BROWARD COUNTY HIV NEEDS ASSESSMENT

Submitted to the Ryan White Part A Program Office
Community Services Department
Broward County Board of County Commissioners

The Ronik Radlauer Group, Inc.

2017-2020

BROWARD COUNTY FLORIDA

Executive Summary

Broward County's Board of County Commissioners Community Services Department Ryan White Part A Program Office commissioned the Ronik-Radlauer Group to conduct a Needs Assessment related to the needs of persons living with HIV (PLWH) who are served through Ryan White services. The Needs Assessment utilized a mixed methods approach to the collection and analysis of data. This report reflects the results of that approach.

The qualitative section of the report is comprised of two areas. The first provides an overview of Broward County in terms of demographics and challenges that may impact PLWH, such as behavioral health issues and the social determinants of health. The second provides an overview of the Care Continuum in Broward County also as it relates to demographics as well specific to Ryan Part A clients. The purpose of this part of the assessment was to identify the extent of the unmet need in the community. The qualitative section of the report builds on the quantitative information. It involved the engagement of additional identified stakeholders through interviews, focus groups and surveys.

The Ronik-Radlauer Group would like to thank everyone who participated in this needs assessment process for their time and input. Their feedback was invaluable and provided a community-focused lens from which to view the epidemic in Broward County. The quantitative data, coupled with the qualitative input resulted in the identification of strengths, challenges, and opportunities for improvement as well as common themes discovered through the process.

Introduction and Overview

A needs assessment is a dynamic process involving multiple sectors of the community. The main purpose of this HIV Health Needs Assessment is to improve the health status and well-being of people living with HIV or AIDS in Broward County and increase access to early testing and enrollment in care for all who have a positive diagnosis. The current needs assessment used a mixed methods approach, drawing upon qualitative and quantitative population health data to identify unmet needs and to improve the quality of life for vulnerable populations.

The setting for this health needs assessment is Broward County, the second-largest county in the state of Florida covering 1,969.76 square miles of land. Located in southeast Florida, Broward County's urbanized area occupies 427.8 square miles of land. The largest portion of the county is the Conservation Area that extends west to border Collier County. The conservation area is 796.9 square miles and consists of wetlands, much of which are part of the Everglades National Park.

According to a 2018 census report, the county had a population of 1,951,260, making it the second-most populous county in the state of Florida. The U.S. Census Bureau (2010) projects Broward County to be the most diverse county in the United States by the year 2030. Immigration of foreign-born minorities and in-migration from other parts of the United States have led to the shifts in the county's demographics. Residents of Broward County represent more than 200 countries of origin, with more than 130 languages spoken. The 2014 American Community Survey reports that 40% of Broward residents spoke a language other than English at home, compared to 28% for Floridians generally.

Broward County is also home to more than 60,000 Lesbian, Gay, Bisexual and Transgender (LGBT) residents. National tourist publications have dubbed Broward "the second most popular LGBT tourist destination in the United States." Broward and Palm Beach counties are part of the Miami-Dade County metropolitan statistical area (MSA). The proximity of these mostly urban counties results in a fluid "work, worship and play environment." In all three counties HIV reported cases are primarily among men who have sex with men (MSM). Social and sexual activities among this population group are not restricted by distance or county boundaries. Sex is a primary mode of HIV acquisition, however, drug use and in particular injecting drug use (IDU) continues to contribute to the ongoing number of new HIV infections among Broward County residents. Other populations who are disproportionately affected in Broward include African American gay, bisexual, and other MSM; White gay men; Latino gay men; and African American women. In addition, large immigrant communities with limited English proficiency may encounter barriers accessing health services and information, leaving many at risk for undiagnosed HIV infection. With improved quality of life issues such as the warm climate, beaches, and nightlife, Broward County has become a center for gay tourism as well as a relocation and retirement destination for HIV positive individuals. This may also lead to an increase in HIV transmission locally.

Broward is one of the most racially diverse counties in the state of Florida. In 2010 and 2018, Broward had a higher percentage of minorities than Florida as a whole, further illustrating the diversity in the county. Broward's Hispanic population is growing at a faster rate than Black and non-Hispanic populations. The county's Hispanic population continues to grow more diverse, as

new residents from Puerto Rico, Columbia, Nicaragua, Mexico, Dominican Republic, Peru, Honduras and Venezuela establish communities in the region (each with more than 30,000 residents). According to the 2010 US Census, Broward was home to 438,247 Hispanics, comprising 25.1 percent of the Broward population. By 2018, this number increased to 593,733, representing 30.4 percent of the population.

The process of an HIV health needs assessment enables a community-wide establishment of health priorities that are targeted and relevant. It also represents an opportunity for a system-wide coordination of efforts to avoid duplication and strengthen partnerships to capitalize on existing resources.

Methodology

The Ronik-Radlauer Group utilized a mixed methods approach to collect, analyze and synthesize the data presented in this report.

- *A review of secondary quantitative data sets was conducted to analyze the health status of the community through reliable external sources, including the Florida Department of Health and the US Bureau of the Census.*
- *Qualitative methods are often regarded as providing rich data about real-life persons living with HIV or AIDS (PLWH/PLWA) and situations to gain an understanding of their health needs. For this Needs Assessment, a key stakeholder interview, focus groups, and provider and consumer surveys were relied upon to identify strengths and challenges viewed by the community.*
- *A review of existing reports and recommendations was completed and integrated into the findings of this assessment.*

A summary analysis relative to the scope of each of these processes is reflected in the body of this report.

Quantitative Data Analysis

The quantitative data provided in this section allows for a portrayal of Broward County in the areas of physical health, behavioral health, and the social determinants of health. These areas contribute to the overall population health of a community and have an impact on the well-being of residents. Persons living with HIV in Broward County are adversely impacted by medical challenges, as well as behavioral health issues, and the social determinants that affect daily living. The results of the quantitative analysis bear out what the qualitative analysis suggests; that in order to address the physical health needs of persons living with HIV in Broward County, it is necessary to address these needs from a holistic perspective. This section of the assessment begins with an overview of the demographics of Broward County, followed by challenges related to behavioral health (mental health and substance use concerns), and finally a discussion of the social determinants of health.

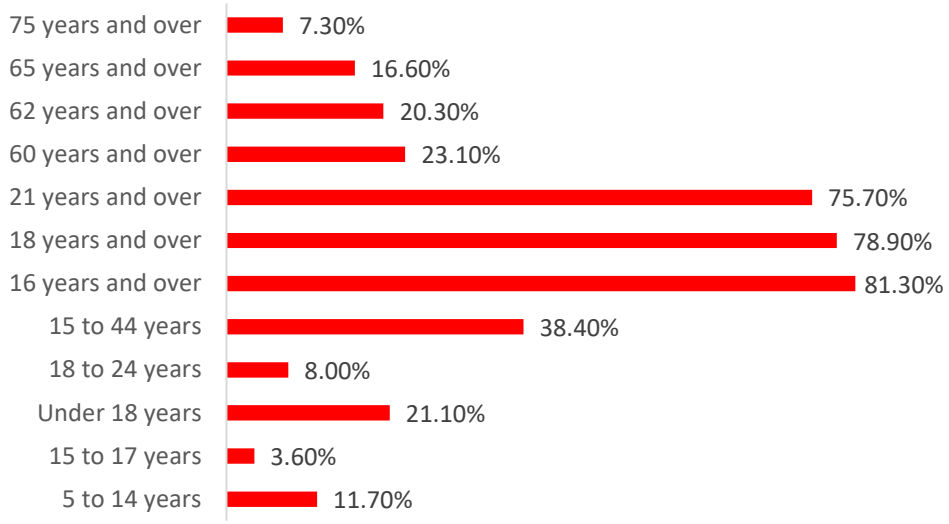
Demographics

The size and diversity of Broward County, in conjunction with a variety of other factors, result in a community with complex needs. Broward is the second most populated county in the State of Florida with 1,951,260 residents in 2018, a 11.6% increase from 2010. 21.2% of the population

is under 18, and 16.6% of residents are 65 and over. The population's racial and ethnic breakdown is as follows: 59.5% White, 28.8% Black or African American and 30.4% Hispanic. 33.7% of the residents are foreign-born. The median household income is $57,333 and 12.6% of the population lives in poverty. The tables and figures below provide a detailed view of Broward County's demographics.

Table 1. Population Estimates, Broward – 2018	
Population estimates, 2018	1,951,260
Population estimates base, 2010	1,748,066
Population, percent change	11.6%

Source: American Community Survey, US Bureau of the Census, 2018.



Source: American Community Survey, US Bureau of the Census, 2018.

Table 2. Race and Ethnicity, Broward County – 2018	
White alone	59.5%
Black or African American alone	28.8%
American Indian and Alaska Native alone	0.3%
Asian alone	3.7%
Native Hawaiian and Other Pacific Islander alone	0.1%
Two or More Races	3.4%
Hispanic or Latino	30.4%
Not Hispanic or Latino	69.6%

Source: American Community Survey, US Bureau of the Census, 2018.

Social Determinants of Health

Social determinants of health are conditions in which we are born, live, work, age, and play that affect a wide range of health risks, functioning, and quality-of-life outcomes. Understanding these factors in the context of health of PLWH inform the needs of the community in terms of access to care and support (whether social, community or systemic). While Broward residents seem to fare better than Florida residents overall, they are generally older and 65.8% participate in the labor force. Broward County shows a higher unemployment rate than Florida (6.6% versus 6.3%) and 13.6% of households receive Food Stamp/SNAP benefits. 14.6% of the civilian non-institutionalized population lacks health insurance and 11.2% of families are living below the federal poverty level ($25,750/year for family of four).

Income

Table 3. Income and Benefits (In 2018 Inflation-Adjusted Dollars)

	Broward		Florida
Total households	**694,980**	**694,980**	**7,621,760**
Less than $25,000	140,494	20.7%	21.1%
$25,000 to $34,999	67,609	9.9%	10.7%
$35,000 to $49,999	91,913	13.5%	14.3%
$50,000 to $74,999	122,637	18.0%	18.4%
$75,000 to $99,999	82,582	12.1%	11.9%
$100,000 to $149,999	93,240	13.7%	12.5%
$150,000 to $199,999	38,323	5.6%	4.8%
$200,000 or more	45,290	6.6%	5.4%
Median household income (dollars)	57,333	-	-
Mean household income (dollars)	82,204	-	-
With Social Security	205,331	30.1%	37.2%
Mean Social Security income (dollars)	18,281	-	-
With retirement income	91,791	13.5%	19.9%
Mean retirement income (dollars)	26,635	-	-
With Supplemental Security Income	29,729	4.4%	5.1%
Mean Supplemental Security Income (dollars)	9,524	-	-
With cash public assistance income	12,164	1.8%	2.1%
Mean cash public assistance income (dollars)	2,572	-	-
With Food Stamps/SNAP in the past 12 months	92,670	13.6%	14.2%

Source: American Community Survey, US Bureau of the Census, 2018.

Employment

Table 4. Employment Status – 2018

	Broward		Florida
Population 16 years and over	**1,548,232**		**16,932,309**
In labor force	1,017,992	65.8%	58.7%
Employed	949,870	61.4%	54.7%
Unemployed	67,089	4.3%	3.7%
Not in labor force	530,240	34.2%	41.3%
Unemployment Rate	-	6.6%	6.3%

Source: American Community Survey, US Bureau of the Census, 2018.

Health Insurance Coverage

Table 5. Health Insurance Coverage – 2018			
	Broward		**Florida**
Civilian noninstitutionalized population	**1,897,256**		**20,288,268**
With health insurance coverage	1,619,933	85.4%	86.5%
With private health insurance	1,181,016	62.2%	61.9%
With public coverage	582,981	30.7%	36.9%
No health insurance coverage	277,323	14.6%	13.5%
Civilian non-institutionalized population under 19 years	**432,007**		**4,391,005**
No health insurance coverage (under 19)	37,193	8.6%	7.6%
Civilian noninstitutionalized population 19 to 64 years	1,165,256	1,165,256	11,901,133
IN LABOR FORCE:	**939,096**		**9,080,041**
Employed:	**879,919**		**8,528,103**
With health insurance coverage	727,824	82.7%	82.3%
With private health insurance	690,380	78.5%	77.0%
With public coverage	52,543	6.0%	7.6%
No health insurance coverage	152,095	17.3%	17.7%
Unemployed:	**59,177**	**59,177**	**551,938**
With health insurance coverage	34,441	58.2%	58.3%
With private health insurance	23,961	40.5%	37.6%
With public coverage	11,386	19.2%	23.3%
No health insurance coverage	24,736	41.8%	41.7%
NOT IN LABOR FORCE:	226,160	226,160	2,821,092
With health insurance coverage	171,572	75.9%	78.2%
With private health insurance	116,942	51.7%	49.7%
With public coverage	65,754	29.1%	35.2%
No health insurance coverage	54,588	24.1%	21.8%

Source: American Community Survey, US Bureau of the Census, 2018.

Poverty

Table 6. Percentage of Families and People Whose Income in the Past 12 Months is Below the Poverty Level – 2018		
	Broward	**Florida**
All families	**10.3%**	**10.6%**
With related children of the householder under 18 years	14.9%	17.3%
With related children of the householder under 5 years only	13.5%	16.1%
Married couple families	**5.9%**	**6.0%**
With related children of the householder under 18 years	7.2%	8.4%
With related children of the householder under 5 years only	5.3%	6.7%
Families with female householder, no husband present	**22.3%**	**25.8%**
With related children of the householder under 18 years	30.1%	35.5%
With related children of the householder under 5 years only	34.5%	38.1%
All people	**13.5%**	**14.8%**
Under 18 years	**18.7%**	**21.3%**

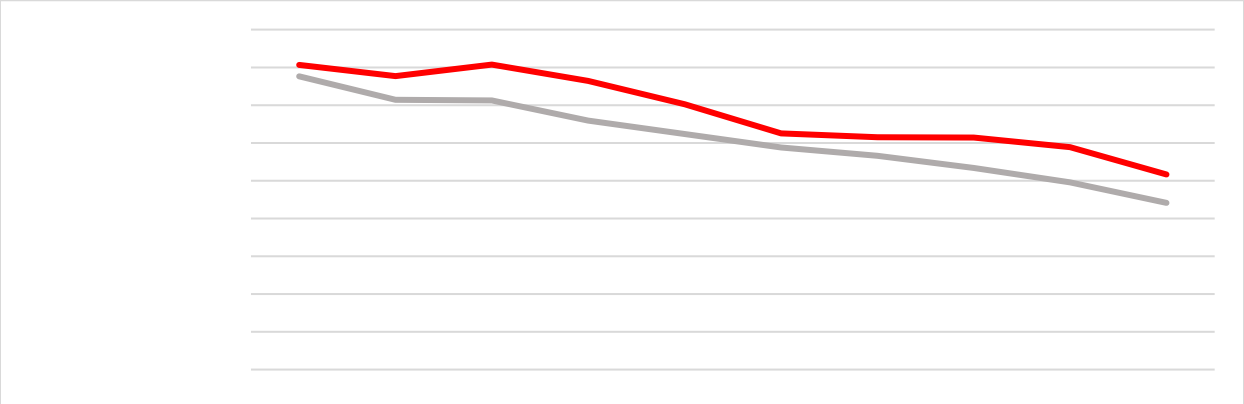
Related children of the householder under 18 years	18.5%	21.0%
Related children of the householder under 5 years	20.6%	23.6%
Related children of the householder 5 to 17 years	17.7%	20.0%
18 years and over	**12.1%**	**13.1%**
18 to 64 years	11.9%	14.1%
65 years and over	**12.7%**	**10.3%**
People in families	11.2%	12.0%
Unrelated individuals 15 years and over	22.9%	25.8%

Source: American Community Survey, US Bureau of the Census, 2018.

While 13.5% of all Broward residents are living below the poverty level, an additional 37% of households are what are called ALICE (United Way of Broward County, 2016). ALICE is an acronym for Asset Limited, Income Constrained, Employed - households that earn more than the Federal Poverty Level, but less than the basic cost of living for the county. Combined, the number of ALICE and poverty-level households equals the total population struggling to afford basic needs. In 2016, the number of ALICE and poverty-level households in Broward County approached 50%. ALICE and poverty-level households exist among all types of living arrangements, including adults living alone, same-sex couples, and senior households.

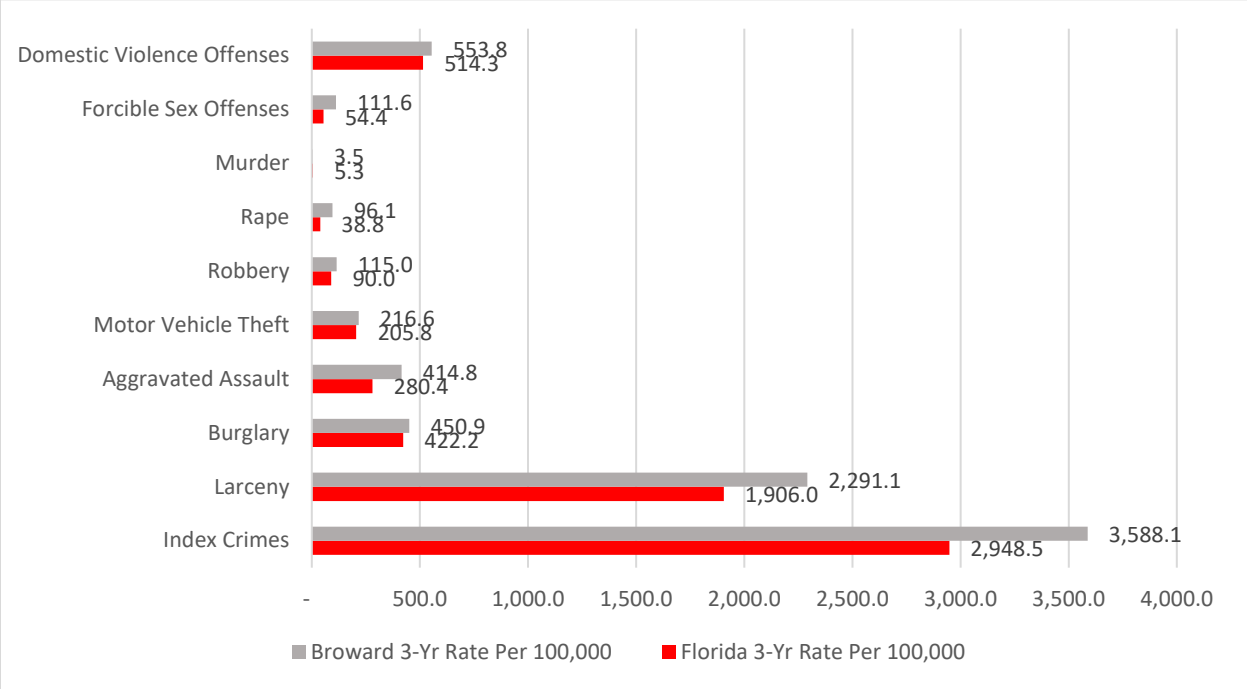
Crime and Safety

Neighborhood and safety have strong correlation with the resiliency of a community. Living in high crime areas contribute to poor mental health, learned helplessness, avoidance of care and degradation of community structures. Broward has shown a consistent decrease in the index crime rate; however, in comparison to the entire state, the county shows higher rates overall index crime: murder, rape, robbery, aggravated assault, burglary, larceny, and motor vehicle theft.



	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Broward Rate	4,530.4	4,382.4	4,536.7	4,318.6	4,013.4	3,624.3	3,576.9	3,569.1	3,445.6	3,082.1
Florida Rate	4,381.3	4,070.1	4,062.4	3,797.0	3,617.0	3,437.9	3,328.8	3,168.5	2,979.1	2,706.2

Source: Florida Health Charts, Florida Department of Health, 2009-2018

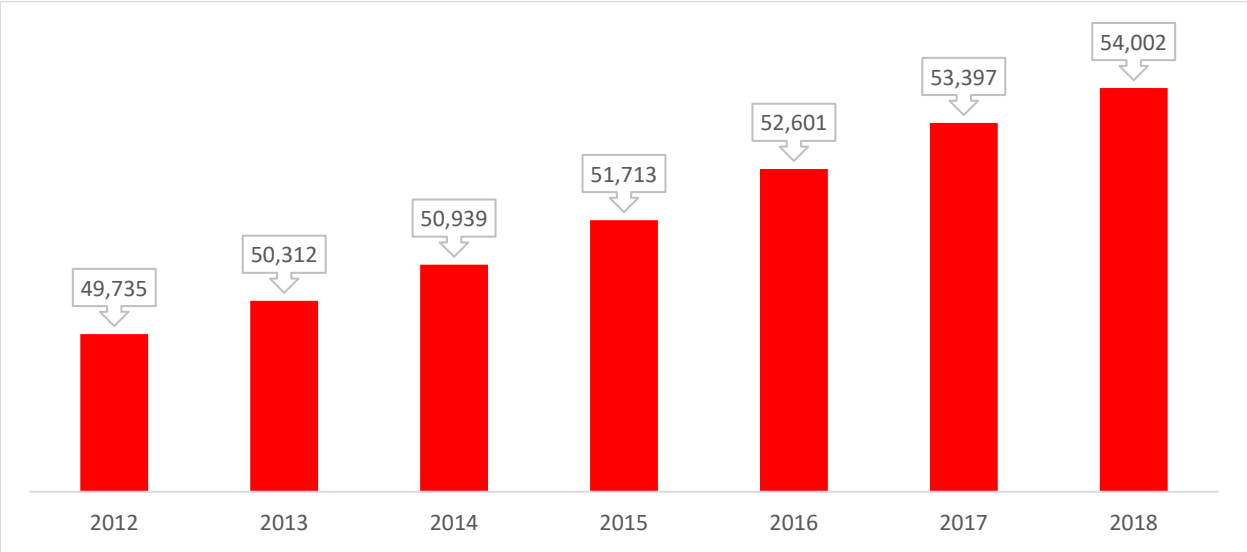


Source: Florida Health Charts, Florida Department of Health, 2016-2018

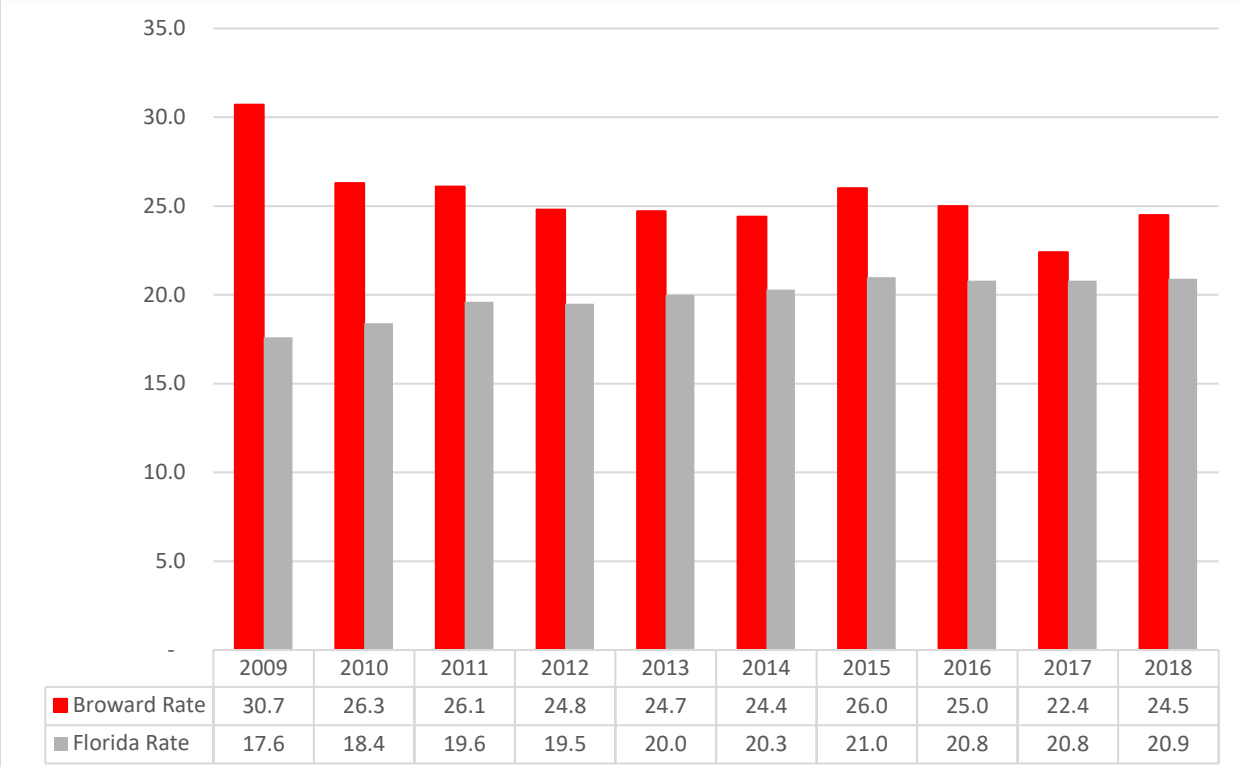
Behavioral Health

Mental Illness and Hospitalizations

Understanding the scope of mental illness establishes a foundation for bringing services and funding to areas in need. Florida Health Charts definition: Serious mental illness among people ages 18 and older is defined as having, at any time during the past year, a diagnosable mental, behavior, or emotional disorder that causes serious functional impairment that substantially interferes with or limits one or more major life activities. Serious mental illnesses include major depression, schizophrenia, bipolar disorder, and other mental disorders that cause serious impairment. Broward County has shown an increase in the number of adults diagnosed with a serious mental illness by more than 4,200 adults in the past seven years, while the availability of adult psychiatric beds has generally decreased over the same time period. Meanwhile, the rate of hospitalizations for mental disorders and mood and depressive disorders has increased and remained consistently higher in Broward County than the state over the past ten years.

