2022 - 2026 INTEGRATED HIV PREVENTION AND CARE PLAN

BROWARD COUNTY, FL

DECEMBER 9, 2022

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This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under the grant number H89HA00002, CFDA # 93.914– HIV Emergency Relief Project Grants, as part of the Fiscal Year 2022 grant. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement by, HRSA, HHS, or the U.S. government.

SECTION I. EXECUTIVE SUMMARY: INTEGRATED PLAN & SCSN

The purpose of this section is to provide an overall description of the Broward County Integrated HIV Prevention and Care Plan (Integrated Plan), including the Statewide Statement of Coordinated Need (SCSN) and the extent to which previous/other plans/SCSNs inform this plan/SCSN.

A. APPROACH

The Broward County Integrated HIV Prevention and Care Plan (Integrated Plan) follows the goals, objectives, and priorities as described in the HIV National Strategic Plan: A Roadmap to End the Epidemic 2021-2025 and the updated National HIV/AIDS Strategy (NHAS) for the United States 2022–2025. Broward County's Integrated Plan utilized data to devise strategies to reduce new HIV infections by 75% by 2025 and 90% by 2030.

Broward's Integrated Plan promotes and supports the Meaningful Involvement of People with HIV/AIDS (MIPA). "Meaningful involvement of people with HIV/AIDS (MIPA) is about ensuring that the communities most affected by HIV are involved in decision-making, at every level of the response. MIPA requires dedication, planning and assessment, organizational buy-in, and a champion to help usher its development and continued assessment."

Broward County's Ryan White Part A Recipient's Office and the Florida Department of Health in Broward County (DOH-Broward) HIV Prevention Program have identified the unique characteristics of its residents and visitors, its distinctive approach to addressing the epidemic, and its ability to bring together groups of diverse stakeholders. Due to these distinct differences and variances within the community, Broward County opted to submit a "City-Only" Integrated Prevention and Care Plan particular to its diverse strengths and needs. The stakeholders recognize that several universal principles align and guide this approach consistent with the Statewide Coordinated Statement of Need (SCSN) and this plan reflects that alignment. Collectively, it is acknowledged that the strengths and challenges that define Broward County should be addressed as a community. The submission of the Integrated City-Only Prevention and Care Plan to the Center for Disease Control and Prevention (CDC) and Health Resources and Services Administration (HRSA) is warranted. This plan is also included as a chapter in the State of Florida Integrated HIV Prevention and Care Plan.

For the Integrated HIV Prevention and Care Plan to be implemented successfully, it needed to be created locally, with input from the people most affected and with the most to gain or lose. The backbone for the collective impact framework was created with the support of Broward County's Human Services Department through the Ryan White Part A Program and the Florida Department of Health in Broward County's Part B and HIV Prevention Programs.

Broward is committed to providing effective prevention, care, and treatment strategies utilizing clinical quality management, monitoring, evaluation, and other local resources to ensure the populations and geographic areas most affected by HIV achieve maximum impact. These strategies can be achieved through 1) the development of active measurement tools; 2) ongoing evaluation practices; 3) reporting of NHAS progress achieved; 4) continuous stakeholder engagement, and 5) integrated planning. Integrated Planning provides a tremendous collaborative opportunity for effective planning and efficiency in responding to local jurisdictional needs.

All programmatic activities organized by the FDOH-Broward HIV Prevention Program, Ryan White Parts A-F, HOPWA, Broward County Public Schools, and other community stakeholders include comprehensive evaluation components in addition to the regular monitoring of outputs. Evaluation findings are critical for the identification of best practices and opportunities for improvement, which then provides vital information for effective program planning and quality improvement of services.

The success of the Integrated Planning process relies on the support of the three local HIV prevention and care planning bodies, which involve stakeholders throughout their planning and development processes. All three bodies insist on parity, inclusion, and representation (PIR), ensuring that the planning bodies reflect the communities served. Both embrace a fully transparent process that allows opportunities for regular feedback and input. The following Guiding Principles were adopted during the beginning stages of the planning process: 1) the focus must be on eradicating the epidemic; 2) prevention and care must cooperate to be successful; 3) continuous communication and inclusivity must be the norm; 4) common definitions for terms must be utilized by both prevention and care; an, and the HIV care continuum must be the framework for the integrated planning process.

Extent To Which Previous/Other Plan Inform This Plan

The local Broward jurisdiction utilized a multi-pronged collaborative approach to preparing the current Integrated Plan submission, including:

- Activities from the RWHAP Part A Ending the HIV Epidemic (EHE) Plan
- Activities from FDOH-Broward's Ending the HIV Epidemic (EHE) Plan
- Activities from the 2022-2025 Florida Integrated HIV Prevention and Care Plan
- Activities recommended during Integrated Planning Community Engagement events
- Activities recommended in RWHAP Part A Needs Assessment activities

The Integrated Plan is a living document updated regularly, based on community input and feedback. Immediately following the submission of this plan, the Integrated Planning body responsible for the Plan will reconvene to further delineate implementation and monitoring activities.

B. DOCUMENTS SUBMITTED TO MEET REQUIREMENTS

Ryan White Part A Documents

- 2022 Broward Part A Integrated Score Cards
- 2022 Broward Part A Continuum of Care Data
- 2022 Broward RW Part A Integrated Assessment Summary Report
- 2022 Broward Ryan White Part A Provider Survey
- 2021 Broward Ryan White Part A Needs Assessment
- Part A Community Conversations and Town Hall Minutes
- Part A EHE Workplan Document

Ryan White Part B Documents

- 2021 Broward Epidemiologic Profile
- Florida HIV Integrated Care and Prevention Plan

Prevention Documents

- EHE Plan Community Update PowerPoint (10/22)
- EHE Planning Documents

SECTION II: COMMUNITY ENGAGEMENT & PLANNING PROCESS

1. JURISDICTION PLANNING PROCESS

The following section describes how the jurisdiction approached the planning process, engaged community members and stakeholders, and fulfilled legislative and programmatic requirements.

Integration of HIV Prevention and Care Planning Bodies

The goal of integration in Broward County is to streamline HIV prevention and care planning to enhance prevention efforts for the highest-risk populations. It will also improve the metrics along the Continuum of Care for those infected with HIV to create a coordinated response to the HIV epidemic and a seamless provision of HIV services. These metrics include the percentage of persons diagnosed and living with HIV, the percentage linked to care, the percentage retained in care, and the percentage with suppressed viral load.

This integrated approach to prevention and care has allowed Broward County to develop a clear roadmap to effectively plan for the provision and coordination of services for PWH. It also allows for the most efficient use of limited resources by minimizing the duplication of services.

Broward's local HIV prevention and care planning bodies are responsible for developing a system-wide plan for delivering HIV prevention and care services. The three local HIV planning bodies: the RWHAP Part A Planning Council (Broward County HIV Health Services Planning Council (HIVPC)); the RWHAP Part B advisory body (South Florida AIDS Network (SFAN)); and the CDC HIV prevention planning body (Broward County HIV Prevention Planning Council (BCHPPC)) worked collaboratively to lead community engagement and HIV planning efforts.

Each of the three HIV planning bodies selected three (3) members to represent their respective areas in developing the Integrated HIV Prevention and Care Plan through membership in the Integrated Plan Workgroup, the oversight body for Integrated Planning in the jurisdiction. Members are responsible for identifying the scope and timeline for integrated plan development activities including types of data to be presented during community engagement events and integrated planning retreats.

Integration of planning activities between the HIVPC and BCHPPC will help the EMA to progress further in reaching the NHAS goals and improve outcomes along the Continuum. The activities described in the Integrated Plan are overarching coordinated activities that support the individualized efforts of both planning councils and their workgroups, as evidenced in their respective work plans. As such, specific activities for priority populations are addressed in the work plans of the three local HIV planning entities' workplans. The HIVPC, SFAN, and BCHPPC will continue to function as separate bodies to implement the assigned activities required in this plan as well as in their work plans and to work collaboratively to address mutually reinforcing

activities. In addition to incorporating portions of previously developed (RWHAP Part A and FDOH-Broward Ending the HIV Epidemic (EHE) Plans) and newly developed Plans (2022-2025 Florida Integrated HIV Prevention and Care Plan)
and associated committee and sub-committee workplans, several activities occurred in Broward County that allowed for the inclusion of the voices of persons impacted and affected by the epidemic. Results of Needs Assessment Surveys, Focus Groups, Key Stakeholder Interviews, Community Feedback Forums, and a Workforce Forum have been synthesized and integrated into this document.

Engagement of Stakeholders and Community Members

Through strategic collaborations among stakeholders, HIV planning in Broward County is based on the belief that local planning is the best way to respond to local HIV prevention and care service delivery needs and priorities.

Community engagement involved the collaboration of key stakeholders and broad-based communities who worked together to identify strategies to increase the coordination of HIV programs throughout the state, and local health jurisdiction. Community stakeholders included persons living with HIV (PWH) who reflect the local demographics of the epidemic with lived experience. PWH can best help align resources and set goals that promote equitable HIV prevention and health outcomes for priority populations. Community engagement also included needs assessment processes (e.g., focus groups, population-specific advisory groups) that take place outside of or in conjunction with the Integrated HIV Care and Prevention body (Integrated Workgroup) and to inform the Integrated Plan submission. In addition to traditional stakeholders, the Prevention Recipient, FDOH-Broward, successfully led efforts to engage new partners and non-traditional organizations.

Planning and community engagement efforts conducted in support of the Ending the HIV Epidemic (EHE) Initiative were successful in broadening the jurisdiction's existing group of partners and stakeholders to include other federal, state, and local HIV programs, local organizations, and community groups not previously engaged for improving data sources, leveraging services, and assisting with key portions of the plan, such as the HIV prevention and care inventories. These expanded efforts were in addition to the engagement of traditional stakeholders and community members (e.g., AIDS Education and Training Centers (AETCs), state Medicaid agencies, STI/sexually transmitted disease (STD) clinics, and local education agencies.

Of the three members that each of the local HIV planning bodies selected to serve on the Integrated Plan Workgroup, at least one (but typically more) representative was a Person Living with HIV (PWH). Having the group responsible for integrated planning be led by PWH, ensured that the priority focus remained on the meaningful involvement of People Living with HIV. The

Integrated Plan Workgroup members' efforts also focused on engaging people with different interests, responsibilities, and involvement with HIV to inform and support the development and implementation of an Integrated Plan submission that guides the delivery of HIV prevention and care services.

The integrated planning body collaborated with the Recipients to analyze data for program activities and decisions, prioritize resources to those at the highest risk for HIV transmission and acquisition, and address health equity by improving both individual and population-based HIV health outcomes.

As discussed in the previous section, the jurisdiction utilized a multi-pronged collaborative approach to preparing the current Integrated Plan submission including incorporating:

- Goals, Objectives, and Strategies of the National HIV/AIDS Strategy
- Florida Integrated HIV Prevention and Care Plan activities
- RWHAP Part A Ending the HIV Epidemic workplan activities
- Prevention Ending the HIV Epidemic workplan activities
- Newly developed activities based on needs assessment results and

In addition to incorporating activities from other local plans, the Integrated Workgroup Members identified additional activities based on results of local needs assessment results and additional input and feedback from key stakeholders and broad-based communities that include People with HIV (PWH), funded-service providers, and stakeholders from disproportionately affected communities.

A. ENTITIES INVOLVED IN THE PROCESS

Key Stakeholders Included in Broward HIV Planning Group Membership & Integrated Planning

- Health department staff
- Community-based organizations serving populations affected by HIV /HIV service providers
- People with HIV and individuals co-infected with Hepatitis B or C
- Populations at risk or with HIV representing priority populations
- Behavioral or social scientists
- Epidemiologists
- HIV clinical care providers including (RWHAP Part C and D)
- STD clinics and programs
- Non-elected community leaders including faith community and business representatives*
- Community health care center representatives including FQHCs
- Substance use treatment providers
- Hospital planning agencies and health care planning agencies
- Intervention specialists
- CDC- funded local education agencies/academic institutions
- Mental health providers

- Individuals/representatives with an HIV diagnosis during incarceration (w/in the last 3 years)
- Representatives from state or local law enforcement and/or correctional facilities
- Social services providers including housing and homeless services representatives
- Local, school-based clinics; healthcare facilities; clinicians; and other medical providers
- Medicaid/Medicare partners (at the State level only)

Key Stakeholders Included in Community Engagement Efforts

- Existing community advisory boards
- Community members resulting from new outreach efforts
- Community members that represent the demographics of the local epidemic (e.g., race, ethnicity, gender, age, etc.)
- Community members unaligned/unaffiliated with agencies funded through HRSA or CDC
- STD clinics and programs
- Other key informants
- City, county, tribal, and other state public health department partners
- Local clinics and school-based healthcare facilities; clinicians; and other medical providers
- Correctional facilities, juvenile justice, local law enforcement, and related service providers
- Community- and faith-based organizations, including civic and social groups
- Professional associations
- Local businesses
- Local academic institutions
- Other key informants

B. PART A PLANNING COUNCIL ROLE

The Part A Planning Council currently serves as the coordinating entity for the Integrated Plan including funding for annual needs assessment and integrated planning activities, as well as professional planning staff that operates under the direction of the RWHAP Part A HIV Planning Council. The role of the Integrated Work Group is documented in the RWHAP Part A HIV Planning Council By-Laws as follows:

Membership. The workgroup will be composed of the Prevention, Part A, and Part B programs, with three members and one alternate representing their respective planning or advisory body, as applicable. Members from the Part A program may include HIVPC members, committee members, or other appropriate community stakeholders, such as HOPWA/housing; FQHC/Hospital districts; Broward County Public Schools; Funded community-based service providers; Behavioral health providers; Client engagement systems, including linkage and re-linkage to care and retention in care; Community leaders. Part A members will be selected for recommendation by the Executive Committee but must be approved by the HIVPC. The desired membership of the work group should be reflective of the demographics of the epidemic in

Broward County, and consideration shall be given to race, ethnicity, self-acknowledged HIV-positivity, and gender.

Purpose. The workgroup will monitor and provide recommendations for completing the activities outlined in the Broward County Integrated HIV Prevention and Care Plan. The workgroup will conduct a comprehensive analysis and review of data from community stakeholders to provide robust recommendations to the Prevention and Care planning bodies and the Recipients. The workgroup will serve as the feedback loop for the collaborative implementation of the Plan and make appropriate recommendations to the respective planning bodies and HIV funders.

Flow of Information. The workgroup is expected to interact with numerous Prevention, Part A and Part B teams, work groups, and committees. The workgroup's main point of contact and coordination will be the Executive Committees of the HIVPC, Prevention Planning Council, and South Florida AIDS Network (SFAN).

Ratification. The work products of the work group are provided to the HIVPC, Prevention Planning Council, and SFAN in the form of recommendations which are subject to the approval of the respective planning body.

C. PLANNING BODIES & OTHER ENTITIES' ROLE

CDC Prevention Program and RWHAP Part B Planning Bodies

As discussed previously, CDC Prevention Program and RWHAP Part B planning bodies are equal partners in the Integrated Planning Workgroup tasked with developing the Integrated Plan. Each of the three HIV planning bodies conducted needs assessment and community engagement activities to ensure a wide range of input and feedback. The results of those efforts play a critical role in informing the Integrated Plan's development. All members of the three planning bodies were invited to participate in Integrated Planning retreats. Additionally, the draft versions of the Integrated Plan were shared with each of the planning bodies for review feedback and concurrence.

Broward Integrated Planning Workgroup Representatives/Members

Planning Body	*Name*
Part A	Lorenzo Robertson, HIVPC Chair (Alternate: Von Biggs, HIVPC Vice-Chair)
Part A	Ronald Bhrangger, HIVPC Member
Part A	Tom Pietrogallo, HIVPC Member
Part B	Joey Wynn, SFAN Chair
Part B	Greg Beltran, SFAN Member
Part B	Ashley Mayfair, SFAN Member
Prevention	Brad Barnes, BCHPPC Member (HIVPC Priorities Chair)

Prevention	Tatiana Williams, BCHPPC Member
Prevention	Alexandru Abelquader, BCHPPC Member, State PCPG and PPG member

Two of the Integrated Planning Workgroup members, as well as representatives from the RWHAP Part A and Prevention Recipients' offices, are members of the statewide Florida Comprehensive Planning Network (FCPN), the body responsible for developing the State of Florida's Integrated HIV Care and Treatment Plan and the Statewide Coordinated Statement of Need.

The State of Florida's HIV Prevention and Care Planning Body, the Florida Comprehensive Planning Network (FCPN), is composed of the Patient Care Planning Group (PCPG), and Prevention Planning Group (PPG). As their titles indicate, the PCPG focuses on care and treatment issues and the PPG on prevention. Within these groups are representatives from all parts of the Ryan White Program, Federally Qualified Health Centers (FQHC), state and local government, academia, service providers, consumers, and advocates. During the development of the State of Florida Integrated HIV Prevention and Care Plan, bi-annual face-to-face statewide meetings FCPN were held.

Florida Comprehensive Planning Network (FCPN) - Broward Representatives

FCPN Seat/Planning Body	*Name*
FCPN/SFAN (Part B)	Joey Wynn
Patient Care/SFAN (Part B)	Kim Saiswick, Holy Cross Hospital
Patient Care/SFAN (Part B)	Greg Beltran (Alternate)
Prevention/BCHPPC	Brad Barnes, Poverello Food Bank
Prevention/BCHPPC	Alexandru Abelquader, IMG HELPS (Alternate)
FDOH Prevention Recipient	Quasia Cowan, FDOH Broward
FDOH Prevention Recipient	Krystle Kirkland-Mobley, FDOH-Broward (Alternate)
RWHAP Part A Recipient	Jessica Roy, Broward County Government
RWHAP Part A Recipient	Glenroy James, Broward County Government (Alternate)

EHE Planning Body Collaboration

For the Florida Unified EHE Plan, the statewide planning body— Florida Comprehensive Planning Network (FCPN)—served as the designated entity to certify concurrence with the strategies and activities included in the plan. In addition, the State Health Office organized an internal taskforce to actively work on developing the statewide EHE committee. While the State Health Office is working to establish a statewide EHE committee that will be used for all EHE jurisdictions, as Broward does not have a separate EHE planning body.

D. COLLABORATION With RWHAP PARTS

Each of the Ryan White Recipients (Part B, Part C, Part D and Part F) as well as the Prevention and Housing Opportunities for People with AIDS (HOPWA) Recipient are RWHAP Part A HIV Planning Council (HIVPC) members. Each of the Recipients provide reports to the HIV Planning Council on the following: service category funding and utilization by demographics; program outcomes; and identified barriers. This information is used in the Part A needs assessment, priority setting, resource allocation and comprehensive planning process.

E. ENGAGEMENT: PEOPLE LIVING WITH HIV

The purpose of this subsection is to describe how the jurisdiction 1) engaged people with HIV in all stages of the process, including needs assessment, priority setting, and development of goals/objectives; and 2) how people with HIV will be included in the implementation, monitoring, evaluation, and improvement process of the Integrated Plan. The jurisdiction engaged people with HIV in all stages of the process, including needs assessment, priority setting, and development of goals and objectives.

Engagement of PWH in Needs Assessment

Each of the three local HIV planning bodies conducted needs assessment activities including surveys, focus groups, community conversations and town halls to engage PWH. The Part A Planning Council engages PWH in needs assessment activities as required by the Ryan White legislation, while the local Part B and Prevention advisory bodies' activities are typically part of the larger statewide FCPN needs assessment activities.

However, the FDOH-Broward conducted an extremely thorough and far-reaching set of needs assessment activities to inform the development of the Ending the Epidemic Plan. From October 2019 through October 2020, surveys were used to collect community input on HIV prevention services and activities needed in Broward County. A total of 2,106 surveys were collected, with the bulk coming from community members identifying as members of Broward's prioritized populations. Responses from these surveys along with the outcomes of other engagement activities—provided prior to the reporting period—were used to formulate Broward County's EHE plan. *The following* PWH priority populations were engaged during needs assessment activities:

- Aging Population
- Black Heterosexual Men
- Black Heterosexual Women
- Hispanic/LatinX Heterosexual Men/Women
- Hispanic/Latino MSM Black MSM

- Homeless Community
- Transgender
- Young Black MSM
- Young Hispanic MSM
- Youth/Adolescents

The FDOH-Broward Prevention Recipient utilized all the following activities to engage the community in the EHE needs assessment:

• Focus groups and interviews
• Town hall meetings
• Topic-focused community discussions
• Community advisory group, ad hoc committees, and panels
• Collaboration building meetings with new partners
• Public planning body meetings
• Social media events

Engagement of PWH in Priority Setting

Activities to determine priorities of PWH were conducted during the extensive Ending the Epidemic needs assessment activities. The RWHAP Part A and Part B consumer surveys included a section which asked consumers to rank service categories. Additionally, the Part A HIVPC Consumer Engagement Community (CEC) ranks service priorities annually. This information was presented at the Integrated Planning retreat.

Engagement of PWH in Development of Goals of Objectives

Each of the local HIV planning bodies, ensure Persons Living with HIV who are reflective of the local epidemic, are recruited, engaged, and hold leadership positions. The Part A Planning Council's Community Empowerment Committee (CEC) hosted a series of Community Conversations to engage consumers in the development of the Integrated HIV Plan. These sessions successfully gathered community feedback and identified gaps in the provision of care. The CEC will continue hosting sessions through the end of the calendar year. Six Community Conversations and one Town Hall were held from April through October 2022:

• Youth Awareness Community Conversations (4/12/22)
• Ryan White Part A HIV Town Hall Meeting (4/14/22)
• Transgender HIV Testing Day (4/18/22)
• Long-Acting HIV Treatment Regimen Presentation (5/17/22)
• Long-Term HIV Survivors (LTS) (6/14/22)
• HIV Faith Awareness Day (8/9/22)

"Leather Kink in Healthcare: What Should Your Provider Know?" (10/18/22)

Role of PWH in Implementation, Monitoring, & Evaluation of the Plan

People with HIV are included in the implementation, monitoring, evaluation, and improvement process of the Integrated Plan through their roles in the local HIV planning bodies, their leadership roles in the Integrated Workgroup, and their feedback at community engagement activities.

Each of the three local bodies additionally engage PWH in Integrated Planning efforts through the workplans of the consumer-led and focused committees and subcommittees.

The HIV prevention body has several committees focused on the engagement of individual priority populations, including the Black AIDS Advisory Council (BAG); Broward County Public Schools HIV Advisory Youth Workgroup; Latinos en Acción; Men who have Sex with Men (MSM) Advisory Group; Perinatal Advisory Group (PHPN); and the Transgender Health in Action (THIA).

The Black AIDS Advisory Council (BAAG) seeks to strengthen Black leadership, link Black PWHA into care, raise HIV science literacy, and mobilize communities to advocate for policy and research priorities. While implementing core components of PS12-1201, BAAG aims to reduce new infections and eliminate racial/ethnic HIV/AIDS disparities within the Black community.

The Broward County Public Schools HIV Advisory Youth Workgroup *serves* the District and Broward County as an advisory and action group. Engaging and empowering youth to increase HIV/AIDS/STI awareness and testing is an objective of this workgroup.

Latinos en Acción is a coalition of Latino community members, representatives from Latino-serving organizations, and the Florida Department of Health in Broward County. Latinos en Acción utilizes High Impact Prevention strategies to improve HIV health outcomes for Latinos in Florida while implementing core components of PS12-1201.

In implementing the core components of PS12-1201, the Men who have Sex with Men (MSM) Advisory Group organizes thought leaders and decision-makers to fully mobilize the MSM community in Broward County and build capacity to address the various factors that facilitate HIV infection in the MSM community.

The Perinatal Advisory Group (PHPN) ensures implementation of PS12-1201 core components while providing education on perinatal HIV to the community, yearly updates to medical providers, and seeking to increase testing and awareness for women of childbearing age.

Transgender Health in Action (THIA) provides peer-on-peer assistance as well as collaborative educational workshops specific to the transgender community in the implementation of core components of PS12-1201. In addition, THIA addresses health, safety, prevention, testing, and stigma issues and provides mentorship to reinforce a sense of self-worth and positive well-being.

F. PRIORITIES

The following section summarizes key priorities identified during the Community Conversations led by the Part A Consumer Engagement Committee (CEC) Committee between April and August 2022.

1. Long-Term HIV Survivors (LTS) and Over 50 Population

Develop targeted mental health services for LTS and the over 50 Population.

- Provide more mental health services for LTS Long-Term HIV Survivors (LTS) and the Over 50 Population. The complications of growing older (aside from their HIV diagnosis) and being lonely can be detrimental to their mental health. This ultimately might be a barrier to remaining in care or continuing their ARV-becoming hopeless in life.
- Create more support groups for long-term HIV survivors.

<u>Provide education regarding Medicare enrollment to providers and consumers.</u>

- Develop provider and case manager trainings on what to expect regarding their clients' Medicare eligibility and enrollment process.
- Develop eligibility protocols to educate clients about eligibility for Medicare coverage and the penalties for missing application deadlines or for not selecting the correct plan.

2. Transgender/Persons with Trans Experience

Resources should be utilized to assess why members of the transgender community are not utilizing HIV testing and prevention resources.

<u>Make HIV Services a Safe Space</u>

- Persons who identify as transgender are discriminated against, and when diagnosed with HIV, they are further discriminated against and stigmatized.
- Immigration is an issue; they fear being deported and do not seek HIV medical care.
- The transgender community does not feel comfortable attending their scheduled appointments, which deters them from attending future health appointments.
- Revise the cultural competency curriculum and provide training providers regarding the transgender community.
- Be more creative in dismantling systems and allow a safe space for the transgender community to access services without judgment and oppression from providers.

<u>Address Unstable Housing, including Shelters</u>

- Housing is a huge issue within the Transgender community. They are displaced from homeless shelters and have no place to go, resulting in homelessness.
- Allocate more funding to Housing services.

