provide Enterprise.
- Out of Network Referrals may be delivered through Confidential Fax Line or directly to PBC RWHAP Registration Clerk.
- Eligibility will be determined using the FL DOH Patient Care /HOPWA requirements.
  - Proof of HIV positive status
  - Proof of Income (80% Area Median Income (AMI), 2021= $47,950 for household of 1)
  - Proof of Residency

Questions?

Open Forum Discussion/Q&A

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