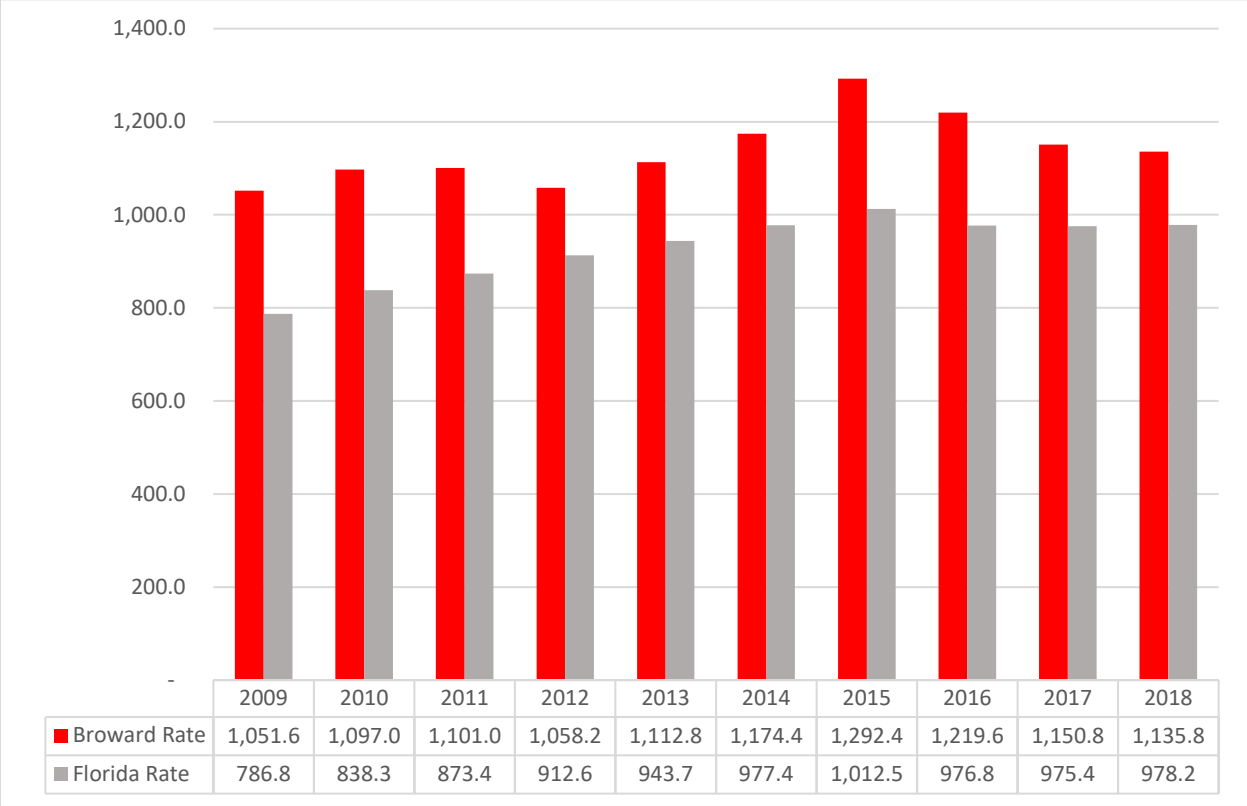


Source: Florida Health Charts, Florida Department of Health, 2012-2018



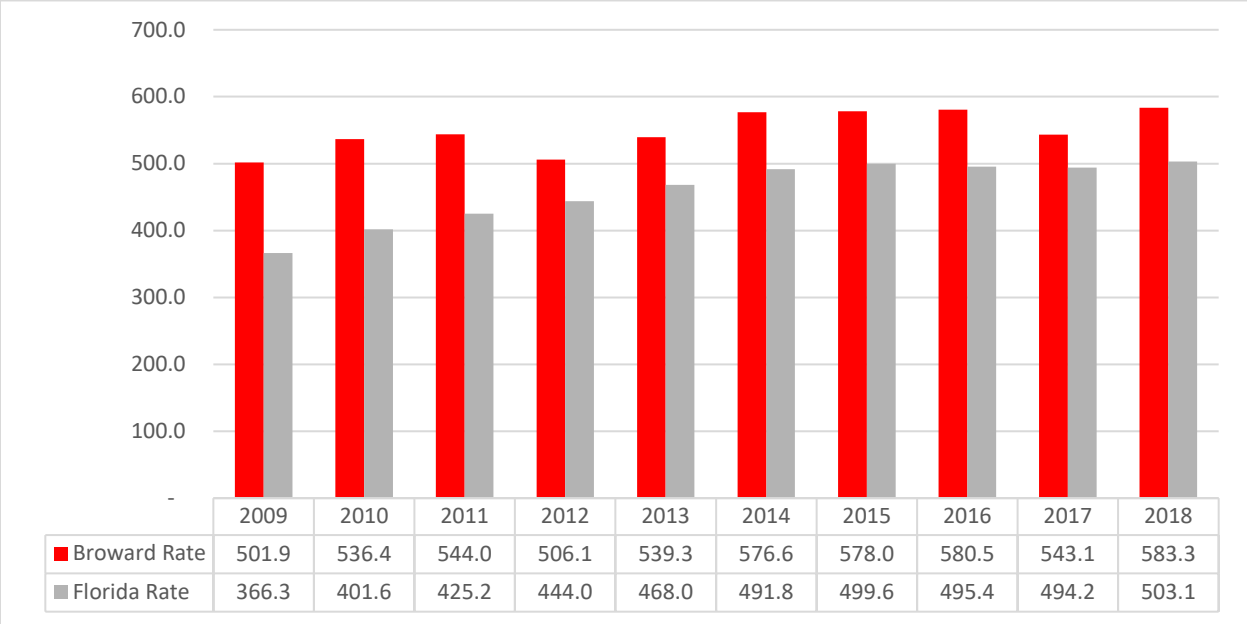
	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Broward Rate	30.7	26.3	26.1	24.8	24.7	24.4	26.0	25.0	22.4	24.5
Florida Rate	17.6	18.4	19.6	19.5	20.0	20.3	21.0	20.8	20.8	20.9

Source: Florida Health Charts, Florida Department of Health, 2009-2018



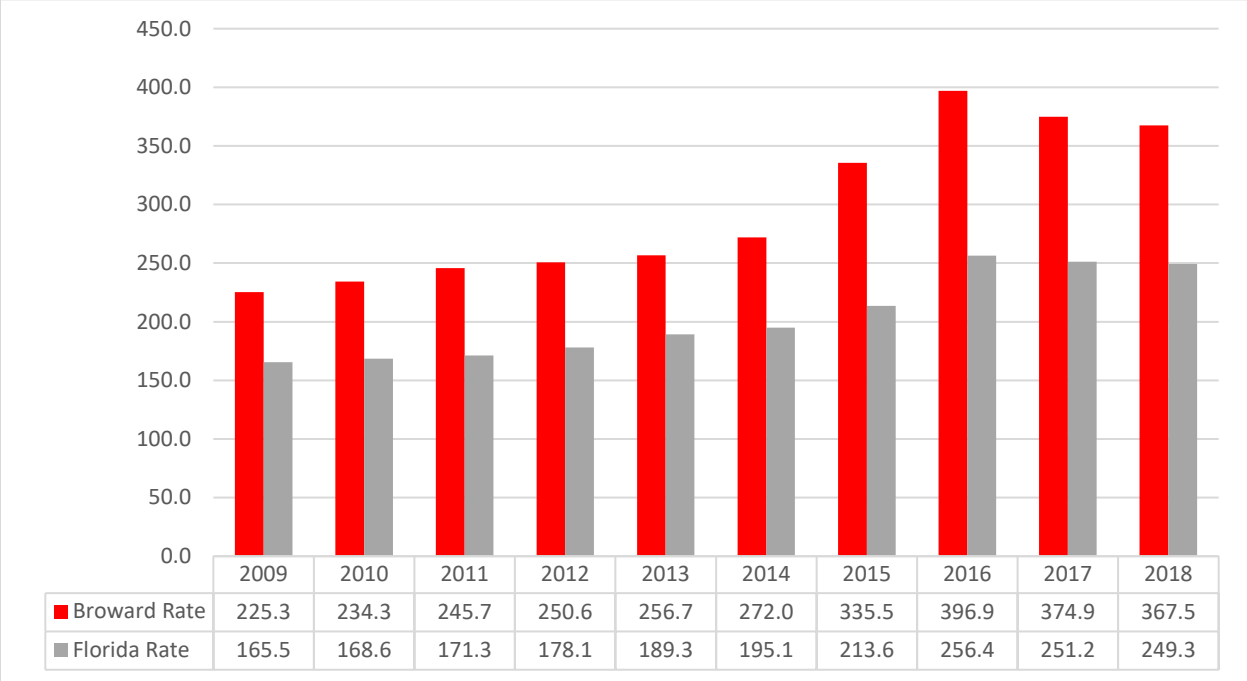
	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Broward Rate	1,051.6	1,097.0	1,101.0	1,058.2	1,112.8	1,174.4	1,292.4	1,219.6	1,150.8	1,135.8
Florida Rate	786.8	838.3	873.4	912.6	943.7	977.4	1,012.5	976.8	975.4	978.2

Source: Florida Health Charts, Florida Department of Health, 2009-2018



	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Broward Rate	501.9	536.4	544.0	506.1	539.3	576.6	578.0	580.5	543.1	583.3
Florida Rate	366.3	401.6	425.2	444.0	468.0	491.8	499.6	495.4	494.2	503.1

Source: Florida Health Charts, Florida Department of Health, 2009-2018

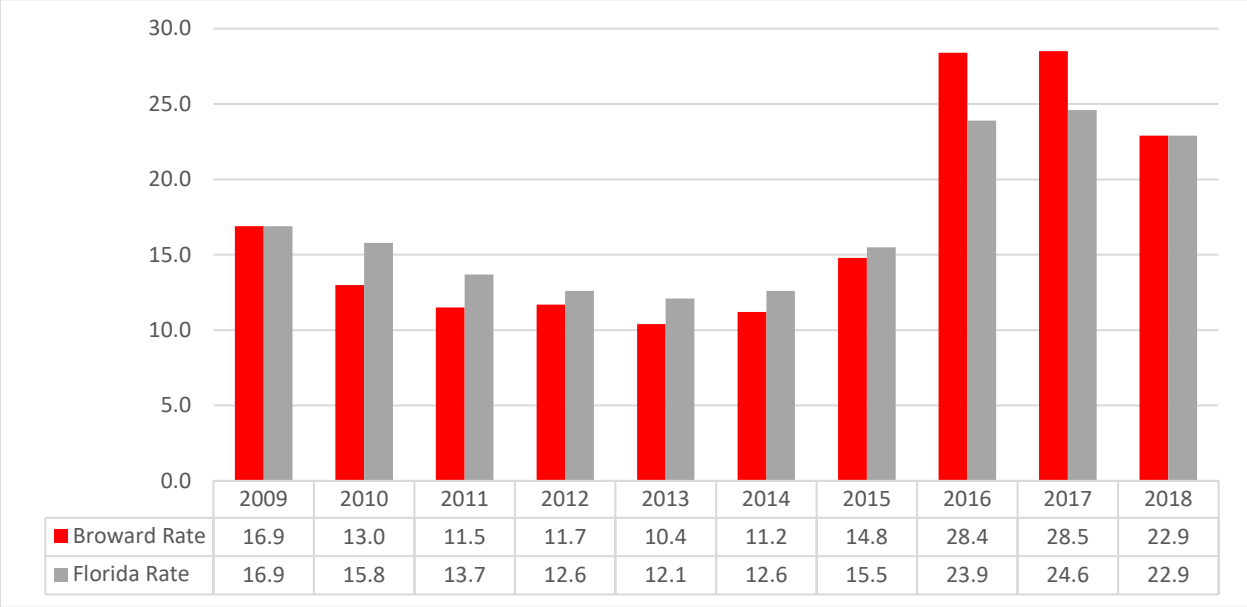


	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Broward Rate	225.3	234.3	245.7	250.6	256.7	272.0	335.5	396.9	374.9	367.5
Florida Rate	165.5	168.6	171.3	178.1	189.3	195.1	213.6	256.4	251.2	249.3

Source: Florida Health Charts, Florida Department of Health, 2009-2018

Drug-Poisoning Mortality

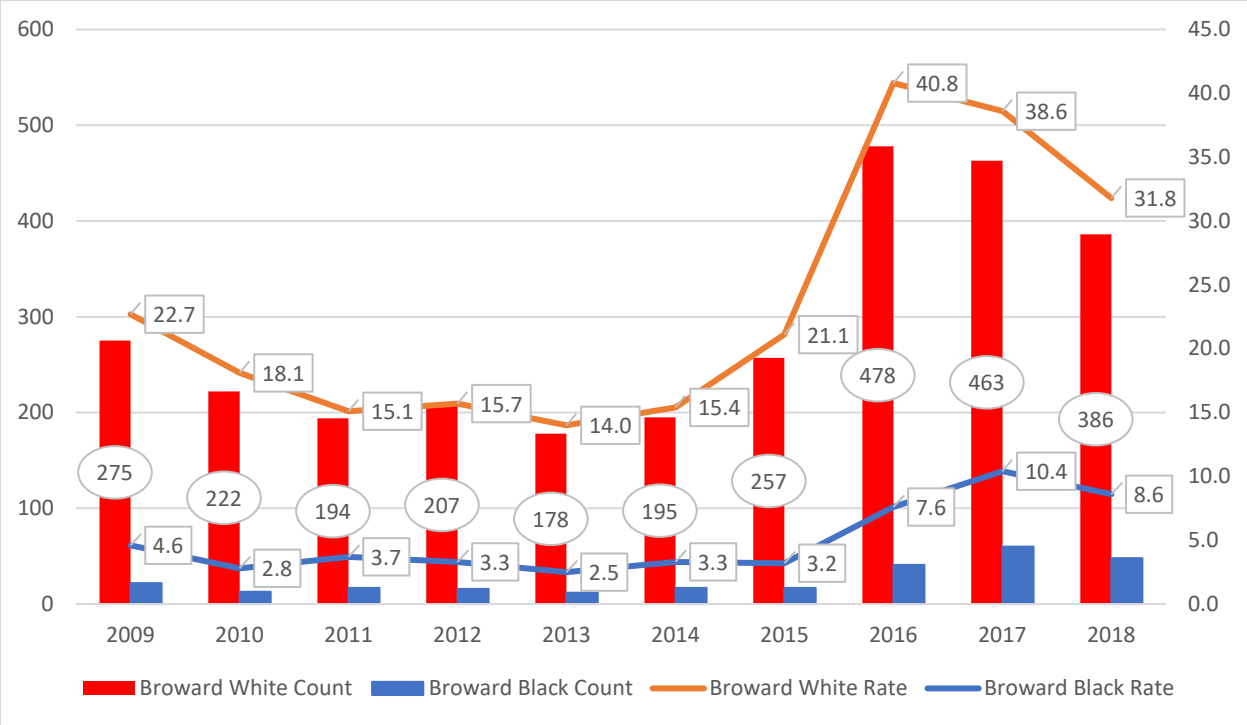
While considered preventable, poisoning is the leading cause of injury death in the nation and are mostly attributable to drugs overdose from either pharmaceutical and illicit drug. Florida Health Charts definition: Deaths resulting from unintentional or intentional overdose of a drug, being given the wrong drug, taking a drug in error, or taking a drug inadvertently. From 2009 to 2017, the drug-poisoning death rates in Broward County increased significantly for all age groups, reaching its peak in 2017 when it nearly tripled compared to the 2013 rate, from 10.4 per 100,000 to 28.5 per 100,000. For that reason, additional data drill downs were conducted to assess which segment of the population is most at-risk. Such analysis revealed that drug-poisoning fatalities were significantly higher within the White population during the past ten years. The count peaked in 2016 and 2017 (543 and 550).



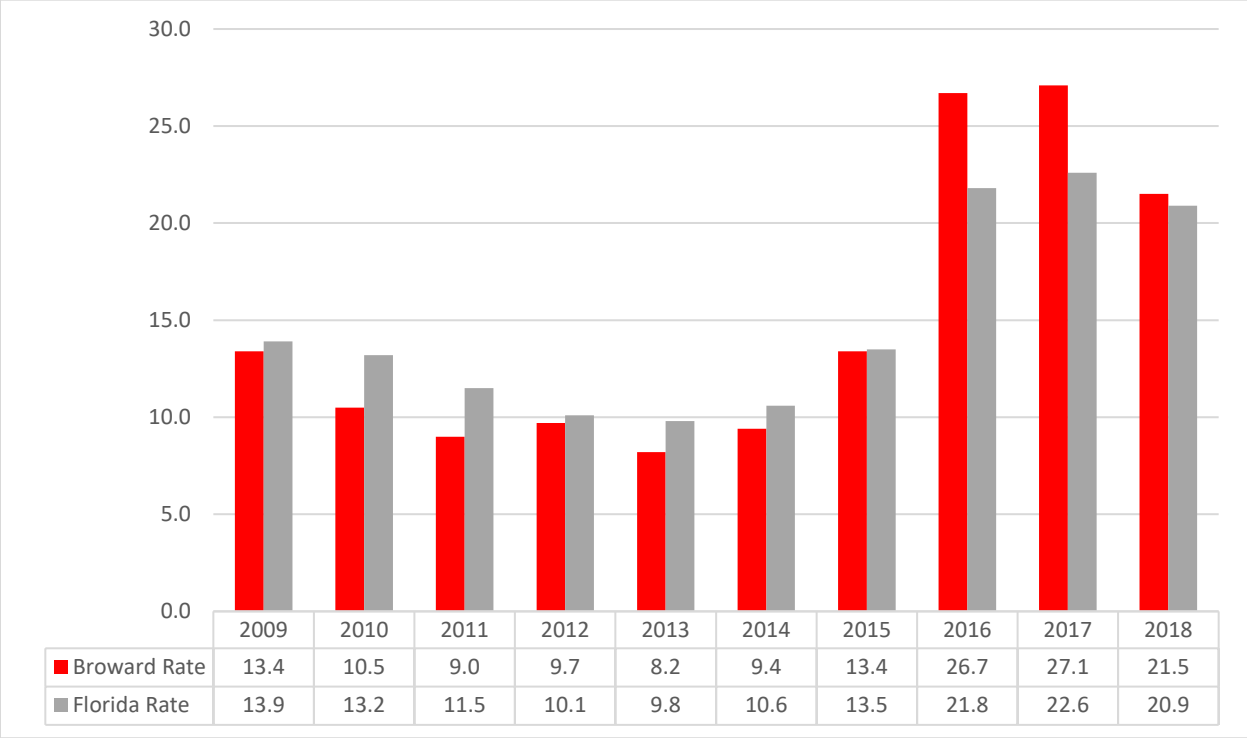
	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Broward Rate	16.9	13.0	11.5	11.7	10.4	11.2	14.8	28.4	28.5	22.9
Florida Rate	16.9	15.8	13.7	12.6	12.1	12.6	15.5	23.9	24.6	22.9

Source: Florida Health Charts, Florida Department of Health, 2009-2018

Figure 10. Age-adjusted Drug Poisoning Deaths by Race, Rate Per 100,000 Population – 2009-2018

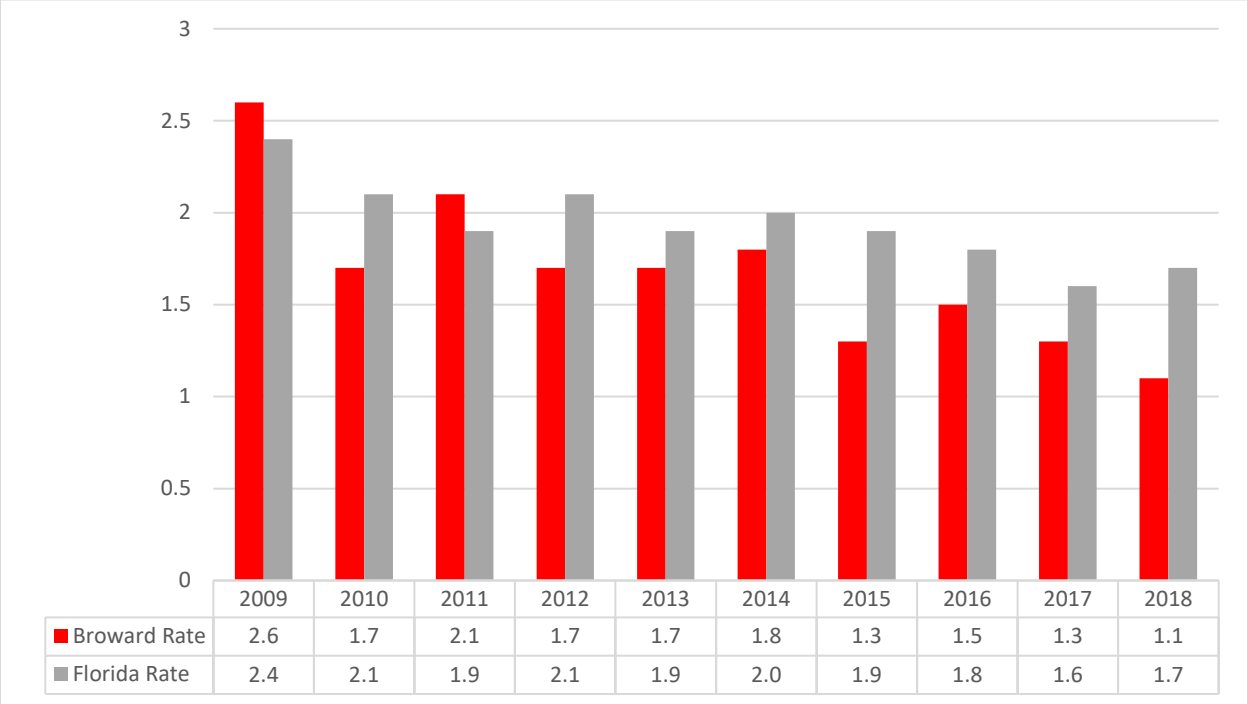


Source: Florida Health Charts, Florida Department of Health, 2009-2018



	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Broward Rate	13.4	10.5	9.0	9.7	8.2	9.4	13.4	26.7	27.1	21.5
Florida Rate	13.9	13.2	11.5	10.1	9.8	10.6	13.5	21.8	22.6	20.9

Source: Florida Health Charts, Florida Department of Health, 2009-2018



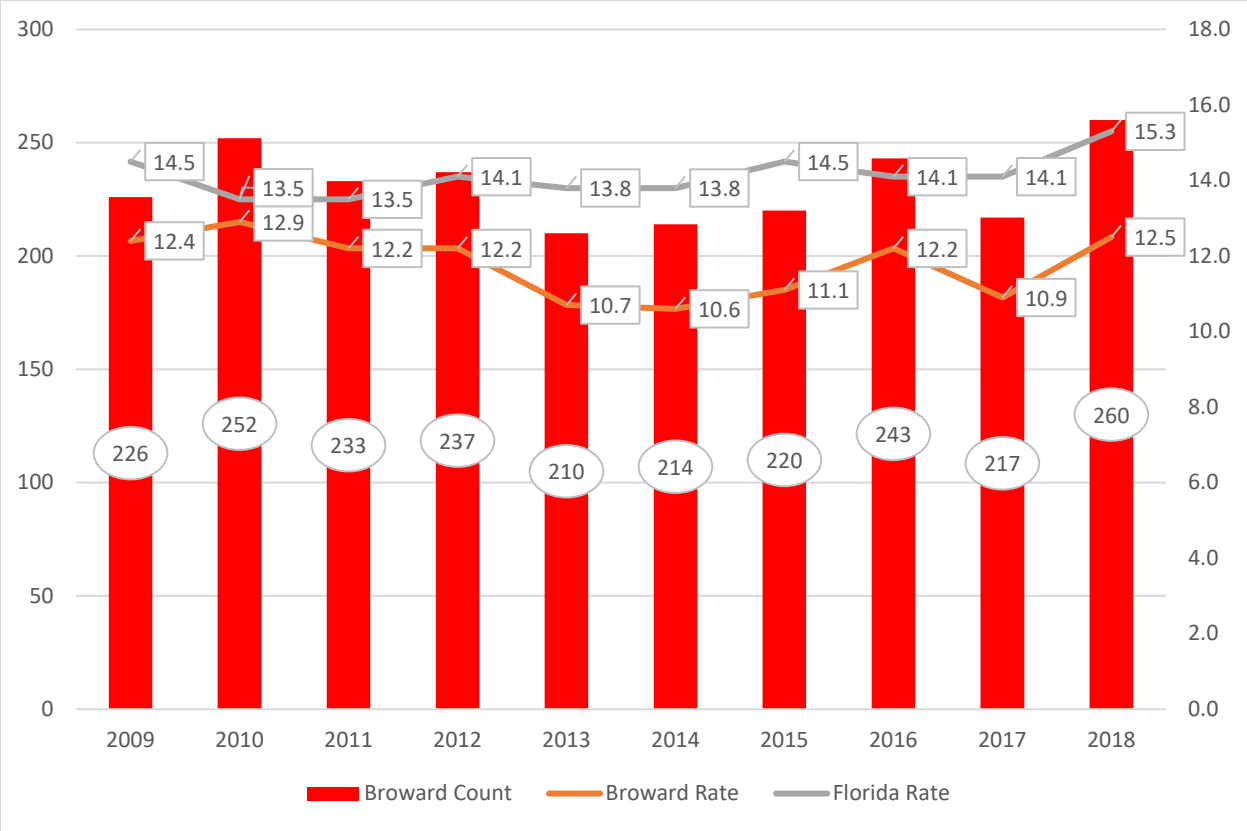
	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Broward Rate	2.6	1.7	2.1	1.7	1.7	1.8	1.3	1.5	1.3	1.1
Florida Rate	2.4	2.1	1.9	2.1	1.9	2.0	1.9	1.8	1.6	1.7

Source: Florida Health Charts, Florida Department of Health, 2009-2018

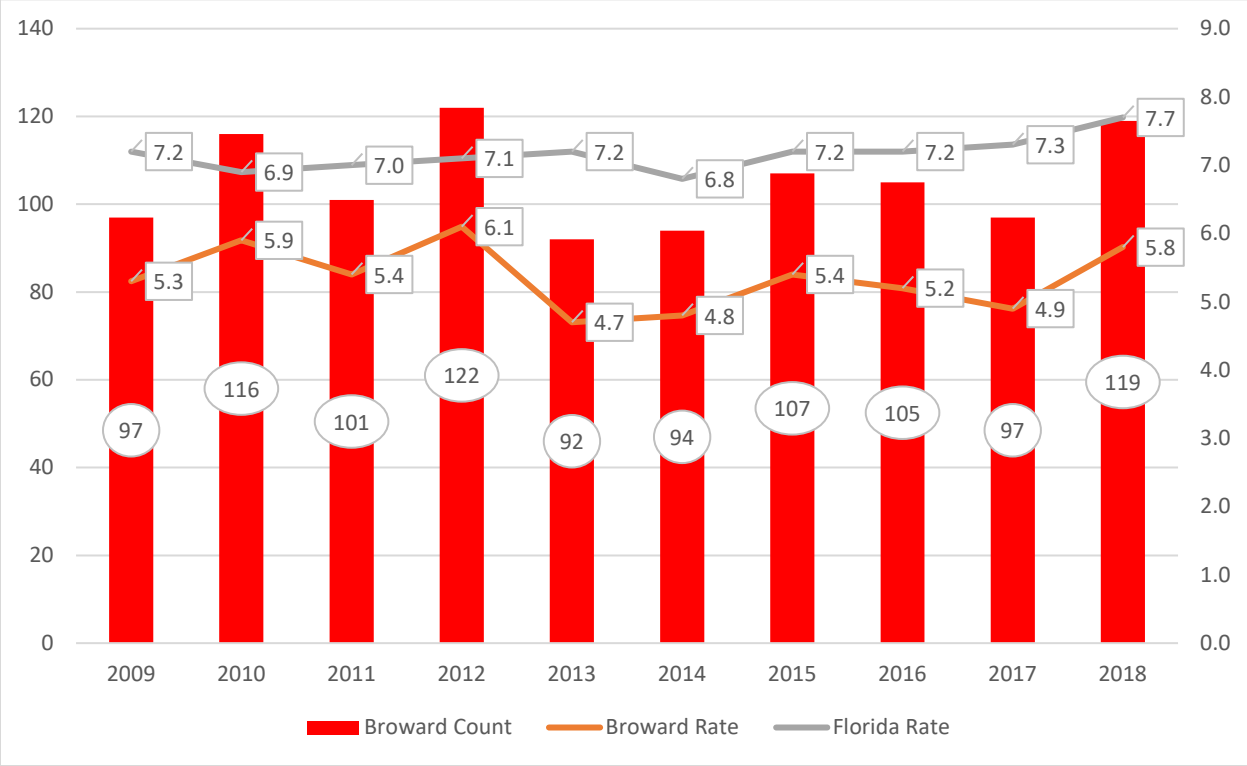
Suicide and Self-Inflicted Injury

One of the nation's leading causes of death, death by suicide or self-inflicted injury is described as when people direct violence at themselves with the intent to end their lives.

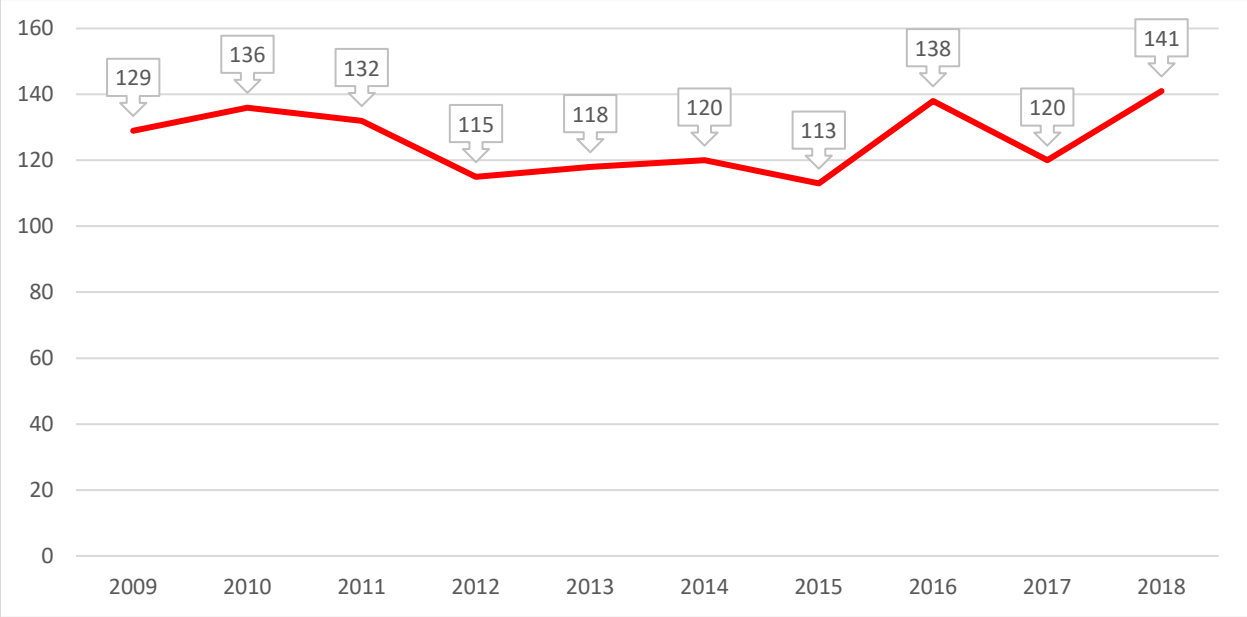
Individuals of all ages and backgrounds may be susceptible to suicide. Risk factors include depression and other mental health disorders, substance abuse, and family history of mental illness and substance use. Other risks include the presence of firearms in the home, violence and abuse, and spending time in prison. The Suicide Age-Adjusted Death Rate in Broward County is lower than Florida. The highest number of cases of suicide were recorded in 2018 (260) and the count for suicide by firearm increased to 119 in 2018.



Source: Florida Health Charts, Florida Department of Health, 2009-2018



Source: Florida Health Charts, Florida Department of Health, 2009-2018



Source: Florida Health Charts, Florida Department of Health, 2009-2018

Behavioral Risk Factor Surveillance System

The Behavioral Risk Factor Surveillance System (BRFSS) county-level survey was conducted among adults in Florida in 2007, 2010, 2013 and 2016. The purpose of this survey is to obtain estimates of the prevalence of personal health behaviors that contribute to morbidity and mortality. The following table outlines the following topics: Health Care Access & Coverage, Health Status & Quality of Life, HIV/AIDS.