Increase Engagement and Representation in HIV Planning

- The transgender community would like more visibility on the Planning Council to voice their concerns and challenges. They would like to advocate and have a seat at the table.
- More outreach work needs to be continued within the community, and more representation on the Council to advocate the needs of the transgender community.
- Recommendation: When unifying forces within the Broward community to end the HIV epidemic, conversations should include the transgender community.

3. Youth Population

Stigma is a barrier to accessing prevention and treatment services.

- Have more hands-on education in schools and a safe place to discuss their concerns.
- Create more accessible sexual health resources.
- Increase the inclusion of educational materials on social media sites that youth utilize.

Lack of awareness of services and understanding of how to access transportation are barriers.

- Make more applications available online and offer "Question and Answer" chats.
- Increase dialogue with youth.
- Create a seat at the table for youth to share their opinions and voices in a safe environment free of judgment and consequences.
- Provide youth with monetary incentives to retain them in care.

Family plays an important role for youth in accessing prevention and treatment services.

- Educating the family members, parents, and guardians, is important. Public health professionals need to understand the older generation, the cultural differences presented within this community, and how to best communicate the needs of the youth to the older generation.
- Develop educational programs for parents and guardians on sexual health topics to create a safe space for parents/guardians and their youth to have healthy dialogue.

4. Leather Kink in Healthcare: What Your Provider Should Know

The leather community would like more visibility to voice their concerns and challenges related to the stigma that they experience when people discover they are part of this community. Some members of the leather community do not feel comfortable when attending their scheduled appointments and do not know the best way to communicate their risk factors with their providers. Not all providers are aware of the risk factors that members of the leather community have, and what activities they partake in which affect

the care they provide. Members discussed how to have open conversations with providers to ensure they are receiving the best care possible, and not be afraid to change providers until they find the one right.

Recommendations

• Educate staff at the provider agencies on cultural competency for the leather community.

• Create safe spaces for people who want to engage with the leather community but do not know how or where to start. Being open and honest with providers is the only way for growth and learning to take place.

Address stigma about the community through education via more events, outreach, and networking. A second event like this should occur to be able to continue this conversation with medical providers and other primary providers present to move this conversation forward.

G. UPDATES TO OTHER STRATEGIC PLANS USED TO MEET REQUIREMENTS

As stated previously, the local Prevention and Part A Ending the Epidemic (EHE) Plans are incorporated into the Integrated HIV Prevention and Care Plan CY 2022-2026. In addition, the Part A and Prevention Recipients host quarterly online community EHE town halls to engage the community in monitoring the progress of activities and to provide feedback. The Recipients also provide updates to the three local HIV planning bodies.

SECTION III: CONTRIBUTING DATA SETS & ASSESSMENTS

1. Data Sharing and Use

The purpose of the data sharing and use section is to provide an overview of data available to the jurisdiction and how data were used to support planning.

Overview of Data Available

The following data sets were available to inform the development of the Integrated HIV Plan:

- Epidemiological Profile for Broward County
- Continuum of Care Data (including Viral Load Suppression)
    - Community Level Continuum of Care Data
    - RWHAP Part A Continuum of Care Data
    - RWHAP Part A Clinical Quality Management (CQM) Data
- HIV Prevention and Care Needs Assessment Results
    - Ending the Epidemic (Prevention) Needs Assessment
    - RWHAP Part A Needs Assessment
- HIV Service Category Expenditures and Utilization
    - Housing Opportunities for People with AIDS (HOPWA)
    - Prevention
    - RWHAP Parts A-F and AIDS Drug Assistance Program (ADAP)
- Other Service Funding Data
    - Other CDC Funding
    - Other HRSA Funding
    - Other Mental Health and Substance Abuse Funding

How Data Were Used to Support Planning

The epidemiology, service utilization, clinical outcome, consumer assessment, and other relevant data were used to identify trends, and gaps in the Continuum, and prioritize the needs of Persons Living with HIV in Broward (PWH).

The Continuum will continue to implement and sustain a seamless system of care, from initial HIV diagnosis through high-quality care, treatment, and support services. Integrated planning and service coordination between the HIVPC, Broward County HIV Prevention Planning Council (BCHPPC), South Florida AIDS Network (SFAN), and Housing Opportunities for People with AIDS (HOPWA) will further the jurisdiction's progress in improving outcomes along the Continuum.

The HIV Care Continuum was used to Plan, Prioritize, and Monitor Resources. The Continuum framework helps to plan, prioritize, and monitor available resources in response to the needs of

HIV+ Broward residents and improves engagement at each Continuum stage. The framework allows Recipients and other stakeholders to measure progress and optimize HIV resources. The Part A Recipient and HIVPC evaluate efforts to impact the Continuum by routinely monitoring health outcomes, performance measures, and indicators at each Continuum stage. The Part A CQM Program, QI Networks, HIVPC, and standing committees all play a role in the overall evaluation of efforts designed to impact the Continuum.

Collaboration between all funding streams was promoted by integrating CDC-funded prevention service data with RWHAP- funded service data in presentations that informed the planning process. Each entity, including all RWHAP Part A Recipients, prevention, and HOPWA, evaluates those stages of the Continuum addressed by Part A (i.e., retention in care, prescribed ARVs, and viral suppression) to identify health disparities and areas of improvement needed along the Continuum.

The Integrated Planning Workgroup used service utilization and clinical quality management data to evaluate the Continuum and identify service gaps and needed resources. The Workgroup reviewed scorecards for each Part A service category, including viral suppression rates for subgroups by service category, to identify disparities and needed improvements. Part A Continuum data and HAB performance measures were compared to prevention, care, and treatment measures and national benchmarks.

Data Sharing Agreements

In November of 2022, two-party Data Sharing Agreement (DSA) between the Ryan White Part A Program and FDOH, was implemented to assist the Part A Program with Linkage to Care Activities to track patient linkage to care. FDOH will match Client Care Data received from the County each quarter, to assist the County with Linkage to Care Activities for the purpose of to track care. Client Care Data: Client information including demographics, contact information, personal identification information, date of last contact and/or care event, and out of-care status. Linkage to Care Activities: A program that seeks to increase the number of people diagnosed and living with HIV who are linked to HIV-related medical care and treatment. Linkage to Care Activities are performed by County staff and community partners including case managers, medical providers, prevention providers, and patient care coordinators who link those persons with HIV to medical care and treatment. Data Elements provided by FDOH:

1) HIV care status and lab Information

   a) Current care status (in care or not in care) determined by last HIV-related care date

   b) Most recent HIV-related care date for clients not in care

   c) Most recent CD_4 lab date and result for clients not in care

   d) Most recent viral load lab date and result for clients not in care

2) Provider information

a) Name of most recent HIV-related medical care provider for clients not in care

b) Name of most recent case management agency and date of last case management service for clients not in care

3) Client locating information

a) Current address and phone number for clients not in care who currently reside in the Part A service area

b) Current state of residence for clients who are in care or currently do not reside in the Part A service area

4) Vital status

a) Vital status (alive or dead)

b) Date of death

c) Source of death information

2. EPIDEMIOLOGIC SNAPSHOT

The data described in this section was the most current available when this section was written in June of 2021 when the Integrated Plan Guidance was released. The most recent epidemiolocal data is included as an attachment to the Integrated Plan. The Epidemiologic Overview narrative will be updated during the next Ryan White Part A fiscal year.

Broward County is located on FL's southeastern coastline, with Miami-Dade County to the south and Palm Beach County to the north. The US Census estimates that in CY 2018, Broward had a population of over 1.9 million- a 12% increase over CY 2010. It is the second most populous FL county.

The Broward County population has achieved significant racial and ethnic diversity. The CY 2021 US Census reported that among 1.93 million Broward residents, 36% were White non-Hispanic/Latinx, 30% Black non-Hispanic/Latinx, and 30% Hispanic/Latinx. Thus, Broward has a "majority of minorities," with rates of racial/ethnic minority residents exceeding that of White non-Hispanic/Latinx. The Census also reports that 42.8% of Broward residents speak a language at home other than English. The evolving Broward population's demographic characteristics are driven by the immigration of foreign-born minorities and includes residents representing over 200 different countries and speaking over 130 languages. In-migration from other US states and territories also contributed to Broward's diverse population.

The HIV/AIDS epidemic reflects the racial/ethnic diversity of Broward's population. FDOH epidemiologic data document significantly higher HIV disease prevalence rates and the disproportionate impact of the epidemic on vulnerable Broward populations. The Broward

HIV/AIDS epidemic disproportionately impacts specific sociodemographic groups. HIV/AIDS rates vary significantly by age, gender, and race/ethnic groups. Trends are most apparent in the incidence and prevalence case rates of youth and aging residents, as well as racial, ethnic, and sexual minorities.

Persons Newly Diagnosed with HIV

Incidence measures the number of persons testing HIV+ in the year they were first diagnosed, regardless of their AIDS status at the time of HIV diagnosis. The CDC reports that Miami/Dade and Broward Counties had population-adjusted HIV incidence rates that were consistently higher than other US Metropolitan Statistical Areas (MSAs) in the last two decades. Broward's HIV population-adjusted incidence rates ranked first or second among MSAs nationally for CY 2008-2018.

FDOH epidemiologic data reflect the impact of Broward's primary and secondary prevention efforts to reduce the rate of new HIV+ infections. Short-term trend analysis shows that Broward experienced a 12% decrease in new HIV cases between CY 2017-2019. Broward's population-adjusted incidence rates dropped from 37.7 per 100,000 population in CY 2017 to 33.6 in CY 2018, and 32.4 in CY 2019. Longer term trend analysis provides a more in-depth understanding of Broward HIV incidence rates. Since CY 2015, the population-adjusted HIV incidence rate rose from 35.5 to 40.0 per 100,000 population in CY 2016. Rates then slowly declined until CY 2019 with a rate of 32.4 per 100,000 population.

Racial/Ethnic Diversity

HIV incidence rates reflect the Broward population's racial/ethnic diversity. In CY 2019, White non-Hispanic/Latinx made up 19% of HIV incidence cases, compared to Black non-Hispanic/Latinx (45%), Hispanic/Latinx (34%), and other non-White races (3%). In CY 2019, Black non-Hispanic/Latinx had an HIV incidence rate of 50.9 per 100,000 population, compared to 36 for Hispanic/Latinx and 17.1 for White non-Hispanic/Latinx.

Trend analysis helps to understand the extent to which racial/ethnic characteristics of new HIV cases changed over time. Between CY 2017-2019, the percentage of HIV new cases dropped for White non-Hispanics (28%) and Black non-Hispanics (16%), while rising 11% for Hispanics.

Longer term trend analysis shows an even more dramatic decrease in new HIV cases in the White non-Hispanic/Latinx group. Between CY 2015-2019, new HIV cases dropped 33% for White non-Hispanics and 9% for Black non-Hispanics, while rising 34% for Hispanics/Latinx. In CY 2015, 27% of new HIV cases were White non-Hispanic/Latinx, 47% were Black non-Hispanic/Latinx, and 24% were Hispanic/Latinx. By CY 2019, 19% of new HIV cases were White non-Hispanic/Latinx, 45% were Black non-Hispanic/Latinx, and were 34% Hispanic/Latinx. In other words, the proportion of new HIV cases among White non-Hispanic/Latinx contracted significantly within five years.

HIV Incidence by Sex at Birth

Newly identified HIV+ Broward cases are disproportionately male. In CY 2019, 78% of new HIV cases were male, while 22% were female. Between CY 2017-2019, new male HIV cases dropped 13% versus 9% new female cases.

HIV Incidence by Age

New HIV cases among newborns and children have dropped considerably since the onset of the HIV epidemic, associated with substantial efforts to provide prenatal counseling and perinatal and postnatal ARV treatment. No new HIV cases among children < 13 years were reported in CY 2018-2019. Among adolescents and adults, new HIV cases decreased significantly from CY 2018-2019 for individuals 25-29 years of age (31%), while individuals 55+ years of age experienced a 22% increase.

HIV Exposure Factors

Among new male HIV cases in CY 2019, 69% reported HIV exposure via MMSC, 26% heterosexual exposure, 3% through injection drug use (IDU), and 3% MMSC/IDU. Among new female HIV cases, 91% reported heterosexual exposure and 9% IDU. Between CY 2017-2019, new HIV cases among adolescent/adult males associated with IDU increased 63%, 14% for heterosexual exposure, and 46% for MMSC/IDU, versus a 22% decrease for MMSC. Among adolescent/adult females, new HIV cases increased 71% for IDU and decreased 10% for heterosexual exposure.

Short and longer-term trend analysis provides insight into the relationship between race/ethnicity and HIV exposure from MMSC. New HIV cases among adolescent/adult males with MMSC decreased 45% from CY 2015-2019 among White non-Hispanic/Latinx, compared to a 4% decrease for Black non-Hispanic/Latinx and an increase of 28% among Hispanic/Latinx. New HIV cases increased 12% from CY 2017-2019 among adolescent/adult Black non-Hispanic/Latinx males with heterosexual HIV exposure factor. Small case counts prevented in depth trend analysis for other sex and exposure factor groups.

Persons Newly Diagnosed with AIDS

AIDS is commonly preventable if HIV+ individuals have access to HIV OAHS, ARVs, and prophylaxis medications for AIDS-related opportunistic infections (OIs). The CDC reports that Broward ranked third in population-adjusted AIDS cases in CY 2017, the most recent national data available. A total of 291 Broward residents were diagnosed with AIDS in CY 2019, or 15.1 cases per 100,000 population. Among AIDS cases diagnosed in CY 2019, 56% were Black non-Hispanic/Latinx, 23% White non- Hispanic/Latinx,17% Hispanic/Latinx, and 3% other races/ethnicities. Almost three-quarters (72%) of CY 2019 AIDS cases were male, versus 29% female. Among male AIDS cases diagnosed in CY 2019, 62% were reported to have been

exposed to HIV via MMSC and 31% from heterosexual exposure. Among newly diagnosed women with AIDS in CY 2019, 87% were reported to have been exposed to HIV via heterosexual contact, 12% IDU, and 1% other HIV exposure factors.

Among adult AIDS cases in CY 2019, 15% were between 20-29 years of age, 23% between 30-39, 19% between 40-49, 25% between 50-59, and 17% 60+ years of age. New AIDS case rates rose 7% between CY 2017-2019. AIDS case rates varied by demographic and HIV epidemiologic group.

Newly Diagnosed AIDS by Race/Ethnicity

White non-Hispanic/Latinx AIDS cases rose 5% between CY 2017-2019, compared to 7% of Black non-Hispanic/Latinx. Among Hispanic/Latinx, the number of AIDS cases increased 25%.

Newly Diagnosed AIDS by HIV Exposure Group

Between CY 2017-2019, AIDS cases increased among adolescent/adult male exposure groups, including 25% MMSC, 14% IDU, and 8% heterosexual exposure category. In contrast, new AIDS cases related to MMSC/IDU dropped 17% between CY 2017-2019. Among adolescent/adult women, AIDS cases increased 400% in the IDU category, while decreasing by 7% in the heterosexual exposure category.

Persons Living with HIV (PWH)

The prevalence rate represents PWH through the end of the CY (regardless of where they were diagnosed). The CDC reports that Broward's prevalence case rates ranked first or second among MSAs nationally for much of CY 2008-2017, the most recent data available. There was an HIV prevalence of 20,507 (PWH) in CY 2019. FDOH reported no significant changes in the number of HIV or AIDS prevalence cases between CY 2017-2019.

Table 1 HIV Prevalence

	CY 2017	CY 2018	CY 2019
HIV (PWH)	20,480	20,453	20,507
AIDS (PWA)	10,518	10,444	10,423

Sex at Birth

In CY 2019, 75% of Broward PWH were male and 25% women, with population-adjusted case rates of 1,631.4 versus 525.4 per 100,000 population. The number of PWH rose < 1% among males and females between CY 2017-2019.

Race/Ethnic Group

In CY 2019, Black non-Hispanic/Latinx were 47% of PWH, compared to 32% White non-Hispanic/Latinx and 19% Hispanic/Latinx. When adjusting for the variable sizes of Broward racial/ethnic populations, White non- Hispanic/Latinx had a rate of 943.3 per 100,000 population

compared to 1753.3 for Black non- Hispanic/Latinx, and 674.8 for Hispanic/Latinx. White non-Hispanic/Latinx PWH decreased by 5% between CY 2017-2019, compared to a 1% increase among Black non- Hispanic/Latinx PWH and 8% of Hispanic/Latinx PWH.

Age Group

FDOH reported that < 1% of PWH < 13 years of age resided in Broward in CY 2019. An additional 2% of PWH were between 13-24 years of age, 12% were 25-34, 16% were 35-44, 45% were 45-59, and 25% were > 60 years. The percentage of PLOW decreased for most age groups between CY 2017-2019. Increases in PWH were reported, however, for the > 60 group (5%).

Exposure Category

All 15 pediatric PWH living in CY 2019 were perinatally exposed. Among adolescent/adult male PWH living in CY 2019, 72% were reported to have been exposed to HIV via MMSC, 20% heterosexual exposure, 4% IDU, 4% MMSC/IDU, and < 1% in other categories. Between CY 2017-2019, increases in the number of PWH were reported in the MMSC and heterosexual categories (3%, respectively). Decreases in the number of PWH ranged from 7% for IDU to < 1% for other categories. Among adolescent/adult female PWH living in CY 2019, 88% were reported to be in the heterosexual category, 9% IDU, and 3% in other categories. In FY2017-2019, the number of female adolescent/adults PWH dropped 7% for IDU, 1% for the heterosexual category, and 2% for other categories.

Persons Living with AIDS (PWA)

PWA is a subset of PWH. Between CY 2017-2019, about half of Broward PWH met the CDC AIDS definition, including CD4 counts <200 copies/mL. PWA were 52% of PWH in CY 2017 and CY 2018 (respectively), with a slight drop in CY 2019 (51%). Trends in PWA cases reflect the large number of PWH diagnosed with AIDS before introduction of ARVs. These individuals benefited from ARVs and AIDS prophylaxis medications, resulting in extended survival. The rate of PWA also reflects the more recent advanced stages of HIV immunocompromise among some PWH upon initial linkage to OAHS or that have returned to care after long periods without ARV treatment.

PWA Sex at Birth

In CY 2019, 72% of Broward PWA were male and 28% women, with population-adjusted case rates of 801.8 versus 293 per 100,000 population, respectively. The number of PWA dropped < 1% among males and rose < 1% among females between CY 2017-2019.

PWA Race/Ethnic Groups

In CY 2019, Black non-Hispanic/Latinx were 52% of PWA, compared to 30% White non-Hispanic/Latinx, and 16% Hispanic/Latinx. When adjusting for the variable sizes of Broward racial/ethnic group, White non-Hispanic/Latinx had a rate of 448.5 population compared to

992.5 for Black non-Hispanic/Latinxs per 100,000 population, and 281.3 for Hispanic/Latinx. The number of White non-Hispanic/Latinx PWA decreased 1% between FY2017-2019, compared to a 1% increase among Black non-Hispanic/Latinx PWA and < 1% of Hispanic/Latinx.

PWA Age Group

FDOH reported that three PWA < 13 years of age resided in Broward in CY 2019. An additional 1% of PWA were between 13-24 year of age, 6% were 25-34, 13% were 35-44, 49% were 45-59, and 31% were > 60 years or older. The percentage of PWA decreased for all age groups between CY 2017-2019 except for the > 60-year age group (6%).

PWA Exposure Category

All three pediatric-exposed PWA living in CY 2019 were perinatally exposed. Among adolescent/adult male PWA living in CY 2019, 65% were reported by FDOH to have MMSC, 24% heterosexual, 5% IDU, 5% MMSC/IDU, and < 1% in other categories. Between CY 2017- 2019, a slight increase in the number of PWA were reported in the MMSC and heterosexual categories (< 1% and 2%, respectively).

Decreases in the number of PWA ranged from IDU exposure category to 5% for the other exposure category. Among adolescent/adult female PWA living in CY 2019, 86% were reported in the heterosexual category, 11% IDU, and 4% in other categories. The number of adolescent/adult female PWA dropped 8% in IDU while increasing 8% in the heterosexual and 6% in other risk categories, respectively.

Persons at High HIV Risk

Throughout Broward's HIV epidemic adolescent/adult males with MMSC have been significantly impacted, including racial/ethnic minority MMSC. The Broward HIV epidemic reflects the uniquely large lesbian, gay, bisexual, transgender, and questioning (LGBTQ) communities in the county. Fort Lauderdale ranks first among mid-sized cities for population-adjusted rates of same-sex couples per 1,000 households, while Hollywood, FL ranks 24th among same-sex couples. Among small cities with populations < 100,000, Wilton Manors ranks 2nd and Oakland Park ranks 10th for population-adjusted rates of same-sex couples per 1,000 households. Broward has an estimated 9,125 same-sex households or 1% of Broward households. Broward is home to the International Gay and Lesbian Travel Association, which reports that > 12.8 million tourists visit Broward annually, including 1.5 million LGBTQ visitors.

The CDC reports that transgender women in the US are at high-risk for HIV. It is estimated that Black/African American transgender people comprise > 56% of all HIV+ transgender people.

Accurate population and HIV epidemiologic data are not available to assess the number of transgender residents and assess their HIV prevention and care needs. Alternatively, the Broward Part A Program collects transgender data through Provide Enterprise (PE), the client-

level database used by RWHAP recipients, Subrecipients, and the HOPWA program in Broward. A total of 60 transgender Part A clients were served in FY2019.

HIV Transmission Clusters and Networks

One aspect of the State and Local EHE plan is to detect and respond to rapidly growing HIV transmission clusters and networks and prevent future HIV diagnoses using data and laboratory results collected through routine public health surveillance. Cluster network analyses are conducted using data from point-of-care HIV-1 genotypic resistance testing to identify genetic (molecular) links of similar virus strains by comparing those with similar HIV genetic sequences; those data are then used to identify networks of recent and rapid transmission for prevention and linkage-to-care interventions. The observed HIV transmission rate in molecular clusters identified across the U.S. is on average 11 times higher than the transmission rate within the general HIV population according to the CDC thus indicating the importance to intervene quickly using proven interventions to stop further transmission of HIV. HIV molecular clusters are considered rapidly growing when there have been five or more new HIV diagnoses within the previous 12 months. Since the beginning of FDOH's cluster detection program in November 2017, the HIV/AIDS Section has identified 44 clusters at a 0.5 percent genetic distance between strains of HIV demonstrating rapid growth. These molecularly linked transmissions comprise a total of 739 persons receiving an HIV diagnosis in Florida with a much larger, often underdefined risk network. Though members of molecular clusters live across the state, 415 (56%) received a diagnosis in an EHE Phase 1 county. Furthermore, of those diagnosed and currently living in the state of Florida as of September 8, 2020, 482 (71%) have a current residence within one of the seven EHE counties.

Socioeconomic Status and HIV Infection

The US Census reports that the Broward median household income was $64,660 in CY 2021 dollars. Socioeconomic data for PWH are unavailable from FDOH. PE Part A household income data were assessed as a substitute. Less than a fifth (13%) of Broward households had an annual income < 100% federal poverty level (FPL), compared to 54% of Part A clients. Almost one-third (27%) of Part A clients are non-permanently housed.

Most (88%) Broward adults > 25 years or older had earned a high school diploma or higher, compared to 62% of Part A clients. The FL Legislature Office of Economic and Demographic Research reports that in August 2019 Broward's unemployment rate was 3%, compared to 29% of Part A clients. About 17% of Broward residents < 65 years of age were uninsured, compared to 42% of Part A clients. An additional 25% of Part A clients had private insurance, 20% Medicare, 9% Medicaid, and < 1% other public insurance.

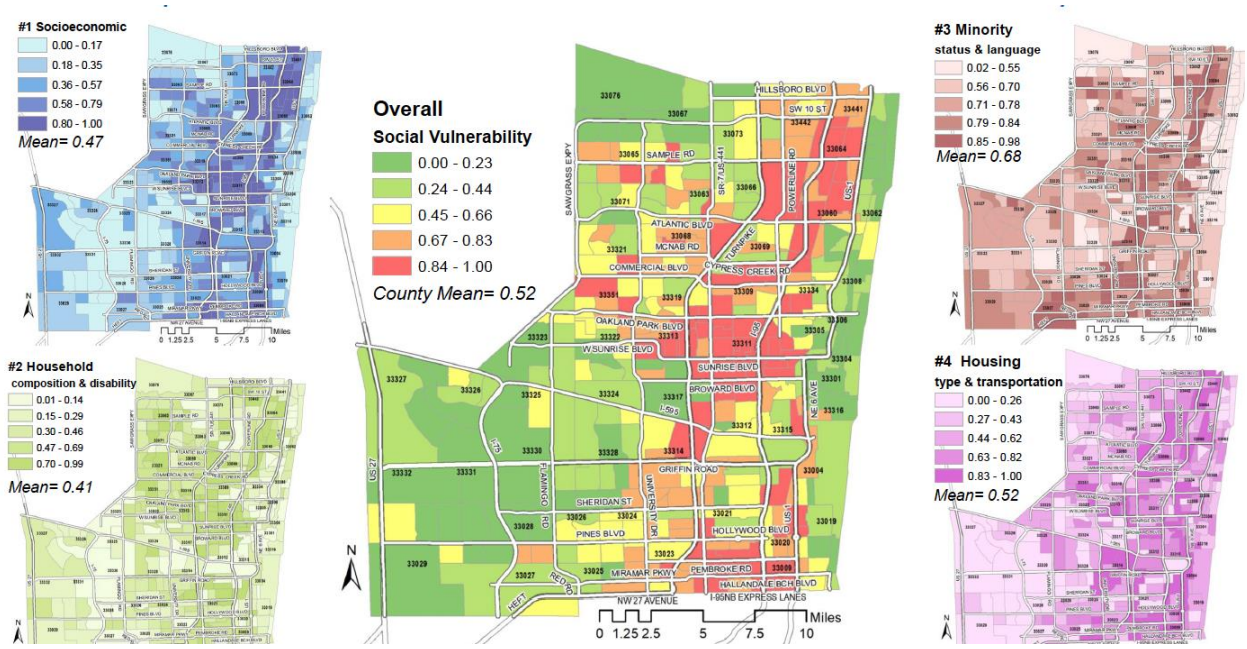
Social Determinants of Health, Social Vulnerability, and Geographical Disparities

Geographic mapping was conducted to depict the geographic variations in Social Determinants of Health (SDOH) using the Social Vulnerability Index (SVI) measure based on sixteen variables developed by the CDC and the Agency for Toxic Substances and Disease Registry (ATSDR).

The CDC/ATSDR SVI ranks each tract on 16 social factors, including poverty, lack of vehicle access, and crowded housing, and groups them into four related themes. Each tract receives a separate ranking for each of the four themes, as well as an overall ranking. The figure below shows overall social vulnerability by Census Tract and Zip Code using the Social Vulnerability Index (SVI) measure

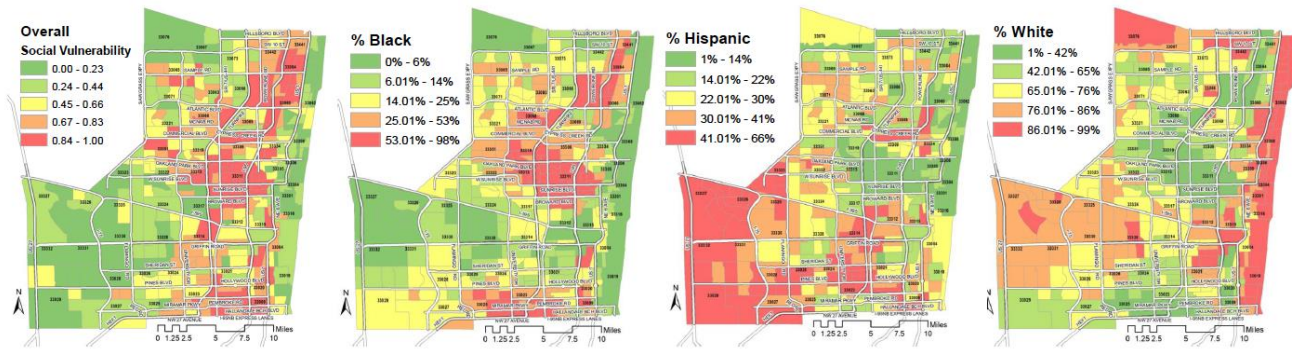
Geospatial Distribution of Social Vulnerability Index (SVI) Themes in Broward County

Figure 1 Geospatial Distribution of Social Vulnerability Index (SVI) Themes in Broward County



Data Sources: 2CDC/ATSDR/GRASP, U.S. Census Bureau, Esri® StreetMapTM Premium

Figure 2 Race, Ethnicity, and Social Vulnerability in Broward County



Data Sources: 2CDC/ATSDR/GRASP, U.S. Census Bureau, Esri® StreetMapTM Premium

Increase in HIV Diagnosed Cases Within New and Emerging Populations

HIV/AIDS disproportionately impacts specific Broward demographic and economic groups, as demonstrated by trends in the age, gender identity, race, and ethnicity of PWH. MMSC and heterosexual HIV exposure, particularly among racial/ethnic minorities, is associated with the highest HIV and AIDS incidence and prevalence rates among adolescent/adult males. The MMSC was associated with 72% of new HIV cases in CY 2019, 63% of new AIDS cases, 72% of HIV prevalent cases, and 65% of AIDS prevalent cases. Heterosexual exposure was associated with 23% of new HIV cases, 30% of new AIDS cases, 19% of HIV prevalent cases, and 24% of AIDS prevalent cases. The IDU was associated with 2% of new HIV cases, 4% of new AIDS cases, 4% of HIV prevalent cases, and 5% of prevalent AIDS cases. The MMSC/IDU exposure was associated with 3% of new HIV cases, 3% of new AIDS cases, 4% of HIV prevalent cases, and 5% of AIDS prevalent cases.

Race and ethnicity are strongly associated with HIV exposure factors among men, especially among MMSC and Black non-Hispanic/Latinx. FDOH reports that among White non-Hispanic/Latinx males in CY 2019, 86% reported MMSC as their HIV exposure category versus 8% heterosexual, 5% MMSC/IDU, and 1% IDU. Among Black non-Hispanic/Latinx males, 29% reported heterosexual exposure, 27% MMSC, 2% IDU, and 1% MMSC/IDU. Almost all (95%) of non-Hispanic/Latinx females reported heterosexual exposure. Among Hispanic/Latinx males, 85% reported MMSC exposure, 14% heterosexual, < 1% IDU, and < 1% MMSC/IDU. Heterosexual exposure is likely over-reported by Black non-Hispanic/Latinx and Hispanic/Latinx to avoid stigma and discrimination associated with being identified as homosexual or bisexual.

FDOH adult HIV infection trend data demonstrate that adults > 50 years or older are the fastest growing sector of the Broward adult HIV+ population, increasing from 54% in CY 2017 to 55% in CY 2017 and 57% in CY 2019. Aging of PWH, advances in HIV treatment, in-migration of MMSC and other older PWH, and Broward's popularity as a retirement community contribute to a growing rate of older HIV+ Broward residents.

In-migration Disproportionately Impacts the Broward HIV Epidemic

FDOH measured the number of PWH migrating to and within FL jurisdictions between CY 2014-2017. Broward consistently had the largest share of in-migrating PWH among FL Part A jurisdictions between CY 2014-2017. It is noteworthy that due to lags in HIV morbidity reporting, FDOH-BROWARD may be unaware of in-migrating PWH for months or years unless they are engaged by the healthcare system and tested for HIV. Thus, accounting for in-migrating HIV+ aware individuals currently in Broward may significantly underestimate the extent of the HIV epidemic and the scale-up required to achieve a virally suppressed HIV+ population.

Haitian-Born PWH Cultural, Linguistic, and Clinical Challenges

A large portion of Broward Black, non-Hispanic/Latinx PWH, and PWA were born in Haiti. The exact figures are unavailable from FDOH, and no timely Census population data are available. FDOH does report, however, that in CY 2019, 2,009 living PWH were born in Haiti, with 51% male and 49% female at birth. The number of living Haitian-born PWH increased by 3% between CY 2017- 2019. (It is important to note that FDOH only reports data on Haitian-born PWH and does not report similar data for PWH of Haitian descent born in the US).

In CY 2019, Haitian-born PWH represented 12% of total PWH and 10% of total PWA. Almost two-thirds (64%) of living Haitian-born PWH met the CDC AIDS criteria, significantly higher than the 51% of total PWH meeting the criteria. Haitian-born individuals made up 10% of new HIV cases and 13% of new AIDS cases in CY 2019. A large portion of Haitian-born RWHAP clients is reported by providers to speak only Creole or prefer to speak in Creole to their healthcare providers. Some Haitian-born clients are also reported to be reluctant to engage in HIV care due to HIV stigma and concern about disclosure of their HIV+ status to other members of the Haitian community. Recently, proposed federal policies that would revoke the visas of some Haitian immigrants have also negatively impacted attendance at medical visits and receipt of other RWHAP services. Avoidance of publicly funded services may also be associated with fear that Haitians may not be eligible for US naturalization.

HIV-Related Deaths

FDOH reported HIV/AIDS-related mortality deaths for CY1998-2017. Broward and FL HIV/AIDS population-adjusted death rates were compared. Broward population-adjusted HIV/AIDS death rates were significantly higher than the FL rates in the 19-year period. While the slope of FL HIV-related death rates decreased relatively smoothly between CY1998-2017, Broward HIV-related death rates decreased less smoothly. Broward and FL population-adjusted death rates decreased significantly for Broward and FL after CY 2006, with spiked increases in Broward rates between CY 2013-2014 and CY 2015- 2016, with death rates plateauing through CY 2017. Factors associated with HIV-related death will be assessed later in FY2020 to identify interventions that can be implemented by the Continuum.

Identifying Emerging Populations

Newly reported HIV and AIDS cases include the number of new cases reported in the CDC Electronic HIV/AIDS Reporting System (eHARS) as of August 2019 and excludes FL Department of Corrections (DOC) cases. AIDS, HIV, and HIV/AIDS living (prevalence) data include the number of cases reported to eHARS as of August 2019, and includes cases currently residing in Broward, regardless of where diagnosed. Inclusion of AIDS and HIV (not AIDS) data for current Broward residents helps measure the size of the HIV epidemic and assess and address the needs

of Broward PWH. Additional data on Broward PWH were collected in PE, the Part A management information system (MIS), statewide/local surveys, and FDOH data.

HIV Surveillance Data: CY 2019 co-morbidity data were captured in eHARS and Patient Reporting Investigating Surveillance System (PRISM) (as of August 2019). Among Broward PWH, 449 were diagnosed with infectious syphilis, 597 with gonorrhea, 569 with chlamydia, and 69 with hepatitis C virus (HCV). Among Broward PWH, 75 were reported to be homeless, 3,440 had a history of drug or alcohol abuse, and 979 had a history of chronic mental illness.

Additionally, 14 PWH were diagnosed with tuberculosis (TB), The population-adjusted rates per 100,000 population include 21.3 with infectious syphilis, 28.4 with gonorrhea, 27.0 with chlamydia, 3.3 with HCV, 3.6 with homelessness, 163.4 with a history of drug or alcohol abuse, and 46.5 with a history of chronic mental illness.

Co-Occurring Conditions

The table below outlines co-morbid conditions associated with HIV in Broward including rates of HCV, sexually transmitted infections (STIs), mental illness, substance use disorder, and homelessness. Data regarding previously incarcerated individuals are also summarized.

Table 2 Co-Occurring Conditions

HIV Prevalence	Number	Prevalence Rate Per 1k Living HIV Cases	Source
Prevalent HIV/AIDS through CY 2020	21,048		
HIV/AIDS w/ infectious syphilis	711	34.6	PRISM (As of 6/21)
HIV/AIDS cases reported w/ gonorrhea	647	31.5	
HIV/AIDS cases reported w/ chlamydia	541	26.3	
Hep C: HIV cases w/ acute or chronic HCV	70	3.4	eHARS
Homelessness: HIV cases noted as homeless	84	4.1	
Substance Abuse: HIV/AIDS cases noted w/ SA	3,181	154.9	
Chronic Mental Illness: HIV cases noted w/ MH	865	42.1	
Offenders Released to Broward Living w/ HIV	**Number**	**Rate Among PWH**	**Source**
CY 2020	60	2.9	FL DOC
CY 2019	64	4.4	
CY 2018	86	4.4	

Complexities of Providing Care

Estimates of Poverty and Healthcare Coverage Status: The table below shows the percentage of clients covered by Medicaid, Medicare, or private insurance, as well as uninsured clients in FY2019. The table also shows the percent of clients with household income ≤ 100% of FPL- and 101 - 400% of FPL- the income corridor for enrolling in an ACA QHPs.

Unmet Need

The Fort Lauderdale/Broward County EMA HAB Unmet Need Framework estimates were developed using the required and enhanced methods. The following tables summarize populations that are late diagnosed, have unmet need, and are in care but not virally suppressed.

Table 3 Broward County Unmet Need Calculation

Years of data			
1	**New Diagnoses:** Most recent calendar year for which data are available	**2020**	
2	**Care Patterns:** Most recent calendar year for which data are available	**2020**	
3	**Population size:** Most recent 5 calendar year period for which data are available	**2016**	**-2020**
	Definition/Description	**Number**	**Percent**
Late Diagnosed			
4	**Late diagnoses:** Number of people with late diagnosed HIV in the most recent calendar year in the jurisdiction based on residence at time of diagnosis. Late diagnosed HIV is based on the first CD4 test result (<200 cells/mL or a CD4 percentage of total lymphocytes of <14) or documentation of an AIDS-defining condition ≤3 months after a diagnosis of HIV infection	102	21.8%
5	**New diagnoses:** Number of people in the jurisdiction with HIV diagnosed in the most recent calendar year based on residence at time of diagnosis	467	
Population Size			
6	**Population size:** Number of people living with diagnosed HIV infection in the jurisdiction based on most recent known address who had an HIV diagnosis or any other HIV-related lab data (e.g., CD4, VL, genotype, or HIV test even if already diagnosed) reported to the HIV surveillance program during the most recent five calendar year period	20,541	
Care Patterns			
7	**Met need (In care):** Number of people living with diagnosed HIV infection in the jurisdiction based on most recent known address with a CD4 test or VL test in the most recent calendar year	16,427	80.0%
8	**Unmet need:** Number of people living with diagnosed HIV infection in the jurisdiction based on most recent known address without any CD4 or VL test in the most recent calendar year	4,114	20.0%
In Care, Viral Suppression			
9	**Virally suppressed:** Number of people living with diagnosed HIV infection in the jurisdiction who are in care and whose most recent viral load test result was <200 copies/mL in the most recent calendar year	14,275	86.9%
10	**Not virally suppressed:** Number of people living with diagnosed HIV infection in the jurisdiction who are in care and whose most recent viral load test result was ≥200 copies/mL in the most recent calendar year	2,152	13.1%

Of the 20,541 Broward PWH, 20% have unmet need. Male adolescents/adults are significantly more likely (74%) than females (26%) to have unmet need. Race/ethnicity is also highly associated with unmet need, with the Black Non-Hispanic/Latine population making up the majority (54%) of the unmet need group, followed by the Hispanic/Latine population (20%). Individuals aged 45-54 make up 25% of unmet need, the largest percentage among all age groups. It is important to acknowledge that many of the factors associated with late diagnosis are unresolved for many PWH in the unmet need group. In other words, they were late to HIV diagnosis and treatment and continue to have personal and structural barriers.

While RWHAP MCM and Non-MCM services can address some structural barriers, others are not readily surmountable. Examination of PE reassessment and utilization data find cycles in which PWH are engaged in care and can achieve and sustain their high CD4 counts and remain unsuppressed. They typically are in stable relationships and housing, employed or enrolled in school, and interact frequently with healthcare providers so that crises are averted. Changes in legal status, housing arrangements, job loss, breaks in drug and/or alcohol recovery, loss of and

personal support systems are associated with destabilization that contribute to return of unmet need.

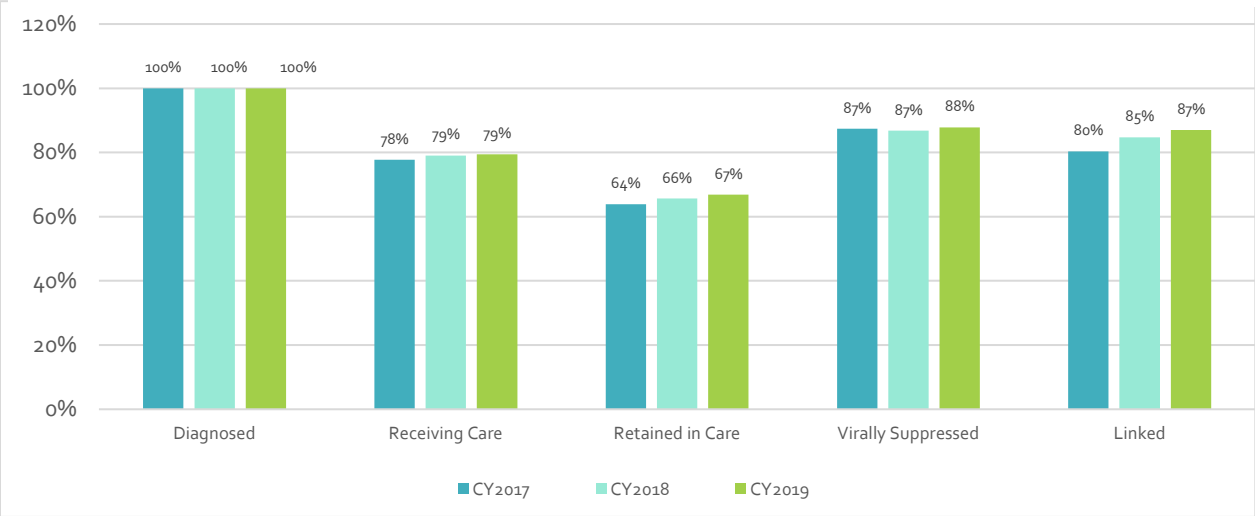
Table 4 FY2019 Part A Client Insurance Enrollment &FPL (8,149 Clients)

Medicaid		Medicare		Private Insurance		Uninsured		≤ 100% FPL		101-400% FPL	
#	%	#	%	#	%	#	%	#	%	#	%
1,352	17%	1,025	13%	2,261	28%	3,469	43%	4,471	55%	3,649	45%

Table 5 2021 Broward ADAP Expenditures: Insurance Assistance & Direct Dispense

Insurance Type	Premiums Payments	Medication Copayments	Total	Clients Served
Marketplace	$13,546,312	$8,504,413	$22,050,725	2,114
Medicare	-	$1,364,198	$1,364,198	533
Employer	$1,824,195	$752,432	$2,576,627	285
COBRA	$176,037	$99,865	$275,902	27
Total Insured	$15,546,545	$10,720,908	$26,267,453	2,959
Direct/Uninsured	-	$27,051,829	$27,051,829	2,967
			$53,319,282	**5,926**

Figure 3 Broward HIV Care Continuum



3. PREVENTION, CARE&TREATMENT RESOURCE INVENTORY

3.A HIV Care and Prevention Providers

Table 6 HIV Care and Prevention Providers

Funding Source	PrEP	Clinical PrEP	HIV CTL	TnT	STD	LTC	Outreach	nPEP S&R	PrEP S&R	Target Population
PS20-2010										
211-Broward										All Populations
AIDS Healthcare Foundation		x	x		x		x			Black Hetero; MSM; Trans experience
Arianna's Center			x						x	Persons with Trans experience
Broward Health	x		x							Black & Hispanic Hetero; MSM & Trans + partners
Continental Wellness Center		x	x				x			Black & Hispanic Hetero; Trans experience
High Impacto		x	x			x	x			Black & Hispanic Hetero; MSM & Trans exp. + partners
IMG Helps		x	x		x		x			Black Hetero; MSM; Trans experience
Midway Specialty Care		x			x		x			Black Hetero; MSM; Trans experience
Transinclusive									x	Trans experience; Black & Hispanic gay and bisexual men
Ujima Men's Collective			x				x	x		Black & Hispanic Hetero; Trans experience
Urban League									x	Black Cisgender Women
PS18-1802										
Broward House										Black & Hispanic Hetero; MSM & Trans exp. + partners
Care Resource										Black & Hispanic Hetero; MSM & Trans exp. + partners
Children's Diagnostic			x	x						Women Infants
Latinos Salud		x	x		x		x			Black & Hispanic Hetero; MSM & Trans exp.
Memorial Healthcare Center										Black & Hispanic Hetero; MSM & Trans exp. + partners
Pride Center	x		x				x	x	x	Black & Hispanic Hetero; MSM & Trans exp + partners
PS20-2011										
Latinos Salud		x	x		x		x			Black & Hispanic Hetero; MSM & Trans exp.
HRSA-PCHP										
BCFH (FQHC)	x		x	x						Newly diagnosed; HIV+ not on ART
Broward Health	x		x							Black & Hispanic Hetero; MSM & Trans + partners

Table 7 2021 FDOH Broward Contracted Providers

Organization	Services	
Latinos Salud	Clinical PrEP	$300,000
Midway Specialty Care Center	Clinical PrEP	$149,952
IMG Helps	Clinical PrEP using a mobile	$150,000
3rd Step Recovery Group	HIV Targeted Testing Using Incentives and SNS	$120,000
Ujima Men's Collective	HIV Targeted Testing Using Incentives and SNS	$120,000
Hight Impacto	Clinical PrEP	$150,000
AIDS Healthcare Foundation	Clinical PrEP using a mobile	$150,000
Pride Center at Equality Park	HIV Testing, Condoms Distribution, Interventions: Promise, PCC	$350,000
Memorial Healthcare System	HIV Testing	$150,000
Latinos Salud	HIV Testing, Condom Distribution, Interventions: DIVERSAFE, CLEAR	$400,000
Care Resource CHC	HIV Testing, Condom Distribution, Interventions: CLEAR	$400,000
Broward Health	HIV Testing, Condom Distribution, Interventions: PFH	$350,000
Broward House	HIV Testing, Outreach, Condom Distribution Interventions: PROMISE	$300,000
Hight Impacto	HIV Testing, Outreach, Condoms Distribution, ARTAS, SNS	$225,000
Hight Impacto	ARTAS Intervention	$150,000
Children's Diagnostic & Treatment Center	Targeted Outreach to Pregnant Women with AIDS (TOPWA)	$170,000
		$3,634,952

Table 8 Broward County RW Contracted Providers

Agency	RW Part	Population	Services
AIDS Healthcare Foundation	A	PWH	Medical, Pharmacy, Case Management, Medical Case Management, Dental
Broward Community & Family Health Centers	A	PWH	Medical, Pharmacy, Case Management, Medical Case Management, Mental Health, Medical Nutrition Therapy, Dental
Broward Health	A & C	PWH	Medical, Pharmacy, Case Management, Medical Case Management, Early Intervention Services
Broward House	A	PWH	Medical, Pharmacy, Case Management, Medical Case Management
Broward Regional Health & Planning Council	A	PWH	Centralized Intake & Eligibility, Health Insurance Continuation Program
Care Resource	A	PWH	Medical, Case Management, Medical Case Management, Mental Health, Dental, Food Vouchers
Community Rightful Center	A	PWH	Case Management
Latinos Salud	A	PWH	Case Management
Legal Aid Services of Broward County	A	PWH	Legal Services
Memorial Healthcare System	A	PWH	Medical, Case Management, Medical Case Management, Mental Health, Substance Abuse
Nova Southeastern University	A & F	PWH	Oral Health and Dental
Poverello Center	A	PWH	Food Bank
Children's Diagnostic & Treatment Center	D	Women, Infants, Children, & Youth	Medical, Support Services

Table 9 2021 Integrated HIV Programs for Health Departments to Support EHE Contracts

FDOH Funded EHE Providers in Broward County		
Organization	**Amount**	**EHE 2010 Contract Activities Funded**
Arianna's Center	$25,580	PrEP education, awareness, and/or referrals; Office of Minority Health & Health Equity provider (OMHHE)
Trans inclusive Group	$50,000	PrEP education, awareness, and/or referral (OMHHE)
Urban League of Broward	$44,141	PrEP education, awareness, and/or referrals; OMHHE provider
FDOH-Broward	$1,949,187	
	$2,068,908	Total PS20-210 Funds Allocated to Broward
FDOH Funded EHE Providers in Broward County		
Organization	**Amount**	**Contract Activities**
Ujima Men's Collective	$120,000	SNS, targeted testing, PrEP/nPEP screening & referrals, linkage/referrals (T&T) services, outreach, condom distribution, HIV planning
Continental Wellness	$50,000	SNS, targeted testing, PrEP/nPEP screening, and referrals, linkage/referrals for PWH to T&T, outreach, condom distribution, and HIV planning
IMG Helps	$150,000	Clinical PrEP/nPEP services, outreach, risk reduction services, linkage/&T referrals, HIV planning
AIDS Healthcare Foundation	$150,000	Clinical PrEP/nPEP services, outreach, risk reduction services, linkage/&T referrals, HIV planning
2-1-1 Broward	$151,360	Operation of local HIV prevention, care, and treatment resource and referral line
Midway Specialty Care Center	$97,149	Payment assistance program PrEP/nPEP medical visit co-pays & labs, linkage/referrals, HIV planning
Broward Regional Health Planning Council	$125,000	Payment assistance program for PrEP/nPEP medical visit co-pays and labs, linkage/referrals, HIV planning
Latinos Salud	$300,000	Clinical PrEP/nPEP services, outreach, risk reduction services, linkage/T&T referrals, HIV planning
Midway Specialty Care Center	$149,952	Clinical PrEP/nPEP services, outreach, risk reduction services, linkage/&T referrals, HIV planning
High Impacto	$150,000	Clinical PrEP/nPEP services, outreach, risk reduction services, linkage/T&T referrals, HIV planning
Subtotal	**$1,563,182**	

Source: PS20-2010: Integrated HIV Programs for Health Departments to Support Ending the HIV Epidemic, End of Year Progress Report, 2021

Table 10 2021 Broward HRSA Funding HIV Specific

HRSA Ryan White HIV Funding	FY 2021
AIDS Drug Assistance Program (Broward Only*)	$ 53,319,281
Part A & MAI: HIV Emergency Relief Grant	$ 15,724,848
Part B: HIV Care Grant Program (Broward Only**)	$ 1,162,079
Part C: Outpatient EIS Program	$ 874,469
Part D: Women, Infants, Children, Youth	$ 2,016,919
Part F: Community Based Dental	$ 219,230
RWHAP Parts A & B: Ending the HIV Epidemic	$ 2,075,933
	$ 75,242,830

Table 11 FY 2021 RWAP Expenditures by Service Categories (Does not include C, D, &F)