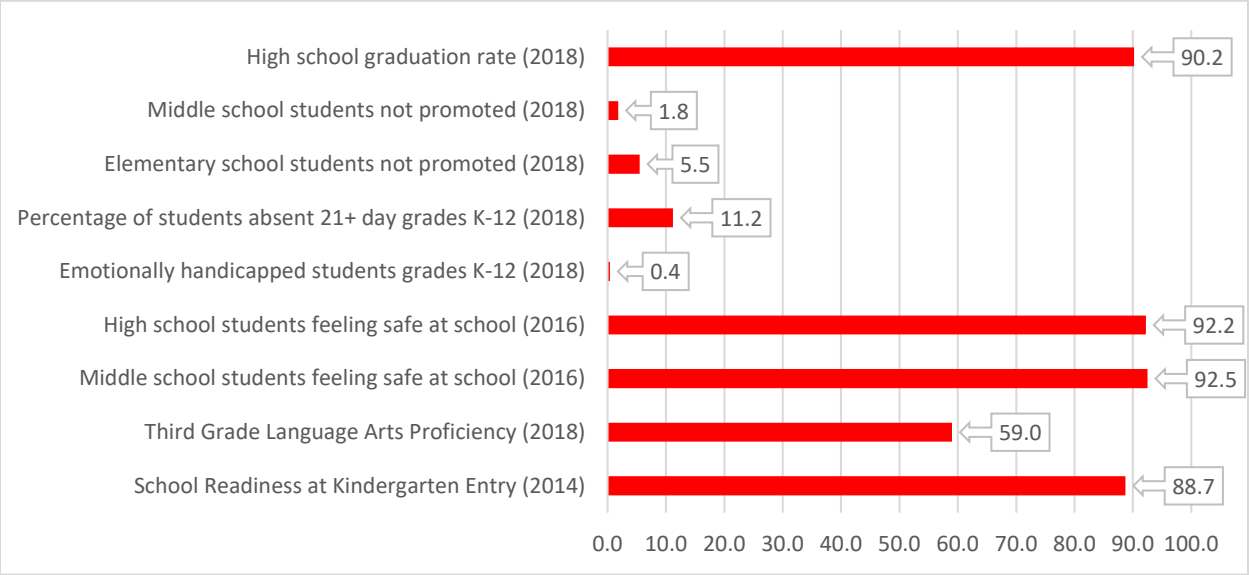
Table 7. Behavioral Risk Factor Surveillance System, Broward – 2007-2016

Indicator	2007 Percent	2010 Percent	2013 Percent	2016 Percent
Health Care Access & Coverage				
Adults who have a personal doctor	75.6 (70.2-80.3)	82.3 (77.6-87.1)	73.8 (68.8-78.7)	72.7 (67.9-77.4)
Adults who had a medical checkup in the past year	75.3 (70-80)	68.3 (62.8-73.8)	70 (64.9-75.2)	73.2 (68.4-78)
Adults who could not see a doctor in the past year due to cost	14.6 (11-19.1)	20.9 (16-25.8)	23.8 (18.9-28.6)	17.2 (13.2-21.3)
Health Status & Quality of Life				
Adults who said their overall health was "good" to "excellent"	83.8 (79.6-87.2)	85.7 (82.1-89.3)	82.4 (78.3-86.6)	85.7 (82.1-89.4)
Adults who said their overall health was "fair" or "poor"	16.2 (12.8-20.4)	14.3 (10.7-17.9)	17.6 (13.4-21.7)	14.3 (10.6-17.9)
Adults with good physical health	90.2 (87-92.7)	90.4 (87.3-93.4)	85.8 (81.8-89.9)	90 (86.8-93.1)
Average number of unhealthy physical days in the past 30 days	3.2 (2.5-4)	3.4 (2.6-4.2)	4.4 (3.4-5.5)	3.4 (2.6-4.3)
Adults with good mental health	91.3 (87.8-93.8)	89.2 (85.6-92.9)	87 (83.3-90.8)	88.1 (84.6-91.6)
Adults whose poor physical or mental health kept them from doing usual activities on 14 or more of the past 30 days (Among adults who have had at least one day of poor mental or physical health)	12.5 (8.3-18.3)	11 (6.9-15.1)	13.6 (8.7-18.5)	14.4 (8.9-19.9)
Average number of days where poor mental or physical health interfered with activities of daily living in the past 30 days (Among adults who have had at least one day of poor mental or physical health)	3.9 (2.9-5)	4.1 (3-5.2)	4.8 (3.4-6.1)	4.6 (3.2-6)
Adults who had poor physical health on 14 or more of the past 30 days	9.8 (7.3-13)	9.6 (6.6-12.7)	14.2 (10.1-18.2)	10 (6.9-13.2)
Adults who had poor mental health on 14 or more of the past 30 days	8.7 (6.2-12.2)	10.8 (7.1-14.4)	13 (9.2-16.7)	11.9 (8.4-15.4)
Average number of unhealthy mental days in the past 30 days	3.2 (2.3-4)	3.4 (2.6-4.2)	4.5 (3.5-5.5)	3.9 (3-4.7)
Adults who have ever been told they had a depressive disorder	-	-	14.6 (10.9-18.4)	13.9 (10.3-17.6)
HIV/AIDS				
Adults who have ever been tested for HIV	-	-	45.7 (40.2-51.2)	57.9 (52.5-63.4)
Adults less than 65 years of age who have ever been tested for HIV	52.9 (46.4-59.2)	51.1 (44.1-58)	52 (45.3-58.7)	65.3 (59.2-71.5)
Adults less than 65 years of age who had an HIV test in the past 12 months	25.5 (19.7-32.2)	10.1 (4.5-15.7)	17.6 (12.6-22.5)	30.9 (23.9-37.8)

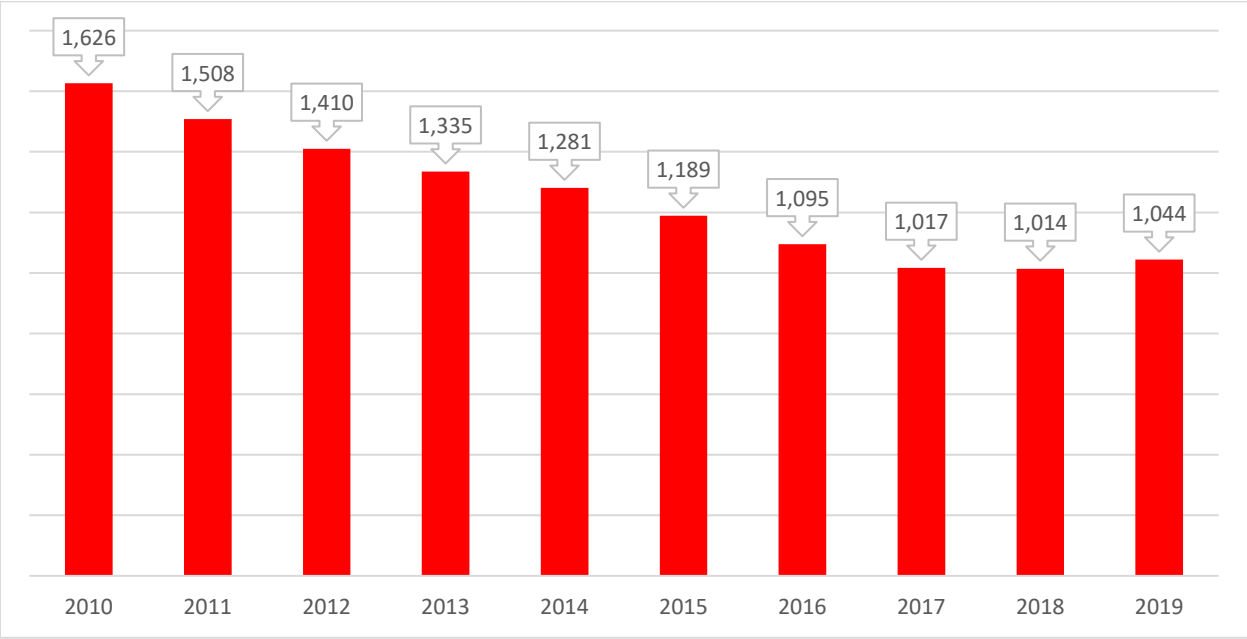
Source: Florida Health Charts, Florida Department of Health, 2007-2016

Youth Social-Emotional/Behavioral Health

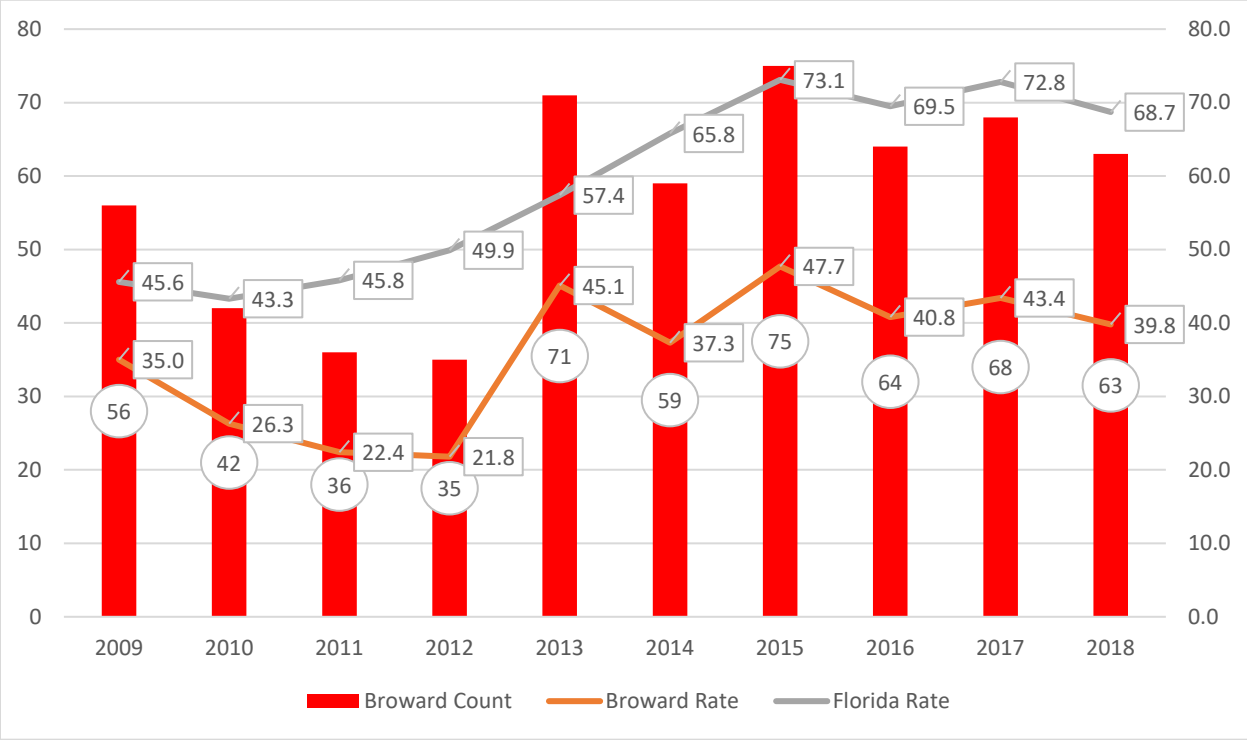
Children's ability to thrive depends on their access to safety, learning, exploration, healthy and supportive relationships, and the expression and control of emotions. These protective factors foster a strong self-esteem and solid interpersonal skills, which are essential for the development of coping mechanisms. The opposite is also true, lack of support and safety combined with high stress in childhood (child abuse, poverty) represent risk factors that can impact brain development and contribute to low academic achievement, delinquency and poor physical and mental health. The following tables provide an overview of Broward youth's social-emotional development measures for 2018: 88.7% school readiness at kindergarten entry, 90.2% high school graduation rate, and 59.0% third grade language arts. There was an overall decreasing trend in the number of children who have an emotional/behavioral disability. However, the count of non-fatal hospitalizations for self-inflicted injuries among children ages 12 to 18 increased in the last ten years, from 56 in 2009 to 63 in 2018, reaching a peak of 75 in 2015.



Source: Florida Health Charts, Florida Department of Health, 2018



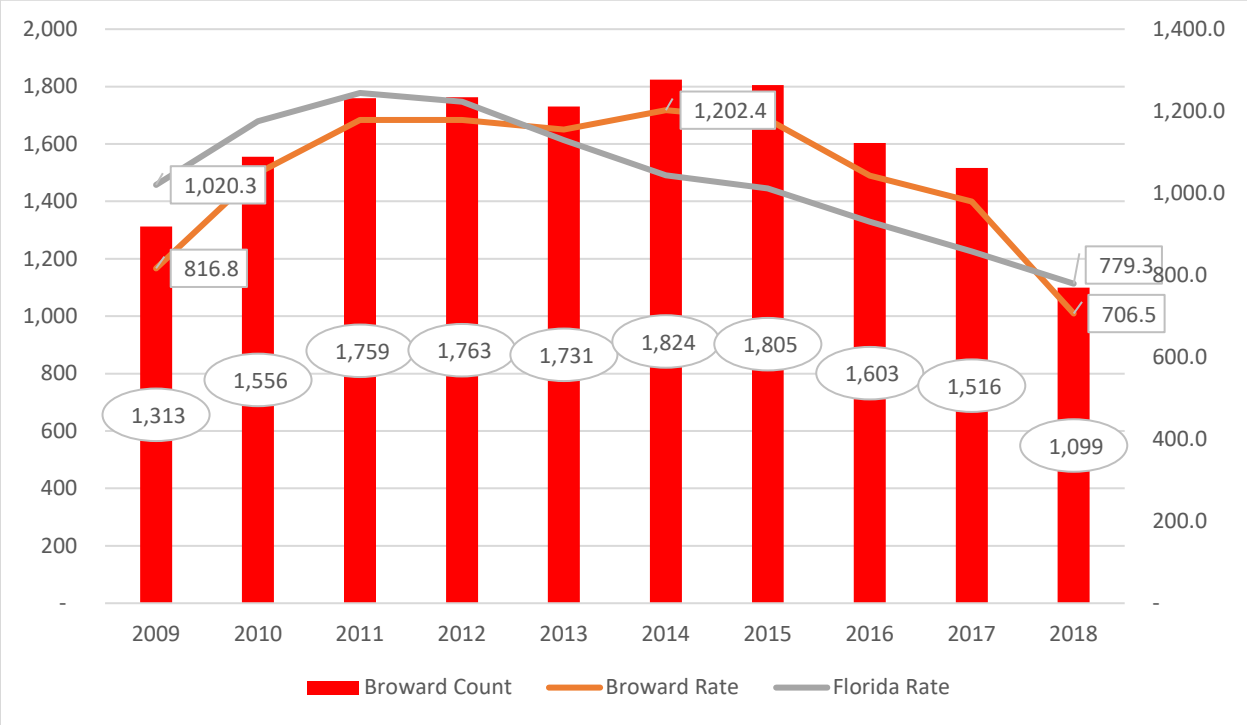
Source: Florida Health Charts, Florida Department of Health, 2010-2019



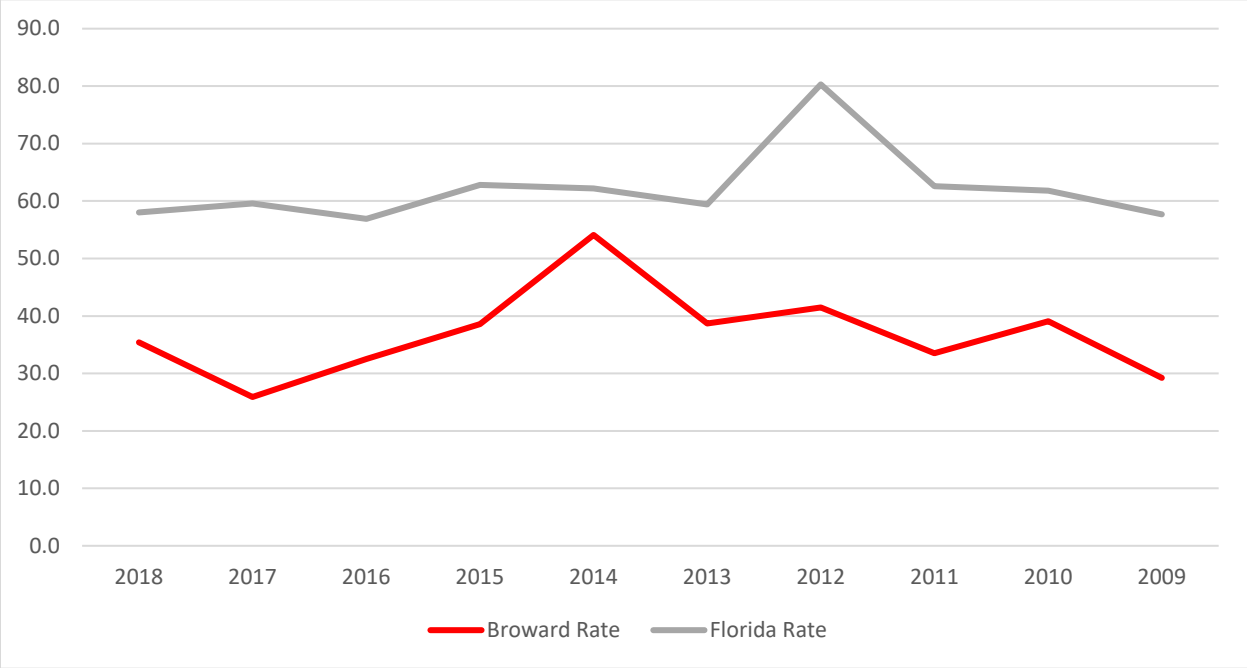
Source: Florida Health Charts, Florida Department of Health, 2009-2018

The U.S. Department of Health and Human Services explains that "child abuse and neglect may affect an individual's physical and mental health in a number of direct and indirect ways. Negative effects on physical development can result from physical trauma (e.g., blows to the head or body

or violent shaking) and from neglect (e.g., inadequate nutrition, lack of adequate motor stimulation, or withholding medical treatments). Maltreatment during infancy and early childhood has been shown to negatively affect early brain development and can have repercussions into adolescence and adulthood. The immediate emotional effects of abuse and neglect–isolation, fear, and an inability to trust can translate into lifelong consequences including low self-esteem, depression, and relationship difficulties." The rate of child abuse in Broward County significantly decreased over time, though it peaked above the state rate in 2014 (1,202.4).



Source: Florida Health Charts, Florida Department of Health, 2009-2018



Source: Florida Health Charts, Florida Department of Health, 2009-2018

Youth Risk Behavior Survey

The Youth Risk Behavior Survey (YRBS) is a statewide, school-based confidential survey of Florida's public high school students. The purpose of the YRBS is to monitor priority health-risk behaviors that contribute substantially to the leading causes of death, disability, and social problems among youth, which contribute to patterns in adulthood. The following table outlines Sexual behaviors related to unintended pregnancy and sexually transmitted diseases, including HIV infection

Table 8. Youth Risk Behavior Survey, Broward – 2017

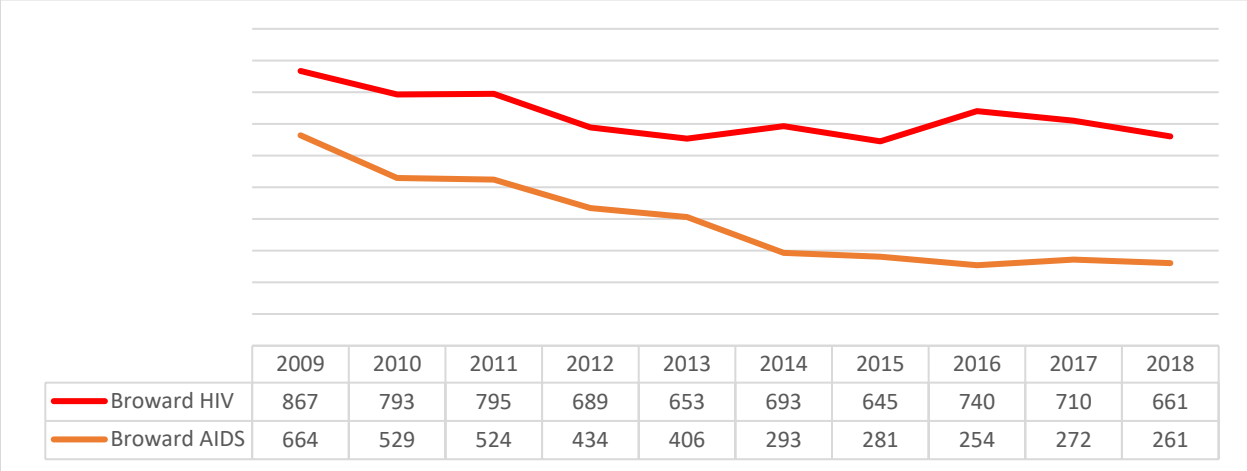
Question	Total %	Total N	Female %	Male %
Ever had sexual intercourse	37.4	782	32.3	43
Had sexual intercourse for the first time before age 13 years	4.2	784	0.6	8.1
Had sexual intercourse with four or more persons during their life	8.9	787	7.2	10.8
Were currently sexually active (had sexual intercourse with at least one person, during the 3 months before the survey)	25.3	786	24.1	26.6
Did not use a condom during last sexual intercourse (among students who were currently sexually active)	43.7	177	62.1	25.6
Did not use birth control pills before last sexual intercourse (to prevent pregnancy, among students who were currently sexually active)	83.7	179	83.6	83.8
Did not use an IUD (e.g., Mirena or ParaGard) or implant (e.g., Implanon or Nexplanon) before last sexual intercourse (to prevent pregnancy, among students who were currently sexually active)	93.1	179	88.7	97.4
Did not use a shot (e.g., Depo-Provera), patch (e.g., OrthoEvra), or birth control ring (e.g., NuvaRing) before last sexual	100	179	100	100

Table 8. Youth Risk Behavior Survey, Broward – 2017				
intercourse (to prevent pregnancy, among students who were currently sexually active)				
Did not use birth control pills; an IUD (e.g., Mirena or ParaGard) or implant (e.g., Implanon or Nexplanon); or a shot (e.g., Depo-Provera), patch (e.g., OrthoEvra), or birth control ring (e.g., NuvaRing) before last sexual intercourse (to prevent pregnancy, among students who were currently sexually active)	76.8	179	72.4	81.2
Did not use both a condom during last sexual intercourse and birth control pills; an IUD (e.g., Mirena or ParaGard) or implant (e.g., Implanon or Nexplanon); or a shot (e.g., Depo-Provera), patch (e.g., OrthoEvra), or birth control ring (e.g., NuvaRing) before last sexual intercourse (to prevent pregnancy, among students who were currently sexually active)	94.4	176	96.3	92.5
Did not use any method to prevent pregnancy during last sexual intercourse (among students who were currently sexually active)	12.6	179	16.4	8.9
Drank alcohol or used drugs before last sexual intercourse (among students who were currently sexually active)	22.3	183	28.3	16.3
Were never tested for human immunodeficiency virus (HIV) (not counting tests done if they donated blood)	80.5	889	80.7	80.5

Source: Centers for Disease Control and Prevention, 2017

Overview of the Epidemic-Broward County

Broward County is Florida's (FL) second-largest metropolitan area, with over 1.9 million residents. In 2018, the FL Department of Health (DOH) reported 21,048 HIV positive (+) Broward residents, with 75% male, 25% female; 661 new HIV cases, and 261 new AIDS cases. HIV incidence data reflect a 5% drop in new incident HIV cases between 2016-2018 due to active HIV prevention efforts.



	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Broward HIV	867	793	795	689	653	693	645	740	710	661
Broward AIDS	664	529	524	434	406	293	281	254	272	261

Source: Florida Health Charts, Florida Department of Health, 2009-2018

Broward Part A funded core medical and support services for 8,233 unduplicated clients in Fiscal Year (FY) 2018, with 85% of individuals being virally suppressed. Table 9 details notable disparities in viral suppression rates for youth, non-permanently housed, and Black, non-Hispanic men who have sex with men (MSM).

Table 9. Viral Suppression Rate (%) for Unduplicated Broward Part A Clients, FY2018

Category	Viral Suppression Rate
HIV+ Youth (Aged 18-28)	71%
HIV+ Older Adults (Aged 49-58)	87%
Non-Permanently Housed	76%
Permanent Housing	88%
Black, non-Hispanic MSM	78%
White, non-Hispanic MSM	90%
Hispanic MSM	91%

Broward's lack of Medicaid expansion, inadequate funds, and absence of teaching hospitals has resulted in an HIV Care Continuum that is much smaller than other Eligible Metropolitan Areas (EMAs) with comparable HIV prevalence rates. Broward's Continuum is comprised of tax district healthcare systems, community health centers, community-based organizations (CBOs), and the Florida Department of Health-Broward County (FLDOH-BC). A network 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 (OAHS). Part A

also coordinates with the FL AIDS Drug Assistance Program (ADAP) to ensure access to HIV and other needed medications. Recent initiatives include the Part A and FLDOH-BC Test and Treat Program (TTP) and Part A integrated primary care and behavioral health services.

The Continuum is financially overburdened due to increased demand for services, non-expansion of Medicaid, growing numbers of HIV+ indigent clients and in-migration of HIV+ individuals. Increased funds targeting HIV core medical and support services are critically needed to locate, link, engage, and retain HIV+ residents in care. The proposed Part A and Minority AIDS Initiative (MAI) direct services budget of $14,213,009 will sustain current services and modestly expand underfunded services. At 86% of proposed funds for core medical services, the 75% Part A core medical requirement is greatly exceeded.

Epidemiologic Overview

FLDOH epidemiologic data demonstrated the impact of Broward primary and secondary prevention efforts to reduce the rate of new HIV+ Broward residents. Broward experienced a 4% decrease in new HIV cases between CY2016-2017 and a 7% decrease between CY2017-2018. Broward's population-adjusted incidence rates between CY2016-2018, dropped from 39.8 per 100,000 population in CY2016 to 37.7 and 34.7 in CY2017 and CY2018, respectively.

FLDOH epidemiologic data also documented significantly high HIV disease prevalence rates and the disproportionate impact of the HIV/AIDS epidemic on vulnerable Broward populations. The Broward HIV/AIDS epidemic disproportionately impacts specific Broward sociodemographic groups. Trends are most apparent in the incidence and prevalence case rates among 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 CY2008-2017. CDC CY2018 data are unavailable.

FLDOH compared new Broward HIV incident cases in CY2016 versus CY2018. In that short period, the percentage of HIV new cases dropped for White non-Hispanics, while it rose for all non-White groups. Among White non-Hispanics, HIV incident cases dropped from 23% in CY2016 to 21% in CY2018. While 50% of new HIV cases were Black non-Hispanic in CY2016, they made up 45% of new cases in CY2018. Among Hispanics, new HIV cases rose from 25% in CY2016 to 30% in CY2018. Among other races/ethnicities, HIV incident cases rose from 2% in CY2016 to 3% in CY2018. The rate of new HIV cases between CY2016-2018 dropped significantly for White non-Hispanics (17%) and Black non-Hispanics (19%). While the rate of new HIV cases among Hispanics rose 7%. Adjusting for population size demonstrates the dramatic racial/ethnicity disparities in HIV incident rates. In CY2018, Black non-Hispanics had a 55.9 per 100,000 population new HIV case rate, compared to Hispanics with rate of 35.6 and White non-Hispanics with 20.3 per 100,000 population, respectively.

Other Broward HIV incidence data from FLDOH are noteworthy.

- *Sex at birth: Newly identified HIV+ Broward cases were disproportionately male. In CY2018, 80% of new HIV cases were male, while 20% were female. Between CY2016-2018, new HIV cases among males dropped 9% versus 17% among females.*
- *Age: New HIV cases among newborns and children have dropped considerable since the onset of the HIV epidemic, associated with considerable efforts to provide prenatal counseling and perinatal and postnatal ARV treatment. There were no new HIV cases among children below 12 years in CY2016, two children in CY2017, and one child in CY2018. Among adolescents and adults, new HIV cases dropped for all age groups except individuals 25-29 years of age (3%), 30-44 years of age (3%), and 55-59 years of age (6%).*
- *HIV Exposure Factors: Among new HIV cases in CY2018, 72% were reported infected via male to male exposure, 23% heterosexual exposure, and 5% reported other factors. Among new HIV cases among women, 96% were reported to have been HIV-infected through heterosexual exposure, 3% through intravenous drug use (IDU), and 1% through other HIV exposure factors. Between CY2016-2018, new HIV cases among adolescent/adult males associated with IDU dropped 39%, versus 11% for male to male exposure, and 17% for MSM/IDU exposure. In contrast, new HIV cases associated with heterosexual exposure among adolescent/adult males rose 2%. Among adolescent/adult females, new HIV cases dropped 67% for IDU and 13% for heterosexual exposure*

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. The CDC reports that Broward ranked third in population-adjusted AIDS cases in CY2017, the most recent national data available. A total of 261 Broward residents were diagnosed with AIDS in CY2018, or 13.7 cases per 100,000 population. Among AIDS cases diagnosed in CY2018, 59% were Black non-Hispanic, 21% White non-Hispanic,16% Hispanic, and 4% other races/ethnicities. Almost two-thirds (69%) of CY2018 AIDS cases were male, versus 31% female. Among male AIDS cases diagnosed in CY2018, 62% were reported to have been HIV-infected via male to male exposure and 31% from heterosexual exposure. Among newly diagnosed women with AIDS in CY2018, 89% were reported to have been HIV-infected through heterosexual exposure, 5% IDU, and 6% other HIV exposure factors. Among adult AIDS cases in CY2018, 16% were between 20-29 years of age, 25% between 30-39, 19% between 40-49, 25% between 50-59, and 14% 60 years of age or older.

New AIDS case rates rose 3% between CY2016-2018. AIDS case rates varied by demographic and HIV epidemiologic group.

- *Race/Ethnicity: White non-Hispanic AIDS cases rose 12% between CY2016-2018, compared to less than 1% of Black non-Hispanics. Among Hispanics, the number of AIDS cases remained steady in the three-year period. Sex at Birth: AIDS case rates rose 7% among females versus 1% for males.*
- *Age Groups: Decreases in new AIDS cases reported in CY2016-2018 varied considerably. Increases in AIDS cases were reported for the 30-34-year-old group (77%), 50-54-year-old group (13%), and the 55-59 and 60 years or older groups (36%, respectively). HIV Exposure Groups: AIDS cases increased among adolescent/adult male exposure groups,*

including MSM/IDU group (150%), MSM (not IDU) group (2%), and 14% IDU group (14%). In contrast, new AIDS cases in the heterosexual exposure group dropped 4% between CY2016-2018. Among adolescent/adult women, AIDS cases dropped 56% in the IDU group, while rising 9% in the heterosexual exposure group.

Persons Living with HIV (PLWH)

The prevalence rate represents PLWH persons living with HIV through the end of the CY (regardless of where they were diagnosed). The CDC reports that Broward's prevalence case rate ranked first or second among MSAs nationally for much of CY2008-2017, the most recent data available. Table 10 shows a prevalence of 21,048 PLWH in CY2018. FLDOH reported that HIV prevalence cases increased 2% between CY2016-2018. No significant change in the number of living AIDS cases were reported.

Table 10. Broward County HIV/AIDS Prevalence (Living), CY2016-2018

	CY2016	CY2017	CY2018
HIV (PLWH)	20,693	20,871	21,048
AIDS (PLWA)	10,776	10,764	10,772

Broward's HIV epidemic, as reflected in Broward PLWH, is highly diverse.

- *Sex at Birth: In CY2018, 75% of Broward PLWH were male and 25% women, with population adjusted case rates of 1,690.9 versus 549.4 per 100,000 population. The number of PLWH rose 2% among males and < 1% among females between CY2016-2018.*
- *Race/Ethnic Group: In CY2018, Black non-Hispanics were 47% of PLWH, compared to 33% White non-Hispanic and 18% Hispanic. When adjusting for the variable sizes of Broward racial/ethnic population sizes, White non-Hispanics had a rate of 988.9 population compared to 1,828.5 for Black non-Hispanics per 100,000 population, and 683.1 per 100,000 population. The number of White non-Hispanic PLWH decreased 3% between FY2016-2018, compared to a 3% increase among Black non-Hispanic PLWH and 8% of Hispanics.*
- *Age Group: FLDOH reported that 17 PLWH < 13 years of age resided in Broward in CY2018. An additional 2% of PLWH were between 13-24 year of age, 11% were 25-34, 17% were 35-44, 29% were 45-59, and 17% were 60 years of age or older. The percentage of PLWH decreased for most age groups between CY2016-2018. Increases in PLWH were reported, however, for the 25-34 age group (2%) and the 60 year or older age group (13%).*
- *Exposure Category: All 17 pediatric-exposed PLWH living in CY2018 were perinatally exposed. Among adolescent/adult male PLWH living in CY2018, 72% were reported to be in the MSM exposure category, 19% heterosexual category, 4% in the IDU and MSM/IDU categories, respectively, and < 1% in other categories. Between CY2016-2018, increases in the number of PLWH were reported in the MSM and heterosexual categories (3%, respectively). Decreases in the number of PLWH ranged from 7% for the IDU category to < 1% for the other category. Among adolescent/adult female PLWH living in CY2018, 88% were reported to be in the heterosexual category, 9% IDU category, and 3% in the other category. The number of adolescent/adult PLWH female PLWH dropped*

7% in the IDU category versus 1% and 2% increases for the heterosexual and other risk categories, respectively.

Persons Living with AIDS (PLWA)

PLWA are a subset of PLWH. Between CY2016-2018, about half of Broward PLWH met the CDC AIDS definition, including CD4 count <200. PLWA were 52% of PLWH in CY2016 and CY2017, with a slight drop in CY2018 (51%). The rate of Broward PLWA reflects the large number of PLWH diagnosed with AIDS prior to introduction of ARVs. These individuals benefited from ARVs and AIDS prophylaxis medications, with extended survival. The rate of PLWA also reflects the more recent advanced stages of HIV immunocompromise among some PLWH when they first are linked to OAHS or that have returned to care after long periods without ARV treatment. Sex at Birth: In CY2018, 72% of Broward PLWA were male and 28% women, with population adjusted case rates of 840.9 versus 304.5 per 100,000 population, respectively. The number of PLWA rose <1% among males and dropped < 1% among females between CY2016-2018.

- *Race/Ethnic Group: In CY2018, Black non-Hispanics were 51% of PLWA, compared to 41% White non-Hispanic and 15% Hispanic. When adjusting for the variable sizes of Broward racial/ethnic group sizes, White non-Hispanics had a rate of 474.2 population compared to 1,033 for Black non-Hispanics per 100,000 population, and 293.4 per 100,000 population. The number of White non-Hispanic PLWA decreased 3% between FY2016-2018, compared to a 1% increase among Black non-Hispanic PLWA and 2% of Hispanics. Age Group: FLDOH reported that three PLWA < 13 years of age resided in Broward in CY2018. An additional 1% of PLWA were between 13-24 year of age, 6% were 25-34, 14% were 35-44, 31% were 45-59, and 20% were 60 years of age or older. The percentage of PLWA decreased for all age groups between CY2016-2018 except for the 60 year or older group (10%).*
- *Exposure Category: All three pediatric-exposed PLWA living in CY2018 were perinatally exposed. Among adolescent/adult male PLWA living in CY2018, 65% were reported by FLDOH to be in the MSM exposure category, 24% heterosexual category, 5% in the IDU and MSM/IDU categories, respectively, and < 1% in other categories. Between CY2016-2018, a slight increase in the number of PLWA were reported in the MSM and heterosexual categories (<1% and 2%, respectively). Decreases in the number of PLWA ranged in the IDU exposure category to 5% for the other exposure category. Among adolescent/adult female PLWA living in CY2018, 86% were reported to be in the heterosexual category, 11% IDU category, and 4% in the other exposure category. The number of adolescent/adult PLWA female PLWA dropped 8% in the IDU category versus 8% and 6% increases for the heterosexual and other risk categories, respectively.*

Persons at High HIV Risk

Broward's HIV epidemic disproportionately impacts adult males with an MSM exposure category. 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, a global network representing over 80 countries. Over 12.8 million tourists visit Broward annually, including 1.5 million LGBTQ visitors.

According to the CDC, 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. Broward Part A collects transgender data through Provide Enterprise (PE), the client-level database used by RWHAP recipients, subrecipients, and HOPWA. A total of 60 transgender Part A clients were served in FY2018.

Socioeconomic Status and HIV Infection

The US Census reports that the Broward median household income was $54,395 in CY2017 dollars, the most recent data available. Socioeconomic data for PLWH are unavailable from FLDOH. 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. Similar data are unavailable from the Census. Most (88%) Broward adults 25 years of age or older had earned a high school diploma or higher. About two-thirds (62%) of Part A clients had at least a 12th grade education. 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. Approximately 17% of Broward residents under the age of 65 years 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.

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 HIV+ residents. MSM and heterosexual HIV exposure categories were associated with the highest HIV and AIDS incidence and prevalence rates among adolescent/adult males. The MSM HIV exposure category was associated with 72% of new HIV cases in CY2018, 63% of new AIDS cases, 72% of HIV prevalent cases, and 65% of AIDS prevalent cases. The heterosexual exposure category 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 HIV exposure category 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 MSM/IDU HIV exposure category 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, ethnicity, and HIV exposure category are strongly associated with the HIV exposure factors among men, especially among MSM and Black non-Hispanics. FLDOH reports that among White non-Hispanic males in CY2018, 86% reported MSM as their HIV exposure category versus 8% heterosexual, 5% MSM/IDU, and 1% IDU. Among Black non-Hispanic males, 29% reported heterosexual exposure, 27% MSM, 2% IDU, and 1% MSM/IDU. Almost all (95%) of non-Hispanic females reported heterosexual exposure. Among Hispanic males, 85% reported MSM exposure, 14% heterosexual, < 1% IDU, and < 1% MSM/IDU.

FLDOH adult HIV infection trend data demonstrate that adults 50 years or older are the fastest growing sector of the Broward adult HIV+ population, rising from 54% in CY2016 to 55% in CY2017 and 57% in CY2018. Aging of HIV+ cases, advances in HIV treatment, in-migration of MSM, 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

FLDOH measured the number of PLWH migrating to and within FL jurisdictions between CY2014-2017. Broward consistently had the largest share of in-migrating PLWH among FL Part A jurisdictions between CY2014-2017. It is noteworthy that due to lags in HIV morbidity reporting, FLDOH-BC may be unaware of in-migrating HIV+ individuals for month 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 PLWH Offer Unique Cultural, Linguistic, and Clinical Challenges

A large portion of Broward Black, non-Hispanic PLWH and PLWA were born in Haiti. The exact figures are unavailable from FLDOH and no timely Census population data are available. FLDOH does report, however, that in CY2018, 2,009 living PLWH were born in Haiti, with 51% male and 49% female. The number of living Haitian-born PLWH increased 3% between CY2016-2018. (It is important to note that FLDOH only reports on Haitian-born PLWH and does not report similar data for PLWH of Haitian descent born in the US).

In CY2018, Haitian-born PLWH represented 12% of total PLWH and 10% of total PLWA. Almost two-thirds (64%) of living Haitian-born PLWH met the CDC AIDS criteria, significantly higher than the 51% of total PLWH meeting the criteria. Haitian-born individuals made up 10% of new HIV cases and 13% of new AIDS cases in CY2018. A large portion of Haitian-born RWHAP clients are 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.

HIV-Related Deaths Continue to Impact Broward

FLDOH reported HIV/AIDS-related deaths data 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 observation period. While the slope of FL death rates decreased relatively evenly between CY1998-2017, Broward death rates decreased

less evenly in the 19-year period. Both FL and Broward death rates dropped significantly in CY2000 and CY2006. These trends may be associated with diffusion of ARVs and reduced pill burden. Broward and FL population-adjusted death rates decreased significantly for Broward and FL after CY2006, with spiked increases in Broward rates between CY2013-2014 and CY2015-2016, with death rates plateauing through CY2017. Factors associated with HIV-related death will be assessed in FY2020 to identify interventions that can be implemented by the Continuum.

Methods of 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 HIV+ residents. Additional data on Broward's HIV+ population were collected in PE, the Part A client-level management information system (MIS), statewide and local surveys, and FLDOH data.

HIV Surveillance Data

CY2018 co-morbidity data were captured in eHARS and Patient Reporting Investigating Surveillance System (PRISM) (as of August 2019). Among Broward HIV+ residents, 449 were diagnosed with infectious syphilis, 597 with gonorrhea, 569 with chlamydia, 69 with hepatitis C virus (HCV). Among Broward HIV+ residents, 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 HIV+ residents were diagnosed with tuberculosis (TB), The population-adjusted rates per 100,000 population were: 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.

Increasing Need for HIV-Related Services

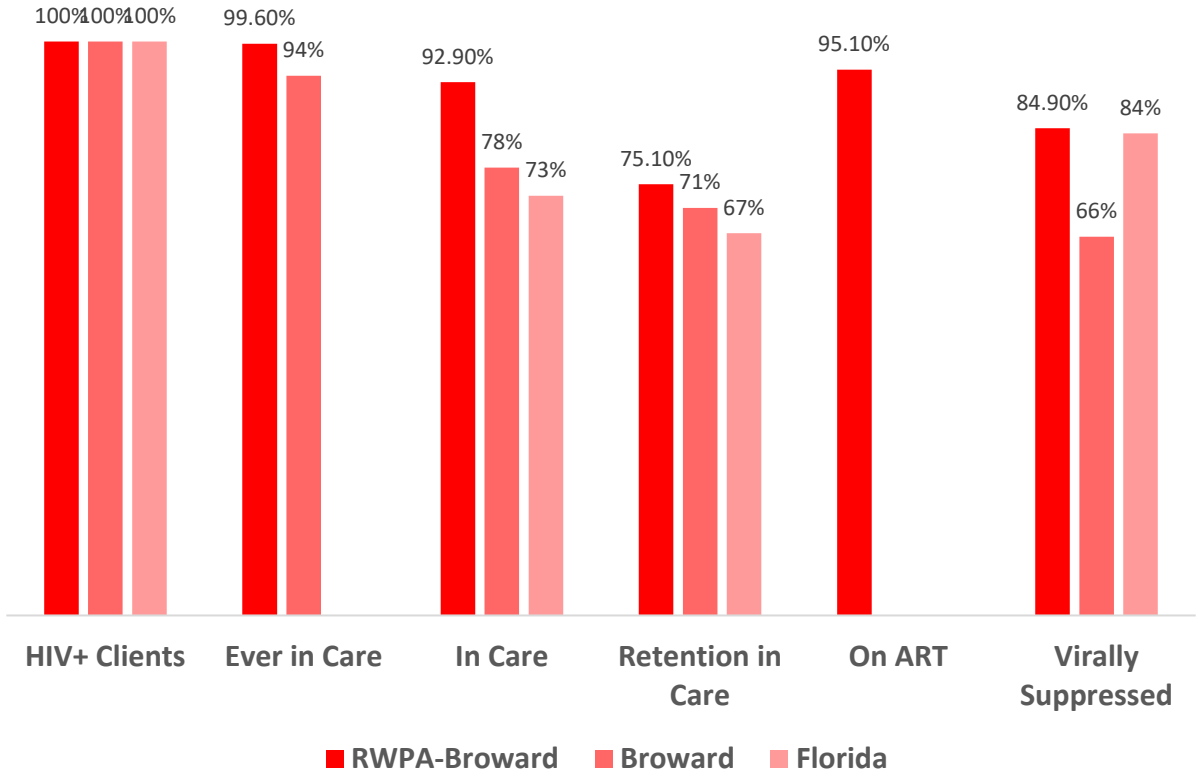
The HIV epidemic disproportionately impacts racial, ethnic, sexual minorities, as well as younger and older residents, the homeless, and formerly incarcerated individuals. Young adults aged 20-34 and adults 50 years or older represent the populations with the greatest need for HIV-related services. To ensure favorable health outcomes, these populations require an array of targeted services. Historically, HIV prevention and care funds were not equitably distributed to Broward County. While the CDC, HAB, and other federal agencies have targeted funds to address the Miami-Dade County HIV epidemic, Broward's epidemic received limited funding, except Part A funds, reflecting a lack of understanding of the severe impact of the HIV epidemic in Broward. Although funding has increased, it is insufficient to support an efficient Part A system of care, creating a monumental need for HIV-related services in Broward. Broward's system of care is overburdened due to increased demand for services, high retention rates and decreased per capita funding targeting HIV prevention and care services critically needed to address the Broward HIV epidemic.

HIV Care Continuum

Application of the Broward HIV Care Continuum in FY2020

Examining the Continuum is vitally important in identifying barriers to engagement and retention in HIV care, assessing effectiveness of the HIV care and treatment system, and improving all stages of the Continuum. The Continuum model provides a conceptual framework that supports funders and community planning efforts to integrate HIV testing, linkage, care, and treatment to create a seamless service system. The Continuum model also informs the RWHAP priority setting and resource allocation (PSRA) and continuous quality improvement (CQI) processes to achieve high quality, accessible, and affordable services for all HIV+ Broward residents. Scientifically sound and evidence-based outcome measures provide critical metrics that assess each stage of the Continuum and discontinuities between the stages.

Figure 22 depicts the rate of HIV+ individuals assumed to be alive and living in Broward in CY2018. Data sources include eHARS, CAREWare, FL ADAP, and CY2018 FL MMP. Completeness of this analysis is impacted by: (1) completeness of eHARS CD4 and viral load (VL) lab reports, (2) timeliness of death reporting, and (3) accuracy and timeliness of reported HIV/AIDS cases' addresses to account for in and out-migration. Note that data is unavailable for individuals on ART for Broward County and the state of Florida.



The Continuum stages assigned to HIV diagnosed, ever in care, retained in care, and suppressed VL eHARS data, as well as CAREWare, PE for Part A EMAs and Transitional Grant Area (TGA), and ADAP. To strengthen Continuum data, FLDOH added Medicaid and HMS as additional sources for care data, conducted a match of HIV/AIDS surveillance data with Lexis Nexus, and identified cases who were deceased, and/or moved out of FL. eHARS records were matched to the National Death Index (NDI) before the end of June 2019. All these methods, along with other data cleaning measures, continue to improve the accuracy of Continuum data. FLDOH was unable to generate county-level data for the prescribed ARV Continuum stage as treatment data are not reported to the FL HIV/AIDS surveillance system. Thus, the summary FL estimated prescribed ARV rate was applied to Broward data. In coming years, FLDOH will consider use of electronic health records (EHRs) to supplement eHARS for a more accurate estimate for FL and its counties. Locally, FLDOH-BC collects and reports to FLDOH the number of Broward HIV+ residents diagnosed and linked to OAHS. Summary data are then disseminated to the Recipient, who monitors data accuracy.

In September 2019, FLDOH provided the Recipient with Continuum estimates for CY2018. Summary numerator and denominator data used to compute each Continuum stage include:

- *PLWH: Stage 1 shows the number of persons known to be living in Broward with an HIV diagnosis at the end of CY2018. A total of 21,048 HIV+ individuals were known to be HIV+ Broward residents through CY2018, regardless of the jurisdiction of their HIV diagnosis.*
- *Ever in Care: Stage 2 shows 94% of Broward residents at the end of CY2018 (n=19,816) with > 1 documented VL or CD4 lab test, OAHS visit, or ARV prescription since diagnosis.*
- *In Care: Stage 3 shows a 78% rate of Broward HIV+ residents (n=16,143) with at least 1 documented VL or CD4 lab, medical visit, or prescription from January 1, 2018 through March 31, 2019.*
- *Retained in Care: Stage 4 shows a 71% rate, with the numerator (retained in care) (n=14,919) the number of HIV+ persons with > 2 or more OAHS visits or VL or CD4 tests at least 3 months apart from January 1, 2018 through June 30, 2019. The denominator is the number of Broward HIV+ cases diagnosed through CY2018 (n=21,048).*
- *Suppressed VL: Stage 5 shows a 66% rate, with the numerator (virally suppressed) (n=13,902) the number of HIV+ individuals whose most recent VL test from January 1, 2018 through March 31, 2019 is < 200 copies/mL (66%). The denominator is the number of HIV+ Broward cases diagnosed through CY2018 (n=21,048).*
- *In Care with Suppressed VL: Stage 6 shows an 86% rate, with the numerator (n=16,143) the number of PLWH with at least 1documented VL or CD4 lab, medical visit, or prescription from January 1, 2018 through March 31, 2019 who also had a suppressed VL (<200 copies/mL) on the last VL test in January 1, 2018 through March 31, 2019.*
- *Retained in Care with Suppressed VL: The Stage 7 shows an 89% rate, with the numerator (n= 13,197) the number of PLWH with 2 or more documented VL or CD4 labs, medical visits, or prescriptions at least 3 months apart from January 1, 2018*

through June 30, 2019 who also had a suppressed VL (<200 copies/mL) on the last VL from January 1, 2018 through March 31, 2019.

To be noted, identifying, linking, engaging, and retaining eligible Broward HIV+ residents in the RWHAP Continuum has been demonstrated to result in much higher viral suppression than achieved in other healthcare settings. For example, 93% of RWHAP clients in FY2018 were in care, 75% were retained in care, 95% were on ARVs, and 85% were virally suppressed.

- *Black Non-Hispanic Heterosexual Males (BHM): BHM accounted for 78% of Broward's heterosexual male PLWH in CY2018. Among the 2,367 BHM residing in Broward in CY2018, 58% were virally suppressed. This is 9% lower than the average suppression rate for adult/adolescent males (67%).*
- *Black Non-Hispanic Women (BW): FLDOH reports that BW accounted for 79% of female PLWH in CY2018. There were 4,244 BW residing in Broward in CY2018, with 61% achieving viral suppression. This is 1% lower than the suppression rate for adult/adolescent women (62%).*
- *Black Non-Hispanic MSM (BMSM): There were 2,543 BMSM residing in Broward in FY2018. BMSM accounted for about 45% of Broward's Black male HIV population and 22% of MSM in CY2018. Over half (58%) of Broward BMSM were virally suppressed. This is 9% lower than the suppression rate for adult/adolescent males (67%).*

HIV Care Continuum Narrative

HIV Care Continuum Used in Planning, Prioritizing, and Monitoring 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 the Recipient and other stakeholders to measure progress and optimize HIV resources. The Recipient and HIVPC evaluate efforts to impact the Continuum by routinely monitoring health outcomes, performance measures, and indicators at each Continuum stage. The 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 in FY2019 by integrating CDC-funded prevention services and RWHAP-funded service data in presentations that informed the PSRA process. Each entity, including all RWHAP Parts, 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 Priority Setting and Resource Allocation (PSRA) Committee uses PE data in the annual PSRA process to evaluate the Continuum and identify service gaps and needed resources. In the FY2020 PSRA process, the Committee 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.

In FY2020, the EMA will continue to analyze PE data to identify disparities in performance and quality measures. Areas of improvement will then be addressed through (Quality Improvement Plans) QIPs, training, and intensive capacity building. The quality of core medical service categories will continue to be monitored and enhanced through PE desktop reviews, EHR

reviews conducted by the Recipient, and service category evaluations. Planning and prioritizing high quality services along the Continuum were contributed to data-driven needs assessments, multi-funder presentations, PSRA, and Continuous Quality Improvement. Data gathered through these processes will continue to be shared with the HIVPC and its committees in FY2020.

Table 11 reflects the Broward EMA Part A HIV Care Continuum from FY2016-2018. The Continuum stages are defined below. No statistically significant changes were experienced in the "ever in care" or "in care in reporting period stages" of the Continuum. The "retained in care stage" dropped by 1% from FY2016-2018. The "on ARV" stage experienced a 7% increase and the "viral suppression stage" increased 6%.

Table 11. Broward EMA Part A HIV Care Continuum, FY2016-FY2018

HIV Care Continuum Stages	FY2016	FY2017	ΔFY2016-2017	FY2018	ΔFY2017-2018	ΔFY2016-2018
HIV+ Clients in Reporting Period	8,151	8,508	4%	8,233	-3%	1%
Ever in Care	8,028	8,443	5%	8,202	-3%	2%
In Care in Reporting Period	7,455	7,657	3%	7,652	0%	3%
Retained in Care	6,095	6,206	2%	6,185	0%	1%
On ARV	7,351	8,030	9%	7,832	-2%	7%
Suppressed VL	6,626	7,099	7%	6,991	-2%	6%

Broward EMA Part A HIV Care Continuum from FY2016 to FY2018. *Please note, these populations reflect Part A HIV+ individuals, using data collected in PE. The numerator and denominator used to compute each Part A Continuum stage is defined below. A medical care service is defined as documented medical visits, VL or CD4 tests, ARV prescription filled and paid by RWHAP Part A, and co-payments made by Part A's HICP. The results of the computation of the Part A Continuum stages include:*

Table 12. FY 18-19 Broward EMA Care Continuum

Care Continuum	***Definition***	***#***	***%***
HIV+ Clients	*Clients who are HIV+ and received at least one service from the selected service category in the reporting period.*	*8,233*	*100%*
Ever in Care	*HIV+ clients who ever had a medical care service* documented.*	*8,202*	*99.6%*
In Care	*HIV+ clients who had a medical care service within the reporting period.*	*7,652*	*92.9%*
Retention in Care	*HIV+ clients who had 2+ medical care services at least three months apart in the reporting period.*	*6,185*	*75.1%*
On ART	*HIV+ clients who have a documented ART at any time during the reporting period within HIV history records.*	*7,832*	*95.1%*
Virally Suppressed	*HIV+ clients with most recent viral load less than 200 copies/mL, as of end of the reporting period.*	*6,991*	*84.9%*

**Medical Care Service: Medical care appointment, viral load or CD4 count test.*

Subpopulation Viral Suppression rates. *The following table reflects subpopulations and their rates of viral suppression. This information is integral in setting priorities for funding and services and resources.*

Table 13. FY18-19 Percent of Clients Virally Suppressed (≤200 copies/mL) by Subpopulation		
	#	%
All Clients	6,991	84.9%
Gender		
Male	5,077	83.6%
Female	1,854	78.5%
Transgender*	60	89.6%
Age		
18-28	461	70.9%
29-38	1,150	77.8%
39-48	1,392	83.7%
49-58	2,355	87.3%
59+	1,641	91.9%
Living Arrangements		
Permanent	5,306	87.7%
Non-Permanent	1,699	75.9%
Institution*	3	75.0%
Race/Ethnicity		
Black, Non-Hispanic Male	1,950	80.5%
Black, Non-Hispanic Female	1,475	82.7%
Total Black, Non-Hispanic	**3,425**	**81.47%**
White, Non-Hispanic Male	1,800	87.9%
White, Non-Hispanic Female	179	86.9%
Total White, Non-Hispanic	**1,979**	**87.80%**
Hispanic Male	1,263	91.4%
Hispanic Female	191	81.6%
Total Hispanic	**1,454**	**89.64%**
Educational Level		
<8th grade	406	84.4%
8th-12th grade	3,810	83.6%
College	2,748	88.0%
Risk Factor		
MSM	3,441	87.0%
Black MSM	778	77.7%
White MSM	2,606	90.1%
Hispanic MSM	1,037	91.4%
Heterosexual	2,200	84.3%
Black Heterosexual	1,760	83.5%
White Heterosexual	423	88.1%
Hispanic Heterosexual	240	90.6%
Hemophilia*	13	81.3%
IDU	104	92.0%
MSM/IDU*	43	86.0%
Perinatal*	62	65.3%
Transfusion*	32	88.9%

*Small population group (N<75 in program year). #s and %s are within each subpopulation.

Qualitative Data Collection and Analysis

In addition to quantitative data collection, the needs assessment also included qualitative data collection in the form of stakeholder interviews, focus groups, and a community and provider survey. The data was collected to assess strengths and challenges as well as to identify needs and common themes.

Key Stakeholder Interviews

To identify the health needs of PLWH/PLWA in Broward County, one (1) key stakeholder interview was conducted with a provider and seven (7) stakeholder interviews were held with Black women from zip codes most impacted by the epidemic. The questions asked and responses given during the interviews are included in Appendix A. The following provides an overview of the data collected during the stakeholder interviews, including strengths, challenges/barriers, and ideas about resources, services, and strategies that may support the system of care.

Key Stakeholder Interview Summary-Provider

The consultant met with Francisco Gomez, Housing Manager, Care Resource on February 7, 2020. The purpose of this interview was to gather information to help inform the needs assessment process for the provision of services for people living with HIV in Broward County. The interviewee was identified by the leadership of Broward County Community Services Department Ryan White Part A Program Office as a subject matter expert around the issue of housing and associated challenges. Information from the interview was analyzed to identify strengths and challenges around housing and supports for PLWH/PLWA. The following highlights the results of this stakeholder interview.

STRENGTHS	CHALLENGES
• Broward has many resources • Leadership of the Ryan White Part A Program • People are passionate	• People don't know about resources available • Funding can be complicated • Need for more Housing Case Managers • Bureaucracy and paperwork • Behavioral Health • People are injecting crystal methamphetamine • G (drug for sex) • Fisting • Internet dating
OPPORTUNITIES FOR IMPROVEMENT	
• More money for housing, particularly for special needs populations, the transgender community • Need to not only access housing, but also to sustain housing (housing with supports) • Educate commissioners, funding sources and clients about the need for medications, for housing, for the use of PrEP, and the need to use condoms for other STDs • Focus on behavioral health-mental health and substance use (counseling, life coaching) • Peer Navigation • Housing Case Management • Focus on the Social Determinants of Health • Provide transportation, bus passes, food vouchers • Employment specialists	• Provide testing for other communicable diseases • More collaboration-Work together toward a common agenda • Educate behavioral health providers about HIV/STDs and collaborate • Special resources for undocumented individuals (like housing) • Provide training in motivational interviewing to staff • Provide customer service training to staff in how to be welcoming • Engage city employees, housing inspectors, hospitals to tell about resources (social workers who can help individuals qualify for social security and Medicaid)

Key Stakeholder Interviews Summary-Black women

Key stakeholder interviews consisting of a series of questions related to knowledge, awareness, beliefs and attitudes towards HIV prevention were conducted in 2019 with a total of seven (7) Black women between the ages of 28 and 51 who lived in Broward County in zip codes similar to those most impacted. The purpose of these interviews was to gain an understanding of women's understanding of the challenges facing their community as well as the benefits of, and barriers to, engaging in risky sexual behavior. They were then asked about methods and strategies to educate women in their community. The mean age of the women interviewed was 33. In terms of marital status, 2 of the women were single, 1 was engaged and 4 were married. Most of the women interviewed had been living in their communities for at least 5 years. The following provides an overview of the strengths, challenges, and needs, opportunities, and strategies identified during the interviews.