Core Service Category	Total	Part A/MAI	Part A EHE	ADAP	Part B
AIDS Pharmacy Assistance	$27,308,567	$256,738		$27,051,829	
Health Insurance Premium & Cost	$27,136,732	$701,530		$26,267,452	$167,750
Outpatient Ambulatory Health	$5,901,256	$5,901,256			
Medical Case Management	$2,361,460	$2,209,108	$152,352		
Oral Health	$2,059,508	$2,059,508			
Substance Abuse (Outpatient)	$804,645	$804,645			
Early Intervention Services	$139,816		$139,816		
Mental Health	$150,207	$150,207			
Home & Community Based Health	$20,000				$20,000
Medical Nutritional Therapy	$5,000				$5,000
Support Service Category					
Non-Medical Case Management	$1,328,200	$973,430			$354,770
Food Bank/Food Voucher	$835,077	$731,623	$103,454		
Transportation	$233,968		$98,492		$135,476
Emergency Financial Assistance	$396,526	$115,872			$280,654
Substance Abuse (Detox & Residential)	$36,650				$36,650
Legal Services	$127,973	$127,973			
Home Delivered Meals	$20,000				$20,000
Total					
Total Core & Support Services	$67,907,317	$13,073,622	$494,114	$53,319,281	$1,020,300

Other Leveraged Public and Private Funding Sources

HRSA's Community Health Center Program, Indian Health Service (IHS) HIV/AIDS Program, Substance Abuse, and Mental Health Services Administration programs, and foundations

Table 12 Other Health-Related Funding

HRSA Primary Health Care Funding	FY 2021
Broward Community & Family Health	
Health Center Program	$4,222,719
Health Care Infrastructure Support	$641,515
American Rescue Plan Act: Health Centers	$3,321,375
Broward Health	
Health Center Program	$3,048,227
Health Care Infrastructure Support	$535,816
American Rescue Plan Act: Health Centers	$1,720,750
	$13,490,402

HRSA Health Workforce Funding (NSU)	FY 2021
Postdoctoral Training: Public Health Dentistry	$650,000
Geriatrics Workforce Enhancement Program	$712,215
Postdoctoral Training: Public Health Dentistry	$299,998
	$1,662,213

Source: HRSA Grant Award Matrix

FY 2021 Housing Opportunities for People W/ AIDS Services	Expenditures
Housing Case Management (HCM)	$590,000
Non-Housing Support Services (Legal)	$180,000
Short-Term Rent, Mortgage & Utility Assistance (STRMU)	$385,500
Short-Term Rent, Mortgage & Utility Assistance (CARES Act)	$618,068
Temporary Emergency Hotel Voucher (TEV)	$61,895
Temporary Emergency Hotel Voucher (CARES Act)	$180,286
Project Based Rent (PBR)	$1,290,859
Tenant Based Rental Vouchers (TBRV)	$2,607,064
Facility Based Housing (FBH)	$1,223,721
Permanent Housing Placement (PHP)	$229,352
Total Unduplicated HOPWA Clients	**$7,366,745**

Table 13 FY 20-21 Broward Substance Abuse and Mental Health Funding (State of Florida)

Clients Served = 16,247	Expenditures
Adult Mental Health	$31,318,340
Child Mental Health	$3,843,282
Adult Substance Abuse	$22,968,186
Child Substance Abuse	$2,931,338
Total	**$61,062,146**

Table 14 FY 20-21 Broward Substance Abuse Funding

Cost Center Description	Expenditures
Assessment	$ 87,164
Case Management	$ 913,605
Crisis Support/Emergency	$ 774,944
Day Treatment	$ 154,377
Federal Project Grant	$ 58,878
FIT Team	$ 800,000
Incidental Expenses	$ 854,069
Information and Referral	$ 137,713
In-Home and On-Site	$ 456,321
Intervention - Individual	$ 344,547
Medical Services	$ 856,298
Medication Assisted Treatment	$ 1,069,995
Other Bundled Projects	$ 24,162
Outpatient - Group	$ 561,030
Outpatient - Individual	$ 1,198,722
Outreach	$ 3,423,412
Recovery Support - Group	$ 26,766
Recovery Support - Individual	$ 665,171
Residential Level II	$ 6,194,555
Residential Level III	$ 519,363
Respite Services	$ 164,200
Selective Prevention	$ 227,695
Start-Up Cost Reimbursement	$ 15,138
Substance Abuse Inpatient Detoxification	$ 1,566,896
Substance Abuse Outpatient Detoxification	$ 420,916
Supported Housing/Living	$ 88,574
Supportive Employment	$ 115,764
Sustainability Payment (COVID)	$ 436,732
Treatment Alternative for Safer Community	$ 11,524
Universal Direct Prevention	$ 646,016
Universal Indirect Prevention	$ 153,640
	$ 22,968,186

Table 15 FY 20-21 Broward Mental Health Funding

Cost Center Description	Expenditures
Assessment	$ 270,593
Case Management	$ 2,419,489
Central Receiving System	$ 4,129,201
Crisis Stabilization	$ 3,439,271
Crisis Support/Emergency	$ 1,571,303
Day Treatment	$ 150,049
Drop-In/Self-Help Centers	$ 329,409
FACT Team	$ 914,082
First Episode Team	$ 749,243
Forensic Multidisciplinary Team	$ 537,931
Incidental Expenses	$ 2,062,859
Information and Referral	$ 83,334
In-Home and on-site	$ 41,949
Intervention - Individual	$ 184,171
Medical Services	$ 1,784,235
Outpatient - Group	$ 402,997
Outpatient - Individual	$ 786,015
Outreach	$ 1,712,188
Recovery Support - Group	$ 227
Recovery Support - Individual	$ 398,494
Residential Level I	$ 2,752,692
Residential Level II	$ 1,195,424
Residential Level III	$ 410,259
Residential Level IV	$ 490,605
Respite Services	$ 114,880
Room and Board with Supervision Level I	$ 260,655
Room and Board with Supervision Level II	$ 576,682
Room and Board with Supervision Level III	$ 994,717
Selective Prevention	$ 108,743
Short-term Residential Treatment	$ 1,219,987
Start-Up Cost Reimbursement	$ 12,095
Supported Housing/Living	$ 345,540
Supportive Employment	$ 584,795
Universal Direct Prevention	$ 118,518
Universal Indirect Prevention	$ 165,707
	$ 31,318,340

Table 16 2021 Substance Abuse and Mental Health Services Administration (SAMHSA) Funding

Grant	Organization	Amount
Campus Suicide Prevention	Broward College	$102,000
First Responders - Addiction & Recovery Act	Broward Sheriff's Office	$500,000
Emergency Department Alternatives to Opioids	Broward Health	$497,625
TCE-HIV: High-Risk Populations	Broward House	$520,693
Minority AIDS Initiative – Service Integration	Broward House	$485,000
System of Care Expansion and Sustainability	County of Broward	$1,000,000
		$3,105,318

Table 17 Broward County Housing CoC Funding from Federal & State Sources

Source		District 10
HUD CoC	$	10,201,816
State Total	$	539,529
State Challenge	$	143,386
State HUD-ESG	$	257,500
State Staffing	$	107,143
State TANF-HP	$	31,500
Total Funding Award	**$**	**10,741,345**

3. A. STRENGTHS & GAPS

This section describes the strengths and gaps in Broward County's HIV prevention, care, and treatment inventory. including areas where the jurisdiction may need to build capacity for service delivery based on health equity, geographic disparities, occurrences of HIV clusters or outbreaks, underuse of new HIV prevention tools such as injectable antiretrovirals, and other environmental impacts.

1. STRENGTHS

Broward County has a system of counseling, testing, and early intervention providers funded by the CDC, and Parts A, B, C, and D offer outreach that targets racial, ethnic, and sexual minority low-income and uninsured groups. Parts A, C, and D fund six healthcare agencies to provide outpatient/ambulatory health services. Part A also coordinates with the FL AIDS Drug Assistance Program to ensure access to HIV and other needed medications.

Comprehensive System of Care: Broward's HIV Care Continuum encompasses core and support services that include outpatient/ambulatory health services (OAHS), oral health care, pharmaceutical assistance, health insurance premium and cost-sharing, mental health, medical case management (MCM), outpatient substance abuse, non-MCM including Centralized Intake and Eligibility Determination (CIED), emergency financial assistance (EFA), food bank/voucher, and legal services. MAI services include OAHS, mental health, outpatient substance abuse, and non-MCM services for Black non-Hispanic/Latinx males, females, and MMSC. Clients access these services through self-referral or Subrecipients located throughout Broward. The EMA's HIV care network is comprised of tax district healthcare systems, Federally Qualified Health Centers (FQHCs), community-based organizations (CBOs), and the FLDOH. A system of HIV counseling, testing, and early intervention providers funded by the Centers for Disease Control and Prevention (CDC) and RWHAP Parts A, B, C, and D targets low-income and uninsured groups. Parts A, C, and D fund six healthcare agencies to provide OAHS. Part A coordinates with the FL AIDS Drug Assistance Program (ADAP) to ensure access to HIV and other needed medications. FLDOH ADAP also funds insurance benefits management services to assist RWHAP clients across FL to enroll in health insurance coverage and manage premium payments and cost sharing. The Housing Opportunities for Persons with AIDS Program (HOPWA) provides housing services to assist HIV+ Broward residents.

Overall Viral Suppression Rate for the EMA: The CDC's CY2017-2019 HIV surveillance data report estimates a viral load suppression rate of 87.8% for the Fort Lauderdale/Broward County EMA.

2. GAPS

Broward's HIV Funding Landscape

CDC, HRSA, and other federal agencies have targeted funds to address the South FL HIV epidemic. Highly disproportionate per capita funds, however, were awarded to Miami/Dade County. In contrast, Broward's HIV epidemic received relatively limited funding, except Part A funds. Such funding may reflect a lack of understanding of the severe impact of Broward's HIV epidemic on its population and HIV infrastructure.

Broward's heavy reliance on Part A funds is also due in large part to lack of FL Medicaid expansion, high rates of denied Social Security Administration (SSA) disability claims, and extremely limited funding of HIV services by the State legislature and Governor.

In many other states, Part A funds are complemented by Medicaid expansion; high rates of enrollment in SSA disability income assistance and Medicaid or Medicare enrollment; and significant investment of State funds in HIV prevention and care. Broward and other FL EMAs must rely heavily on Part A funds and Part B funds for the AIDS Drug Assistance Program (ADAP) and HICP. No Part B or State revenue funds support OAHS. While RWHAP program income is helpful, it is insufficient to support an HIV healthcare delivery system.

The Continuum's capacity has stretched to meet the needs of a growing and complex population living with HIV. The Continuum is greatly constrained by insufficient physical and staffing capacity of OAHS subrecipients. This constraint has been exacerbated by decreased Part A per capita expenditures since FY2015. While there was a slight increase in Part A and MAI expenditures in FY2016, total and per capita expenditures decreased through most of FY2015-2018. For example, per capita Part A and MAI expenditures in FY2015 were $1,716 versus $1,689 in FY2018- a mean decrease of $27.38 per client. When increased labor costs, malpractice insurance, and overhead are accounted for, the drop in actual per capita expenditures in the four-year period is probably much higher.

Due to Broward Part A funding constraints, income caps are applied for some core medical and all support services. For example, only clients with household incomes ≤ 400% FPL are eligible for Part A-funded DCM, IPCBH, AIDS Pharmaceutical Assistance- Local (LAPA), HICP, and Oral Health Care. Only clients with household incomes ≤ 300% FPL are eligible for Mental Health Services, Outpatient Substance Abuse Services, and Legal Assistance. As a result of the income caps, access is constrained for services promoting treatment education and adherence, care coordination, and ARVs. While reducing barriers to Mental Health and Substance Abuse services is critical for many PWH, access via RWHAP is constrained except for the very poorest PWH. Accessing community-based behavioral health services is almost impossible unless insured, except for emergency psychiatric and detox services. Due to these financial constraints, Initiative funds are needed to significantly expand access to DCM, IPCBH, and Mental Health.

Current RWHAP funds are insufficient to support an efficient Part A Continuum, creating a monumental need for HIV-related services. Thus, Initiative funds are greatly needed and appreciated at this time.

Capacity of Broward's RWHAP Clinical Infrastructure is Inadequate

Despite the scale and complexity of Broward's HIV epidemic, clinical infrastructure is surprisingly lean. Five OAHS subrecipients serve Parts A and C clients. Two tax district hospitals have three HIV outpatient department clinics in community settings, two CHCs operate four HIV community clinic sites, and one ASO has three community clinic sites. The tax district clinics can only accept patients that reside in their service areas. All clinic sites are relatively small, with clinical, administrative, case management, support service, and CIED staff sharing the space. The physical limitations of most of the sites impede the subrecipients' capacity to efficiently move patients through registration, exam room, lab station, and other stops in a medical visit. While several clinics operate until the early evening, no clinic offers weekend hours. Other indicators of capacity are also constrained at most sites including waiting room and parking lot size.

Clinical staff capacity is relatively limited compared to other RWHAP EMAs. The number of full-time equivalent (FTE) clinicians supported by Part A funds is relatively small, with about 6.5 FTEs. Only two subrecipients employ physician assistants (PA) or advanced practice nurses, with physicians managing most RWHAP clients. The Parts C and D recipient funds an additional two FTE physicians who serve pediatric, adolescent, and adult female patients. While the five subrecipients employ 21 clinicians in total, most of them are part-time or serve private or publicly funded patients not enrolled in RWHAP.

Unlike other US counties with similar size HIV epidemics, Broward has no medical school or teaching hospital with faculty, clinical fellows, or students that can expand clinical capacity. The only two CHCs in Broward are RWHAP-funded. While there is a small group of community physicians that treat PWH, they are do not participate as RWHAP subrecipients.

Housing Insecurity Presents a Serious Challenge for PWH

In FY2018, 75% of Part A clients reported having stable/permanent housing, 20% were in temporary housing arrangements, and < 1% had unstable housing. While 2% of clients were reported to be homeless, with 7% of clients with $0 income homeless. Almost one-third (30%) of Part A clients are non-permanently housed, commonly with short periods of homelessness, living with friends or family, or exchanging sex for a place to stay. Stable housing was significantly more common for women (78%) than men (74%) and transgender people (68%). Black non-Hispanics had a lower rate of stable housing (73%) than White non-Hispanics (79%) and Hispanics (77%). Employed clients had a higher rate of stable housing (94%) versus non-employed clients (73%).

In many states, HOPWA funds have expanded access to affordable, stable housing. In Broward, however, being eligible for HOPWA funds is unlikely to result in housing stability. Among the 1,727 PWH enrolled in HOPWA in FY2018, 33% received financial subsidies and 67% received housing case management. Barriers to providing HOPWA financial assistance included constrained affordable housing, as well as a requirement that HOPWA applicants live in Broward for at least six months before receiving housing assistance.

Food Insecurity Remains a Barrier for PWH

Part A reduced Food Service funds in FY2017 due to demand for services that exceeded available funds. Currently, RWHAP clients in households with ≤ 150% FPL are eligible for only 12 total Food Service units per year, with up to 50% of the units as vouchers. A unit of food is either a food box or a voucher to a retail grocery store. Clients with 151-250% FPL are eligible for only six total Food Service units per year, with up to 50% of the units as vouchers. Clients with households 251-300% FPL, emergency provision of Food Services is available for a maximum of three Food Service units per year. The client must demonstrate an emergency need (e.g., verified loss of or reduction in income due to unexpected expense). While Part A requires that clients enroll in Supplemental Nutritional Assistance Program (SNAP), those benefits commonly cover one week of adult food consumption per month. While some pantry and soup kitchens are available in Broward, PWH commonly walk long distances or take public transportation to access them. Persistent food insecurity undermines the ability of PWH to sustain health eating habits, ensure nutritional food intake, and address wasting common in PWA. OAHS appointment keeping and ARV adherence may be undermined.

3.B. APPROACHES & PARTNERSHIPS

To complete the HIV prevention, care and treatment inventory, the Integrated Plan Consultant utilized the funding data from the Recipients of HOPWA, Prevention and Ryan White that is reported to the Part A HIV Planning Council. Additional data was received from a new partner, the Managing Entity for Substance Abuse and Mental Health Services.

4. NEEDS ASSESSMENT

a. Priorities

The top priority core medical service categories identified by the Broward County HIV Health Services Planning Council (HIVPC) for FY2022 in order of rank include Outpatient Ambulatory Health Services (OAHS), AIDS Pharmaceutical Assistance – Local (LPAP), Health Insurance Continuation Program (HICP), Oral Health Services, Medical Case Management (MCM), Mental Health Services, and Substance Abuse Outpatient Care (SAOC). OAHS provides Integrated Primary Care and Behavioral Health (IPCBH) services in all RWHAP Part A-funded primary care clinics. MCM funds Disease Case Management (DCM) services provided by interdisciplinary care teams in primary care clinics.

The top priority support service categories in order of rank are Food Bank/Home-Delivered Meals, Non-Medical Case Management (Non-MCM) including Centralized Intake and Eligibility Determination (CIED), Emergency Financial Assistance (EFA), and Legal Services.

The following subsection summarizes the **key priorities** arising from the RWHAP **Part A focus groups and key informant interviews**:

1. Support the Development of Statewide Peer Education and /or Certification Program. The jurisdiction has a strong need for and commitment to Peer Education and Peer Certification. The Broward RW Part A program has an incredible background in supporting peers. The effort to implement a State of Florida Peer Certification process will require all Part A programs to support the program

2. Create a Critical Access Management Program for Oral Health, Food, Housing, and the integration of Mental Health Services. These services are recognized by Consumers and Key Informants as being vitally important to overall health and wellness for PWH. Work to coordinate a system of services that supports access for all clients, regardless of socioeconomic status, ethnicity, and gender identification. Create protocols that support the development of these "Critical Access Services," and ensure that Consumers are part of program development. Engage Key Informants from all 13 agencies and consumers to create interventions that improve and measure/monitor access to these important services all the while looking at changes in engagement/retention in HIV care and viral suppression outcomes.

3. Engage Consumers and Key Informants in creating an innovative approach to build "trust, diversity and equity" into the Broward Part A EMA service delivery models and system of care and strongly consider building an EMA that uses a "trauma informed approach to care" that is written into all service delivery models and agency protocols to support client-centered care and self-care for all providers and care team members.

b. Actions Taken

The narrative below describes key activities undertaken by the jurisdiction to address needs and barriers identified during the needs assessment process. The Broward County Eligible Metropolitan Area (EMA) designed and implemented a five-year Ending the HIV Epidemic Initiative to strengthens the HIV Prevention, Care, and Housing Continuum and provides severely needed funds to expand HIV testing, linkage, clinical capacity, retention and reengagement, housing, and behavioral health services. The target populations for this initiative are newly HIV diagnosed Broward residents, as well as individuals not engaged in HIV care since diagnosis, no longer in care, or in care but not virally suppressed.

Key Initiative activities: (1) further expand rapid engagement services that promote readiness for HIV care, secondary HIV prevention, and antiretroviral drugs (ARVs); (2) adopt effective Data to Care (D2C) methods to locate and link newly identified persons living with HIV (PWH) not engaged in care or out of care; (3) expand integrated behavioral health and medical care to diagnose and treat mental illness, addiction, and alcoholism; (4) expand temporary and permanent housing for homeless or unstably housed PWH and intensive support services that provide skills for independent living; (5) train and deploy multidisciplinary peer and healthcare worker Intensive Care Teams to assess and meet clients' needs through client-centered, coordinated services in clinical and community settings; and (6) link clients to training, income/disability assistance, food, legal, and other services to improve life management skills, treatment adherence, and housing and income security. Recent initiatives include the Part A integrated primary care and behavioral health services, online Part A eligibility recertification portal, and enhanced disease case management services to target individuals reengaging in care through the Ending the HIV Epidemic Initiative.

Table 18 Actions Taken: Newly Diagnosed

Activities Conducted Newly HIV-Diagnosed Individuals			
Black Non-Hispanic/ Latine Heterosexual[1]	**White MMSC**	**Hispanic/ Latinx MMSC**	**Outcomes**
System-Level Primary Activities to Impact HIV Outcomes			
• Conduct Sista's Organizing to Survive (SOS) Summit • Host National Black HIV/AIDS Awareness Day event • Brown Bag meetings in collaboration with the Black AIDS Institute to engage and reengage patients out of care. • Host BTAN/BAGG monthly meetings to increase HIV scientific	• Provide clinical PrEP and nPEP services via mobile unit • Provision of PrEP and nPEP clinical services including via telehealth • Conduct outreach and testing events • Provide risk reduction activities • Link/refer PWH to applicable services (TTP, TOPWA, etc.) • Payment of PrEP and nPEP Labs and Medical Visit Co-Payments	• Provide clinical PrEP and nPEP services via mobile unit • Provide PrEP and nPEP clinical services including via telehealth • Conduct outreach and testing events • Provide risk reduction activities • Link/refer PWH to applicable services	• ID individuals unaware of their HIV status • Inform individuals testing HIV+ • Refer to care newly HIV diagnosed • Link to care new diagnosed individuals • Increase HIV and PrEP/nPEP awareness

literacy w/in Black communities and increase number in appropriate early care and treatment • Provide cultural competence training to all registered counselors to better serve LGBTQI • Implement Social Network Strategy • Provide focused testing • Screen and refer people to PrEP/nPEP services • Link/refer PWH to applicable services, conduct outreach • Disseminate condoms • Provide clinical PrEP and nPEP services • Payment of PrEP and nPEP Labs and Medical Visit Co-Payments • Conduct Business Responds to AIDS Initiative	• Host MSM Advisory Workgroup Meetings to mobilize the MSM community in Broward County and build capacity to address the various factors that facilitate HIV infection in the MSM community. • Host Bi-Annual MMSC Health and Wellness Conference • Provide In-Home HIV Test kits, condoms, and lube to non-traditional partners (e.g., bath houses, Adult Entertainment Stores and Venues). • Host Bi-Annual MMSC Health and Wellness Conference	(TTP, TOPWA, etc.) • Payment of PrEP and nPEP Labs and Medical Visit Co-Payments • Provide cultural competence training to all registered HIV testing counselors to better serve the LGBTQI community • Host MSM Advisory Workgroup Meetings to mobilize the MSM • Host Bi-Annual MMSC Health and Wellness Conference	• Increase the availability and accessibility of HIV testing in traditional and non-traditional healthcare settings • Decrease the number of individuals diagnosed with HIV • Expand focused HIV testing of priority populations in non-healthcare settings • Incorporate health equity into HIV testing • Improve and promote access to ARVs, PrEP, and nPEP

Table 19 Broward EMA Part A HIV Care Continuum, FY2016-2019

Continuum Stages	FY2016	FY2017	FY2018	FY2019	ΔFY2016-19
HIV+ Clients	8,151	8,508	8,233	8,170	*0.2%*
Ever in Care	98.5%	99.2%	99.6%	99.7%	*1.2%*
In Care	91.5%	90.0%	92.9%	93.1%	*1.7%*
Retained in Care	74.8%	72.9%	75.1%	72.7%	*-2.8%*
On ARV	90.2%	94.4%	95.1%	96.5%	*7.0%*
Suppressed VL	81.3%	83.4%	84.9%	86.5%	*6.5%*

Increased rates of ARV use and suppressed VL may also be the effect in part of the Part A- funded IPCBH launched in FY2017 to address drop-offs between rates of being on ARVs and suppressed VL. IPCBH is designed to integrate OAHS and behavioral health services through teams of clinicians that collaborate to assess and addressed barriers to ARV treatment and viral suppression due to mental illness and/or addiction. The goal of this service category is to improve health outcomes by coordinating care and treatment for clients and to reduce stigma associated with mental health issues. DCMs function as care coordinators for clients receiving IPCBH services by assisting clients to improve and sustain ARV adherence by providing multidisciplinary education interventions, developing coordinated POCs that help clients to receive needed services, and ensuring that clients are engaged in services to prevent loss to care. Additionally, a main component of the care coordinator role of DCMs is the continuous exchange of patient treatment information with IPCBH providers and the rest of the care team.

As a result of this enhanced screening effort, interventions such as applying the Patient Health Questionnaire (PHQ)-9 have been implemented to assess clients and provide interventions through the care team approach.

The benefits of the TTP may also be reflected in positive trends in ARV use and viral suppression. Part A collaborates with FDOH-BROWARD to provide immediate access to ARVs for clients entering TTP. Those clients receive a 30-day supply of ARVs at the provider's on-site pharmacy or their clinician directly dispenses ARVs at the first IPCBH visit. Via the Part A- funded EFA service category, Part A ensures ARVs are available at all of Part A IPCBH sites. FDOH-Broward hos agreements to reimburse at 340b pricing for the ARVs and pay a dispensing fee for Outpatient medical providers without a Pharmacy services contract. For Ryan White providers who do not have a pharmacy or are unable to receive samples due to internal policies, FDOH-Broward provides them using their wholesale pharmacy license and a 30-day supply bottle of the Test and Treat medication covered under the Test and Treat formulary.

Published studies, such as the San Francisco Rapid ARV Program Initiative for new Diagnoses Model and the randomized unblinded same-day HIV testing versus standard care trial conducted in Haiti, demonstrate a medical benefit to patients when ARVs are started immediately at initiation of IPCBH, particularly in patients with acute HIV infection. Peer reviewed studies also demonstrate patients initiating ARVs early in their HIV infection contribute significantly to reduced community VL.

The HIVPC examines the rate of PWH engaged at each Continuum stage. They identify barriers to linkage and retention in sustained, high-quality care, as well as implement improvements to support clients transitioning through the Continuum stages. The HIVPC uses PSRA to identify factors contributing to drop-off between the Continuum stages, including disparities between subgroups. In their PSRA activities, the Part A Recipient and HIVPC consider the services funded by other funders to avoid duplication and ensure seamless transition along the Continuum. Part A funds services that engage individuals along the Continuum from initial linkage to core medical and support services to achievement of sustained undetectable VL. The HIVPC monitors available resources in response to the needs of PWH to improve engagement at each Continuum stage. This is accomplished during the PSRA process through presentations from other Broward RWHAP Part A Recipients, other funders, and stakeholders including RWHAP Parts B, C, D, F, and HOPWA. Each presentation provides an overview of the program's purpose and legal mandate, budget, client demographics, provided services, existence of waiting lists, and notable trends. Each presenter makes recommendations for the Part A Program, including service gaps and needed resources.