STRENGTHS	CHALLENGES
• Awareness of modes of transmission • Awareness of methods of prevention • Desire for better health outcomes	• People don't know about disparities in their community • It is taboo to talk about HIV • Lack of awareness of resources • Lack of efficient healthcare for women of color • Lack of knowledge about female condoms and PreP • Misconceptions about spermicide • False hope that significant other is monogamous • Condoms uncomfortable • Fear of stigma • Transportation
OPPORTUNITIES FOR IMPROVEMENT	
• Abstinence from IV drug use • Safe disposal of needles • First aid care • Access to free condoms • Education about the level of the epidemic and how it is affecting their community • Pop-up community-based clinics • Share information in the community by people they know, like, and trust • Use social media like Facebook groups • Use peer-to-peer activities, like "sister circles"	

Focus Groups

Opportunities to learn from individuals with lived experience and other stakeholders were provided through focus groups. Between 2018 and 2020 a total of eight (8) focus groups were held. Four (4) of the focus groups were held with staff who work with PLWH. An additional four (4) focus groups were held with persons with lived experience who represented a special needs subpopulation. These groups included Black women, individuals with substance use and/or mental health conditions, long-term survivors, and transgender individuals. A total of 98 individuals were reached through these focus groups. The complete results of all focus groups are included in Appendix B.

Table 12. Overview of Focus Groups

Type of Focus Group	*Date*	*# of Participants*
Individuals with substance use and/or mental health conditions at Broward House	*March 29, 2018*	*18*
Disease Intervention Specialists at FDOH-BC	*May 17, 2018*	*7*
Long-term survivors at World AIDS Museum	*September 5, 2018*	*22*
HIV Medical Case Managers	*January 17, 2019*	*10*
Doctors and Disease Case Managers	*January 23, 2019*	*11*
Black women at Comprehensive Care Center	*February 28, 2019*	*5*
Medical Quality Management Case Management	*January 29, 2020*	*7*
Transgender Support Group	*February 12, 2020*	*18*
Total		*98*

Table 15. Provider Focus Group Results

STRENGTHS

- Many opportunities for testing in the County
- PROACT has been very helpful
- Poverello has helped in providing food
- Linkage and Retention Specialists have been helpful
- 90-day supply of medications has helped
- Delivery of medications has helped
- Sunserve and Care Resource good providers
- Able to access PE among providers
- Test and Treat has helped bring people into care

CHALLENGES

- Stigma
- Homelessness
- Transient population
- Affordable, safe, stable housing
- Polysubstance use
- Noncompliance
- Lack of family support (some people do not disclose their diagnoses to family or friends)
- Cultural issues/religious beliefs (use of alternative treatments)
- Gaps in coverage to follow-up with treatment
- Resources not available for co-morbidities
- "Repeat" people who fall out of care
- Transportation
- Lack of public transportation
- Rules are barriers
- Motivation (denial, stigma) among the newly diagnosed
- Case Management is a band-aid; it is not true wraparound case management
- Inter-generational lack of education regarding prevention strategies
- Perinatally infected not knowing their status (not being told by their parents or others)

Table 15. Provider Focus Group Results	
• Risky behaviors in community (bareback parties, fisting, using poppers, increase in crystal methamphetamine, Grinder app, G drink) • Lack of insurance or underinsurance for medications • Mental health issues • Nobody is teaching sexual or health education in schools • Hiding medications (because of stigma) • Lack of access to affordable housing for people with mental health conditions • Anxiety, depression • Need more coordinated care	• BMSM-not gay with wife and kids (stigma around being gay) • HMSM-defensive • Length of time spent in pharmacy (don't want to be seen) • Pregnant women using heroin and cocaine • Difficult to get information from the VA • Clients selling meds • Substance abuse treatment center has barriers • Use of PrEP does not prevent other STDs/STIs (people don't want to use condoms) • 2-1-1 not user friendly • Aging population needs more services
OPPORTUNITIES FOR IMPROVEMENT	
• More focus groups regularly for PLWH, particularly MSM • More education regarding testing • Work with primary care doctors not just infectious disease doctors • Destigmatize standard of care • Test women at OB/GYN offices (not only when they are pregnant) • Reach out to faith-based organizations • Use blister packs to remind people to take their meds daily • Share information in high schools • Injectable medications • More Case Managers/Navigators to follow-up • Transportation/bus passes • Develop strategies to address behavioral health conditions • Share results of viral loads with clients • Using a phone app as a reminder to take medications • Co-locate services (behavioral health) • Educate primary care physicians • Educate dental providers • Use social media • Prioritize special needs populations (research Latina women over the age of 50)	• Educate ER physicians and conduct testing in ERs • Work with adult entertainment establishments, bath houses • Distribute information at festivals • Provide support groups for family members • Provide information and testing at sex shops • Engage in neighborhood locations (grocery stores, hair salons, barber shops) • More peer navigators • Conduct a study regarding individuals who are continually falling out of care to identify challenges and develop strategies • Provide training in welcoming and engagement • Focus on the root causes of racial disparities • Research the special needs of individuals who are perinatally infected • Trigger system for ADAP recertification • Process flow for ADAP • Address the social determinants of health • Increase collaboration with providers • Have peers on Test and Treat • Hold an HIV Summit • Provide training on co-occurring mental health/substance use conditions • Resource guide/map of services

Table 16. Persons with Lived Experience Focus Group Results	
CHALLENGES	
• Transportation • Lack of follow-up for missed appointments • Don't know where to go for services • Certification every six months • Need for legal services • Stigma • Lack of education for youth and young adults • Cultural/religious beliefs • Don't know how to navigate insurance • Lack of bus passes • People don't want to go to clinics that are "HIV clinics" because they may be seen • Intergenerational discrimination • Bigotry within the medical community • A lot of other STDs are not being talked about, like herpes	• People are having unprotected sex • Men don't disclose to women that they are positive • Women tend to stay in their own communities and sleep with the same men that other women are sleeping with • Men are infecting multiple people • People don't like to use condoms • Younger generation is not as scared as the older generation • Doctors have specialties; difficult to manage everything in one place • There are new drugs young people are using and they are taking more risks
OPPORTUNITIES FOR IMPROVEMENT	
• Telehealth • Concurrent certification of CIED/ADAP • Certification annually • Provide information about medications covered by ADAP • Resource guide about Ryan White services and a list of specialists • One-stop shop for all medications • Anti-stigma campaign in the parks and schools • Educate youth and young adults (ages 13-24); people who conduct the education need to speak their language. They need a spokesperson who looks like them • Go into communities of older adults and challenge them • Engage families • Make commercials that emphasize the use of protection	• Address mental health and substance use issues • Educate about nutrition and alternative practices • More dollars for education and research • Reverse stigma-peer pressure for not getting tested • Have a celebrity be an ambassador • Train doctors to have good bedside manners • Tell friends to go together to get tested • Learn how to be advocates • Pay attention to certain communities because of their cultural beliefs (e.g., Haitian community and Hispanic community because of machismo) • Educate the community about test and treat and prevention • Talk to people about the internalization of stigma • Increase the knowledge of testers in drug treatment centers • Conduct a focus group with youth and young adults

Surveys

Two surveys were distributed to gather additional information for the needs assessment process. One survey was distributed to providers, the other to PLWH in the community. The consultant sent the provider survey to a list of organizations given by the Ryan White Program Office. A reminder email was sent to the contact people at the organizations. The PLWH online survey was sent through a link to current Ryan White Part A clients. It was also posted on the Ryan White Facebook page and Twitter account. Additionally, the FLDOH-BC sent the link to its listserv.

Thirteen (13) provider surveys were distributed, with a total of twelve (12) completed and returned. The Persons Living with HIV survey was distributed online in November 2019. A total of 203 PLWH surveys were received between November 19, 2019 and January 18, 2020. Three (3) surveys were blank and discarded. One (1) survey was a duplicate and was discarded. Four

(4) individuals identified as either transgender (male to female) (1); transgender (female to male) (1); and "do not identify as either male, female, transgender, or any gender" (2). These four surveys were not included in the analysis due to the low numbers for subpopulations. The final survey tally was therefore 195.

Surveys-PLWH Results

The following represents an overview of the results of the PLWH survey. First, demographics are presented followed by strengths, challenges, and opportunities for improvement and strategies. Surveys were filtered by gender and by care status (in care compared to out of care for more than six months during the past five years). A complete analysis of the survey results is included in Appendix C.

Demographics

Table 17 represents demographic information gathered from 195 individuals who identified as male or female. An additional four individuals identified as either transgender (male to female) (1); transgender (female to male) (1); and "do not identify as male, female, transgender, or any gender" (2). One survey was a duplicate and was discarded.

Most (78%) of respondents identified as male with 21% identifying as female (Figure 22). The majority of the male sample were White, non-Hispanic gay men between the ages of 55 and 64. The majority of the female sample were Black, non-Hispanic heterosexual women between the ages of 55 and 64. The majority of the entire sample were Ryan White clients (90%) and had received treatment for HIV in the past year (97%). There were no clear differences among respondents in terms of employment status.

In care vs. Out of Care: A total of 69 (35%) of respondents indicated they had been out of care for over six months during the past five years. Forty-six (46) of those out of care participants were male (67%), while twenty-three (23) were female (33%). Females were disproportionately represented as having been out of care compared to the overall sample of females (33% to 21%). Males represented 67% of the out of care participants and 78% of the overall sample. It should also be noted that women represent 27% of the total Ryan White Part A program.

Table 17. Demographics of survey respondents

				Out of Care		In Care	
	Male	Female	Total	Male	Female	Male	Female
Total	154 (78%)	41 (21%)	195	46 (67%)	23 (33%)	108 (86%)	18 (14%)
Age							
18-24	0 (0%)	0 (0%)	0 (0%)	0	0	0	0
25-34	12 (7%)	2 (5%)	14 (7%)	6 (13%)	2 (9%)	6 (13%)	0
35-44	23 (15%)	10 (24%)	33 (17%)	10 (22%)	7 (30%)	13 (12%)	3 (17%)

Table 17. Demographics of survey respondents				Out of Care		In Care	
	Male	Female	Total	Male	Female	Male	Female
45-54	34 (22%)	7 (17%)	41 (21%)	6 (13%)	3 (13%)	27 (25%)	4 (22%)
55-64	64 (42%)	16 (39%)	81 (41%)	19 (41%)	8 (35%)	45 (42%)	8 (44%)
65+	19 (12%)	6 (15%)	25 (13%)	4 (9%)	3 (13%)	16 (15%)	3 (17%)
No response	2 (1%)	0	2 (1%)	1 (2%)	0	1 (2%)	0
Sexual Orientation							
Straight (heterosexual)	23 (15%)	40 (98%)	62 (8%)	6 (13%)	22 (96%)	17 (16%)	18 (100%)
Gay or lesbian (homosexual)	122 (79%)	0 (0%)	122 (63%)	38 (83%)	0	84 (78%)	0
Bisexual	9 (6%)	1 (2%)	10 (5%)	2 (4%)	1 (4%)	7 (6%)	0
Other (please specify)	0 (0%)	0	1 (.5%)	0	0	0	0
Race/Ethnicity							
White, non-Hispanic	72 (47%)	2 (5%)	74 (38%)	16 (35%)	1 (4%)	56 (52%)	1 (6%)
White, Hispanic	32 (21%)	4 (10%)	36 (19%)	14 (30%)	3 (13%)	18 (17%)	1 (6%)
Black or African-American, non-Hispanic	24 (16%)	33 (83%)	57 (29%)	5 (11%)	19 (83%)	19 (18%)	14 (78%)
Black or African-American, Hispanic	1 (1%)	0	1 (1%)	1 (2%)	0	0	0
Multi-racial, non-Hispanic	4 (3%)	1 (3%)	5 (3%)	2 (4%)	0	2 (2%)	1 (6%)
Multi-racial, Hispanic	10 (6%)	0	10 (5%)	4 (9%)	0	6 (6%)	0
Prefer not to answer race, non-Hispanic	2 (1%)	0	2 (1%)	0	0	2 (2%)	0
Prefer not to answer race, Hispanic	9 (6%)	1 (2%)	10 (5%)	4 (9%)	0	5 (5%)	1 (6%)

Table 17. Demographics of survey respondents				Out of Care		In Care	
	Male	Female	Total	Male	Female	Male	Female
Employment Status							
Employed, full-time	49 (32%)	9 (22%)	58 (30%)	12 (26%)	4 (17%)	37 (34%)	5 (28%)
Employed, part-time	26 (17%)	11 (27%)	37 (19%)	6 (13%)	7 (30%)	20 (19%)	4 (22%)
Not employed	31 (20%)	13 (32%)	44 (23%)	12 (26%)	7 (30%)	18 (17%)	6 (33%)
Disabled	48 (31%)	8 (20%)	56 (29%)	16 (35%)	5 (22%)	33 (31%)	3 (17%)
Ryan White client							
Yes	136 (88%)	39 (95%)	175 (90%)	41 (87%)	21 (91%)	95 (88%)	18 (100%)
No	16 (11%)	2 (5%)	18 (9%)	4 (9%)	2 (9%)	12 (11%)	0
Don't Know	2 (1%)	0 (0%	2 (1%)	1 (2%)	0	1 (1%)	0
No response	0 (0%)	0 (0%)	0 (0%)	0	0	0	0
Received HIV treatment in past year							
Yes	151 (98%)	38 (93%)	189 (97%)	45 (98%)	21 (91%)	106 (98%)	17 (94%)
No	2 (1%)	2 (5%)	4 (2%)	1 (2%)	2 (9%)	1 (1%)	0
Don't Know	0	1 (2%)	1 (.5%)	0	0	1 (1%)	0
No response	1 (1%)	0 (0%)	1 (.5%)	0	0	0	1 (6%)
Struggling with mental health or substance use issues							
Yes	38 (25%)	7 (17%)	45 (24%)	18 (39%)	6 (26%)	20 (19%)	1 (6%)
No	100 (65%)	28 (68%)	128 (66%)	25 (54%)	12 (52%)	75 (69%)	16 (89%)
Unsure	11 (7%)	2 (5%)	13 (7%)	3 (7%)	2 (9%)	8 (7%)	0 (0%)
Prefer not to answer	5 (3%)	4 (10%)	9 (5%)	0 (0%)	3 (13%	5 (5%)	1 (6%)

The following identifies aggregate results of the PLWH survey in terms of challenges and opportunities for improvement and potential strategies.

CHALLENGES	*OPPORTUNITIES FOR IMPROVEMENT*
• *Need information about what services are available and where to go* • *Free treatment for behavioral health* • *Need peer support* • *Need an understanding counselor* • *Housing* • *Stigma* • *Money to pay for rent, housing, utilities* • *Need more dental services* • *Need money to pay for medications and other services* • *Need more case management* • *Need more food services* • *Side effects of medications* • *Anxiety or depression due to medications* • *Pills too large to swallow* • *Forget to take medications* • *Transportation* • *Services not conveniently located* • *Problems with insurance* • *Have to wait a long time at doctor's office*	• *Entrepreneurship training* • *Hotline to access services* • *Peer support* • *Training of staff (empathy, welcoming, confidentiality)* • *Online re-enrollment* • *Annual recertification for Ryan White Part A and ADAP* • *Longer hours* • *Weekend hours* • *Focus on long-term survivors (needs are different); not only newly diagnosed* • *More support groups* • *More case management* • *Section 8 housing vouchers* • *Improve transportation*

Surveys-Providers

A provider survey was distributed to Ryan White Part A providers in January 2020. Thirteen (13) provider organizations were invited to participate and twelve (12) organizations responded. The following represents aggregate results of provider surveys. A full analysis of the results is included in Appendix D.

Table 18. Strengths and Challenges of System

STRENGTHS	CHALLENGES
• RW is an amazing system to helping clients. multiple provider locations • Client focused and care oriented staff and doctors • Coordinated care resources • Broward County has agencies able to serve our diverse community with proficiency • condom distribution • allocation of funding to non-clinical community agencies, with creation of a strong referral system • more people in the community are learning about things such as viral suppression (undetectable status) • Great community providers and a dedicated grantee staff • Partnerships, linkages, collaboration, resources	• The red tape associated with the program is a challenge • public transit • services offered in the Western portion of the County • Challenges with transportation • Challenges with coordinating HIV testing among agencies • stigma causes clients to split care between PCP and different community agency and this is not being addressed • Trust is a challenge, as more agencies are popping up to treat HIV, clients are going from one agency to the next (playing the healthcare field), there is not a sure way of identifying if the client is new to care or is just for care the site can give then disappears • Resources for other services • clients unsure how to navigate the system • financial barriers • cultural issues • immigration • addiction and mental health issues • housing, homelessness

Table 18. Strengths and Challenges of System
OPPORTUNITIES FOR IMPROVEMENT
• more trainings and, technical assistance • more time at provider meetings for collaboration and sharing of resources • more community feedback meetings • eradicate stigma • affordable long-term housing, increased transitional housing • routinization of HIV testing in all healthcare settings • focus on special needs populations • rapid engagement into care • innovative prevention campaigns • increase outreach efforts • engage faith-based organizations • educate those who are incarcerated • include education in middle/high schools • increase access to PrEP • increase access to mental health and substance use services • reduce redundancies in the system

Common Themes: Quantitative and Qualitative Analysis

The following common themes emerged during the analysis of data gathered during the needs assessment process.

- *System collaboration: There is a need for providers, funders, and other stakeholders to work together to address the needs of this population in Broward County. This includes breaking down silos across sectors, populations, and communities. Ancillary providers such as housing, transportation, early childhood, primary and secondary school, behavioral health and primary health providers should be engaged in cross-system, cross-sector collaboration.*
- *Co-occurring psychiatric, substance use, and other complex conditions: As individuals living with HIV often experience co-occurring behavioral health challenges as well as additional medical co-morbidities, there is a need to understand the interaction of these challenges and evidence-based practices to address them. In addition to individuals experiencing co-occurring conditions, families may have multiple challenges that are complex and require specific strategies.*
- *Social Determinants of Health: The provision of HIV-related services is one component to address the needs of individuals and families living with HIV and possible co-occurring conditions. In addition to the physical and behavioral aspects of health, there is a critical need to focus on the social determinants of health. These include access to safe, stable, and affordable housing; education; employment; transportation; healthy foods and clean water; and safe neighborhoods.*
- *Evidence-based practices: There is a need to continue to learn about and evaluate opportunities to utilize evidence-based practices in the scope of services provided in the community. This includes continued collaboration with behavioral health and primary health providers, local, state, and national leaders, researchers and evaluators, and others.*
- *Community engagement: There is a need to expand efforts to educate the community about HIV to increase awareness and decrease stigma. This includes working with the business and faith-based community, behavioral health and primary health care providers, community leaders, and government representatives.*
- *Peer support: Peer support is recognized as a strength and an opportunity to build capacity within the system of care to address the needs of individuals living with HIV. There is a need to expand and enhance the availability of peer support across Broward County.*
- *Equity: There is a need to address health disparities, particularly related to HIV and associated co-morbidities. This includes but is not limited to evaluation of access to types of services; service utilization; and outcomes associated with services. Services provided should be evaluated based not only on race and ethnicity; they should also be assessed*

for disparities in gender, gender identity, and sexual orientation. There is a need to provide training in the area of cultural competence and humility and to educate community members to decrease stigma associated with behavioral health.

- *Capacity building: The system of care has seen challenges in recent years, related to increases in need, retention in services, a changing demographic population, and a decrease in funding. There is a need to provide capacity building through workforce development, infrastructure support, and continuous communication to providers of HIV-related services.*

Appendix A: Key Stakeholder Interviews

Key Stakeholder Interview Summary-Provider

The consultant met with Francisco Gomez, Housing Manager, Care Resource on February 7, 2019. The purpose of this interview was to gather information to help inform the needs assessment process for the provision of services for people living with HIV in Broward County. The interviewee was identified by the leadership of Broward County Community Services Department Ryan White Part A Program Office as a subject matter expert around the issue of housing and associated challenges. Information from the interview was analyzed to identify strengths and challenges around housing and supports for PLWH/PLWA.

The interview began with the strengths of Broward County related to persons living with HIV. The interviewee stated that Broward had many resources and that the leadership of the Ryan White Part A Program Office are excellent to work with; they are passionate and will fight for people who have needs. In terms of Care Resource, Mr. Gomez said that it is a one-stop shop; they help people with moving/rental assistance, provide free medications for PLWH, mental health counseling, and Medication Assisted Treatment (MAT) for free on an outpatient basis. They also assist with resume building and job readiness training as well as identify various resources for food such as churches.

Some of the challenges identified were that people don't know about all the resources that are available and that at times funding can be complicated. There is a need for more housing Case Managers. Certain organizations may be challenging to work with due to bureaucracy and paperwork; for example, the city of Ft. Lauderdale used to help people for six (6) months, now it is for three (3) months. Additionally, the city had to return monies received because it was unable to start-up on time.

When asked what he thought the top five ideas were to eliminate HIV, Mr. Gomez said the following:

- *More money for housing, particularly for special needs populations such as the transgender community who may face discrimination. There is a need for individuals to not only access housing, but to sustain and stay in housing.*
- *Educate commissioners and funding sources and clients about the need for medications, for housing, and for the use of PrEP as well as the need to use condoms for other STDs*
- *Need help for behavioral health issues (counseling, life coaching)*
- *More treatment for HIV*
- *More treatment for substance use*

When asked what services should be focused on in the next five years, Mr. Gomez stated:

- *Peer Navigation*
- *Housing Case Management*
- *Community Education*
- *Focus on the Social Determinants of Health*
- *Focus on behavioral health*

Mr. Gomez was asked who else he thought needed to be engaged to help eliminate the epidemic:

- *City employees*
- *Housing inspectors*
- *Hospitals to tell about resources (social workers who can help individuals qualify for social security and Medicaid)*
- *Provide customer service training to staff in how to be welcoming*

Trends:

- *People are injecting crystal methamphetamine*
- *G (drug for sex)*
- *Fisting*
- *Internet dating*

Potential solutions and strategies:

- *Provide testing for other communicable diseases*
- *Work together toward a common agenda*
- *More collaboration*
- *Provide transportation, bus passes, food vouchers*
- *Share resources*
- *Education at all levels*
- *Funding for housing Case Managers to look for stable housing*
- *Employment specialists*
- *Educate behavioral health providers about HIV/STDs and collaborate*
- *Special resources for undocumented individuals (like housing)*
- *Provide special housing and one-stop shop for the transgender population*
- *Provide training in motivational interviewing to staff*
- *Provide customer service training to staff in how to be welcoming*

Key Stakeholder Interview Summary-Black women

Key stakeholder interviews consisting of a series of questions related to knowledge, awareness, beliefs and attitudes towards HIV prevention were conducted with a total of 7 Black women between the ages of 28 and 51 who lived in Broward County in zip codes similar to those most impacted. The purpose of these interviews was to gain an understanding of women's understanding of the challenges facing their community as well as the benefits of, and barriers to, engaging in risky sexual behavior. They were then asked about methods and strategies to educate women in their community. The mean age of the women interviewed was 33. In terms of marital status, 2 of the women were single, 1 was engaged and 4 were married. Most of the women interviewed had been living in their communities for at least 5 years.

The process began with an overview of the reasons for conducting the interview, with a question assessing the participant's general knowledge of the prevalence of HIV in the state of Florida and associated racial disparities. Several of the women indicated they were aware of the disparities related to HIV, however, some did not know how large the disparities were. Others stated they were unaware of the rates and were surprised at the differences. When asked why they thought these disparities existed, interviewees attributed it to a lack of knowledge, the conversation is not happening in our community ("it is taboo to talk about it"), it may be a "lack of education thing or money," "lack of awareness of resources available" and a lack of efficient healthcare for women of color, including resources and information.

Respondents were aware of the various methods of transmission of HIV including unprotected sexual intercourse, mother-to-child transmission, sharing contaminated needles, and exchange of bodily fluids such as breast milk and blood. Interviewees were also aware of methods of prevention. All respondents mentioned the use of male condoms. Some women mentioned female condoms, although several had never seen a female condom, nor did they know how to use one. Several women also mentioned the use of PrEP as a medication that exists to prevent HIV transmission, however many stated they knew little about it outside of just knowing it existed. Some respondents also stated that abstaining from IV drug use, safe disposal of needles and first aid care could help to prevent the transmission of HIV. Some women expressed the lack of awareness of and promotion for female condoms as a possible barrier to HIV prevention. Women interviewed stated they did not know where they could obtain female condoms. Additional barriers include misconceptions such as falsely believing spermicide could prevent HIV transmission.

Participants shared benefits for engaging in safe sexual behaviors. These included the desire for better health outcomes, not having to go to the doctor as often and being able to work if you're not sick, so you don't have to lose time off from work. Some participants expressed concern that their community was dying and that the disease was "closer to home than people think"; they knew family members and others who have passed away (some they knew were HIV positive, some they didn't). The women interviewed that were married did not feel the need to wear condoms because they were in exclusive relationships with their spouses who they trust. Participants who were single expressed a desire to change personal attitudes toward safe sex practice, knowing that these practices would prevent them from potentially being infected with the HIV virus and other sexually transmitted infections and diseases. They also stated that HIV prevalence education and access to free condoms would improve HIV prevention and reduce

unplanned pregnancies. Some women indicated that male condoms were readily available and free, compared to female condoms. Participants mentioned that marketing or promotion did not really exist for female condoms, including through media outlets. This difference may be a barrier for women using female condoms during sexual activity.

Interviewees expressed various barriers for not engaging in safe sex behaviors. A recurrent theme was the false hope that their significant other was monogamous and therefore there is no need to wear condoms, that the use of condoms is not comfortable, it does not feel natural, and that they want to please their partners. In terms of female condoms, participants stated that they were not familiar with it, that it was not advertised as much as male condoms and that there is fear of the unknown. There is a lack of education about female condoms ("there are no commercials about female condoms"). The decision to wear a condom is a male decision and the media creates this situation. One interviewee expressed she believed male partners "would look at her crazy" if she advocated to use a female condom.

Participants were asked about some reasons Black women have given for not using safe sex practices, their responses are as follows:

1. *Not having money to buy condoms: This was an unacceptable reason for not using condoms, as interviewees pointed out, free condoms are given out at health fairs and the health department. One interviewee responded: "If I value myself enough, this should be a priority in my life, my health."*
2. *Condoms are not available to purchase: Many interviewees believed this was also a poor excuse as condoms are sold everywhere.*
3. *Female condoms are too expensive; insurance does not cover: Goes back to priorities and values. Some disagreed as condoms are available for free in certain locations such as the health department and planned parenthood, however many women may not be aware of these locations.*
4. *Female condoms are not available: While the interviewees believed female condoms to be less accessible and poorly marketed, some did acknowledge that they are sold in stores. Others had never seen a female condom before.*
5. *Partner refuses to use a condom: All interviewees acknowledged partners refusing to use condoms as a barrier to safe sex practices. Many of the women interviewed agreed that many men express not wanting to use a condom and the women comply.*
6. *A partner may become abusive if I ask them to use a condom: Many interviewees thought partners becoming abusive if asked to wear a condom was a possibility.*
7. *Condoms are uncomfortable: This was seen as a potential reason men decide not to wear a condom. Although condoms come in different sizes and some are lubricated in efforts to make them feel more "natural," this is a reason some do not practice safe sex.*
8. *Their religion teaches me not to use contraception: For the most part this was not seen as a barrier to not using condoms.*
9. *They want to have a baby: Wanting to become pregnant was considered a valid reason for not wearing condoms. In the process of wanting to have a baby, many women do not use protection.*
10. *They engage in sex work to make money and don't use condoms: The interviewees believed this was possible. However, one woman made the point that "If you contract HIV*

you won't be able to live longer or pay for healthcare," therefore there is even more of a need to wear condoms as a sex worker.

11. *They are afraid to ask their partner if they have other sex partners: All interviewees agreed that sometimes having this conversation with their partner can be difficult and uncomfortable to have. Many women also believe that their partners are monogamous and faithful, therefore there is no need to wear condoms.*
12. *Not knowing where to go for other prevention methods (PrEP): All interviewees acknowledge that lack of education of PrEP can keep them from accessing this prevention method. Some interviewees mentioned the health department as a possible location to gain knowledge about PrEP.*
13. *Not having insurance to get PrEP: Interviewees acknowledge that not having insurance can prevent women from accessing PrEP.*

Participants were also asked about reasons for not getting tested for HIV and their thoughts about those reasons.

1. *Fear of stigma (not wanting friends or family to know their HIV status): Most interviewees agreed with this statement. They stated this was a reality. They don't want to know themselves and they don't want anyone else to know ("what I don't know won't hurt me; out of sight, out of mind."). They believe it is embarrassing and shameful. They don't get tested because of fear of the stigma and they don't know where to get it for free. It is not something that is widely accepted and can make them feel isolated.*
2. *Not knowing where to get tested: Some interviewees agreed with this, while others did not. The ones who did not agree said women are just afraid to ask-they don't want anyone to know why they are asking. The health department provides free testing, they may just not know where the free testing is located.*
3. *The test is not affordable: All respondents indicated that this was not an excuse. One interviewee stated, "What's your priority?" Some believed that lack of awareness of and access to locations where free testing was available was the issue. All said that the test was free and therefore should not be an excuse.*
4. *There is no free test center near my house: Several respondents indicated this was true, especially for those with limited access to transportation. Another respondent said she would not go near her house because "I don't want people to see me because people will know why I went." Transportation was a significant issue; a question was raised about whether tests could be mailed.*
5. *There is no transportation available to get to the testing center: This relates back to the prior question, however several respondents indicated that women have to have priorities-for example, you can get to the mall or other places. Some agreed that transportation was an issue. Some women may be unable to access Uber, Lyft or cabs and public transportation may be complicated. This is a problem that the Black community is often faced with. A suggestion was made to have some community pop-up clinics that give out gift cards like "Publix does to promote people getting that crazy flu shot."*
6. *They don't care about their HIV status: Respondents did not agree with this statement. They responded that "it's not they they don't care, they are afraid of it, don't want to face*

the repercussions or the stigma associated with a positive status." Others said there is a lack of education and awareness and a lack of information about resources available.

7. *Other reasons (please specify): At-home test might be effective, but stores are not accessible (they are more public where people hang out, like the corner store). May think other people will see them and say something to someone. Need to weigh the costs vs. the benefits of being healthy. "Aren't you worth that investment?" There is a fear of knowing their own status.*

Participants were asked why they believed the rates of HIV were so high in their community and why Black women were disproportionately affected by HIV compared to White women. Interviewees indicated that there are taboos associated with talking about HIV as well as stigma. Women are fearful to be educated and take preventive measures. "We think we are "superwomen"-we have been taught to be strong. If we are seen as weak, that is not good. Rumors get spread about people in the community." Many of the women stated that Black women are supposed to be strong. It is difficult to speak out in our relationships; we don't want to look like we are weak. We have to be strong, but we also want to please our partners.

Interviewees indicated that messaging needed to be told by somebody who looked like them and who shared common characteristics, as a trusted entity in their community. Respondents stated that the message should include informational sessions provided by people they trusted within their community. Messaging should include information about the statistics about HIV in their community and the associated disparities. They indicated that people who could share their stories with others would be the most powerful. Further, programs and messages should be positive and upbeat (not showing people in a casket); they should talk about how do we persevere, how do we live. Some women stated that they would be most receptive to small, intimate and informative talks like community round tables that were facilitated by trusted community leaders. One important characteristic that was discussed was that the facilitators of these talks should be African American women as they could better relate to the group that the intervention most impacts. Messages about prevention have to look like my community and stories should be shared that are real and relevant.

Participants were asked about the best locations to reach Black women in their community to educate them about the risks of HIV and the benefits of prevention. Respondents indicated that these locations included areas within their community that were considered safe, such as churches, nail salons, hair salons, weave stores, barber shops, the little corner store, and little league fields as well as football fields as well as at community events.

Respondents were asked about promotional strategies. Who are the spokespersons or champions in their community that others look up to? Who would be a good spokesperson to deliver the message? Many individuals identified Pastors and their wives, people who have been impacted by HIV who are living in their community, and community activists who are willing to share their stories. They discussed local sorority chapters who conduct initiatives for health and who could serve as community ambassadors to promote healthy behaviors and positive health outcomes. Several women identified national celebrities as being trusted entities such as Michelle Obama.

The last question asked interviewees about the best methods to reach Black women in their community. They indicated that social media such as Facebook was a good place for people to learn things, especially in Facebook groups. They said that texts, not email, were also a good way to communicate. Mostly, they stated that small intimate forums, like "sister circles" that were conducted peer-to- peer by a trusted member of their community would be most effective. These should be facilitated by members of their community for members of their community. These could take place at health fairs in the parking lots of places where people hang out (restaurant, nail salon, beauty salon, corner store). Flyers could be distributed at these locations and they should be called something positive (not about HIV). One interviewee gave an example about a woman who came to speak about recently being released from prison; she spoke at a sit-down restaurant in the neighborhood-had dinner then she spoke and talked about resources in the community-people found out about it from Facebook groups and communities).

Appendix B: Focus Groups

Opportunities to learn from individuals with lived experience and other stakeholders were provided through focus groups. Between 2018 and 2020 a total of eight (8) focus groups were held. Four (4) of the focus groups were held with staff who work with PLWH. An additional four (4) focus groups were held with persons with lived experience who represented a special needs subpopulation. These groups included Black women, individuals with substance use and/or mental health conditions, long-term survivors, and transgender individuals. A total of 98 individuals were reached through these focus groups.

Overview of Focus Groups		
Type of Focus Group	*Date*	*# of Participants*
Individuals with substance use and/or mental health conditions at Broward House	*March 29, 2018*	*18*
Disease Intervention Specialists at FDOH-BC	*May 17, 2018*	*7*
Long-term survivors at World AIDS Museum	*September 5, 2018*	*22*
HIV Medical Case Managers	*January 17, 2019*	*10*
Doctors and Disease Case Managers	*January 23, 2019*	*11*
Black women at Comprehensive Care Center	*February 28, 2019*	*5*
Medical Quality Management Case Management	*January 29, 2020*	*7*
Transgender Support Group	*February 12, 2020*	*18*
Total		*98*

Aggregate Focus Group Results (Providers)

Provider Focus Group Results	
STRENGTHS	
• Many opportunities for testing in the County • PROACT has been very helpful • Poverello has helped in providing food • Linkage and Retention Specialists have been helpful • 90-day supply of medications has helped • Delivery of medications has helped • Sunserve and Care Resource good providers • Able to access PE among providers • Test and Treat has helped bring people into care	
CHALLENGES	
• Stigma • Homelessness • Transient population • Affordable, safe, stable housing • Polysubstance use • Noncompliance	• "Repeat" people who fall out of care • Transportation • Lack of public transportation • Rules are barriers • Motivation (denial, stigma) among the newly diagnosed

• Lack of family support (some people do not disclose their diagnoses to family or friends) • Cultural issues/religious beliefs (use of alternative treatments) • Gaps in coverage to follow-up with treatment • Resources not available for co-morbidities • Risky behaviors in community (bareback parties, fisting, using poppers, increase in crystal methamphetamine, Grinder app, G drink) • Lack of insurance or underinsurance for medications • Mental health issues • Nobody is teaching sexual or health education in schools • Hiding medications (because of stigma) • Lack of access to affordable housing for people with mental health conditions • Anxiety, depression • Need more coordinated care	• Case Management is a band-aid; it is not true wraparound case management • Inter-generational lack of education regarding prevention strategies • Perinatally infected not knowing their status (not being told by their parents or others) • BMSM-not gay with wife and kids (stigma around being gay) • HMSM-defensive • Length of time spent in pharmacy (don't want to be seen) • Pregnant women using heroin and cocaine • Difficult to get information from the VA • Clients selling meds • Substance abuse treatment center has barriers • Use of PrEP does not prevent other STDs/STIs (people don't want to use condoms) • 2-1-1 not user friendly • Aging population needs more services
OPPORTUNITIES FOR IMPROVEMENT	
• More focus groups regularly for PLWH, particularly MSM • More education regarding testing • Work with primary care doctors not just infectious disease doctors • Destigmatize standard of care • Test women at OB/GYN offices (not only when they are pregnant) • Reach out to faith-based organizations • Use blister packs to remind people to take their meds daily • Share information in high schools • Injectable medications • More Case Managers/Navigators to follow-up • Transportation/bus passes • Develop strategies to address behavioral health conditions • Share results of viral loads with clients • Using a phone app as a reminder to take medications • Co-locate services (behavioral health) • Educate primary care physicians • Educate dental providers • Use social media • Prioritize special needs populations (research Latina women over the age of 50)	• Educate ER physicians and conduct testing in ERs • Work with adult entertainment establishments, bath houses • Distribute information at festivals • Provide support groups for family members • Provide information and testing at sex shops • Engage in neighborhood locations (grocery stores, hair salons, barber shops) • More peer navigators • Conduct a study regarding individuals who are continually falling out of care to identify challenges and develop strategies • Provide training in welcoming and engagement • Focus on the root causes of racial disparities • Research the special needs of individuals who are perinatally infected • Trigger system for ADAP recertification • Process flow for ADAP • Address the social determinants of health • Increase collaboration with providers • Have peers on Test and Treat • Hold an HIV Summit • Provide training on co-occurring mental health/substance use conditions • Resource guide/map of services

Aggregate Focus Group Results (Persons with Lived Experience)

Persons with Lived Experience Focus Group Results	
CHALLENGES	
• Transportation • Lack of follow-up for missed appointments • Don't know where to go for services • Certification every six months • Need for legal services • Stigma • Lack of education for youth and young adults • Cultural/religious beliefs • Don't know how to navigate insurance • Lack of bus passes • People don't want to go to clinics that are "HIV clinics" because they may be seen • Intergenerational discrimination • Bigotry within the medical community • A lot of other STDs are not being talked about, like herpes	• People are having unprotected sex • Men don't disclose to women that they are positive • Women tend to stay in their own communities and sleep with the same men that other women are sleeping with • Men are infecting multiple people • People don't like to use condoms • Younger generation is not as scared as the older generation • Doctors have specialties; difficult to manage everything in one place • There are new drugs young people are using and they are taking more risks
OPPORTUNITIES FOR IMPROVEMENT	
• Telehealth • Concurrent certification of CIED/ADAP • Certification annually • Provide information about medications covered by ADAP • Resource guide about Ryan White services and a list of specialists • One-stop shop for all medications • Anti-stigma campaign in the parks and schools • Educate youth and young adults (ages 13-24); people who conduct the education need to speak their language. They need a spokesperson who looks like them • Go into communities of older adults and challenge them • Engage families • Make commercials that emphasize the use of protection	• Address mental health and substance use issues • Educate about nutrition and alternative practices • More dollars for education and research • Reverse stigma-peer pressure for not getting tested • Have a celebrity be an ambassador • Train doctors to have good bedside manners • Tell friends to go together to get tested • Learn how to be advocates • Pay attention to certain communities because of their cultural beliefs (e.g., Haitian community and Hispanic community because of machismo) • Educate the community about test and treat and prevention • Talk to people about the internalization of stigma • Increase the knowledge of testers in drug treatment centers • Conduct a focus group with youth and young adults

Appendix C: PLWH Survey Results

Two surveys were distributed to gather additional information for the needs assessment process. One survey was distributed to providers, the other to PLWH in the community. The consultant sent the provider survey to a list of organizations given by the Ryan White Program Office. A reminder email was sent to the contact people at the organizations. The PLWH online survey was sent through a link to current Ryan White Part A clients. It was also posted on the Ryan White Facebook page and Twitter account. Additionally, the FLDOH-BC sent the link to its listserv.

Thirteen (13) provider surveys were distributed, with a total of twelve (12) completed and returned. The Persons Living with HIV survey was distributed online in November 2019. A total of 203 PLWH surveys were received between November 19, 2019 and January 18, 2020. Three (3) surveys were blank and discarded. One (1) survey was a duplicate and was discarded. Four (4) individuals identified as either transgender (male to female) (1); transgender (female to male) (1); and "do not identify as either male, female, transgender, or any gender" (2). These four surveys were not included in the analysis due to the low numbers for subpopulations. The final survey tally was therefore 195.

Surveys-PLWH Results

The following represents the results of the PLWH survey. First, demographics are presented in tables and charts. Following the demographics responses to questions regarding housing, behavioral health, medications, and services are presented. Several of these questions provided opportunities for respondents to offer open-ended answers; these are included as well. Surveys were filtered by gender and also by status of care (in care compared to out of care for more than six months during the past five years). A summary of the results is provided at the end of this presentation.

The table below represents demographic information gathered from 195 individuals who identified as male or female. An additional four individuals identified as either transgender (male to female) (1); transgender (female to male) (1); and "do not identify as male, female, transgender, or any gender" (2). One survey was a duplicate and was discarded.

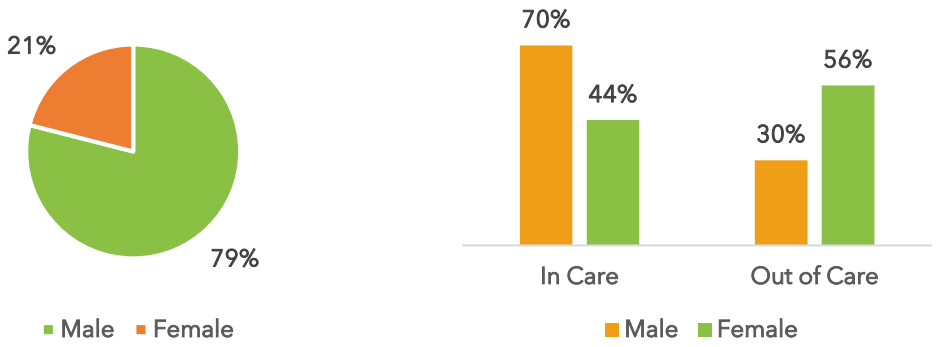
Most (78%) of respondents identified as male with 21% identifying as female (Figure 22). The majority of the male sample were White, non-Hispanic gay men between the ages of 55 and 64. The majority of the female sample were Black, non-Hispanic heterosexual women between the ages of 55 and 64. The majority of the entire sample were Ryan White clients (90%) and had received treatment for HIV in the past year (97%). There were no clear differences among respondents in terms of employment status.

In care vs. Out of Care: A total of 69 (35%) of respondents indicated they had been out of care for over six months during the past five years. Forty-six (46) of those out of care participants were male (67%), while twenty-three (23) were female (33%). Females were disproportionately represented as having been out of care compared to the overall sample of females (33% to 21%). Males represented 67% of the out of care participants and 78% of the overall sample. It should also be noted that women represent 27% of the total Ryan White Part A program.

Table 1. Demographics of survey respondents							
				Out of Care		*In Care*	
	Male	*Female*	*Total*	*Male*	*Female*	*Male*	*Female*
Total	*154 (78%)*	*41 (21%)*	*195*	*46 (67%)*	*23 (33%)*	*108 (86%)*	*18 (14%)*
Age							
18-24	*0 (0%)*	*0 (0%)*	*0 (0%)*	*0*	*0*	*0*	*0*
25-34	*12 (7%)*	*2 (5%)*	*14 (7%)*	*6 (13%)*	*2 (9%)*	*6 (13%)*	*0*
35-44	*23 (15%)*	*10 (24%)*	*33 (17%)*	*10 (22%)*	*7 (30%)*	*13 (12%)*	*3 (17%)*
45-54	*34 (22%)*	*7 (17%)*	*41 (21%)*	*6 (13%)*	*3 (13%)*	*27 (25%)*	*4 (22%)*
55-64	*64 (42%)*	*16 (39%)*	*81 (41%)*	*19 (41%)*	*8 (35%)*	*45 (42%)*	*8 (44%)*
65+	*19 (12%)*	*6 (15%)*	*25 (13%)*	*4 (9%)*	*3 (13%)*	*16 (15%)*	*3 (17%)*
No response	*2 (1%)*	*0*	*2 (1%)*	*1 (2%)*	*0*	*1 (2%)*	*0*
Sexual Orientation							
Straight (heterosexual)	*23 (15%)*	*40 (98%)*	*62 (8%)*	*6 (13%)*	*22 (96%)*	*17 (16%)*	*18 (100%)*
Gay or lesbian (homosexual)	*122 (79%)*	*0 (0%)*	*122 (63%)*	*38 (83%)*	*0*	*84 (78%)*	*0*
Bisexual	*9 (6%)*	*1 (2%)*	*10 (5%)*	*2 (4%)*	*1 (4%)*	*7 (6%)*	*0*
Other (please specify)	*0 (0%)*	*0*	*1 (.5%)*	*0*	*0*	*0*	*0*
Race/Ethnicity							
White, non-Hispanic	*72 (47%)*	*2 (5%)*	*74 (38%)*	*16 (35%)*	*1 (4%)*	*56 (52%)*	*1 (6%)*
White, Hispanic	*32 (21%)*	*4 (10%)*	*36 (19%)*	*14 (30%)*	*3 (13%)*	*18 (17%)*	*1 (6%)*
Black or African-American, non-Hispanic	*24 (16%)*	*33 (83%)*	*57 (29%)*	*5 (11%)*	*19 (83%)*	*19 (18%)*	*14 (78%)*
Black or African-American, Hispanic	*1 (1%)*	*0*	*1 (1%)*	*1 (2%)*	*0*	*0*	*0*
Multi-racial, non-Hispanic	*4 (3%)*	*1 (3%)*	*5 (3%)*	*2 (4%)*	*0*	*2 (2%)*	*1 (6%)*

Table 1. Demographics of survey respondents							
Multi-racial, Hispanic	*10 (6%)*	*0*	*10 (5%)*	*4 (9%)*	*0*	*6 (6%)*	*0*
Prefer not to answer race, non-Hispanic	*2 (1%)*	*0*	*2 (1%)*	*0*	*0*	*2 (2%)*	*0*
Prefer not to answer race, Hispanic	*9 (6%)*	*1 (2%)*	*10 (5%)*	*4 (9%)*	*0*	*5 (5%)*	*1 (6%)*
Employment Status							
Employed, full-time	*49 (32%)*	*9 (22%)*	*58 (30%)*	*12 (26%)*	*4 (17%)*	*37 (34%)*	*5 (28%)*
Employed, part-time	*26 (17%)*	*11 (27%)*	*37 (19%)*	*6 (13%)*	*7 (30%)*	*20 (19%)*	*4 (22%)*
Not employed	*31 (20%)*	*13 (32%)*	*44 (23%)*	*12 (26%)*	*7 (30%)*	*18 (17%)*	*6 (33%)*
Disabled	*48 (31%)*	*8 (20%)*	*56 (29%)*	*16 (35%)*	*5 (22%)*	*33 (31%)*	*3 (17%)*
Ryan White client							
Yes	*136 (88%)*	*39 (95%)*	*175 (90%)*	*41 (87%)*	*21 (91%)*	*95 (88%)*	*18 (100%)*
No	*16 (11%)*	*2 (5%)*	*18 (9%)*	*4 (9%)*	*2 (9%)*	*12 (11%)*	*0*
Don't Know	*2 (1%)*	*0 (0%*	*2 (1%)*	*1 (2%)*	*0*	*1 (1%)*	*0*
No response	*0 (0%)*	*0 (0%)*	*0 (0%)*	*0*	*0*	*0*	*0*
Received HIV treatment in past year							
Yes	*151 (98%)*	*38 (93%)*	*189 (97%)*	*45 (98%)*	*21 (91%)*	*106 (98%)*	*17 (94%)*
No	*2 (1%)*	*2 (5%)*	*4 (2%)*	*1 (2%)*	*2 (9%)*	*1 (1%)*	*0*
Don't Know	*0*	*1 (2%)*	*1 (.5%)*	*0*	*0*	*1 (1%)*	*0*
No response	*1 (1%)*	*0 (0%)*	*1 (.5%)*	*0*	*0*	*0*	*1 (6%)*

Figures 1 and 2. Gender of Survey Respondents and Care Status by Gender



Figures 3 and 4. Care Status by Gender and Age

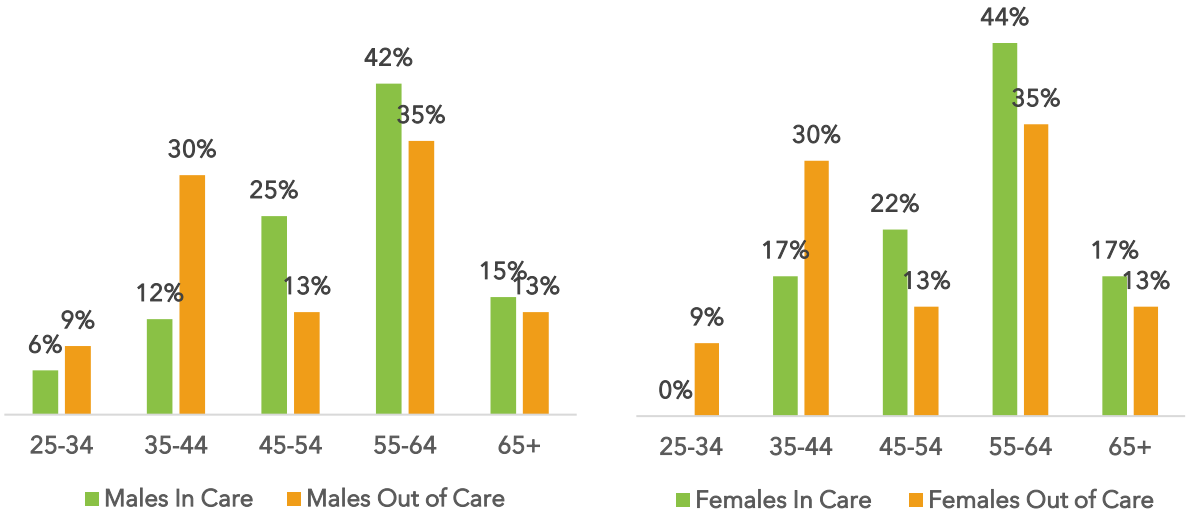
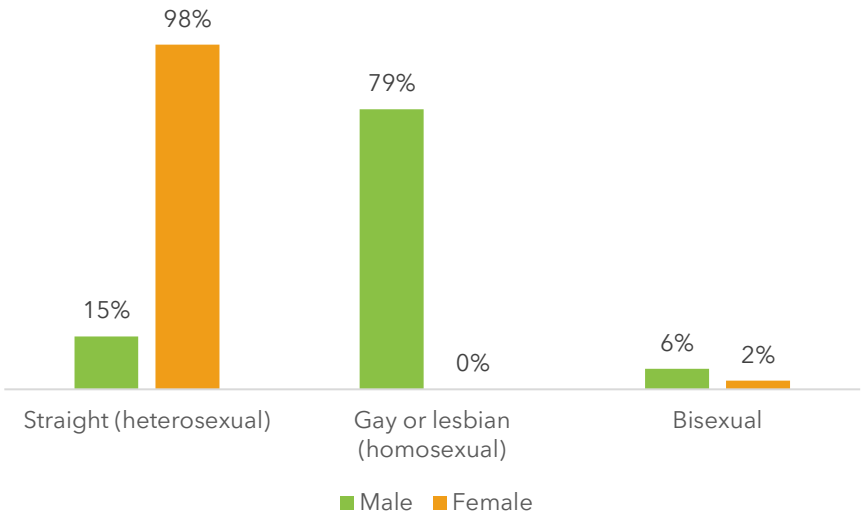