Access to health insurance assistance promotes retention in IPCBH and ensures access to ARVs. Parts A and B fund HICP to purchase insurance premiums and assist QHP beneficiaries with co-payments and deductibles. Both Parts A and B assist clients to enroll in QHPs that cover ARVs.

Part A clients not enrolled in employer-sponsored insurance or QHPs most commonly access ARVs through ADAP. Clients ineligible for ADAP receive access to ARVs and other medications through LPAP. Part A LPAP and Part B ADAP offer adherence counseling that encourages collaboration between patients and clinicians.

Several gaps, barriers, and unique challenges have been identified in developing and applying the Continuum framework. Through MOUs and co-location of service sites, Part A- funded CIED staff and FDOH-BROWARD prevention workers collaborate to address the gap between HIV diagnosis and linkage. FDOH-BROWARD facilitates HIV testing and collaborates with CIED to link clients rapidly to IPCBH. An important effort in addressing this gap is data systems integration to track newly identified HIV+ individuals to ensure linkage to and sustained retention in IPCBH. To this end, the Part A Recipient and FDOH-BROWARD CTS staff have successfully integrated TTP data into PE.

In Care but Not Virally Suppressed

Of the 20,541 Broward PWH, 13% are in care but not virally suppressed. Male adolescents/adults are significantly more likely (65%) than females (35%) to be in care but not virally suppressed. Race/ethnicity is also highly associated with being in care but not virally suppressed, with the Black Non-Hispanic/Latine population making up the majority (65%) of the group. In CY 2019, the Evaluator conducted an intensive examination of the PE and EHRs of approximately 100 PWH with persistently high VLs. Once again, the personal barriers experienced by the late-diagnosed and unmet need groups were highly amplified for the not virally suppressed group. The individuals in this group had a wide range of factors contributing to the inability to attain and sustain viral suppression. Chronic mental illness, alcoholism, and other substance use were several of the many factors experienced by this group, commonly with cycles of recovery over many years. Some PWH had serious chronic medical conditions that resulted in frequent hospital stays, during which they were taken off their ARVs. Some PWH reported that they were no longer willing to take ARVs due to treatment fatigue, depression, or other life priorities. Over-riding conclusions of the assessment of this group were that reasons for being in care but not virally suppressed were highly individual and RWHAP-funded providers were unable to intervene despite their efforts.

4.c. Needs Assessment Approach

The Broward County Part A HIV Needs Assessment approach is a coordinated and collaborative set of activities lead by the following three groups:

1. Ryan White Part A Planning Council,
2. Florida Comprehensive Planning Network (FCPN), and
3. FDOH-Broward EHE Needs Assessment Activities.

1. Ryan White Part A Planning Council

The EMA conducts Needs Assessment activities as prescribed by legislative requirements for Part A programs which is based on a three-year Needs Assessment cycle.

Table 20 Broward County Ryan White Part A Needs Assessment Activities

Year	Needs Assessment Activity/Document
2022	Resource Inventory
	Consumer Focus Groups
	Provider Key Informant Interview
	Consumer Ranking of Priorities
	PSRA Committee Ranking of Priorities
	Recommendations on How Best to Meet the Need
	Outcomes Evaluation (CQM)
2021	Ryan White Part A Provider Survey
	Consumer Focus Groups
	Provider Key Informant Interview
	Epi Profile Update
	Consumer Ranking of Priorities
	PSRA Committee Ranking of Priorities
	Recommendations on How Best to Meet the Need
	Outcomes Evaluation (CQM)
2020	Ryan White Rapid COVID-19 Consumer Needs Assessment Survey
	Consumer Focus Groups
	Provider Key Informant Interview
	Epi Profile Update

The major components of a RW Part A comprehensive needs assessment include:

1. Epidemiologic profile, which describes the current status of the epidemic in the EMA specifically the prevalence of HIV and AIDS overall and among defined subpopulations and trends in the epidemic. The epidemiologic profile provides the best available information to better understand the probable characteristics of individuals who have HIV/AIDS but are unaware of their status, such as percent of late testers and their characteristics and place of residence. It also provides data on the treatment cascade where possible; a treatment cascade

follows PWHA over a period of years, documenting data such as the number of people who are tested, test positive, are linked to care, receive anti-retroviral therapy (ART), remain in care, and achieve viral suppression.

2. Estimates of the number and characteristics of PWHA with unmet need and of individuals with HIV/AIDS who are unaware of their status. It is important to understand approximately how many people in the EMA are unaware of their status and how many are out of care, who they are, and where they are most likely to live. Needs assessment based on analysis of epidemiologic data can provide an understanding of populations most likely to be undiagnosed, including their race/ethnicity, age, gender, risk factors, and places of residence. Analysis of epidemiologic data provides profiles of people who know their status and are not in care.

3. Assessment of service needs (including core services and support services) among affected populations, including barriers that prevent PWHA both in and out of care from receiving needed services or from continuing in care. The needs assessment gathers an array of information to identify trends and common themes. The EMA collects this information from multiple sources, among them PWHA and other community members, DOH, the State Medicaid agency, community-based providers, and, where applicable, Recipients of other Ryan White Parts. Information is obtained from and about HIV-positive individuals who know their status and are not in care.

4. Resource inventory, which describes organizations and individuals providing the full spectrum of services available to PWHA. The goal of the resource inventory is to develop a comprehensive picture of services, regardless of funding source. At a minimum, the resource inventory includes for each provider a description of the types of services provided, the number of clients served, and funding levels and sources. (Note: A resource inventory can often be turned into a resource for clients and providers to use in locating services, especially online. In this format, data on the number of clients served and funding levels are usually removed.)

5. Profile of provider capacity and capability which identifies the extent to which services identified in the resource inventory are available, accessible, and appropriate for PWHA, including specific subpopulations. Estimates of capacity describe how much of which services a provider can deliver. Assessment of capability addresses staff knowledge and skills to provide high-quality services to various groups of PWHA. The Broward EMA Part A Provider Survey is one of the main tools utilized in Broward to develop the Profile of provider capacity and capability. (See Attached Broward EMA Part A Provider Survey).

• Availability focuses on the number of providers overall and by community or county within the EMA and the extent to which providers have the ability to serve additional clients, since caseloads may increase as a result of increased attention to HIV testing and linking those testing positive to care.

• Accessibility involves factors like provider hours (including weekend and evening hours) and location, how easily facilities can be reached via bus or other rapid transit, the extent to which they have parking available, and whether they can be accessed by individuals with physical disabilities.

• Appropriateness describes the degree to which a provider has the expertise to provide high-quality services for specific subpopulations – defined by race/ethnicity, sex/sexual identity, gender orientation, age, and risk factor – including staff with needed training, experience, language skills, and cultural competence. A careful assessment of how issues of provider capacity and capability can create barriers for PWHA receiving services is an important aspect of this component.

6. Assessment of unmet need/service gaps, which brings together the quantitative and qualitative data from all the other components on service needs, resources, providers, and barriers. This should include an assessment of unmet needs for PWHA who know their HIV status but are not in care and an assessment of service gaps for all PWHA—both in and out of care. This should include the identification of both categories of service that are unavailable or insufficiently available or service gaps for specific population groups.

2. Florida Comprehensive Planning Network

The Florida Comprehensive Planning Network (FCPN) is the statewide Ryan White Planning Body which is made up of members that represent each local area. Broward County's representative is a past HIV Planning Council Chair who also serves as the Chair of the FCPN. The FCPN committees meet monthly through an online platform.

The FCPN Needs Assessment Committee's purpose is to provide independent, ongoing review and feedback on statewide needs assessment activities, including the Statewide Coordinated Statement of Need. The committee is also responsible for developing a Needs Assessment toolkit for implementation in local areas. The Coordination of Efforts (CoE) Committee is the entity that is tasked with providing review and feedback on the statewide inventory/assessment tool, "Florida HIV Continuum of Care Dashboard" (Dashboard), the State of Florida Integrated HIV Prevention and Care Plan and Florida's Unified Ending the HIV Epidemic Plan.

Community engagement is an overriding element of Florida's 4 Key Component Plan which intersects with the EHE initiative efforts. In the events described below, community engagement took place at the state level and in the seven EHE Phase 1 jurisdictions. Community members were engaged in all phases of the planning process and will continue with the implementation of strategies and activities to end the HIV epidemic in Florida.

The FDOH, HIV/AIDS Section works in partnership with the statewide planning body—the Florida Comprehensive Planning Network (FCPN). Members of FCPN include PWH and representatives across the state representing patient care and prevention groups, local planning

bodies, CBOs, academic institutions, local and regional clinics, city, and county governments, RWHAP Program recipients, the transgender community, advocacy groups, substance use and social service providers, and behavioral science groups.

November 19–21, 2019, in Lutz, FL, the full FCPN membership (48 voting members and 60 guests) met to discuss the state of HIV/AIDS at the federal, state, and local levels. Participants were divided into working groups tasked with providing input on common strategies for each of the four EHE pillars. These common strategies reflected a unified approach to ending the HIV epidemic in Florida. On July 8–9, 2020, and August 27–28, 2020, the FDOH, HIV/AIDS Section, and FCPN met again virtually to further refine the elements of the unified EHE plan from the state perspective. Strategies identified as county-specific are included in subsequent sections of this plan.

AD-HOC CONSULTATIONS

From 2016 to 2020, the FDOH, HIV/AIDS Section held sessions with representatives from priority populations to engage in conversation and obtain programmatic feedback on HIV prevention and care activities. Certain recommendations from these sessions became key strategies and activities in FDOH's statewide plans—the Agency Strategic Plan and State Health Improvement Plan—as well as the state's Integrated HIV Prevention and Surveillance Cooperative Agreement (CDC PS18-1802), which was founded in January 2018.

Black Cisgender Women

In 2017, a group of 15 Black women from across the state convened in Fort Lauderdale, FL, to participate in a Black women's consultation. The participants were tasked with summarizing and discussing data presented by FDOH on the HIV epidemic in Florida. The group identified a common agenda, which was to recommend systems, activities, and responsibilities by various entities that would assist in progressing toward zero HIV cases for Black women. Recommendations were provided to FDOH with examples of activities, programs, actions, messaging, and messengers that should be included in a framework designed to address HIV among Black women. Recommendations focused on five areas: individuals, providers/policy, community, social media, and FDOH programming. For individuals, they recommended promoting HIV education with professionals outside of the traditional workforce. For providers/policy, they recommended incorporating health equity strategies and reviewing the legislative intent of the Targeted Outreach for Pregnant Women Act (TOPWA) to ensure comprehensive services are offered. For the community, the women recommended implementing an ambassador program for Black women. For social media, they suggested using minority media companies to develop minority-focused materials and a campaign focused on newly diagnosed individuals to demonstrate that PWH can live happy, healthy, and productive lives.

3. DOH-Broward EHE Needs Assessment Activities

FDOH-Broward conducted an extensive needs assessment which included analysis of epidemiological data and gathering community input through various community engagement efforts in developing the Broward County Ending the HIV Epidemic Plan including surveys, key informant interviews listening sessions, focus groups, and community presentations. FDOH-Broward EHE Needs Assessment activities included:

Activities Prior to EHE Plan Development

Ending the HIV Epidemic Survey (n=2210) 1,780 Community & 430 Provider; Student Survey (n=135); Key Informant Interviews (n=40); EHE Listening Session; EHE Focus Groups (Five groups n=50); and EHE Community Presentations (n=28)

Post-EHE Engagement & Communication Plan Data-Gathering Methodology

Four (4) large at-risk focus groups; Four (4) small at-risk focus groups; Three (3) community sessions; Ten (10) key informant interviews; and Four (4) small professional focus groups.

Post-EHE Engagement & Communication Plan Data-Gathering Methodology

Four (4) large at-risk focus groups; Four (4) small at-risk focus groups; Three (3) community sessions; Ten (10) key informant interviews; and Four (4) small professional focus groups.

Figure 4 EHE Survey, n= 2,210

1. Ending the HIV Epidemic Survey n=2,210

Survey Development: Sept-Oct 2019. Input gathered; community and provider surveys drafted; field tested with ADAP clients, members of BCHPPC, and community. Revisions made prior to launch in English, Spanish, Creole, and Portuguese

Su**rvey Marketing.** Media Campaign Sources: to reach priority populations and broader audiences. Newspapers (full-page color ads): Sun-Sentinel, El Sentinel, SF Gay News, Westside Gazette, AcheiUSA Brazilian News, Caribbean National Weekly, Gazeta Brazilian News. Radio: WHYI-FM (Y100), WEDR-FM/WHQT-FM (Black/Caribbean), WZTU-FM (Spanish), WLQY 1320/WSRF 1580 (Creole). Social Media: Twitter, Facebook, NextDoor

Phone Apps: Grindr (11/13): Grindr for Equality created a free ad pop-up link for 24 hours

Press Release: Florida Department of Health in Miami-Dade and Broward Counties Seek Community

Involvement on "Ending the HIV Epidemic: A Plan for America" Initiative

Survey Implementation: 10/18/2019 - 10/2/2020

Figure 5 EHE Survey Street Outreach

2. EHE Survey Street Outreach

Street Outreach Site: Bus & Train Stations, Homeless Shelters, Lauderhill Mall and other malls, Sistrunk Blvd., Fort Lauderdale & Hollywood Beaches, Wilton Drive, Other Neighborhoods, Faith Based Institutions, Oakland Park Flea Market and Venues where substance users congregate.

Survey Street Outreach Key Findings/Themes:

Access to **housing, health care, mental health** care, and **employment** are clearly needed in the community and would greatly improve the quality of life for priority populations.

Most common themes:

Improving **access to care**

Addressing **stigma**

Lack of **education** about HIV in the community and among providers

Promoting **availability of resources**, including HIV testing, care and treatment, and prevention (PrEP)

Figure 6 EHE Student Survey

3. EHE Student Survey

Broward County Public Schools survey updated for EHE
High school students visiting sexual health services offices responded
Survey conducted Nov 5-22, 2019 (18 days) during an HIV and/or STI test
135 students in 7 public high schools were asked:
Q12: Do you think that HIV transmission is a big issue among students and youth in Broward?
93% reported YES, 7% reported NO
Q13: What ideas do you have for how to better educate students and youth about HIV risk behaviors and the virus? Themes: increase education, increase condom access, increase HIV/STI testing

Student Survey Key Findings/Themes:

Expand HIV education and awareness for youth and students
Common suggestions: improve sex ed/health classes, presentations, guest speakers, assemblies, summits, posters, peer education, social media, teen talks
Increase access to condoms and HIV/STI testing
Build upon current BCPS comprehensive sexual health curriculum

Figure 7 EHE Plan Development Key Informant Interviews

4. EHE Plan Development: Key Informant Interviews

Forty (40) interviews were conducted with individuals representing the following:

Law enforcement	Department of Children & Family Services
Medical care and Pharmacies	HIV Care & Treatment Continuum Services
Food/nutritional services	CBOs and Hospitals
Racial equity and social justice	Case management
Substance use	Legal services
Mental health treatment	Public schools
LGBTQ & transgender programs/services	Current/former DOH staff
Latinx organizations	Planning/advisory board members
Ryan White Part A	Youth, seniors, PWH, on PrEP, Latinx, Black

Key Informant Interviews Key Findings/Themes:

Provide basic HIV education and awareness (community and providers)
Eliminate barriers to health care (including affordability, mobile)
Implement effective community education campaigns
Eliminate HIV stigma and discrimination (U=U messaging)
Implement harm reduction programs (SEPs, innovation)
Increase access to PrEP

Common concerns raised:

Need safe, affordable housing (especially for priority populations)
Increase HIV education in schools/with youth
Increase support for transgender programs & community
Opportunities to improve communication & collaboration with DOH HIV/AIDS Program
Expand access to routine HIV testing
Dismantle institutional racism and increase racial equity

Figure 8 EHE Listening Series

5. EHE Listening Session

Listening Session Participants n=21

HIV care and treatment provider staff	Staff from CBOs
Community stakeholders	HIV care orgs
Planning body groups membership	MSM & transgender programs
Staff from CBOs	Latinx programs
HIV care orgs & Local healthcare facilities	MSM & transgender programs

Key Findings/Themes:

Increase access points for PrEP and make it accessible (PrEP-AP)
Address HIV stigma
Adopt Undetectable=Untransmittable messaging
Advocacy to protect PWH (disclosure/criminalization laws)
Increase HIV education in community and with providers
Enhance Test & Treat model for rapid HIV care and treatment
Expand routine HIV testing and Implement harm reduction programs (SEPs)

Common concerns raised:

Need for more community involvement
Grassroots/homegrown programs need to be funded
Opportunities to improve communication & collaboration w FDOH (HIV/ Program)
Not enough people were involved – conduct more sessions & forums

Figure 9 EHE Focus Groups

6. EHE Focus Groups (5 Groups/50Consumers)				
Transgender	LatinX/(MSM	MSM	Black Hetero Females	WICY
Top 5 Themes				
Eliminate HIV Stigma (U=U)				
Improve Access to Care (PWH, PrEP, Testing)	PrEP/nPEP Ed. & Access		Expand HIV Testing & PrEP Awareness	Expand routine HIV testing
Need Safe Housing	Community/ Provider Education			
Trans-led Programs	HIV Hotline	Eliminate Barriers	HIV Hotline	Eliminate Barriers
Resilience	Outreach	VLS Incentives	Resilience	Expand T&T

Key Findings/Themes:

Address HIV stigma & Adopt Undetectable=Untransmittable messaging
Increase HIV education in community and with providers
Expand routine HIV testing & Expand access to PrEP
Enhance Test & Treat model for rapid HIV care and treatment

Common concerns raised:

Need for more community involvement
Grassroots/homegrown programs need to be funded
Conduct more focus groups to reach priority populations throughout community

Figure 10 EHE Community Presentations

7. EHE Community Presentations n=28

Grassroots/homegrown programs need to be funded
Opportunities to improve communication & collaboration w FDOH (HIV/ Program)
Not enough people were involved – conduct more sessions & forums

Broward HIV Prevention Planning Council
Biomedical Advisory Group
MSM Advisory Group
Black Treatment Advocates Network
Integrated Prevention & Care Workgroup
HIV Health Services Planning Council
South Florida AIDS Network (SFAN)
HIV Prevention Provider Meeting

Latinos en Acción Advisory Group
Broward Public Schools Student Advisory
Perinatal Advisory Group
Medical/Disease Case Management Network
Coordinating Council of Broward
Homeless Continuum of Care Advisory Board
Healthcare Access Committee

Community Presentations Key Themes

Eliminate HIV stigma
Provide broad community & provider education
Expansion of PrEP access
Expansion of Test & Treat to ensure immediate linkage to care
Addressing barriers to care, including health coverage, housing, mental health
Expansion of HIV testing in healthcare and non-traditional settings
Addressing structural racism and promoting racial equity
Build resources and support on a local level to support grassroots programs

Figure 11 EHE Plan Engagement & Communication

8. Ending the HIV Epidemic Plan Engagement & Communication

5-year plan; Living document; Will evolve with continued community engagement; Contingent upon funding and Implementation involves the whole Local Public Health System
Continued EHE Engagement & Communication plan data-gathering methodology:
Four (4) large at-risk & Four (4) small at-risk focus groups conducted

- Three (3) community sessions conducted
- Ten (10) key informant interviews conducted
- Four (4) small professional focus groups conducted

Participants included HIV care and treatment continuum providers and priority populations, MSM, Transgender, Latin MSM, Minority youth/adolescents; Black heterosexual women, Bi-sexual minority women, Black heterosexual men

Total 159 individuals or organizations engaged from July – September 2020

AIDS Servicing Organization; Youth Advocate; Health Centers; Hospitals; Faith-Based Organizations; Museums; Human Trafficking and Homeless Coalitions; Community At-Large (non-affiliated with any organization); HIV care and treatment continuum providers; community HIV planning group membership; Broward Community College (BCC) students; Broward County School District students and Priority Populations (MSM, Transgender, Latin MSM, Minority youth/adolescents; Black heterosexual women, Bi-sexual minority women, Black heterosexual men)

Key Themes: Community Sessions/Focus Groups Facilitate access to PrEP nPEP

- Improve DOH-Broward branding & collaboration
- Expand access to PrEP/nPEP via telehealth
- Create one-stop health centers
- Increase access to HIV info/ services in the west
- Increase sexual health and PrEP education
- Increase health fairs and community education

Addressing the Gaps:

- Continue to increase community engagement to reach broader geographic areas (South, West, North) and more priority populations
- More community involvement in the EHE planning process will allow for more opportunities to support filling in gaps and get buy-in

Section IV: Situational Analysis

I. DIAGNOSE

The FDOH-BROWARD HIV prevention program leads efforts in identifying HIV+ unaware individuals by promoting HIV testing in community and healthcare settings. This responsibility will continue to be shared by FDOH-BROWARD and Broward Health, which will continue to use Part C EIS, FDOH, and health insurance funds for HIV testing. The FDOH-BROWARD will continue to use CDC funds to conduct the Broward>AIDS Initiative, a comprehensive community education, prevention, and media campaign targeting high-risk populations. The campaign will maintain its focus on health promotion and wellness, with messaging centered on Broward>AIDS and other evidence-based population-focused campaigns designed to change community norms. FDOH will maintain funding for HIV awareness, outreach, testing, linkage, and prevention interventions in FQHCs, EDs and other hospital departments, and CBOs.

Rapid HIV Testing through Non-Traditional Settings and Modalities

Considering Florida's percentage of PWH unaware of their status (14%), increased access to rapid HIV testing is required. Feedback received through community engagement indicated a need for expanded use of mobile testing units, HIV self-test kits, social/sexual network screening, and testing at non-traditional settings and hours. FDOH currently supports more than 1,600 registered HIV testing sites around the state that conduct targeted HIV testing in non-health care settings in areas and communities with high HIV incidence. FDOH supports these sites with rapid HIV test kits at no cost to the site. Sites must register with FDOH and submit HIV testing data as criteria to receive rapid HIV test kits. FDOH will continue to conduct rapid HIV testing trainings to certify individuals to perform rapid HIV testing in non-health care settings.

In June 2019, FDOH began an HIV self-test kit distribution program to provide rapid HIV self-test kits to individuals, at no cost, and through an online request form (available at KnowYourHIVStatus.com). This program was particularly important as COVID-19 closures and restrictions fueled increases in the demand for alternative options for HIV testing. As shown in the figure below, monthly requests for HIV self-test kits rose sharply beginning in April 2020 and continuing through July 2020. Monthly requests tapered slightly from September through December 2020. In 2021, monthly requests for HIV self-test kits decreased but are still higher than pre-COVID levels. The HIV/AIDS Section continues to look for opportunities to collaborate, especially with internal FDOH partners such as the Bureau of Tobacco Free Florida to advertise the availability of free, in-home testing kits. The Pride Center and Holy Cross Health, two local Broward community-based organizations, each received $100,000 in funding from the CDC Foundation. Broward County residents can obtain a free home testing kit along with condoms and resources by filling the order on www.getprepbroward.com.

Barriers to Accessing Existing HIV Testing

In July 2015, the Florida Legislature amended Florida's HIV testing law to remove the need for separate informed consent prior to HIV testing in health care settings. In September 2016, Florida Administrative Code Rule 64D-2.004 was adopted to implement the amended HIV testing law. The intent of this amendment was to simplify routine HIV testing in health care settings, improve the identification of new or existing HIV infections, and help to normalize HIV testing as a routine component of primary health care. There was no change in the law regarding non-health care settings. These changes align Florida more closely with the CDC's 19 HIV Screening Recommendations.

Since 2015, FDOH, including CHDs, have developed a collaborative model for routine communicable disease screening with the Gilead Sciences' Frontlines of Communities in the United States (FOCUS) initiative. The FOCUS Program is a public health initiative that enables partners to develop and share best practices in routine blood-borne virus (HIV, HCV, HBV) screening, diagnosis, and linkage to care in accordance with screening guidelines promulgated by the U.S. Centers for Disease Control and Prevention (CDC), the U.S. Preventive Services Task Force (USPSTF), and state and local public health departments. FOCUS funding supports HIV, HCV, and HBV screening and linkage to the first appointment after diagnosis. FOCUS partners do not use FOCUS awards for activities beyond linkage to the first appointment.

Current efforts to support expansion include the inclusion of this initiative as an objective within the State Health Improvement Plan, where by December 31, 2026, FDOH and external partners aim to increase the number of emergency room or acute care hospitals that are conducting opt-out HIV screening, routine HCV screening and syphilis testing with a smart screen algorithm from 1 (2021) to 15. The figure below visualizes 2022 partner reach for the State of Florida.

Gaps still exist in the implementation of routine HIV, STI, and HCV testing in hospital emergency departments (EDs) and primary health care settings. Accounts of individuals seeking medical care in hospital EDs for symptoms akin to acute HIV infection are frequent, and, oftentimes, persons visit the ED several times before being tested for HIV, diagnosed, and linked to care. Approximately seven in 10 PWH saw a health care provider in the 12 months prior to diagnosis and failed to be diagnosed.59 Additionally, reimbursement by Medicaid for HIV testing in hospital EDs is a challenge as we move forward with routinizing testing in EDs; in some cases, testing may not be covered unless deemed medically necessary or clinicians may be less likely to bill when they frequently receive rejections.

From June 2019 to April 2020, the University of Miami AIDS Education and Training Center (UM-AETC) performed outreach to health care facilities in the highest HIV incidence areas throughout Miami-Dade and Broward counties to conduct assessments and academic detailing. Facilities

included community health centers and primary care and internal medicine clinics. Assessments examined the status of health care facilities in implementing routine HIV testing and PrEP provision in accordance with CDC guidelines and in implementing or extending third-party billing for routine HIV screening. Less than a quarter (20%) of the health care provider practices reported offering routine HIV screening services to all patients ages 13–64, regardless of symptoms or demographics. Of the remaining clinics, 28.6 percent reported that they test patients based on symptoms and demographics, and 30 percent reported testing only those who requested an HIV test. Among barriers to rapid HIV testing, most practices indicated that they never considered rapid HIV testing as a service (30%). Other barriers to providing rapid HIV testing were the perceived need to obtain consent, staff lacking training for administering and billing, the concern that testing would not be reimbursed by payors, and uncertainty about the implementation of in-office rapid testing.