Figure 5. Sexual Orientation Total Sample



Figures 6 and 7. Sexual Orientation by Care Status and Gender

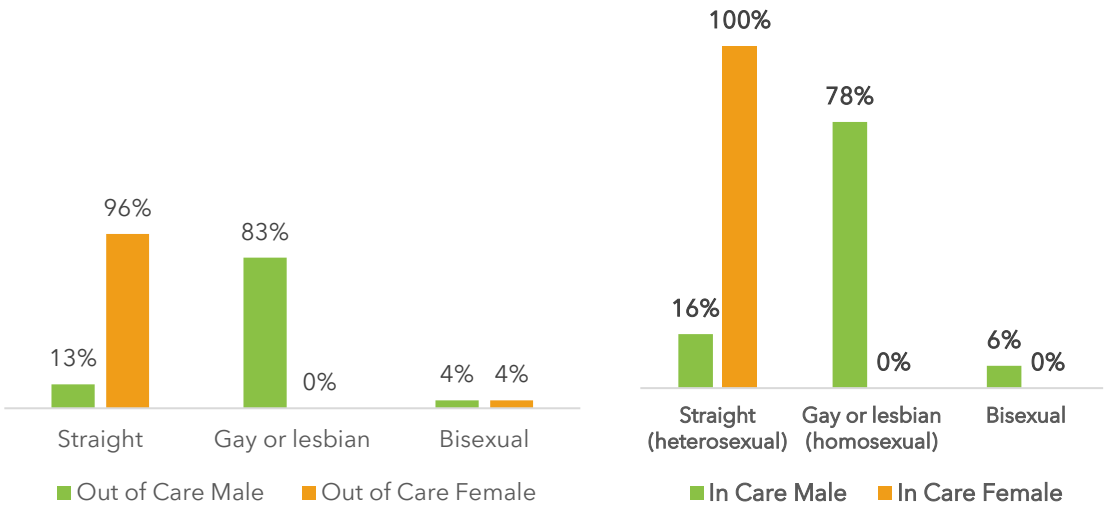


Figure 8. Race/Ethnicity for Total Sample

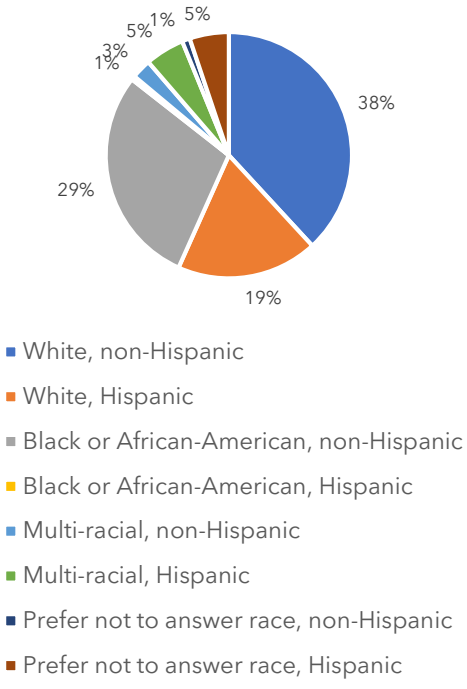


Figure 9. Race and Ethnicity by Gender

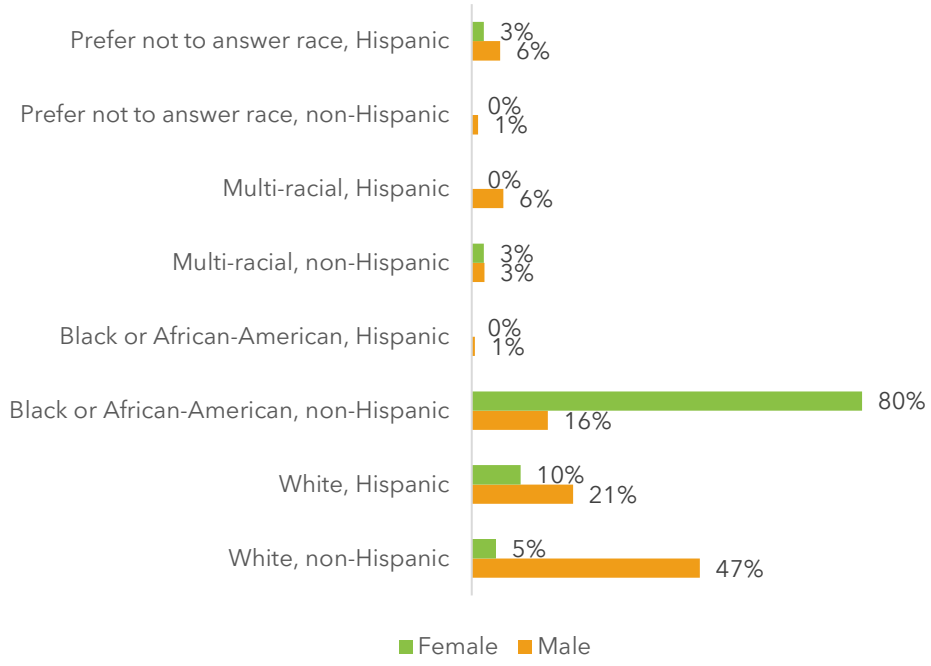


Figure 10. Race and Ethnicity by Gender, In Care Status

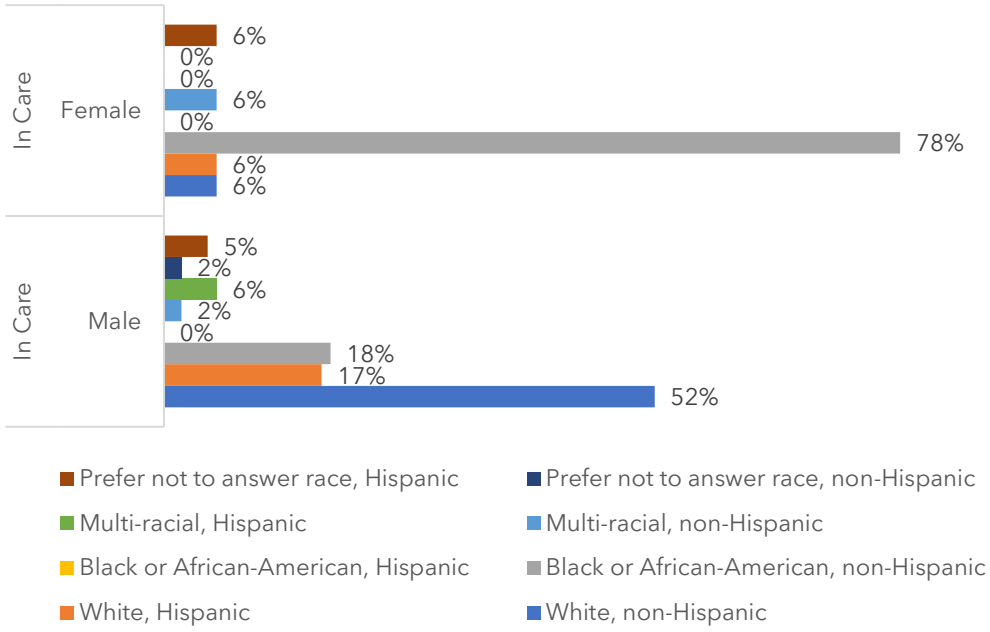


Figure 11. Race and Ethnicity by Out of Care Status

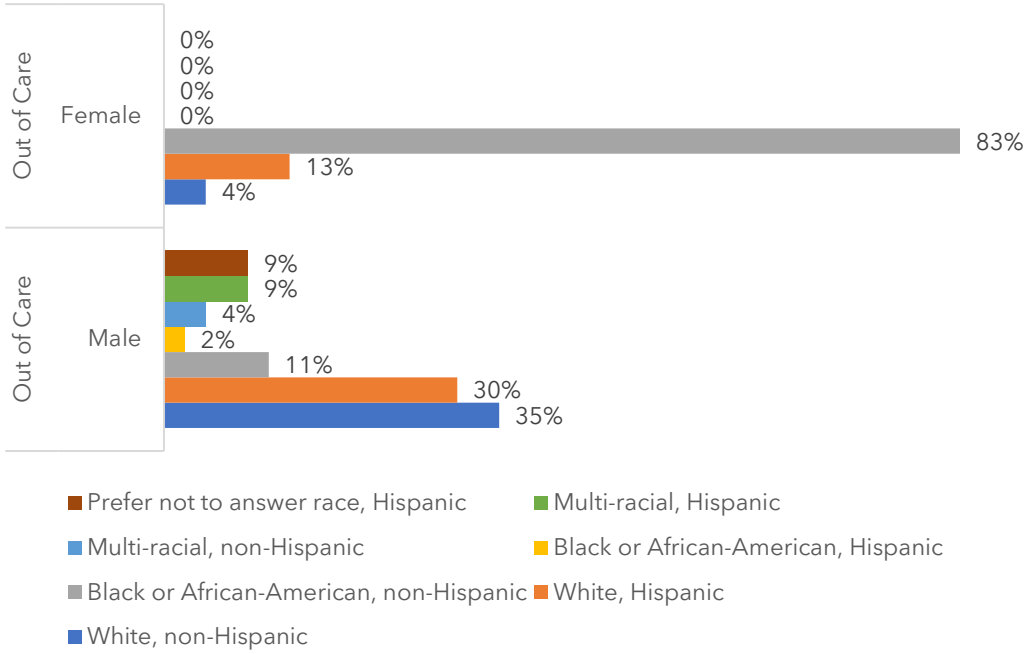


Figure 12. Race and Ethnicity All Males

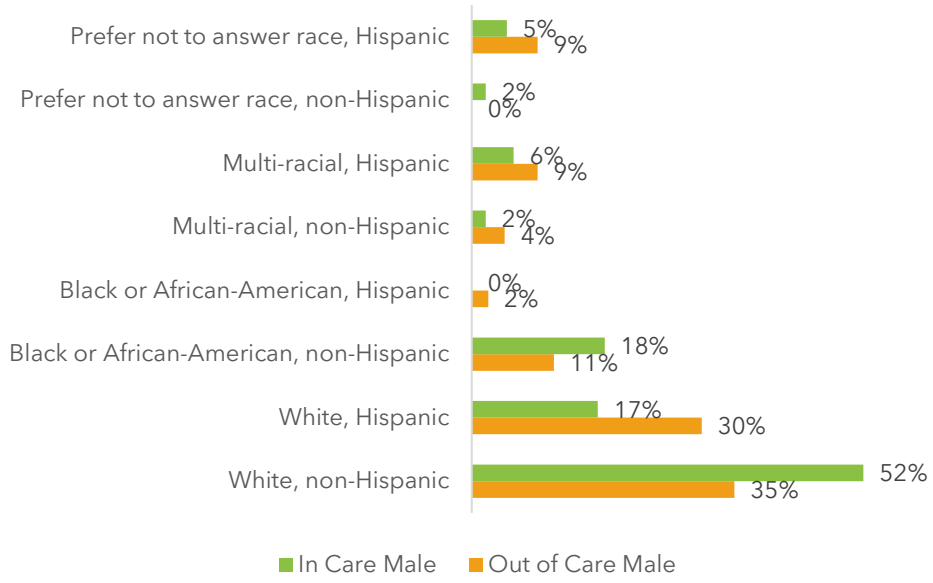


Figure 13. Race and Ethnicity All Females

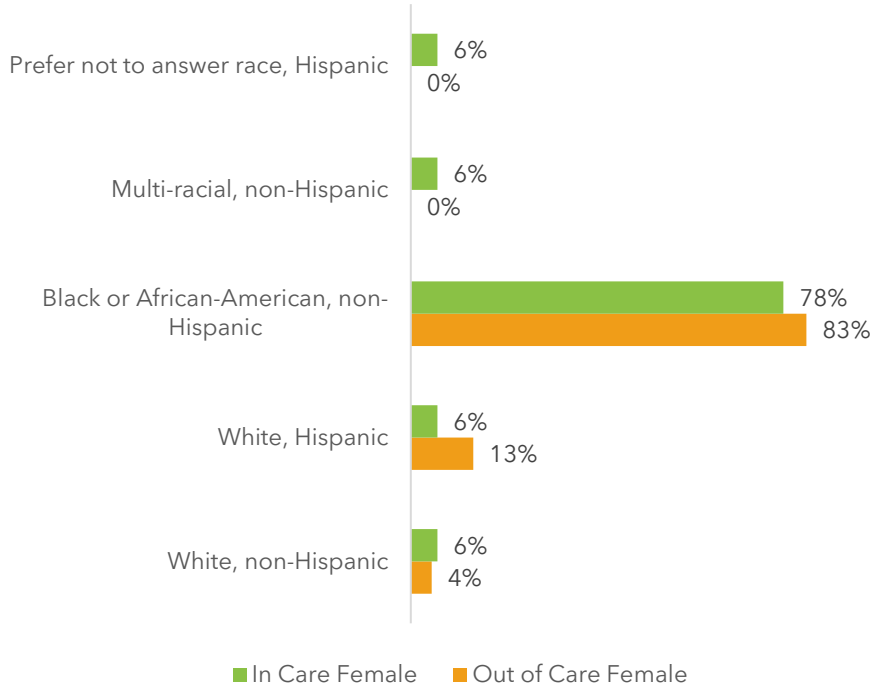


Figure 14. Employment Status Total Sample

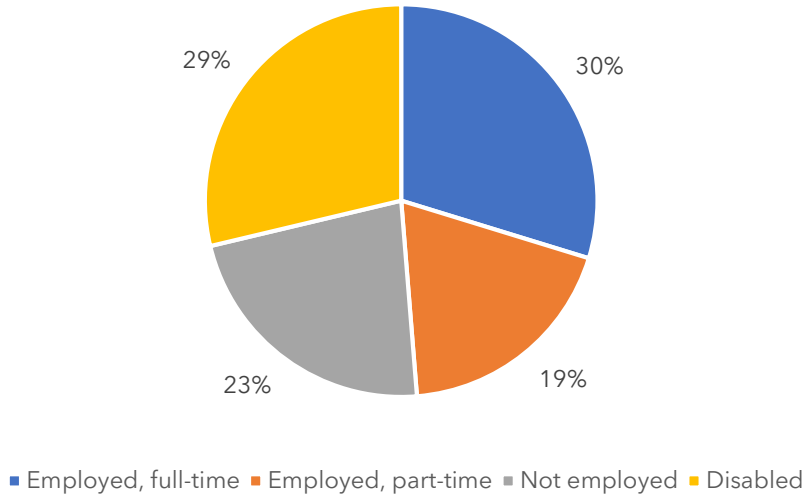


Figure 15. Employment Status by Gender

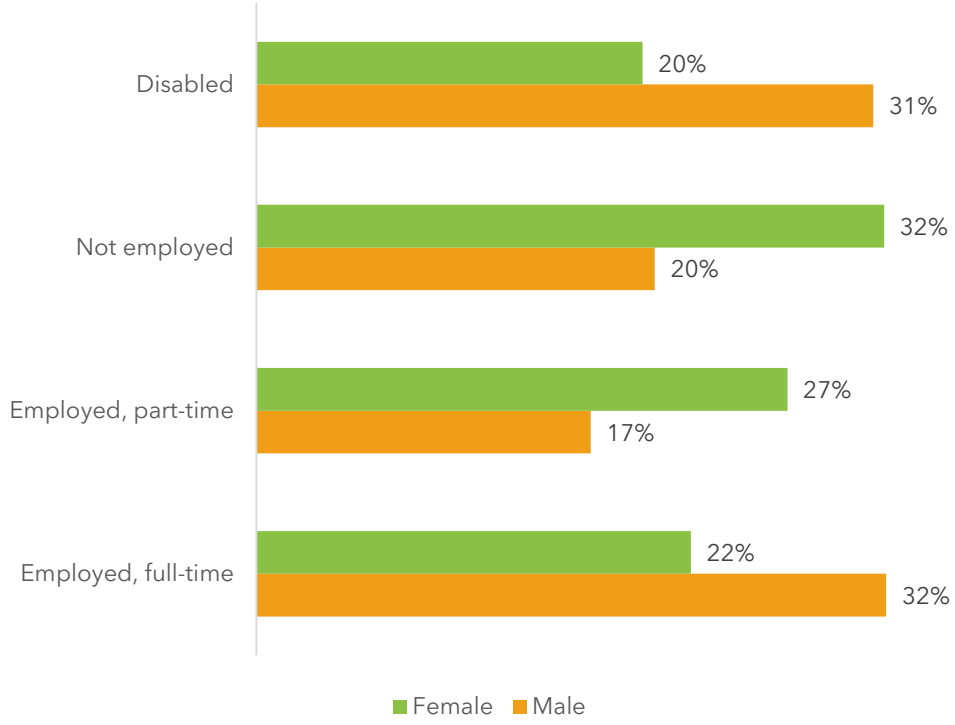


Figure 16. Employment Status by Gender and Care Status

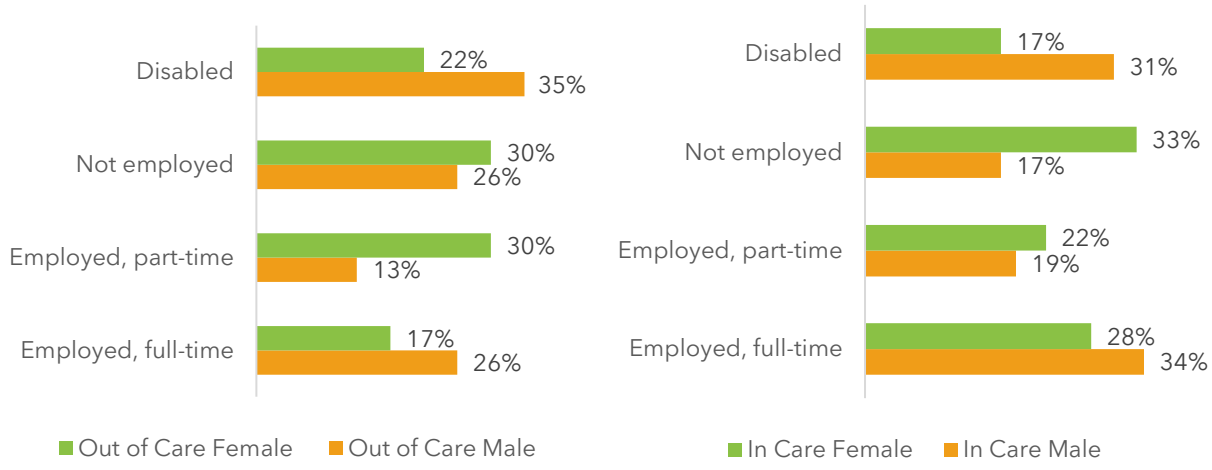
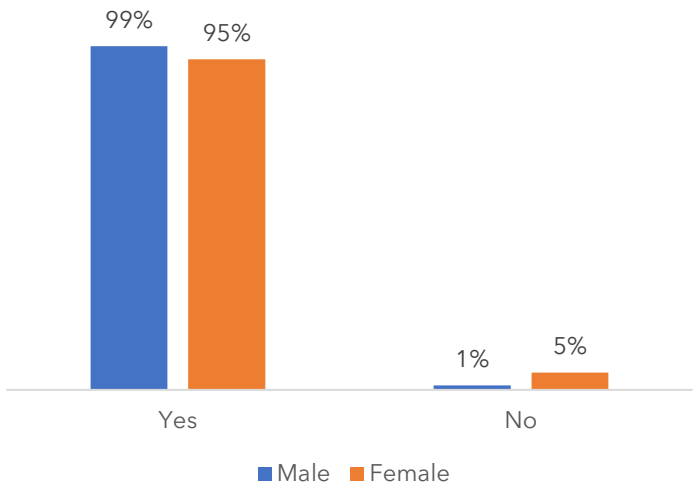


Figure 17. Ryan White Part A Clients Total Sample



Behavioral Health

Are you struggling with mental health or substance use issues?

Table 2. Individuals struggling with mental health or substance use issues							
	Out of Care		*In Care*		*Total*		*Total*
	Males n=46	*Females n=23*	*Males n=108*	*Females n=18*	*Males n=154*	*Females n=41*	*Total n=195*
Yes	*18 (39%)*	*6 (26%)*	*20 (19%)*	*1 (6%)*	*38 (25%)*	*7 (17%)*	*45 (24%)*
No	*25 (54%)*	*12 (52%)*	*75 (69%)*	*16 (89%)*	*100 (65%)*	*28 (68%)*	*128 (66%)*
Unsure	*3 (7%)*	*2 (9%)*	*8 (7%)*	*0 (0%)*	*11 (7%)*	*2 (5%)*	*13 (7%)*
Prefer not to answer	*0 (0%)*	*3 (13%*	*5 (5%)*	*1 (6%)*	*5 (3%)*	*4 (10%)*	*9 (5%)*

Which of the following might help you get into or stay in treatment for your mental health or substance use issues? Check all that apply.

Table 3. Help for getting into or staying in treatment for mental health or substance use issues							
	Out of Care		In Care		Total		Total
	Males n=72	Females n=47	Males n=84	Females n=1	Males n=176	Females n=47	N=223
Immediate admission to the program when I am ready	10 (12%)	4 (9%)	12 (14%)	0 (0%)	22 (13%)	4 (9%)	26 (12%)
Information about what services are available and where to go	16 (20%)	7 (15%)	15 (18%)	0 (0%)	31 (18%)	7 (15%)	38 (17%)
Free treatment	19 (23%)	8 (17%)	24 (29%)	0 (0%)	43 (24%)	8 (17%)	51 (23%)
Transportation to treatment	10 (12%)	7 (15%)	13 (15%)	0 (0%)	23 (13%)	7 (15%)	30 (13%)
An understanding counselor	15 (18%)	11 (23%)	12 (14%)	0 (0%)	27 (15%)	11 (23%)	38 (17%)
Peer support (someone who has gone through similar challenges)	12 (15%)	10 (21%)	18 (21%)	1 (100%)	30 (17%)	10 (21%)	40 (18%)

Other responses given by males out of care:

- *meals and meds*
- *People need Housing that's where it starts*
- *Just when I feel like it is an issue to fix...and whether it is honestly worth trying to fix with me anymore. I am just plain tired.*
- *Housing that I can AFFORD*
- *There is no substance abuse, it is more mental health issues.*
- *system doesn't work together*
- *I'm under treatment*
- *I think i don't have mental issues..time ago i was told i have PTSD...*
- *In therapy*

Other responses given by females out of care:

- *Most of the RW Mental Health counselors are judgmental*

Other responses given by males in care:

- *Already in the appropriate programs*
- *No Substance abuse or mental health problems*
- *Mental illness has been addressed sometimes depression due to problem walking pain all the time hips legs lower back*

- *Receive help getting the needed services when I am not able to get help!*
- *No issues with mental health*
- *I no longer have a drug or alcohol abuse*
- *No mental issues or drug issues*
- *I see a doctor*
- *I have not problems or substance addiction*
- *I've stayed in treatment*
- *I don't have a substance problem.*
- *I see my therapist twice a month which helps*
- *I have anxiety and depression*
- *No mental issues*
- *Other, depresión*

Other responses given by females in care:

- *I am taking my medication*
- *always in treatment*
- *I don't have any mental issues*
- *I get my treatment*
- *I haven't had to use this service*
- *No need for it*
- *Have been doing mental health treatment since brain surgery*

The following graphs display the behavioral health status of respondents, indicating if they struggle with mental health or substance use conditions, as well as services that might help them get into or stay in treatment.

Figure 18. Behavioral Health Status Total Sample

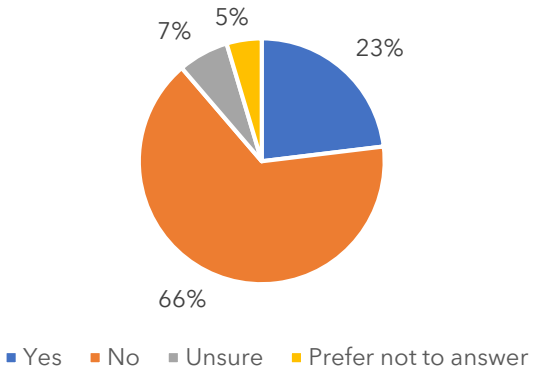


Figure 19. Behavioral Health Status by Gender

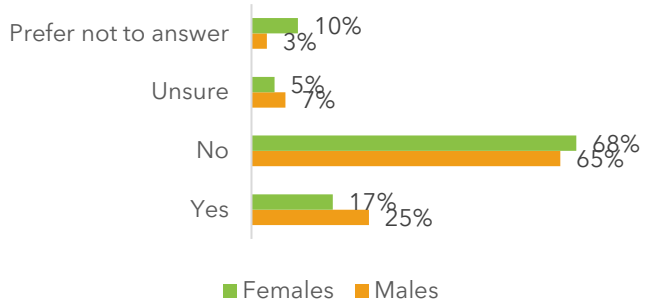


Figure 20. Behavioral Health Status by Gender and Care Status

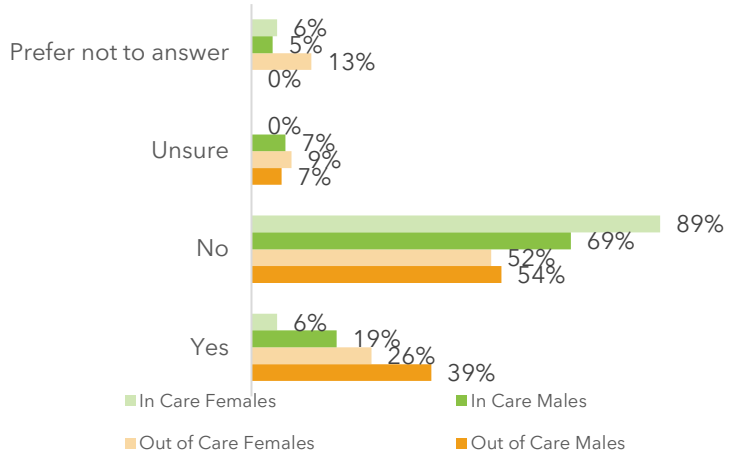
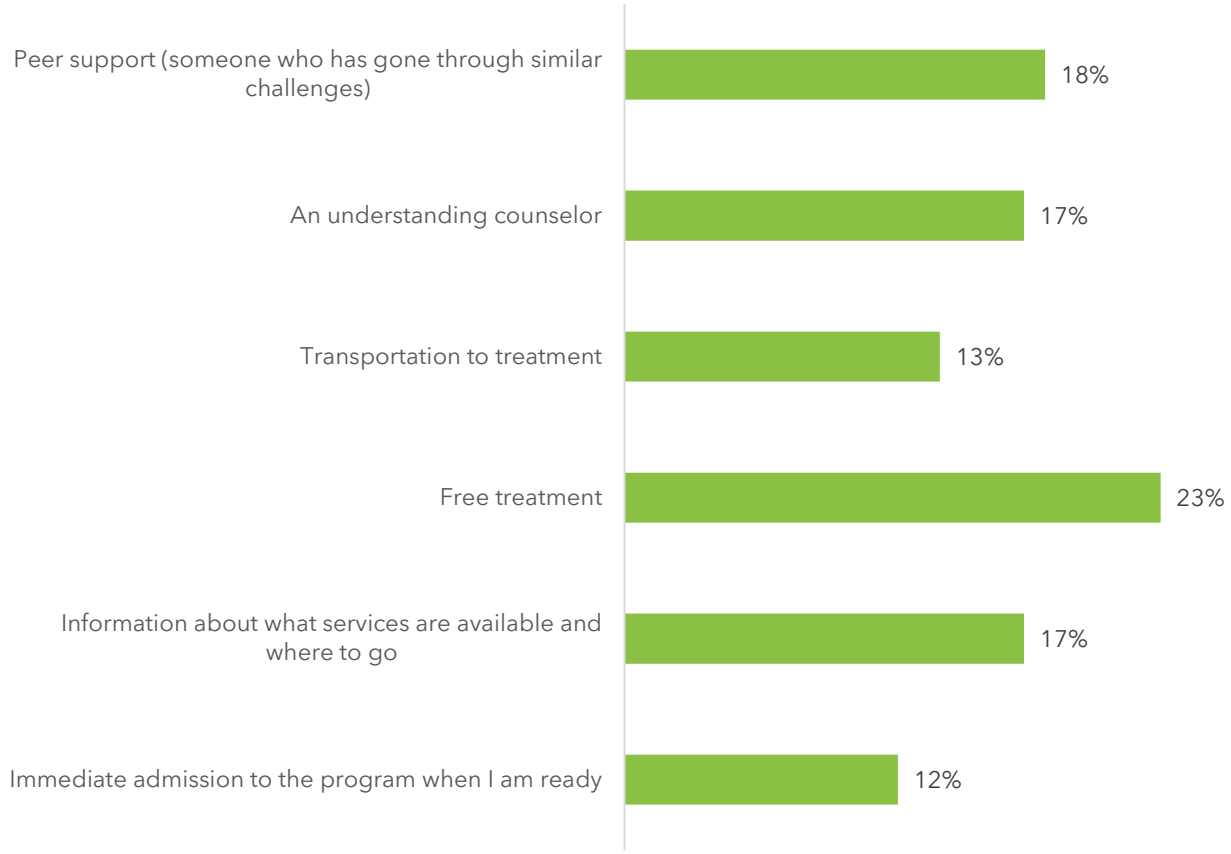


Figure 21. Services that would help individuals get into or stay in treatment for behavioral health issues.



Social Determinants of Health-Housing

Housing

Thinking about your housing situation now, do any of the following stop you from taking care of your HIV? (Check all that apply). The first number represents the total number of responses in that category; the number in parentheses represents the percentage of total responses. The table below displays the responses given by gender and care status.

Table 4. Reasons for not taking care of HIV related to housing situation

	Not in care		In care		Total		Total
	Males n=69	Females n=29	Males n=41	Females n=5	Males n=110	Females n=34	Total N=144
I don't have a safe and private room	7 (10%)	1 (3%)	4 (10%)	0 (0%)	11 (10%)	1 (3%)	12 (8%)
I am afraid of others knowing I am HIV positive	11 (16%)	9 (31%)	10 (24%)	1 (20%)	21 (19%)	10 (29%)	31 (22%)
I don't have money to pay for rent	21 (31%)	4 (14%)	10 (24%)	1 (20%)	31 (28%)	5 (15%)	36 (25%)
I don't have a bed to sleep in	8 (12%)	3 (10%)	1 (2%)	0 (0%)	9 (8%)	3 (9%)	12 (9%)
I don't have a place to store my medications	5 (7%)	2 (7%)	1 (2%)	1 (20%)	6 (5%)	3 (9%)	9 (6%)
I don't have a telephone where someone can call me	1 (1%)	3 (10%)	3 (7%)	0 (0%)	4 (4%)	3 (9%)	7 (5%)
I don't have enough food to eat	10 (15%)	6 (21%)	10 (24%)	2 (40%)	20 (18%)	8 (24%)	28 (19%
I can't get away from drugs and alcohol	5 (7%)	1 (3%)	2 (5%)	0 (0%)	7 (6%)	2 (6%)	9 (6%)

Other responses given by males out of care:

- *food stamps 25.00 because I own my home*
- *Hospital did not provide ARV medication*
- *I vigilantly take care of my HIV*
- *I don't feel safe in my neighborhood*
- *Affordable housing shortages*
- *I am all alone..some friends help me sometimes, but they are busy...*
- *Sickness*
- *Is too much...*

Other responses given by females out of care:

- *Housing case management is limited in what they do...*

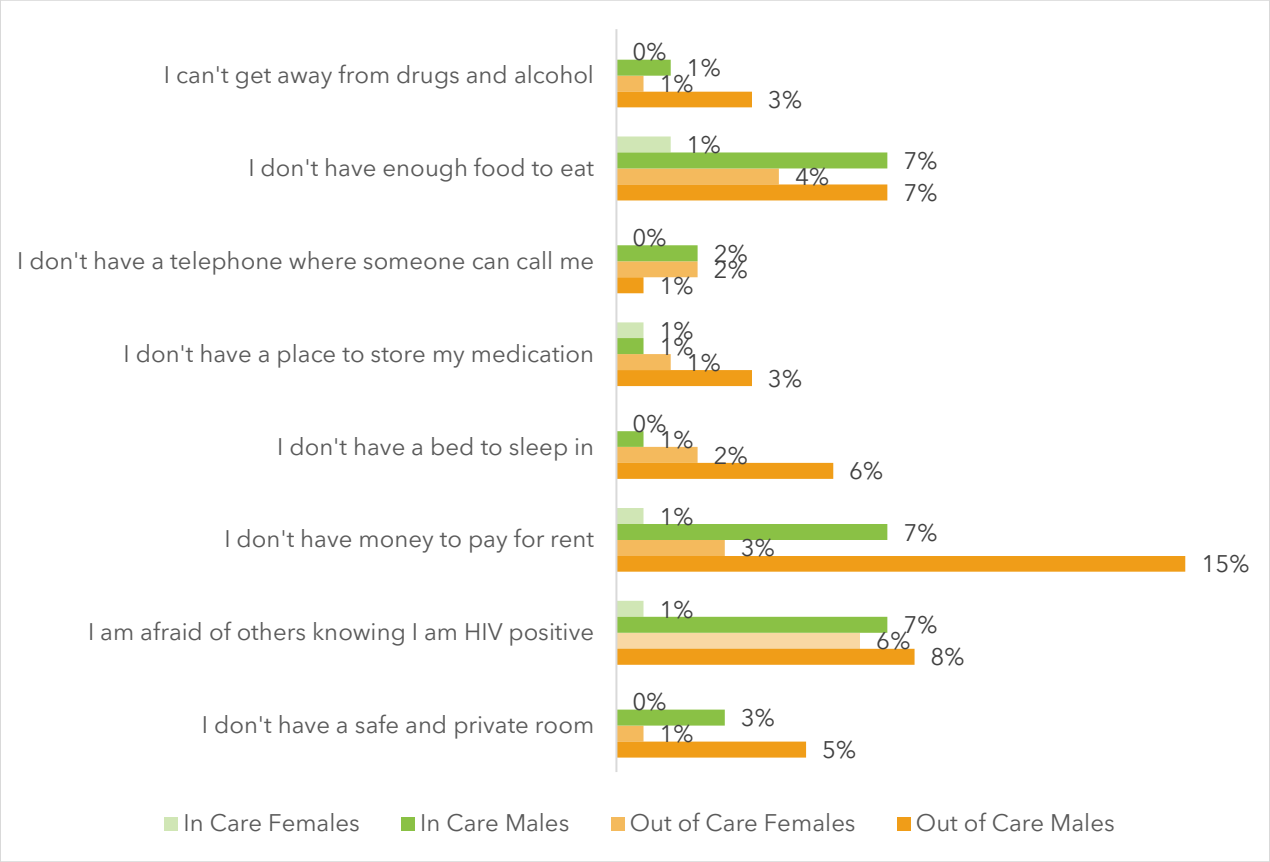
Other responses given by males in care:

- *Have safe housing*
- *ALWAYS TAKE MY HIV MEDS*
- *Soon I'll be seeking out HOUSING Assistance*
- *I do not have these problems. My main issue is case management! I need help organizing Dr appointments and getting assistance when I am sick!*
- *I'm fine with housing*
- *I am a recovered alcoholic and addict*
- *Nothing stops me from taking care of my hiv*
- *I have housing*
- *Harassment*
- *I have an apartment that is for low income people.*
- *Lately I am having trouble with rent money*
- *Insurance not covering certain drugs*

Other responses given by females in care:

- *I pay rent*
- *I live in my own residence but have been receiving some subsidy*
- *Need help with light bill and water*
- *I'm good*
- *I have no problem of taken care of myself*
- *I don't have a problem taking medicine.*
- *Even if I was homeless I would take it*

Figure 22. Housing challenges



Services needed in the last 12 months

The following were services identified by respondents, followed by charts broken down by gender and care status.