Billing and Reimbursement

In April 2013, the U.S. Preventive Services Task Force (USPSTF) gave routine HIV screening of all adolescents and adults, ages 15 to 65, an "A" rating – aligning the rating with the CDC's HIV screening guidelines. The "A" rating has further implications given the Affordable Care Act (ACA), which requires or incentivizes new private health plans, Medicare, and Medicaid to provide preventive services rated "A" or "B" at no cost to patients. Challenges exist with reimbursement by Medicaid for routine HIV screening in hospital EDs and some facilities report only being able to reimburse for those tests deemed medically necessary. As the state moves forward with expanding routine HIV screening in hospital EDs, more work is needed to ensure these facilities can bill and receive reimbursements from Medicaid for these screenings.

Billing third-party insurance was reported as a barrier to billing and reimbursement by almost one-third of providers assessed by UM-AETC and was the most prominent barrier encountered. Most clinics reported staff lack of knowledge regarding billing/coding and corporate decisions to be the greatest barriers to implementing routine HIV screening. Other notable barriers were lack of time/staffing capacity to perform billing, challenges in contracting with third-party payors, and difficulty managing multiple contracts with third-party payors.

Stigma

Stigma around HIV affects healthcare seeking behavior. Stigma related to HIV/STI screening can occasionally lead individuals to state they do not possess insurance coverage for the service. Similar confidentiality concerns exist for young people who receive health insurance coverage through their parent or guardian (e.g., Explanation of Benefits). Fear of disclosure of confidential health information can deter youths and adults from seeking out HIV/STI screening and PrEP services. HIV testing locations that are associated with HIV/AIDS service organizations are also perceived as more stigmatizing, with clients citing additional disclosure concerns. There is a

need for integration of HIV testing locations with other health care services and screenings to minimize stigma.

The MMP surveillance system also asks questions to understand the various types of stigmas PWH have experienced, including anticipated, enacted, and internalized stigma using a ten-item scale ranging from zero (no stigma) to 100 (high stigma) that measures four dimensions of HIV stigma: personalized stigma since HIV diagnosis, current disclosure concerns, current negative self-image, and current perceived public attitudes about people living with HIV. Analysis of the 2015–2020 Florida MMP data found that females (n=44) experienced a higher level of stigma compared to transgender individuals (n=39) and males (n=32). Black/African American persons (n=37) experienced a higher level of stigma than White (n=32) and Latino (n=32) persons who experienced the same level of stigma. Heterosexuals or straight people (n=38) experienced a higher level of stigma than bisexual persons (n=36). Lastly, it was also found that those ages 18–29 experienced a higher level of stigma (n=43) than ages 40–49 (n=36), and ages 30–39 (n=35). It was found that ages 50 and higher experienced the lowest level of stigma (n=32).

<u>To eliminate these barriers, FDOH has done or will do the following:</u>

• Conducted a Routine Screening Expansion Roundtable, which took place May 26, 2022. The purpose of this meeting, hosted by the Lieutenant Governor, was to bring together a wide variety of external stakeholders to discuss how to expand routine opt-out HIV, syphilis, and HCV screenings in emergency departments and acute care settings and move toward ending these syndemics in Florida.

• Under Chapter 64D-3, FAC, "Control of Communicable Diseases and Conditions which may Significantly Affect Public Health", providers and laboratories are required to report only positive HIV test results to FDOH. FDOH is currently working to update the Administrative Code to include the mandatory reporting of all HIV test results to:

1. Improve the reporting and surveillance of stage zero or acute diagnoses to understand the burden of recent transmission for intervention and prevention Understand the scope and total HIV testing being conducted in Florida and calculate a state positivity rate that can be used to drive future interventions and prevention efforts.

• Conduct an assessment on current Florida FOCUS partners to understand who is aging out of the program and when and use current funding to support testing and linkage to care efforts.

• Work with directly funded RWHAP Part A programs within the six metropolitan areas of the state to collaborate on supporting routine screening efforts in those areas.

• Collaborate with AHCA to develop a Dear Colleague letter from Medicaid to clarify reimbursement support for routine HIV and hepatitis C screening in hospital EDs.

• Explore leveraging Opioid Settlement Funds to help support the expansion of medication assisted treatment (MAT) pathways in hospitals.

In addition to the FOCUS program, the HIV/AIDS Section also has a $250,000 annual contract funded through federal grants with the University of Central Florida HealthARCH program that aims to assess the readiness of health systems within the seven metropolitan counties of high HIV burden and onboard them to modify their electronic health records and offer routines screening for HIV.

II. TREAT

a. Services people need to rapidly link to HIV medical care & treatment after diagnosis

FDOH will also continue to fund agencies based on their expertise in HIV testing and linkage with the priority populations addressed by the Integrated Plan. As part of the integration of prevention, care, and treatment, plans are being developed to implement data-to-care activities that supplement eHARS with PE data to identify clients needing re-engagement services and VL monitoring. Subrecipients will be required to demonstrate their ability to implement services in a timely manner, test large numbers of individuals, identify individuals unaware of their HIV+ status, link HIV+ persons to IPCBH, and participate in data collection, CQM, and evaluation.

HIV+ Broward residents access the Continuum through many entry points. CDC, Part C EIS, and insurers fund most Broward HIV testing activities. CDC and Part C EIS-funded services support anonymous and confidential testing at FDOH-BROWARD's CTS. Individuals identified as HIV+ at one of the numerous community testing sites are referred to the **Test and Treat Program** (TTP).

Broward's EIS activities support the Continuum's diagnosis and linkage stages for newly identified HIV+ residents. Part A-funded CIED coordinates with EIS sites to ensure timely eligibility and linkage to IPCBH and other Part A services, achieved by co-locating service sites. CIED conducts RWHAP eligibility determination, assesses health insurance eligibility, assists in insurance enrollment, schedules IPCBH visits, and makes referrals for other needed services.

The Part A Recipient coordinated efforts with FDOH-Broward to design and implement the **Test and Treat Program** (TTP). Since 2017, TTP has provided same-day linkage to IPCBH for HIV+ individuals. Part A TTP funds were used to serve 1,468 in FY2019. TTP clients initiate ARVs at the time of HIV+ confirmation or return to care. TTP benefits clients' health and the community by promoting immediate access to ARVs, while completing RWHAP eligibility and linkage to ongoing core medical and support services. The Part A Recipient and FDOH-BROWARD monitors the impact of the TTP on the Continuum via analysis of client-level PE data. Standardized PE reports measure TTP clients' outcomes at each stage of the Continuum. An in-

depth evaluation of the TTP was completed for the Part A Recipient in August 2019, with recommendations for further enhancement of the TTP.

Part A-funded CIED and CDC-funded prevention providers collaborate to close the gap between HIV diagnosis and linkage to IPCBH. Part A CIED protocols assist clients to be retained in IPCBH. CIED conducts RWHAP eligibility certification and annual recertification using PE to ensure clients are engaged in IPCBH. TTP clients are provided with an expedited provisional 30-day CIED eligibility certification to ensure rapid access to IPCBH and other Part A services. A PE scheduling system alerts CIED staff when clients are out of care. CIED staff facilitate rapid re-engagement in IPCBH via client contact and appointment scheduling. PE also alerts Subrecipients when a client has not had an IPCBH appointment in the last six months. If a client has fallen out of care, Part A Subrecipients refer the client to FDOH-BROWARD for intensive linkage services. Part A Subrecipients are required to use PE to monitor retention in IPCBH. This approach allows Subrecipients to query PE and receive alerts on clients kept or missed medical visits.

b. Services Needed to Stay in HIV Care & Treatment & Achieve Viral Suppression

In addition to core medical services, social support services are offered to Broward PWH to support the NHAS goals, including linkage to and retention in IPCBH, ARV access, and viral suppression. Parts A and B fund support services including food bank, home-delivered meals, legal, medical transportation, and non-MCM services. These services are designed to promote IPCBH engagement and retention. Federal, state, and local funds support these and other services to enhance Broward's high-quality Continuum. HIV prevention, care, and treatment providers collaborate with key funders and other stakeholders to identify HIV+ residents, link them to IPCBH, initiate and sustain access to ARVs, and retain clients in IPCBH. The Part A Recipient and HIVPC also considers the Continuum in the PSRA process. The Part A Recipient and FDOH-BROWARD collaborate to implement the Continuum and improve engagement at each stage. This effort includes close collaboration in integrating HIV prevention and care services.

Part A-funded Disease Case Management (SCM) helps clients to engage in IPCBH, adhere to ARVs, and address barriers that impede IPCBH appointment keeping. DCM and non-MCM workers advocate on behalf of their clients, counsel patients on effective ways to navigate the healthcare and entitlement systems, and link clients to other services to achieve sustained viral suppression. DCMs and CIED intake specialists follow up on client referrals and eligibility recertification, which helps to engage and retain clients in IPCBH.

Part A examines performance and outcomes measures across the Continuum, which is necessary to monitor program effectiveness and utilization.

III. PREVENT. Services people at-risk for HIV need to stay HIV negative

FDOH-BROWARD has developed an HIV Prevention Continuum, like the Care and Treatment Continuum, as part of the FDOH-BROWARD EHE Plan. The Prevention Continuum framework builds on HIV testing as the foundation of linking "high-risk" HIV negative individuals to biomedical and behavioral prevention, retention, and adherence services. This approach is necessary to frame a comprehensive response to HIV in Broward and assess the performance of HIV prevention services.

Services for people at-risk for HIV need to stay HIV negative include pre-exposure prophylaxis (PrEP), non-occupational post-exposure prophylaxis (nPEP), and comprehensive syringe service programs (SSPs).

FDOH-Broward funds ten local agencies to provide HIV prevention services, including services specific to PrEP/nPEP. Five of the ten organizations provide clinical PrEP/nPEP services. Two service providers' funded tasks include PrEP/nPEP screening and referrals. Two providers received funding to provide financial assistance for PrEP/nPEP clinical services. One provider receives funding to operate a local HIV prevention, care, and treatment resource and referral line. In Year 1 of the EHE grant, FDOH-Broward funded five service providers to provide clinical PrEP and nPEP services. In addition, FDOH-Broward's HIV prevention website, getprepbroward.com, houses a comprehensive directory of PrEP Providers located throughout Broward County.

Barriers to readily accessing PrEP services include awareness, access, and cost are barriers impacting PrEP uptake. FDOH-Broward used numerous strategies to address PrEP barriers. PrEP-specific social marketing campaigns were exhibited in prioritized ZIP codes for several months. Telehealth and mobile units were funded to increase access to PrEP/nPEP. Of the five funded clinical PrEP/nPEP service providers, three are mandated to have telemedicine as an option for patients, and the remaining two provide PrEP/nPEP services in a mobile unit. Lastly, two agencies were funded to establish a financial assistance program for payment of clinical PrEP/nPEP medical visit co-pays and labs.

Broward County's Human Services Department recently selected a local FQHC to provide a free safe syringe exchange program (SSP). The statute allowing SSPs to operate under a county ordinance doesn't allow for county, state, or federal funding for SSP operations.

Partner Notification Services

Per section 384.26, Florida Statutes, FDOH is the only entity authorized to perform HIV and STI partner services and notification, and these activities are carried out by trained DIS. While Florida maintains a mature and robust HIV/STI partner services program, opportunities to strengthen the DIS workforce and update partner notification mechanisms exist. Extensive training needs, high caseloads, and low staff retention not only contribute to high DIS turnover

rates, averaging 40 percent annually over the past five years, but also impact the effectiveness of partner elicitation. Numbers of claimed partners have decreased as numbers of anonymous partners reported through mobile dating applications has increased, creating challenges for intervention. In 2017, FDOH piloted the usage of mobile dating applications as an added partner notification tool for persons exposed to HIV/STIs, with marginal success. Additional strategies are being explored to allow for HIV partner notification via text messaging or phone calls. In Summer 2022, the Bureau of Communicable Diseases provided interim guidance allowing DIS to use Facebook Messenger and Text to initiate contact for partner services for STI/HIV partner notification.

Florida is unique in that there are now four qualified staff to teach the week-long Passport to Partner Services training. In 2022, the STD Section will enter a contract with the University of South Florida to establish a learning academy and completely revamp the existing core training curriculum for DIS and STD program supervisors.

IV. RESPOND. Respond quickly to potential HIV outbreaks

In 2021, FDOH hired a lead outbreak response epidemiologist to build the Bureau of Communicable Diseases' capacity to develop, implement, and maintain an integrated HIV/STI/HCV transmission outbreak and response unit.

The COVID-19 pandemic has impacted EHE counties by pulling DIS and linkage staff from regular duties to COVID-19 related activities. This severely impacted the ability to respond quickly to potential HIV outbreaks by limiting the number of available staff who can follow up on potential and/or rapidly growing clusters.

In addition, limited education, and training of DIS and linkage staff also hinders quick and adequate response to HIV outbreaks, as they lack the requisite knowledge and/or skills to respond appropriately to the identification of a cluster. Also, limited awareness and understanding at the community level continue to be a challenge, as community members are reluctant to engage with staff related to cluster related discussions. In response, targeted training within the county health departments as well as community engagement activities will shed light on the importance of cluster response. No definitive date has been set for these education and training sessions; however, resources are being gathered, and the development of the curriculum is underway.

Lastly, data systems not having the functionality to provide a clear workflow and task list to send and receive information from investigations as well as a standardized interviewing process for HIV cases continue to be a major barrier. FDOH is working with its data integration team to develop a more interoperative system as well as working to develop a more standardized questionnaire.

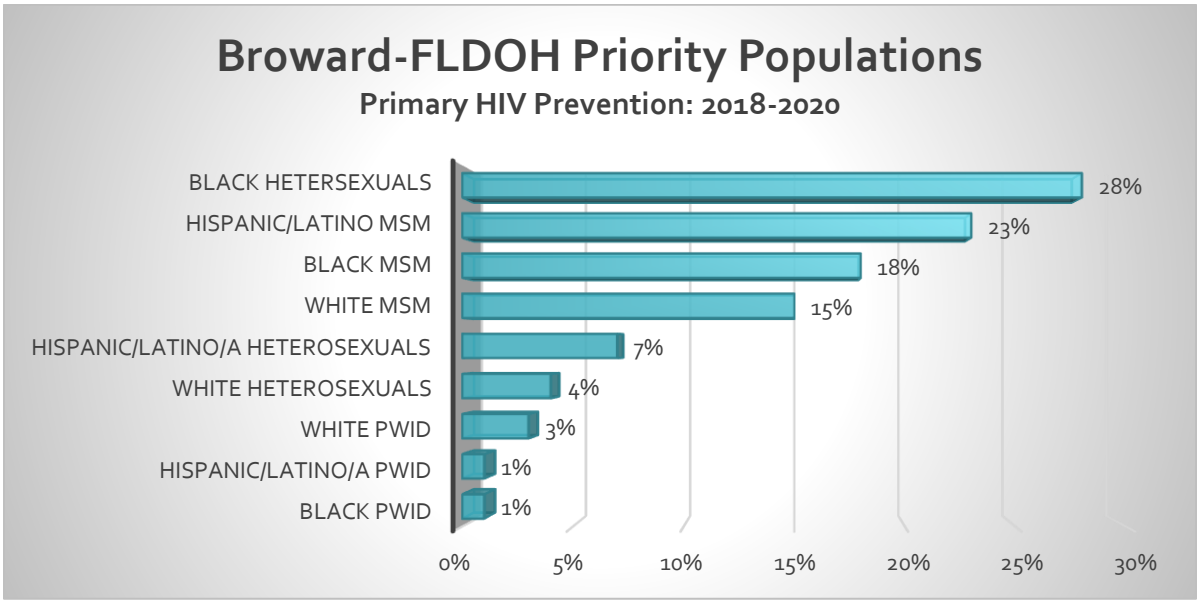
Though no formal processes to facilitate robust, real-time cluster detection and response exist at present, data systems and policies have been approved and are in place, and the internal FDOH cluster committee continues to establish and develop partnerships at the national, state, and local levels to better understand and inform themselves of identified barriers but also to recognize the best and most applicable practices for real-time cluster detection and response in Florida. Formalized processes, data systems, and policies are tentatively planned to be implemented in the spring of 2022.

The FDOH Bureau of Communicable Diseases Chief and staff from the HIV Surveillance Program are working with FDOH's Florida Community Health Assessment Resource Tool Set (FL CHARTS) team to discuss the creation of and support for an EHE dashboard that can modernize and enhance the data already in FL CHARTS. This public facing dashboard would provide timely data to the community to inform on disease burden, drive actionable interventions, and measure and track performance for both national and state/EHE county-level indicators.

4.a Priority Populations

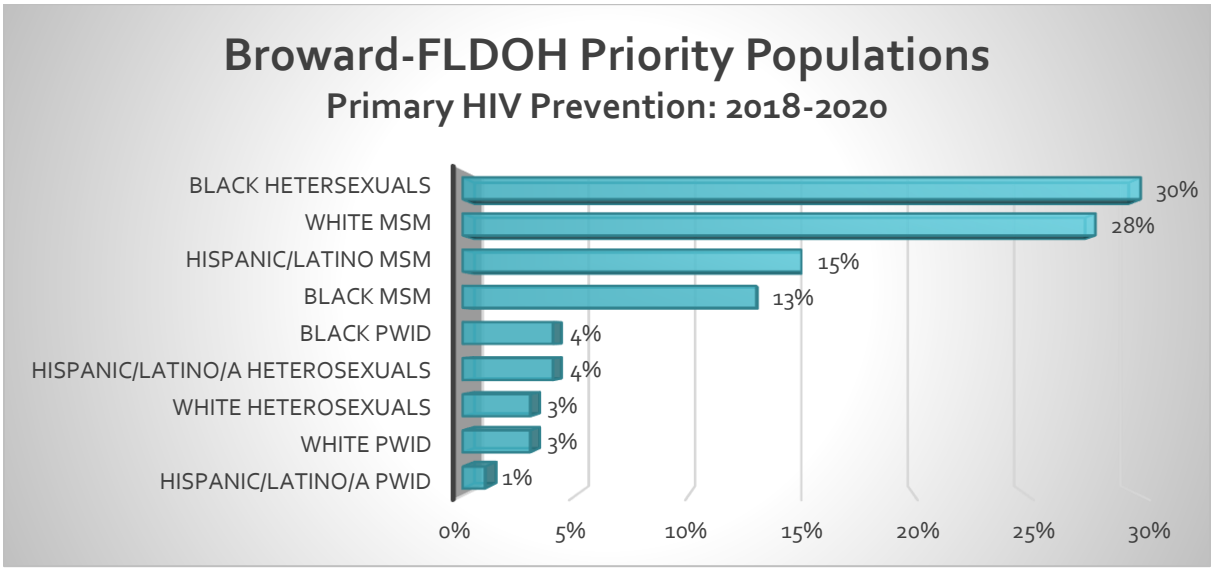
Priority populations for primary HIV prevention were calculated from HIV diagnoses over the last three years (2018–2020) and represent the proportion of each race or mode of exposure group to total diagnoses. These data are used to identify and prioritize testing, PrEP and other HIV prevention services to those at greatest risk for acquiring HIV in Broward County. As shown in the figure below, the top five priority populations are Black heterosexual men and women (28%), Hispanic/Latino Men who have sex with Men (MSM) (23%), Black MSM (18%), White MSM (15%), and Hispanic/Latino/a heterosexual men and women (7%).

Figure 12 Broward Priority Populations for Primary HIV Prevention



Priority populations for secondary prevention for PWH data were calculated from PWH living in Broward County at year-end 2020 and represent the proportion of each race or mode of exposure group to the number of PWH. 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 viral suppression. The top five priority prevention populations in 2020 for PWH living Broward County are Black heterosexuals (30%), White MSM (28%), Hispanic/Latino MSM (15%), Black MSM (13%), and Hispanic/Latino/a heterosexuals.

Figure 13 Broward Priority Prevention Populations for PWH



Section V: 2022-2026 Goals and Objectives

GOAL 1: PREVENT NEW HIV INFECTIONS

EDUCATIONAL CAMPAIGNS

1.1 Increase the percentage of people living in Broward County who are aware of their HIV status from the national baseline of 88.8% in 2019 to 95% by December 31, 2026. *

Strategy 1.1.1: Develop and implement campaigns, interventions, and resources to provide education about comprehensive sexual health; HIV risks; options for prevention, testing, care, and treatment; and HIV-related stigma reduction.

Strategy 1.1.2: Develop and implement a social marketing campaign (e.g., www.hivtestnow.com).

FDOH-Broward EHE Plan Activities

1. Develop/ implement a community-driven campaign to decrease HIV testing stigma and fear.
2. Develop and implement a community-driven campaign to educate the community on the importance of knowing your HIV status and where to obtain an HIV test.

Community Recommended Activities

1. Develop measures to quantify the impact of stigma on HIV prevention and care.
2. Tailor HIV education to subpopulations - Caribbean, Black, Hispanic/Latinx, etc.
3. Ensure that HIV /STI mobile test units are at festivals, beaches, concerts, etc.
4. Incorporate comprehensive and inclusive sex ed for adolescents and young adults discussing gender, sexuality, consent, and relationship wellness in various venues including schools
5. Digitize educational materials on popular social media sites that youth utilize.

Strategy 1.1.3: Increase HIV knowledge among communities and health workforce.

Community Recommended Activities

1. Assess the feasibility of mobile training units for wider outreach capabilities.
2. Develop indicators to measure an increase in HIV knowledge among communities and the health workforce in areas disproportionally affected.
3. Collaborate with traditional and non-traditional partners to conduct HIV/STI testing in non-traditional settings (i.e., faith-based o, domestic violence/ human trafficking agencies)

TESTING

1.2 Increase Knowledge of HIV status

Strategy 1.2.1: Test all people for HIV according to current USPSTF and CDC guidelines.
Strategy 1.2.2: Expand routine HIV testing in targeted healthcare settings.

RWHAP Part A EHE Plan FDOH-Broward EHE Plan Activities

1. Provide continuing education regarding routine HIV testing (opt-out law, sexual history taking, stigma, insurance reimbursement, to health professionals and students (explore mandatory continuing ed with license renewal).
2. Expand testing detailing (opt-out law, sexual history taking, stigma, insurance PCP reimbursement)
3. Partner w/ FOCUS Project to recruit additional EDs to provide routine testing

Activities

1. Increase the number of high-risk individuals tested for HIV, including sex partners of PWH.
2. Increase the number of PWH aware of their HIV status but not in care and rapidly link them to outpatient/ambulatory health services (OAHS) and initiate ARVs.

Strategy 1.2.2: Develop new and expand implementation of effective, evidence-based, or evidence-informed models for HIV testing that improve convenience and access.

FDOH-Broward EHE Plan Activities
1. Partner with big box stores, pharmacies, & urgent care to offer routine HIV and STI testing.
2. Explore provision of routine HIV testing in dental practices starting with a pilot at a college.
3. Explore provision of HIV testing in a mobile healthcare clinic
4. Partner with BSO to provide routine HIV testing upon intake in clinics and correctional facilities.
5. Partner with substance use treatment providers to provide routine HIV testing on admission
6. Partner with assisted living facilities and skilled nursing facilities to provide routine HIV testing.
7. Partner with academic institutions to provide routine HIV and STI testing in student health clinics.

Strategy 1.2.3: Expand targeted HIV testing of priority populations in non-healthcare settings.

FDOH-Broward EHE Plan Activities
1. Use social network strategy to identify and test persons at risk for HIV through peers and partners.
2. Expand access to HIV testing through the provision of in-home test kits at community sites.
3. Expand the free in-home test kit program to high-risk ZIP codes.

Strategy 1.2.4: Incorporate status-neutral approach to testing, offering linkage to prevention for people who test negative and immediate linkage to HIV care/treatment for those who test positive.

FDOH-Broward EHE Plan Activities
1. Create a seamless status-neutral HIV care continuum.
2. Collaborate with community partners to conduct SWOT analyses of HIV Continuum.

Strategy 1.2.5:Collaborate with community partners to conduct SWOT analyses of care continuum data, number of participants in trainings, PrEP prescribing data, number of physicians detailed.

Strategy 1.2.6: Provide partner services to PWH or other STIs and sexual or syringe-sharing partners.

Strategy 1.2.7: Increase awareness and access to HIV testing.

Community Recommended Activities
1. Include activity related to self-testing.
2. Include activity related to targeted (prioritized) testing

PREVENTION INTERVENTIONS INCLUDING PrEP

1.3 Expand and improve implementation of safe, effective prevention interventions, including treatment as prevention (TasP), PrEP, PEP, and SSPs, and develop new options.

Strategy 1.3.1 Engage people at risk for HIV in traditional and nontraditional community settings.

RWHAP Part A EHE Plan Activities
1. Provide intensive interventions that promote linkage and engagement in Outpatient Ambulatory educate about HIV and ways to avoid HIV transmission and support a rapid transition to OAHS.

Community Recommended Activities
1. Implement strategies to target PWH experiencing homelessness
2. Implement strategies that increase ability to make good decisions in the sexual setting

Strategy 1.3.2 Scale up treatment as prevention (i.e., U=U) by diagnosing all people with HIV as early as possible and engaging them in care and treatment to achieve and maintain VL suppression.

FDOH-Broward EHE Plan Activities
1. Provide education to community stakeholders, organizations, and elected officials about U=U and Treatment as Prevention to support HIV modernization activities that impact state laws.

2. Implement a social marketing campaign promoting the U=U strategy.
3. Explore the implementation of a pilot program to provide incentives for attaining and maintaining VL suppression.
4. Explore the expansion of our local resources and referral line to serve PWH.

RWHAP Part A EHE Plan Activities
1. Provide HIPAA-compliant medical transportation

Strategy 1.3.3: Make prevention services, including condoms, PrEP, PEP, and SSPs, easier to access.
Strategy 1.3.4: Expand access to PrEP throughout the system of care.

FDOH- Broward EHE Plan Activities
1. Expand hours for PrEP/nPEP provision at public providers to include evenings and weekends
2. Utilize telemedicine to provide PrEP/nPEP.
3. Explore the provision of PrEP/nPEP in a mobile healthcare clinic.

Strategy 1.3.5: Raise community awareness of PrEP/nPEP through outreach and social marketing.

FDOH- Broward EHE Plan Activities
1. Expand Street outreach regarding PrEP/nPEP.
2. Develop community-driven campaign to educate community on PrEP/nPEP and decrease stigma.
3. Work with partners to provide PrEP/nPEP in conjunction with a SEP, if implemented.
4. Partner with big box stores and retail pharmacies to offer PrEP/nPEP in on-site clinics
5. Expand education to primary care physicians to recruit additional PrEP/nPEP prescribers.
6. Address the financial barriers to PrEP/nPEP initiation and retention.

Strategy 1.3.4 Implement culturally competent and linguistically appropriate models and other innovative approaches for delivering HIV prevention services.

Community Recommended Activity
1. Seek opportunities to increase culturally competent providers (e.g., Haitian Creole).

DIVERSITY AND EQUITY

1.4 Increase diversity and capacity of systems and workforce to prevent and diagnose HIV.

Strategy 1.4.1: Provide resources, incentives, training, and TA to expand workforce and systems capacity to provide or link clients to culturally competent, linguistically appropriate, and accessible HIV testing, prevention, and supportive services.
Strategy 1.4.2: Incorporate health equity into HIV testing.

FDOH- Broward County Ending the HIV Epidemic Activities
1. Provide Racial Equity Institute (REI) training to all registered HIV testing counselors.
2. Provide cultural competence training to all HIV testing counselors to better serve LGBTQ+
3. Provide capacity-building and TA to grassroots organizations serving priority populations.
4. Provide mini grants to grassroots organizations that serve priority populations.
5. Provide REI training to FDOH-Broward contracted PrEP/nPEP providers.
6. Provide cultural competence training to FDOH-Broward contracted PrEP/nPEP providers

Strategy 1.4.3 Increase diversity of HIV prevention, testing, and supportive services.

Strategy 1.4.4 Increase the inclusion of paraprofessionals on prevention teams by advancing training, certification, supervision, financing, and team-based care service delivery.

GOAL 1: PREVENT NEW HIV INFECTIONS

KEY PARTNERS:

Health Departments, Community-based organizations, Federally Qualified Health Centers, correctional facilities, school-based clinics, sexual health clinics, women's health services, prenatal service providers, Primary care physicians, pharmaceutical companies, academic institutions (Nova Southeastern University, Florida International University, Southeast AETC, FOCUS Project, Press Play Project, hospitals, testing device manufacturers, Broward Sheriff's Office, contracted correctional medical providers, substance use treatment providers, United Way, Broward Addiction and Recovery Center, CDC Capacity Building Assistance Providers, peers, adult entertainment venues, HIV Prevention contracted providers, registered HIV testing sites, trans-led organizations, HIV planning councils, advisory boards, Test and Treat providers, and PrEP/nPEP providers.

POTENTIAL FUNDING RESOURCES:

EHE Funding, CDC HIV /STD Prevention and Surveillance Programs, RWHAP, Bureau of Primary Health (Health Centers), State and Local funding, Medicaid

OUTCOMES (reported annually, locally monitored more frequently):

- Number of newly identified persons with HIV: Increased number of individuals who know their status; Increased number of health care settings implementing a routine screening protocol.
- Increased number of persons receiving care,
- Number of peer programs,
- Minimize stigma as a barrier to obtaining care.

MONITORING DATA SOURCES: EMR data, HIV/STD surveillance data

EXPECTED IMPACT ON THE HIV CARE CONTINUUM:

Increase the number of people who know their HIV diagnosis by 6.2% and are linked to medical care within 30 days.

***Note**

1. AHEAD Dashboard: defines "knowledge of HIV status" as "the estimated percentage of people with HIV who have received an HIV diagnosis," and the percentages for Broward County are 88.8% in 2019, and 95% in 2026 https://ahead.hiv.gov/locations/broward-county

GOAL 2: IMPROVE HIV-RELATED HEALTH OUTCOMES

LINKAGE TO CARE

2.1 Link people to care immediately after diagnosis and provide low-barrier access to HIV treatment.

Strategy 2.1.2 Increase the number of schools providing on-site sexual health services through school-based health centers and school nurses, and linkages to HIV testing and medical care through providers with youth in care or virally suppressed.

FDOH- Broward County Ending the HIV Epidemic Activities

1. Partner with schools to expand the provision of HIV and STI testing for students

Community Recommended Activities

1. Create more hands-on educational programming in schools for students, have a safe place to discuss their concerns, and create more accessible sexual health resources.
2. Increase educational programs for parents and guardians to educate them on sexual health topics.
3. Dialogue more with youth and create a seat at the table for youth to share their opinions and voices in a safe environment free of judgment and consequences.
4. Provide youth with monetary incentives to retain youth in care.

RWHAP Part A EHE Plan Activities

1. Increase the number of PWH aware of their HIV status but not in care and rapidly link them to outpatient/ambulatory health services (OAHS) and initiate ARVs.
2. Provide intensive interventions that promote linkage and engagement in OAHS, educate about HIV and ways to avoid HIV transmission, and support a rapid transition to OAHS.

Strategy 2.1.3 Identify, engage/ reengage PWHV who are not in care or are not virally suppressed.

Community Recommended Activities

1. Increase awareness of available programs by developing a high-end visual guide depicting available programs across all communities including a flow-chart to educate clients to maneuver the system
2. Create a coordinated universal eligibility and recertification system for Parts A and B with an annual recertification hybrid (in-person or electronic) process.
3. Utilize a quality approach to redesign a system of care that has its structure built on interagency communication, interservice networking, and meaningful collaborations.
4. Enhance the client health experience to outcomes by providing transparent and understandable information on the "steps" to access needed support and eligibility continuation services.
5. Develop helpline to assist and empower consumers for access /eligibility concerns and/or challenges.
6. Develop a formal client orientation with visual tour and access procedures explained by a Peer.
7. Create a countywide geo-mapping dashboard to identify service locations.
8. Create a resource inventory for HIV health services -including housing providers.
9. Streamline the process for patients entering care/already in care
10. Develop a system of handing off patients to case management after test and treat
11. Ensure patient information is up to date
12. Expand education to the community about services available to meet their needs to establish a clear presence within the community in need of care

RETENTION IN CARE, ADHERENCE, AND VIRAL SUPPRESSION

2.2 Increase retention and adherence to achieve/maintain long-term suppression, provide integrative services for HIV-associated comorbidities, coinfections, & complications, including STIs

Strategy 2.2.1 Support the transition of health care systems, organizations, and patients/clients to become more health literate in the provision of HIV prevention, care, and treatment services.

Strategy 2.2.2 Develop and implement effective, evidence-based, or evidence-informed interventions and supportive services that improve retention in care.

Strategy 2.2.3 Expand implementation /successfully adapt effective evidence-based interventions, such as HIV telehealth, patient and peer navigators, accessible pharmacy services, community health workers, and others, to local environments to facilitate uptake and retention to priority populations.

RWHAP Part A EHE Plan Activities

1. Deploy multidisciplinary Intensive Care Teams (ICTs) to engage and retain clients through rapid assessment, care planning, active referrals, follow-up, care coordination, and ongoing ICM
2. Increase number of trained and credentialed peer workers and deployed as active ICT members
3. Increase number of clients receiving thorough behavioral health assessments and actively link them to behavioral health services
4. Increase the number of clients retained in high-quality OAHS through (a) efficient transportation that ensures clients keep their OAHS and other healthcare appointments and (b) telehealth, specialty consultation, and patient co-management with community physicians
5. Increase percentage of clients residing in temporary or transitional housing via the BCHSD HIP
6. Increase retention in care and stable housing rates by addressing social determinants such as illiteracy, unemployment, poverty, disability, inability to conduct activities of daily living (ADLs), and no insurance.

Community Recommended Activities

1. Employ peer navigators at each agency.
2. Expand funding for peer navigator services.
3. Develop systems that serve the needs of PWH using technology

Strategy 2.2.4 Increase the capacity of public health, healthcare delivery systems, and the healthcare workforce to effectively identify, diagnose, and provide holistic care and treatment for people with HIV.

PEER TRAINING, CERTIFICATION, SUPERVISION, REIMBURSEMENT

2.3 Increase inclusion of paraprofessionals on teams by advancing training, certification, supervision, reimbursement, and team functioning to assist with screening/management of HIV, STIs, viral hepatitis, mental and substance use disorders, and other behavioral health conditions.

RWHAP Part A EHE Activities

1. Increase the number of trained and credentialed peer workers deployed as active ICT members.

Community Recommended Activities

1. Increase the number of Service Categories that integrate peer services.
2. Revise employment requirements for peers to allow for expansion to include lived/professional experiences outside of educational requirements.
3. Secure funding to continue the Broward HIV Peer Certification Training to equip individuals with the needed skills and capacity to serve on healthcare teams.

AGING POPULATION AND LONG-TERM SURVIVORS

2.4 Expand capacity to provide whole-person care to older adults with HIV and long-term survivors.

Strategy 2.4.1 Identify, implement, and evaluate models of care that meet the needs of people with HIV who are aging and ensure the quality of care across services.

Community Recommended Activities

1. Develop Age-friendly support services for PWH 55+ to assist in navigating access to services.
2. Develop a system of care that supports healthy aging for PWH including education and community resources on Medicare, Medicaid, telehealth, wellness, and strategies to adopt/adapt healthy behaviors.

Strategy 2.4.2 Identify and implement best practices related to addressing the psychosocial and behavioral health needs of older people with HIV and long-term survivors (LTS) including substance use treatment, mental health treatment, and programs designed to decrease social isolation.

Community Recommended Activities

1. Develop targeted mental health services for LTS addressing loneliness and mental health.
2. Implement PE alert clients turning 65 of their eligibility for Medicare coverage as supplemental insurance. Not applying for Medicare can become a burden for LTS, as patients are penalized with hefty monthly fees when they do not meet the deadline for applying for the correct Medicare plan.
3. Have more educational training for providers and case managers for persons turning 65. Educating them on what to expect for their patient's medical insurance and eligibility process.
4. Create more support groups for LTS.

Strategy 2.4.3 Increase HIV awareness, capability, and collaboration of providers to support older people with HIV, including in settings such as aging services, housing for older adults, substance use treatment, and disability and other medical services.

Community Recommended Activities

1. Include HIV awareness, capability, and collaboration of Long-Term Care/assisted living facility providers to support older people with HIV to increase cultural competence and decrease stigma.

Strategy 2.4.4 Promote cross-agency collaborations that address specific aging-related conditions in people with HIV, and other comorbidities and coinfections that can impact people with HIV of all ages.

Community Recommended Activities

1. Develop a promotional PSA and associated social media messaging on healthy aging.
2. Engage with partner agencies and programs to address the multitude of aging and chronic conditions affecting persons with HIV over the age of 50.

Strategy 2.4.5 Develop and optimize collaborative multi-agency and multi-sectoral approaches and strategies to address emergent and evolving challenges facing people living with HIV at various life stages to support healthy aging.

GoI 2: Key Partners, Funding Resources, Outcomes, Monitoring Data & Impact

KEY PARTNERS: Ryan White Part A office and primary care providers, primary care physicians, infectious disease specialists, Health Departments, Community-based organizations, Federally Qualified Health Centers, Medicare, correctional facilities, school-based clinics, sexual health clinics, women's health services, prenatal service providers, Primary care physicians, pharmaceutical companies, academic institutions (Nova Southeastern University, Florida International University), Southeast AETC, FOCUS Project, hospitals, testing device manufacturers, Broward Sheriff's Office, contracted correctional medical providers, substance use treatment providers, United Way, Broward Addiction and Recovery Center, CDC Capacity Building Assistance Providers, peers, adult entertainment venues, HIV Prevention contracted providers, registered HIV testing sites, Transgender-led organizations, HIV planning councils, and advisory boards, Test and Treat providers.

POTENTIAL FUNDING RESOURCES: CDC HIV /STD Prevention and Surveillance Programs, RWHAP, Bureau of Primary Health (Health Centers), State and Local funding, Medicaid

OUTCOMES (reported annually, locally monitored more frequently): Improved access to the system of care for PWH, increased number of PWH retained in care, decreased number of persons out of care, increased number of persons linked to care in 30 days, increased number of PWH virally suppressed and adherent to medication regimen, increased number of Peers trained, certified, and hired throughout the system of care, Increase support systems for PWH 55+.

MONITORING DATA SOURCES: Electronic Health Records data, HIV/STD surveillance data, Provide Enterprise Data, CAREWare Ryan White Part B Database

EXPECTED IMPACT ON THE HIV CARE CONTINUUM: Increased number of PWH retained in care, virally suppressed and adherent to a medication regimen; Increased number of persons linked to care in 30 days; Viral suppression to > 75% to reduce HIV transmission among their partners and newborns; Retained in care to > 80% to ensure access to ARVs, increased life expectancy, increased viral suppression, and reduced morbidity and mortality.

GOAL 3: REDUCE HIV-RELATED DISPARITIES AND HEALTH INEQUITIES

CIVIL RIGHTS LAWS AND WORKFORCE

3.1 Reduce HIV-related stigma and discrimination

Strategy 3.1.1: Strengthen enforcement of civil rights laws (including language access services and disability rights), promote reform of state HIV criminalization laws, and assist states in protecting people with HIV from violence, retaliation, and discrimination associated with HIV status, homophobia, transphobia, xenophobia, racism, substance use, and sexism.
Strategy 3.1.2: Explore supporting HIV modernization activities that impact state laws (i.e., HIV decriminalization).

Community Recommended Activities
1. Partner with the Florida HIV/AIDS Advocacy Network (FHAAN) in its public policy and legislative advocacy activities.

Strategy 3.1.3: Ensure that healthcare professionals and front-line staff complete education and training on stigma, discrimination, and unrecognized bias toward populations with or who experience risk for HIV, including LGBTQI+ people, immigrants, people who use drugs, and people involved in sex work.

RWHAP Part A Ending the HIV Epidemic Activities
1. Incorporate health equity into HIV care and treatment.
2. Provide REI training to all Ryan White Part A HIV primary care providers.
3. Provide cultural competence training to all Ryan White Part A HIV primary care providers.
4. Provide trauma-informed care training for all Ryan White Part A HIV primary care providers.

Community Recommended Activities
1. Assess the ability to require organizations to adopt a DEI framework and are held accountable to the Diversity, Equity, and Inclusion (DEI) Framework.
2. Revise the language in the cultural competency curriculum for providers.
3. Assess the possibility of expanding the HIV "helpline" functionality to include receiving calls regarding poor experiences with providers and addressing issues of provider cultural sensitivity.
4. Expand provider network to meet the needs of HIV+ Haitian descent residents; expand cross-training in cultural competence to assist providers effectively. communicating with clients of varying background.
5. Provide training and development for front-line staff.
6. Mitigate and eliminate stigma in HIV-related service provision.
7. Partner with NMAC to increase access for RWHAP providers and RWAP planning bodies to participate in their ESCALATE stigma reduction program (training, technical assistance, and learning collaborative.
8. Encourage and incentivize RWHAP providers to participate in the Escalate training.

Strategy 3.1.4: Support communities in efforts to address misconceptions and reduce HIV-related stigma and other stigmas that negatively affect HIV outcomes.

1. Institute a countywide summit for stakeholder collaborations to address various HIV-related issues including misconceptions and HIV-related Stigma.
2. Revise language and visuals surrounding stigma.

Strategy 3.1.5: Ensure resources are focused on communities and populations where the need is greatest, especially Black, Latine, and other people of color, particularly those who are also gay and bisexual men, transgender people, people who use substances, sex workers, and immigrants.

Strategy 3.1.6: Create funding opportunities that specifically address social and structural drivers of health (SDOH) as they relate to Black, Latino, American Indian/Alaska Native, and other people of color.

Community Recommended Activities

1. Provide financial resources for disproportionately affected communities i.e., wrap-around services.
2. Define priority populations.
3. Develop more appropriate and accessible mental health services.
4. Improve collaboration across Continuum by enhancing the partnership among Part A, HOPWA, BCHSD housing services, and FDOH to secure additional housing funds.
5. Ensure the County EHE program includes housing, skills building, self-empowerment programs, work development, and partnerships with correctional facilities.

DISPARITIES IN NEW INFECTIONS

3.2 Reduce disparities in new HIV infections, in knowledge of status, and along HIV care continuum.

Community Recommended Activities

1. Increase awareness of HIV disparities through data, analysis, and dissemination of findings.
2. Develop new and scale-up effective, evidence-based, or evidence-informed interventions to improve health outcomes among priority and other populations or geographic areas experiencing disparities.

PWH EMPLOYMENT AND LEADERSHIP OPPORTUNITIES

3.3 Engage, employ, and provide public leadership opportunities at all levels for people with HIV.

Strategies 3.3.1 Create and promote public leadership opportunities for PWH or at risk for HIV.

Community Recommended Activities

1. Build the capacity of PWH to be meaningfully involved in the planning, delivering, and improving RWHAP services. (Incorporate programs from the organization, Meaningful Involvement of People with HIV/AIDS (MIPA) in Broward.
2. Partner with the National Minority AIDS Council's (NMAC) ELEVATE program to address workforce recruitment, development, and advancement needs for PWH in populations 50+, Young Black Men, T/GNC, Latinx, and the recovery community.
3. Build website: PWH Resources on Reducing Stigma, Leadership, Advocacy, Ed., and Opportunities.
4. Work with communities to reframe services and messaging to not stigmatize people or behaviors.

SOCIAL AND STRUCTURAL DETERMINANTS OF HEALTH (SDOH)

3.4 Address social and structural determinants of health and co-occurring conditions that impede access to HIV services and exacerbate HIV-related disparities.

Strategy 3.4.1 Develop whole-person systems of care and wellness that address co-occurring conditions for people with or who experience risk for HIV.

Strategy 3.4.2 Adopt policies that reduce cost, payment, coverage, and/or access barriers to improve the delivery and receipt of services for people with or who experience risk for HIV.

Community Recommended Activities

1. Identify opportunities to expand hours/access to HIV services.
2. Ensure services/information is available in different languages.

Strategy 3.4.3 Improve screening and linkage to services for people with or who experience risk for HIV who are diagnosed with and/or are receiving services for co-occurring conditions.

Strategy 3.4.4 Develop and implement effective, evidence-based, and evidence-informed interventions that address social and structural determinants of health among people with or who experience risk for HIV including lack of continuous healthcare coverage, HIV-related stigma and discrimination in public health and healthcare systems, medical mistrust, inadequate housing and transportation, food insecurity, unemployment, low health literacy, and involvement with the justice system.

Community Recommended Activities

1. Implement a plan to educate all eligible consumers about benefits of enrolling in ACA and Medicare.
2. County needs to expand transportation to include ride-share services to access HIV services
3. Assess food insecurity needs and gaps resulting in a county-specific food resource directory.
4. Develop model employment services initiatives and increase awareness of various programs to increase capacity of case managers to understand and help clients navigate intricacies of programs.

Strategy 3.4.5: Expand access to safe/affordable housing opportunities for PWH.

FDOH – Broward County Ending the HIV Epidemic Activities

Increase communication and coordination across agencies that provide affordable housing.

1. Community Recommended Activities
2. Implement a Housing workgroup in partnership with HOPWA to:
   a. Conduct a comprehensive assessment of housing need and develop plan to integrate services
   b. Share data on housing opportunities
3. Allocate more funding to Housing services.
4. Identify and provide additional affordable housing opportunities in Broward County
5. Challenge requirements for housing programs

Strategy 3.4.7: Increase financial security for people with HIV receiving SSDA or SSI by expanding knowledge of and access to existing work incentive programs to allow people to work and earn more income without losing disability benefits.

Community Recommended Activities

1. Identify the appropriate stakeholders to develop interventions to address low health literacy
2. Prioritize the quality of life in addition to viral suppression

Strategy 3.4.8: Develop new and scale-up effective, evidence-based, or evidence-informed interventions that address intersecting factors of HIV, homelessness or housing instability, mental health and violence, substance use, and gender especially among cis- and transgender women and gay and bisexual men.

Community Recommended Activities

1. When collaborating with the community to end the epidemic, conversations should include the transgender community
2. Be more creative in dismantling systems and creating a safe space for the transgender community to access services without judgment and oppression from providers.

Strategy 3.4.9 Advance HIV-related communications to achieve improved messaging and uptake, as well as to address misinformation and healthcare mistrust.

Community Recommended Activities

1. Develop and test strategies to promote accurate creation, dissemination, and uptake of information and to counter associated misinformation and disinformation.
2. Increase diversity and cultural competence in health communication research, training, and policy.
3. Expand community engagement in health communication initiatives and research.
4. Include critical analysis and health communication skills in HIV programs to provide participants with tools to seek and identify accurate health info and to advocate for themselves and their communities.

5. Expand effective communication strategies between providers and consumers to build trust, optimize collaborative decision-making, and promote evidence-based prevention and treatment.

Goal 3: Key Partners, Funding Resources, Outcomes, Monitoring Data & Impact

KEY PARTNERS: FHAAN, REI, HOPWA, Housing Department, NMAC, MIPA, Legal Aid, Ryan White Part A office and primary care providers, primary care physicians, infectious disease specialists, Health Departments, Community-based organizations, Federally Qualified Health Centers, Medicare, correctional facilities, school-based clinics, sexual health clinics, women's health services, prenatal service providers, Primary care physicians, pharmaceutical companies, academic institutions (Nova Southeastern University, Florida International University), Southeast AETC, CDC Capacity Building Assistance Providers, Peers, adult entertainment venues, Transgender-led organizations, HIV planning councils and advisory boards, test and treat providers.

POTENTIAL FUNDING RESOURCES: CDC HIV /STD Prevention and Surveillance Programs, RWHAP, Bureau of Primary Health (Health Centers), State and Local funding, Medicaid

OUTCOMES (reported annually, locally monitored more frequently): Improved diversity and health equity training in the health care workforce; increased number of trained and certified PWH working throughout the network of care; improved housing opportunities for PWH

MONITORING DATA SOURCES: EMR data, HIV/STD surveillance data, Provide Enterprise Data, CAREWare. HOPWA database, number of Peers trained and certified.

EXPECTED IMPACT ON THE HIV CARE CONTINUUM: Increased number of PWH retained in care, virally suppressed and adherent to a medication regimen; Increased number of persons linked to care in 30 days.

GOAL 4: ACHIEVE INTEGRATED, COORDINATED EFFORTS THAT ADDRESS THE HIV EPIDEMIC AMONG ALL PARTNERS AND INTERESTED PARTIES

4.1 Integrate programs to address the syndemic of HIV, STIs, viral hepatitis, substance use, and mental health disorders in the context of social and structural/institutional factors including stigma, discrimination, and violence.

Strategy 4.1.1: Coordinate and align strategic planning efforts on HIV, STIs, and viral hepatitis across programs and jurisdictions, specifically between Palm Beach, Broward, and Miami-Dade.

Strategy 4.1.2: Increase coordination among and sharing of best practices from HIV programs across all levels of government and with public and private health care payers, faith-based and community-based organizations, the private sector, academic partners, and the community.

Strategy 4.1.3: Focus resources including evidence-based and evidence-informed interventions in the geographic areas and priority populations disproportionately affected by HIV.

Strategy 4.1.4: Enhance collaboration among local, state, tribal, territorial, national, and federal partners, and the community to address policy and structural barriers that contribute to persistent HIV-related disparities and implement policies that foster improved health outcomes.

Strategy 4.1.5: Coordinate across partners to quickly detect and respond to HIV outbreaks.
Strategy 4.1.6: Enhance the ability to conduct molecular cluster response by increasing genotype testing.

FDOH-Broward EHE Plan Activities

1. Conduct physician detailing to encourage genotype testing.

Strategy 4.1.7: Support collaborations between community-based organizations (CBOs), public health organizations, education agencies and schools, housing providers, and health care delivery systems to provide linkage to and delivery of HIV testing, prevention, care, and treatment services as well as supportive services.

Community Recommended Activities

1. Support equitable collaborations between larger organizations, schools, providers, and smaller community-based organizations serving priority populations by offering meaningful support for their work (money, capacity building, partnerships, collaborative grants, etc.).
2. Provide training for non-traditional Ryan White providers (smaller CBOs without RHWAP contracts).
3. Develop and/or promote third-party advocacy and empowerment training.
4. Collaborate with mental health, substance abuse, and housing providers.
5. Extend partnership with other stakeholders (e.g., faith-based organizations).

Data Quality and Data Sharing

4.2 Enhance the quality, accessibility, sharing, and uses of data, including HIV prevention and care continuum data and social determinants of health data.

Community Recommended Activities

1. Conduct a Broward data-sharing pilot to reduce clients falling out of care due to lapses in eligibility by revisiting sharing client ADAP, Part A, and HOPWA.
2. Implement a robust integrated HIV information management system
3. Use interoperable health information technology, including application programming interfaces (APIs), clinical decision support tools, electronic health records, and health IT products certified by the Office of the National Coordinator's Health IT Certification Program, and health information exchange networks, to improve HIV prevention efforts and care outcomes.

4. Encourage and support patient access to and use of their individual health information, including the use of their patient-generated health information and the use of consumer health technologies in a secure and privacy-supportive manner.

Strategy 4.2.1 Foster private-public-community partnerships to identify and scale up best practices and accelerate HIV advances.

Community Recommended Activities

1. Adopt approaches that incentivize the scale-up of effective interventions among academic centers, health departments, community-based organizations, allied health professionals, people with HIV and their advocates, the private sector, and other partners.
2. Expand opportunities and mechanisms for information sharing and peer technical assistance within and across jurisdictions to move effective interventions into practice more swiftly.
3. Develop and optimize collaborative multi-agency and multi-sectoral approaches and strategies to address emergent and evolving challenges facing persons of all ages living with HIV.

Monitor, Evaluate, and Report Progress

4.3 Improve mechanisms to measure, monitor, evaluate, and use the information to report progress and course correct as needed to achieve the Strategy's goals.

Community Recommended Activities

1. Ensure all planning bodies and committee/workgroup chairs identify activities to advance NHAS strategies including participating in a half-day "think tank"/IP training session.
2. Committee/workgroup chairs should include activities in their committee/work plans and report on the progress at a bi-annual Joint Executive meeting.
3. Streamline and harmonize reporting and data systems to reduce the burden and improve the timeliness, availability, and usefulness of data.
4. Monitor, review, evaluate, and regularly communicate progress on the NHAS.
5. Implement bi-annual Joint Executive (Committee Chairs of Part A, B, Prevention & CSB) IP meeting
6. Strengthen monitoring and accountability for adherence to requirements, targets, and goals by funded partners.
7. Identify and address barriers and challenges that hinder achievement of goals by funded partners and other parties.

Strategy 4.3.1 Develop an integrated Priority Setting and Resource Allocation (PSRA) process using data with input from stakeholders and consumer forums.

Community Recommended Activities

1. Review data relevant to the PSRA process including recommendations from the quality management, the system of care, and community empowerment committees every quarter.
2. Develop a coordinated and integrated PSRA process with established mechanisms that integrate cross-sector collaboration.
3. Establish a formalized collaborative structure with stakeholders to ensure that the needs of the HIV community are being addressed.
4. Assess the coordination with core and support services providers through the case management model to increase retention in care and viral load suppression.
5. Encourage the creation of memorandums of understanding between appropriate provider agencies that serve PWH, such as housing, transportation, correctional facilities, outpatient care facilities, education, employment, behavioral health, domestic violence agencies, childcare, food and nutrition, and faith-based communities.

Goal 4: Key Partners, Funding Resources, Outcomes, Monitoring Data & Impact

KEY PARTNERS:
Health Department, infectious disease specialists, Hospital systems, FQHCs, private providers, Ryan White Part A HIV/AIDS Program recipient, HIV planning councils and advisory boards, Ryan White Part A medical providers, elected officials, PWH, CBOs, advocacy groups

POTENTIAL FUNDING RESOURCES:
Federal, state, and local funding, private funding, CDC HIV Prevention and Surveillance funding

OUTCOMES (reported annually, locally monitored more frequently): Increased number of genotype tests performed, improved integration of syndemic conditions in the network of care; improved data quality and reporting; reduced stigma, improved decision making for ranking services and allocating funds.

MONITORING DATA SOURCE:
Progress Reports, Aggregate Reports, Allocation and Expenditure Reports- submitted annually, including an Initiative Allocation Report and Initiative Expenditure Report, Ryan White HIV/AIDS Program Services Report (RSR), Federal Financial Report (FFR); Provide Enterprise, CAREWare

EXPECTED IMPACT ON THE HIV CARE CONTINUUM:
Increased retention in care; Increased VL suppression

Section VI: 2022-2026 Integrated Planning Implementation, Monitoring and Jurisdictional Follow Up

1. 2022-2026 Integrated Planning Implementation Approach

The purpose of this section is to describe the infrastructure, procedures, systems, and tools that will be used to support the key phases of integrated planning. This section includes detail on how best to ensure the success of Integrated Plan goals and objectives through the following 5 key phases: Implementation, Monitoring, Evaluation, Improvement, and Reporting and Dissemination.

a. Implementation

Broward County initiated the Implementation, Monitoring, Evaluation, Improvement, and Reporting/Dissemination with the establishment of the Integrated Workgroup in April 2022, which involves representatives from each planning body, the health department, Ryan White Part A, B, C, and D, HOPWA, affected community members, and stakeholders.

Broward County supports the National HIV/AIDS Strategy for the United States (NHAS) related to preventing new HIV infections; improving HIV-related health outcomes for PWH; reducing HIV-related disparities and health inequities and achieving a more coordinated national response to the HIV epidemic. To achieve these goals, the jurisdiction is committed to increased monitoring and accountability through the following:

- Development of Integrated HIV Prevention, Care, and Treatment indicators
- Ongoing evaluation practices
- Reporting of progress achieved
- Continuous stakeholder engagement

The goal of integration in Broward County is to streamline HIV prevention and care planning in a manner that will enhance prevention efforts for the highest-risk populations and improve the metrics along the Continuum of Care for those infected with HIV to create a coordinated response to the HIV epidemic and a seamless provision of HIV services. Broward County has identified a set of shared metrics that include the percentage of persons diagnosed and living with HIV, the percentage linked to care, the percentage retained in care, and the percentage with suppressed viral load.

The Integrated Workgroup will track the Plan's progress to identify areas where the Plan is performing optimally and where progress is falling behind. Findings and recommendations will be reported to the noted participants through quarterly meetings.

As described in a previous section, each of the three HIV planning bodies selected three (3) members to represent their respective areas in developing the Integrated HIV Prevention and Care Plan through membership in the Integrated Plan Workgroup, the oversight body for

Integrated Planning in the jurisdiction. Members are responsible for identifying the scope and timeline for integrated plan monitoring, evaluation, improvement, and reporting.

The HIVPC, SFAN, and BCHPPC will continue to function as separate bodies to implement the assigned activities required in this plan as well as in their individual work plans and to work collaboratively to address mutually reinforcing activities.

The Integrated Workgroup will complete its implementation activities within CY 2023 and will be the forum for monitoring, evaluating, and improving the conduct of the various processes and activities that make up the Plan going forward. Therefore, within CY 2023, the Integrated Workgroup will be tasked with identifying:

- Weaknesses in implementation, measurement, and processes.
- How well the RWHAP and FDOH-BOC and their responsible entities are doing to advance the Plan.
- What parts of the Plan are working well or are falling behind; and
- Where technical assistance should be provided.

b. Monitoring

While the Integrated Plan Workgroup assumes overall responsibility for monitoring progress to implement the goals, objectives, and activities of the Plan, each of the three HIV planning bodies and their respective Recipients will be responsible for collecting, tracking, and reporting data specific to the requirements by their grant award. As mentioned previously, the Integrated Plan is a living document that will be updated on at least a quarterly basis.

At the first Integrated Plan Workgroup meeting following the submission of this Plan, each of the HIV planning bodies will be asked to provide additional input on the monitoring and evaluating the Plan through input of the respective bodies.

Prevention/Ending the HIV Epidemic Activities

Prevention and EHE specific activities will be monitored by the FDOH, and results will be reported at quarterly prevention planning meetings. As appropriate, committees will be tasked with coordinating the implementation and monitoring of activities, tracking the progress of specific activities, providing regular status updates, including challenges and proposed solutions, and suggesting revisions to better achieve the goals.

Part B and ADAP Specific Activities

Part B and ADAP specific activities will be monitored by FDOH, and results will be reported at bi-annual Florida Comprehensive Planning Network (FCPN) meetings. The FDOH-Broward Recipient's office will report results to the local HIV planning bodies, the Funder's Collaborative, and the Integrated Workgroup.

Part A Specific Activities

The Integrated HIV Plan functions as the foundation for each HIVPC committee's work plan. As appropriate, committees will be tasked with coordinating the implementation and monitoring

of activities, tracking the progress of specific activities, providing regular status updates, including challenges and proposed solutions, and suggesting revisions to better achieve the goals. While the process of implementing, reviewing, and reporting on the Integrated Plan goals will be revised to ensure participation and accountability from all committees, many monitoring activities are already included in the work of committees as shown below.

The RWHAP PART A/HIVPC approach:

Each HIVPC committee will develop an annual work plan that includes monitoring and evaluation of Part A specific Plan goals. Review of the Plan goals will be a standing agenda item for all committees.

The annual work plans will be modified as needed to reflect: 1) Identified successes and challenges achieving plan goals, 2) Changes in resources and priorities, 3) Changes in the implementation process of each goal and activity, and 4) Roles and responsibilities.

Each committee will report progress achieving Plan goals as well as identified challenges, barriers, and next steps to the HIVPC on a monthly/bi-monthly/quarterly basis. An annual review of the Plan goals will identify system-wide accomplishments, challenges, barriers, and next steps to be reported to the HIVPC.

Client-level data and clinical outcomes will be used to assess the Part A's success.

c. Evaluation

Describe the performance measures and methodology the jurisdiction will use to evaluate progress on goals and objectives. Include information about how often the jurisdiction conducts analysis of the performance measures and presents data to the planning group.

Evaluation findings are critical for the identification of best practices and opportunities for advancement which then provides vital information for effective program planning and quality improvement of services. Over the next five years, hired external consultants will review the data yearly to measure the impact of the Integrated Plan on the local HIV epidemic. The results of this evaluation will be submitted for academic publishing and then larger dissemination. The external evaluator will also be responsible for presenting to the three planning bodies the outcomes of their evaluation.

The local jurisdiction will evaluate progress on the Integrated Plan goals and objectives by based on achieving the HIV National Strategic Plan (NHAS) indicator and the Ending the Epidemic indicators targets. Data will be collected from the AHEAD Dashboard, an online data visualization tool that reports data on six different measures (known as "indicators") that track progress toward meeting EHE goals. The section below provides an overview of the performance measures and performance targets. Progress on these measures will be reported on a bi-annual basis to the local HIV planning bodies and the Integrated Planning Workgroup.

HIV National Strategic Plan and Ending the Epidemic Indicators (Broward Targets)

1. Increase **knowledge of status** to 95% from a 2017 baseline of 88%. (EHE Midterm Goal)
2. Reduce **new HIV infections** by 75% from the 2017 baseline of 670. (*EHE Overarching Goal)
3. Reduce new **HIV diagnoses** by 75% from a 2017 baseline of 671. (EHE Diagnoses Indicator)
4. Increase **PrEP coverage** to 50% from a 2017 baseline of 10%. (EHE PrEP Coverage Indicator)
5. Increase **linkage to care** w/in 1 month of diagnosis to 95% from 2017 baseline of 80.6%. (EHE LTC)
6. Increase **viral suppression** to 95% from 86.5% for RWHAP clients. (FDOH reporting on all PWH)

(6 and 6a-6h below include 2020 baseline data for RWHAP clients from HRSA COMPASS Dashboard)

   a. Increase MSM VL suppression to 95% from 87.7%.
   b. Increase Black MSM VL suppression to 95% from 81.4%.
   c. Increase Latino MSM VL suppression to 95% from 92.6%.
   d. Increase AI/AN MSM VL suppression to 95% from 93.5%.
   e. Increase Black female VL suppression to 95% from 84.9%.
   f. Increase Transgender female VL suppression to 95% from 80.8%.
   g. Increase PWID VL suppression to 95% from 90.2%.
   h. Increase Youth VL suppression to 95% from 79.9%.

7. Decrease stigma among PWH by 50% from a 2018 baseline median score of 31.2 (National Baseline)
8. Reduce homelessness among PWH by 50% from the 2017 baseline of 5.1%. (RWHAP)
9. Increase the median percentage of secondary schools that implement at least 4 out of 7 LGBTQ-supportive policies and practices to 65% from a 2018 national baseline of 59.8%.
10. Improve the quality of life for PWH (*Will be identified by CDC/HRSA and progress monitored thereafter)

Data Notes

- NHAS Indicators 1 through 6 are identical to EHE's 6 indicators which are included in the AHEAD Dashboard. AHEAD is a data visualization tool designed to display EHE data on the six indicators for each of the Phase I jurisdictions.
- NHAS Indicators 6 & 6a - 6h are also included in the HRSA COMPASS Dashboard (RWHAP Clients Only).
- NHAS Indicator 1 and 2 = FCPN Objective 1.2

*The overarching EHE goal refers to the main goal of the Ending the HIV Epidemic initiative: to end the HIV epidemic in the U.S. by reducing the number of HIV infections by 75% by 2025 and 90% by 2030. That is why the overarching goal is tied to the incidence indicator. The midterm goal refers to the indicator that will give us the best idea of overall progress which is knowledge of HIV status. The knowledge of the HIV status indicator is tied to the midterm goal because an increase in knowledge of status gives us a good indication of progress.

Figure 14 Indicators to Measure Progress with 2025 Targets

								Goals	
Fort Lauderdale/Broward EMA HIV Integrated Plan Indicators								**NHAS**	**EHE**
NHAS Indicator #1		**Knowledge of HIV Status**	**2017**	**2018**	**2019**	**2020**	**2021**	**2025**	**2025**
	Midterm EHE Goal	Living diagnosed or undiagnosed	21,500	21,800	22,100				
		Living diagnosed	19,209	19,542	19,863				
			89.3%	89.6%	89.9%			95%	95%
NHAS Indicator #2		**New HIV Infections**	**2017**	**2018**	**2019**	**2020**	**2021**		
	Overall EHE Goal	Estimated incidence	2,028	1,680	1,703			507	420
NHAS Indicator #3		**New HIV Diagnoses**	**2017**	**2018**	**2019**	**2020**	**2021**		
	EHE Indicator	New diagnoses	671	616	594	460	510	168	168
NHAS Indicator #4		**PrEP Coverage**	**2017**	**2018**	**2019**	**2020**	**2021**		
	EHE Indicator	Number prescribed PrEP	2,011	2,861	3,767	6,711	5,684	10235	
		Number w/ PrEP indications	20,030	20,470	20,470	20,470	20,470	20,470	
		PrEP coverage	10.0%	14.0%	18.4%	32.8%	27.8%	50%	
NHAS Indicator #5		**Linkage to Care**	**2017**	**2018**	**2019**	**2020**	**2021**		
	EHE Indicator	At least one CD4 or VL test	622	611	604	488	382		
		Total diagnoses	671	626	594	460	339		
	Residents	Linkage Percent All Residents	80.6%	84.2%	87.0%	87.2%	87.0%	95%	95%
	RWAP	Linkage RWAP Clients							
NHAS Indicator #6		**Viral Suppression**	**2017**	**2018**	**2019**	**2020**	**2021**		
	EHE Indicator	Total persons alive	18,513	18,862	19,237				
		VL below 200	12,567	12,935	13,486				
	Residents	Viral suppression	67.9%	68.6%	70.1%				
RWAP Clients		Viral suppression: RWHAP Clients	84.2%	82.9%	86.3%	86.5%			
N=4,418	54%	MSM	86.7%	83.3%	87.8%	87.6%		95%	
N=1,841	22%	Black MSM	79.5%	74.5%	80.6%	81.4%		95%	
N=1,435	17%	Latino MSM	90.8%	87.6%	93.3%	92.6%		95%	
N=1461	18%	Black Female	78.2%	82.0%	82.3%	84.9%		95%	
N=156	2%	Transgender Women	76.8%	75%%	83.8%	80.8%		95%	
N=112	1%	People who Inject Drugs (PWID)	84.8%	90.3%	82.5%	90.2%		95%	
N=455	6%	Youth	72.2%	68.0%	80.3%	80.2%		95%	
		People Aged 50 and Over	90%	89%	90%	91%		95%	
NHAS Indicator #7		**Stigma Among PWH**	**2017**	**2018**	**2019**	**2020**	**2021**		
To implement, a measurement tool and administration protocol is needed									
NHAS Indicator #8		**Homelessness Among PWH**	**2017**	**2018**	**2019**	**2020**	**2021**		
		RWHAP w/ Unstable Housing	73	94	246	332			
NHAS Indicator #7		**Schools w/ LGBTQ policies**		**2018**	**2019**	**2020**	**2021**		
Secondary schools w/ 4/7 LGBTQ supportive policies								59.8%	
NHAS Indicator #10		**Improve Quality of Life**	**2017**	**2018**	**2019**	**2020**	**2021**		
*(*Data sources, measures, and targets will be identified by CDC/HRSA and progress monitored thereafter.)*									
Resident Data Source: EHE AHEAD Dashboard									
Note: 2020 & 2021 Data are Preliminary									
RWAP Data Source: RWHAP Compass Dashboard: Jusristictional Benchmarking Report									

d. Improvement

The purpose of this section is to describe the methods and/or means by which progress in achieving goals and meeting challenges will be monitored. Monitoring and evaluation will ensure that the activities implemented to achieve the goals are prioritized, analyzed, and adapted as needed to align with shifts in resources and priorities. This section of the Plan describes how to progress in achieving goals, meeting challenges and barriers, and adapting over time will be monitored. It also provides a detailed description of the well-established Quality Management (QM) process already in place designed to promote quality services and improved health outcomes.

e. Reporting and Dissemination

Progress in the implementation and execution of this Plan will be shared at the quarterly or bi-annual Integrated Workgroup meetings reported to each planning body as part of regular committee reporting. Groups who participated in community engagement activities, the system of care, quality management, and other community stakeholders will also be advised of updates and will be encouraged to contribute to ongoing planning and execution of the Plan goals. Special presentations may be made to any community stakeholders, as appropriate or by request. Reports will be posted on a dedicated page on www.brhpc.org. Printed copies will be distributed at in-person meetings and are always available by request. Findings will also be incorporated into the Annual Report provided to the Ryan White Part Office.

f. Updates to Other Strategic Plans Used to Meet Requirements

Throughout the reporting period, those attending the Broward County HIV Prevention Planning Council's full council and advisory workgroup meetings received routine updates on pertinent information related to EHE. Attendees of these meetings included community leaders, people with HIV (PWH) affected by HIV, and representatives from community-based organizations (CBOs), healthcare facilities, grassroots organizations, and non-profits.

In July 2021, the Florida Department of Health in Broward County (FDOH-Broward) hosted an EHE townhall in partnership with Broward's Ryan White Part A Program and two local federally qualified health centers (FQHCs) that received Health Resources and Services Administration Primary Care HIV Prevention funding. During the townhall, community members received updates on each organization's Year 1 EHE activities and learned about new activities planned for Year 2.

Section VII: Letters of Concurrence

CDC Prevention Program Planning Body Chair(s) or Representative(s)

Kristin Athey, LCSW-C, RWHAP Part A Project Officer, HRSA, HIV/AIDS Bureau
Mr. George Hill, Project Officer, (CDC/DDID/NCHHSTP/DHP):

Dear Ms. Athey and Mr. Hill:

The Broward County HIV Health Services Planning Council (HIVPC), the Broward County HIV Prevention Planning Council (BCHPPC), and the South Florida AIDS Network concur with the following submission by the e Ryan White Part A Program and Florida Department of Health-Broward County HIV Prevention Program in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan, including the Statewide Coordinated Statement of Need (SCSN) for calendar year (CY) 2022-2026.

The HIVPC, BCHPPC, and SFAN reviewed the Integrated HIV Prevention and Care Plan submission to the CDC and HRSA to verify that it describes how programmatic activities and resources are being allocated to the most disproportionately affected populations and geographical areas with high rates of HIV. As a result, the planning bodies concur that the Integrated HIV Prevention and Care Plan submission fulfills the requirements of the CDC's Notice of Funding Opportunity for Integrated HIV Surveillance and Prevention Programs for Health Departments and the Ryan White HIV/AIDS Program legislation and program guidance.

The HIVPC, BCHPPC, and SFAN appointed a minimum of three representatives to the integrated planning workgroup. The workgroup monitored and provided recommendations for completing the activities outlined in the Broward County Integrated HIV Prevention and Care Plan. The integrated workgroup meetings were launched on April 22, 2022, with additional planning meetings on May 27, 2022, and June 24, 2022. The workgroup received presentations and reviewed data from both Part A and Prevention. The workgroup synthesized the information and recommended objectives and action items for each of the four goals and revised the mission and vision for 2022-2026. The information was synthesized, then submitted to each planning body for review and feedback for the preparation of the Plan.

Based on the review of the Integrated HIV Prevention and Care Plan for 2022 through 2026, the HIVPC, BCHPPC, and SFAN reached a consensus and concurrence with the priorities and strategies proposed in the Plan. The signatures below confirm the ***concurrence*** of the Broward County Planning Bodies with the Integrated HIV Prevention and Care Plan.

Sincerely,

Emilio Apontesierraparetti, BCHPPC Community Co-Chair

12/07/2022
Date

RWHAP Part A Planning Council/Planning Body Chair(s) or Representative(s)

Kristin Athey, LCSW-C, RWHAP Part A Project Officer, HRSA, HIV/AIDS Bureau
Mr. George Hill, Project Officer, (CDC/DDID/NCHHSTP/DHP):

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Sincerely,

Lorenzo Robertson
Lorenzo Robertson, HIVPC Chair

12/7/2022
Date

RWHAP Part B Planning Body Chair(s) or Representative(s)

Kristin Athey, LCSW-C, RWHAP Part A Project Officer, HRSA, HIV/AIDS Bureau
Mr. George Hill, Project Officer, (CDC/DDID/NCHHSTP/DHP):

Dear Ms. Athey and Mr. Hill:

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Sincerely,

Joey Wynn, Chairman
SFAN – Broward (South Florida AIDS Network of Broward County)

12/07/22
Date

ORIGINAL

ACRONYMS

ACA: The Patient Protection and Affordable Care Act 2010
ADAP: AIDS Drugs Assistance Program
AETC: AIDS Education and Training Center
AHF: AIDS Health Care Foundation
AIDS: Acquired Immuno-Deficiency Syndrome
ART: Antiretroviral Therapy
ARV: Antiretrovirals

BARC: Broward Addiction Recovery Center
BCFHC: Broward Community and Family Health Centers
BH: Behavioral Health
BISS: Benefits Insurance Support Service
BMSM: Black Men Who Have Sex with Men
BRHPC: Broward Regional Health Planning
Council, Inc.

CBO: Community-Based Organization
CDC: Centers for Disease Control and Prevention
CDTC: Children's Diagnostic and Treatment Center
CEC: Community Empowerment Committee
CIED: Client Intake and Eligibility Determination
CLD: Client-Level Data
CM: Case Management
CQI: Continuous Quality Improvement
CQM: Clinical Quality Management
CTS: Counseling and Testing Site

DCM: Disease Case Management
DOH-Broward: Florida Department of Health in Broward County

eHARS: Electronic HIV/AIDS Reporting System
EIIHA
: Early Intervention of Individuals Living with HIV/AIDS
EFA: Emergency Financial Assistance
EMA: Eligible Metropolitan Area

FDOH: Florida Department of Health
FPL: Federal Poverty Level
FQHC: Federally Qualified Health Center

HAB: HIV/AIDS Bureau
HHS: U.S. Department of Health and Human Services

HICP: Health Insurance Continuation Program
HIV: Human Immunodeficiency Virus
HIVPC: Broward County HIV Health Services Planning Council
HMSM: Hispanic Men who have Sex with Men
HOPWA: Housing Opportunities for People with AIDS
HRSA: Health Resources and Service Administration
HUD: U.S Department of Housing and Urban Development

IW: Integrated Workgroup
IDU: Intravenous Drug User

JLP: Jail Linkage Program

LPAP: Local AIDS Pharmaceutical Assistance Program

MAI: Minority AIDS Initiative
MCDC: Membership/Council Development Committee
MCM: Medical Case Management
MH: Mental Health
MIPA: Meaningful Involvement of People with HIV/AIDS
MNT: Medical Nutrition Therapy
MOU: Memorandum of Understanding
MSM: Men Who Have Sex with Men

NBHD: North Broward Hospital District (Broward Health)
NGA: Notice of Grant Award
NHAS: National HIV/AIDS Strategy
NOFO: Notice of Funding Opportunity
nPEP: Non-Occupational Post Exposure Prophylaxis
NSU: Nova Southeastern University

OAHS: Outpatient Ambulatory Health Services
OHC: Oral Health Care

PE: Provide Enterprise
PIR: Priority, Inclusion, and Representation
PWH: People with HIV
PWHA: People with HIV/AIDS
PrEP: Pre-Exposure Prophylaxis
PRISM: Patient Reporting Investigating Surveillance System
PROACT: Participate, Retain, Observe, Adhere, Communicate and Teamwork is DOH-Broward's treatment adherence program.
PSRA: Priority Setting & Resource Allocations

QI: Quality Improvement
QIP: Quality Improvement Project
QM: Quality Management
QMC: Quality Management Committee

RSR: Ryan White Services Report
RWHAP: Ryan White HIV/AIDS Program
RWPA: Ryan White Part A

SA: Substance Abuse
SBHD: South Broward Hospital District (Memorial Healthcare System)
SCHIP: State Children's Health Insurance Program
SDM: Service Delivery Model
SOC: System of Care
SPNS: Special Projects of National Significance
STD/STI: Sexually Transmitted Diseases or Infection

TA: Technical Assistance
TB: Tuberculosis
TGA: Transitional Grant Area

VA: United States Department of Veteran Affairs
VL: Viral Load
VLS: Viral Load Suppression

WMSM: White Men who have Sex with Men
WICY: Women, Infants, Children, and Youth

ATTACHMENTS

1. CY2022 – 2026 CDC DHAP and HRSA HAB Integrated Prevention and Care Plan Guidance Checklist
2. HIV Epidemiology in Broward County, 2020
3. RWHAP Part A EHE Final Grant Narrative
4. FDOH-Broward EHE Documents
    a) Draft FL Unified EHE Plan_ConcurrenceFCPN_12.20
    b) Broward Ending the HIV Epidemic Survey Evaluation Report
    c) EHE Local Perspective PPT