Table 5. Services needed in the last 12 months

	Out of Care		In Care		Total		Total
	Males n=213	Females n=96	Males n=252	Females n=29	Males n=465	Females n=125	N=590
Help coordinating and planning for HIV care and other services (case management)	22 (10%)	11 (12%)	26 (10%)	2 (7%)	48 (10%)	13 (10%)	61 (10%)
Help getting benefits such as health, social security, or disability	20 (9%)	7 (7%)	18 (7%)	2 (7%)	38 (8%)	9 (7%)	47 (8%)
Help paying for or getting medications for HIV/AIDS and for related medical issues	24 (11%)	7 (8%)	34 (13%)	4 (14%)	58 (13%)	11 (9%)	69 (12%)
Help taking medications regularly and dealing with side effects	6 (3%)	3 (3%)	3 (1%)	1 (3%)	9 (2%)	4 (3%)	13 (2%)
Mental health counseling or treatment	13 (6%)	9 (9%)	25 (10%)	1 (3%)	38 (8%)	10 (8%)	48 (8%)
Support from other people living with HIV/AIDS (one-on-one or in groups)	11 (5%)	8 (9%)	10 (4%)	0 (0%)	21 (5%)	8 (6%)	29 (5%)
Services that help with alcohol and drug abuse	2 (1%)	2 (1%)	1 (.3%)	0 (0%)	3 (.6%)	2 (2%)	5 (.8%)
Help finding a place to live	15 (7%)	6 (5%)	12 (5%)	1 (3%)	27 (6%)	7 (6%)	34 (6%)
Help paying rent or utilities	23 (11%)	9 (10%)	18 (7%)	4 (14%)	41 (9%)	13 (10%)	54 (9%)
Food services	21 (10%)	12 (13%)	29 (12%)	5 (17%)	50 (11%)	17 (14%)	67 (11%)
Help with legal issues	16 (7%)	2 (2%)	17 (7%)	2 (3%)	33 (7%)	4 (3%)	37 (6%)
Dental services	26 (13%)	11 (11%)	46 (18%)	6 (21%)	72 (15%)	17 (14%)	89 (15%)
Transportation	14 (6%)	9 (10%)	13 (5%)	1 (3%)	27 (6%)	10 (8%)	37 (6%)

Other comments made by males out of care:

- *Help with an attorney to fix my situation with someone who made my life the way is, sleeping in a sofa in a friend place!*
- *Miss guided trust in the program takes lives*
- *treatment for side effects*
- *Help at home.*
- *I am living now like i were in a 3rd world country.*

No other comments by females out of care.

Other comments made by males in care:

- *HICP (Health Insurance Continuation Program)*
- *Already in appropriate programs*
- *Soon seek legal counsel for possible chapter 7*
- *I still don't have affordable housing*
- *I see a doctor*
- *Nothing apply because I do receive Dr. all benefits with Care Resource*
- *I Haven't had any of these problems.*

Other comments made by females in care:

- *I got everything*
- *employment*
- *Trying to move because I can't afford where I live*

Figure 23. Identification of Needed Services

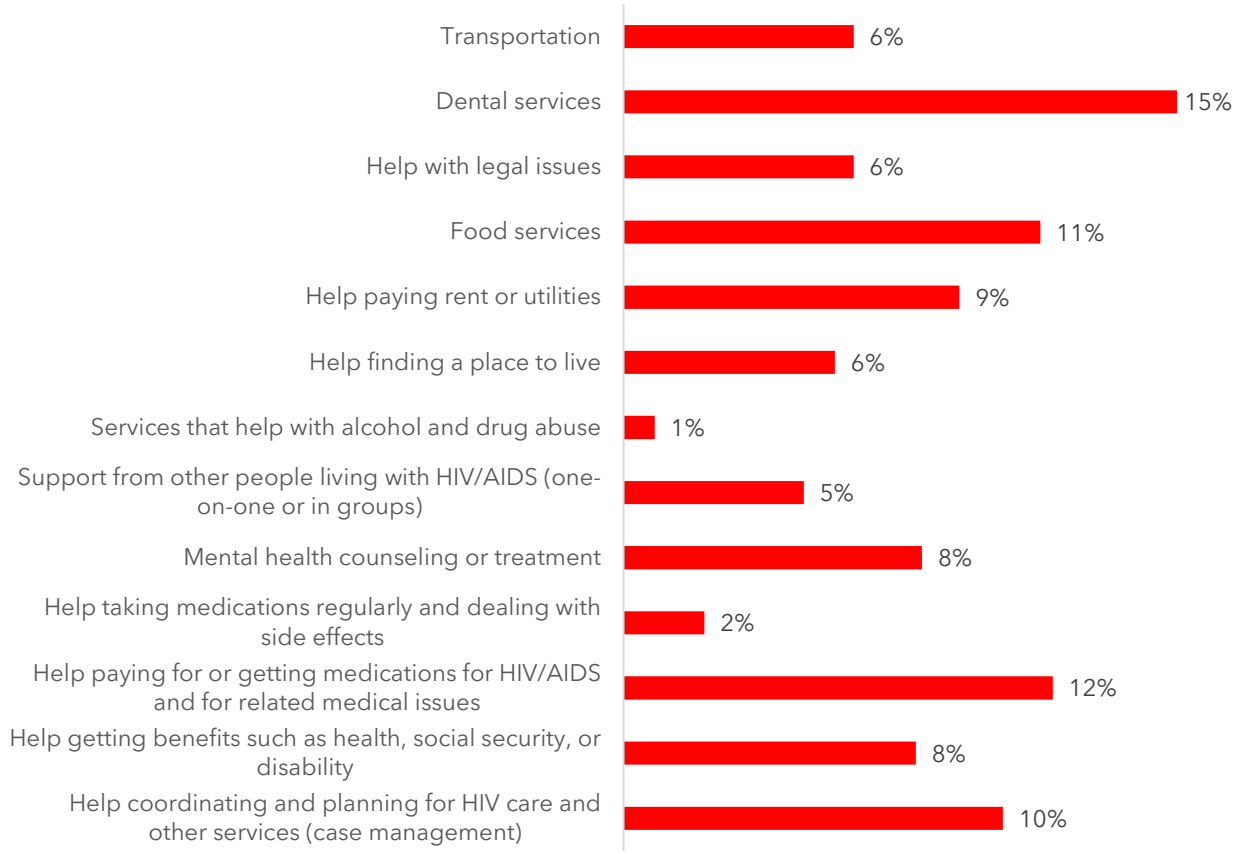


Figure 24. Identification of services needed by gender

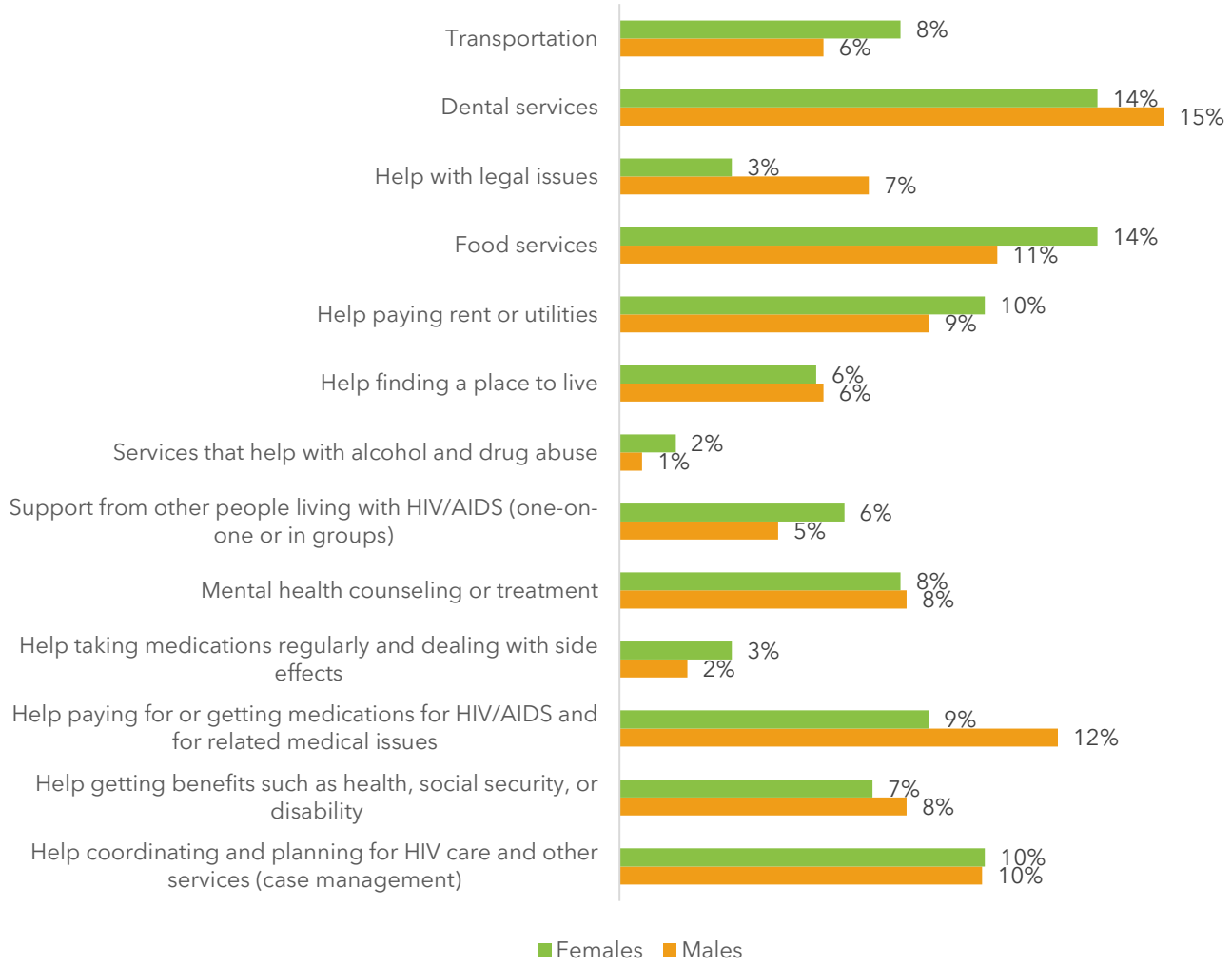
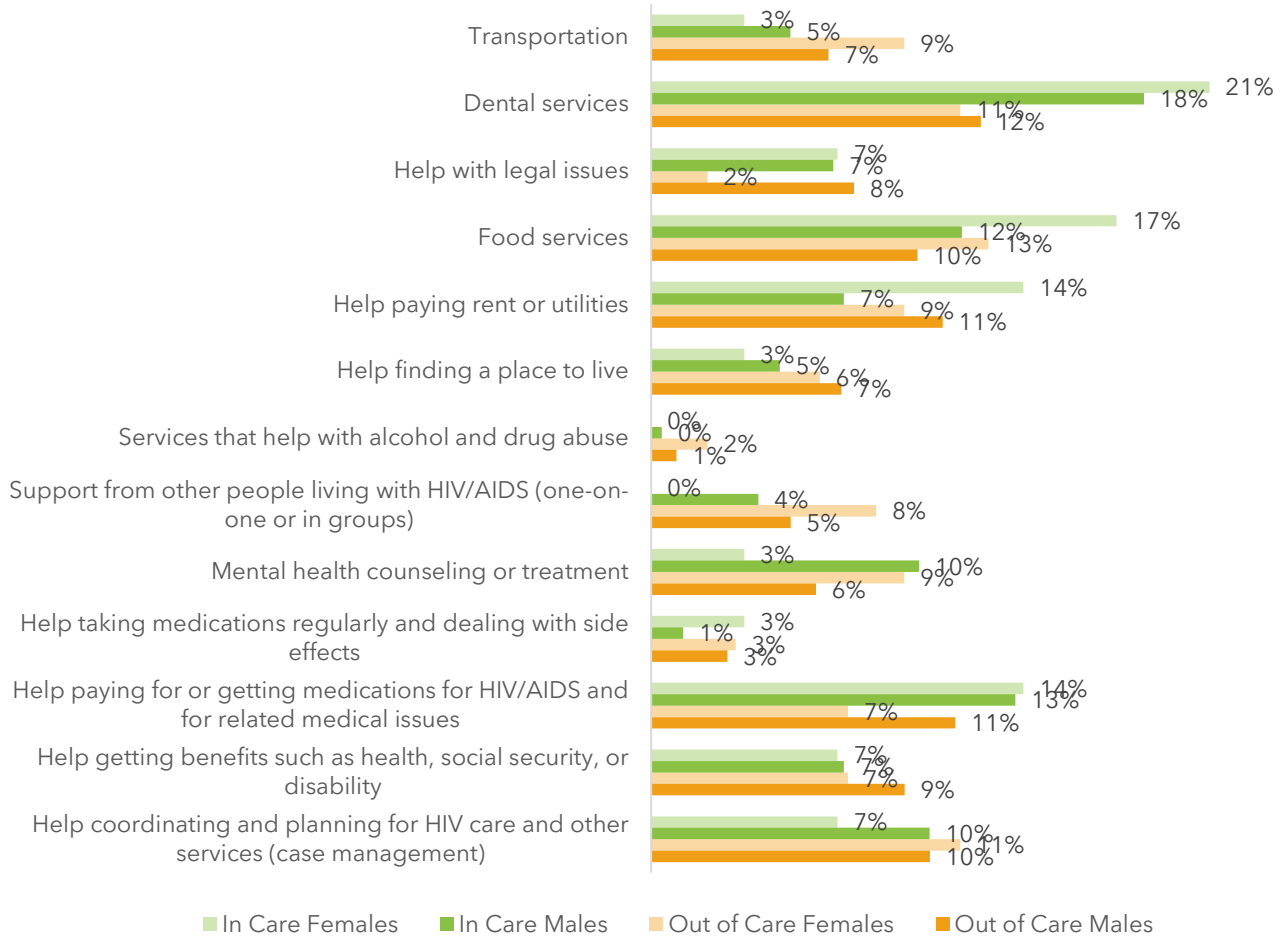


Figure 25. Identification of services needed by care status



Medications

The following tables and figures represent responses related to challenges taking medications. Sometimes people living with HIV have difficulty taking their medication as prescribed. Check all challenges you have had taking your medication as prescribed.

Table 6. Challenges taking medications as prescribed

	Out of Care		In Care		Total		Total
	Males n=73	Females n=44	Males n=45	Females n=4	Males n=118	Females n=48	N=166
Getting sick from the medications (side effects)	12 (16%)	4 (10%)	7 (16%)	1 (25%)	19 (16%)	5 (10%)	24 (14%)
Not understanding how to take all of my medications.	2 (3%)	4 (10%)	2 (4%)	0 (0%)	4 (3%)	4 (8%)	8 (5%)
I prefer to use alternative treatments instead of medicine.	6 (8%)	2 (5%)	2 (4%)	0 (0%)	8 (7%)	2 (4%)	10 (6%)
The pills are too big, too hard to swallow, or make me gag.	4 (5%)	10 (23%)	5 (11%)	3 (75%)	9 (8%)	13 (27%)	22 (13%)
I don't have food to take with my medicine.	5 (7%)	4 (10%)	3 (7%)	0 (0%)	8 (7%)	4 (8%)	12 (7%)
I forget or can't remember to take my medicine.	13 (18%)	6 (14%)	11 (24%)	0 (0%)	24 (20%)	6 (13%)	30 (18%)
Believing that HIV is going to kill me so I don't want to take medicine.	2 (33%)	0 (0%)	2 (4%)	0 (0%)	4 (3%)	0 (0%)	4 (2%)
Not trusting the government or the healthcare system that the medicines are safe for me to take.	7 (10%)	3 (7%)	1 (2%)	0 (0%)	8 (7%)	3 (2%)	11 (7%)
Having anxiety, depression, or other mental health issues that get in the way of me taking my medicine.	16 (22%)	11 (25%)	11 (24%)	0 (0%)	27 (23%)	11 (23%)	38 (23%)
Having challenges with alcohol or substance use that get in the way of me taking my medicine.	6 (8%)	0 (0%)	1 (2%)	0 (0%)	7 (6%)	0 (0%)	0 (0%)

Other comments made by males out of care:

- *Get busy*
- *Having anxiety, problem sleeping, very low self esteem……, consequence of my situation that I was put out the house where I was leaving for 3 years and UNFAIRLY I was put out with a restraining order and I'm not able to do my artwork!*
- *Take 48 meds a day never missed a dose*
- *Get so busy I forget.*
- *I have problems with my legs…so, if i am in pain, i will forget everything. I am alone.*

No other comments made by females out of care.

Other comments made by males in care:

- *Have not had issues taking medication.*
- *Take daily adherence Equals Better Health*
- *On a good safe regime*
- *As adherent as one can be*
- *Challenges to start new regiment for HEP C, another pill yuck.*
- *No problems with taking my medications*
- *Sometimes is hard to get medication especially transportation*
- *I take my medicine when I remember but I take it*
- *Insurance not covering certain meds*

No other comments made by females in care.

Accessing appointments and medications

Sometimes people living with HIV have difficulty getting to their appointments and to pick up their medicine. Which of these challenges have you experienced? Check all that apply.

Figure 26. Challenges taking medications all respondents

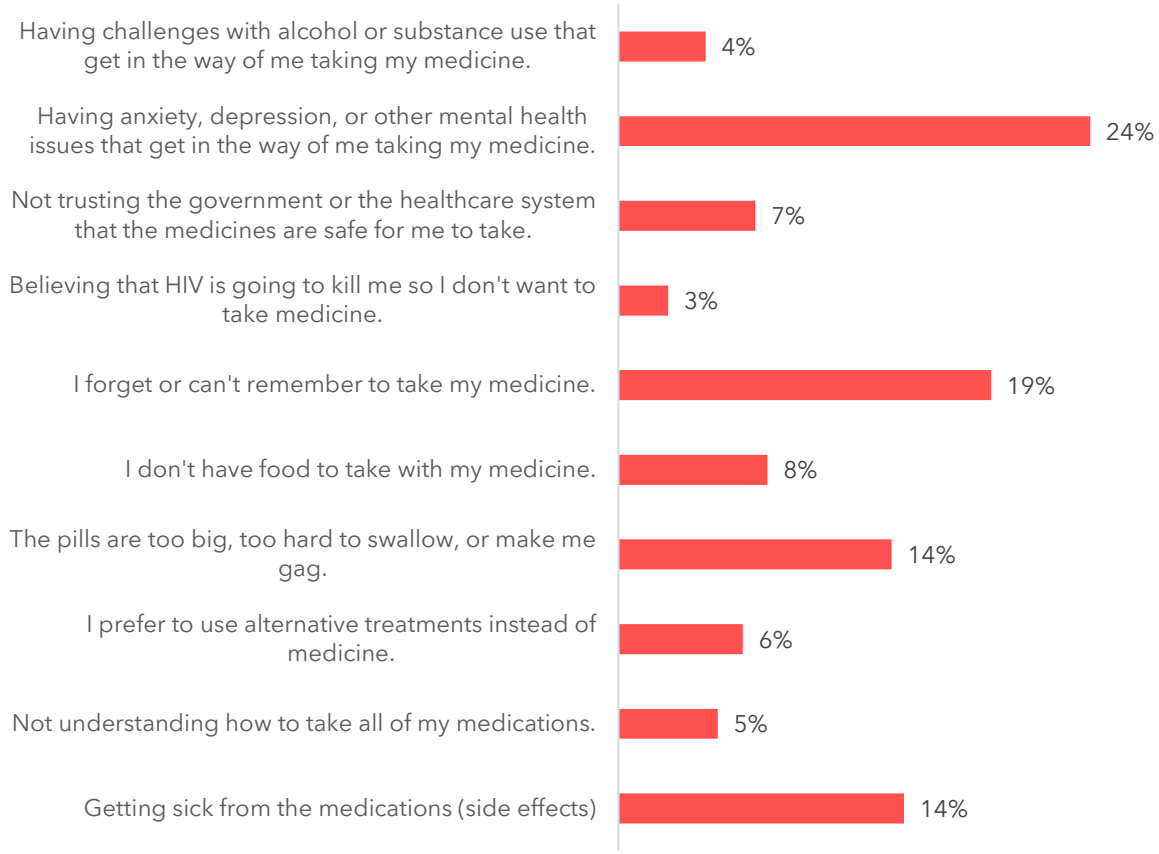


Figure 27. Challenges taking medications as prescribed by gender

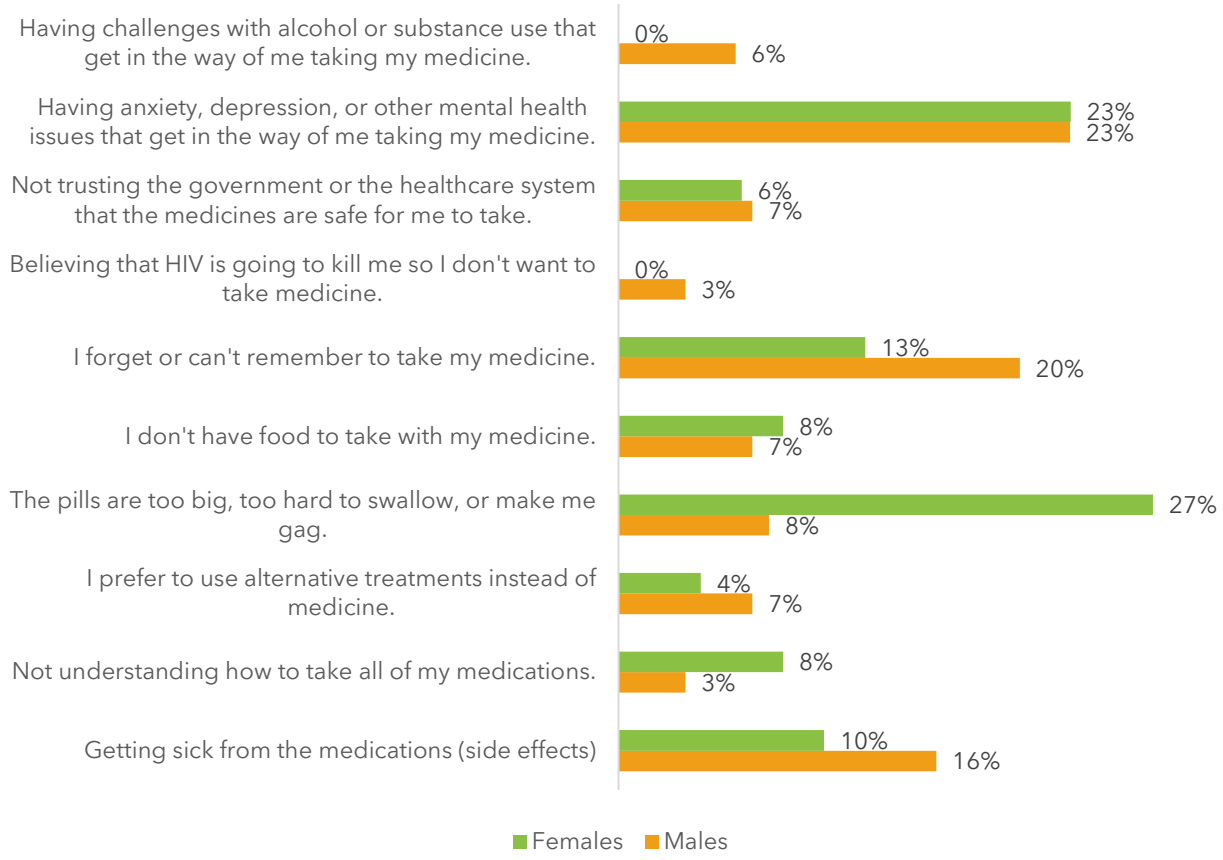
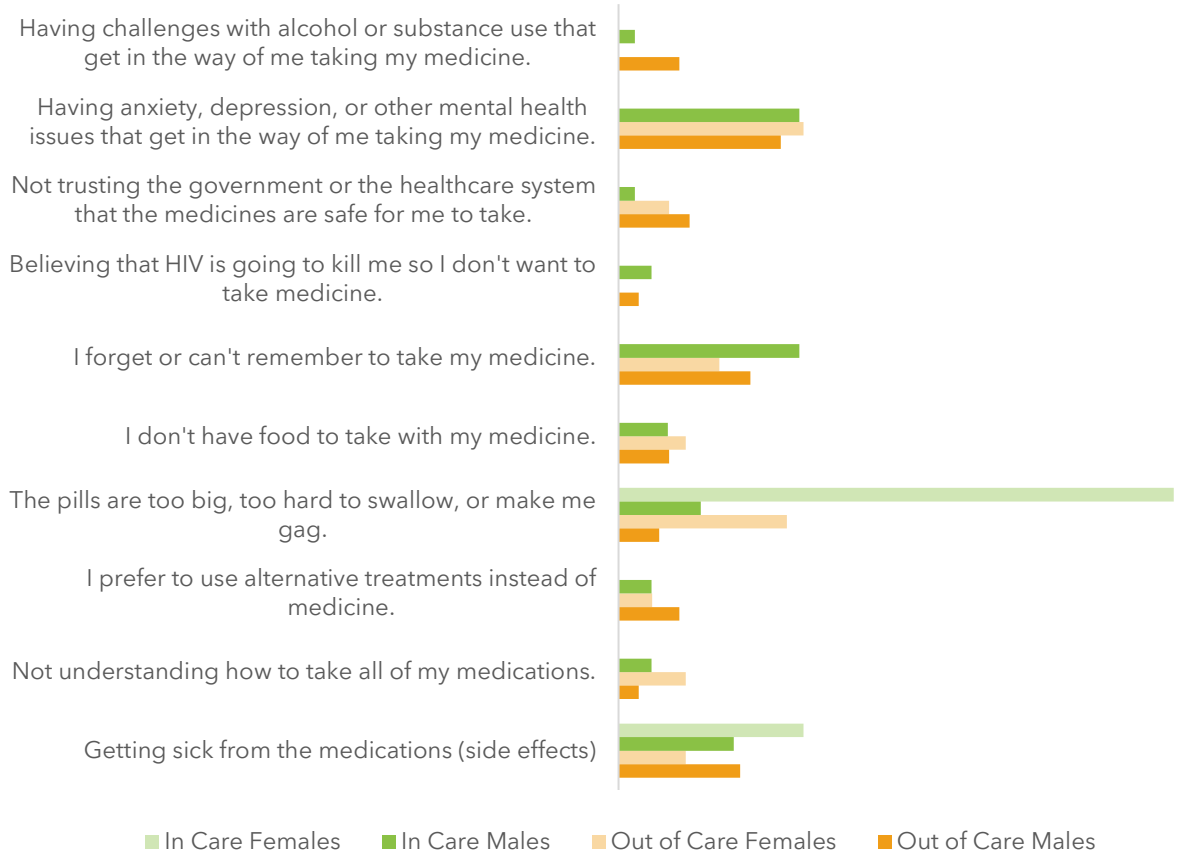


Figure 28. Challenges taking medications as prescribed by gender and care status



Accessing Appointments and Medications

The following section asked respondents to identify challenges they may have accessing appointments and medications. The table below displays all responses followed by open-ended responses and figures identifying responses by gender and care status.

Table 7. Challenges accessing appointments and medications							
	Out of Care		*In Care*		*Total*		*Total*
	Males n=92	*Females n=55*	*Males n=73*	*Females n=2*	*Males n=165*	*Females n=57*	*N=222*
Problems with transportation.	*18 (20%)*	*9 (16%)*	*18 (25%)*	*1 (50%)*	*36 (22%)*	*10 (18%)*	*46 (21%)*
Services are not conveniently located.	*13 (14%)*	*7 (13%)*	*9 (12%)*	*0*	*22 (13%)*	*7 (12%)*	*29 (13%)*
Problems with insurance.	*11 (12%)*	*4 (7%)*	*8 (11%)*	*0*	*19 (12%)*	*4 (7%)*	*23 (10%)*
Not enough money to pay for my medicine.	*9 (10%)*	*2 (4%)*	*8 (11%)*	*0*	*17 (10%)*	*2 (7%)*	*19 (9%)*
Having to take care of my family and I can't get to my appointments.	*3 (3%)*	*6 (11%)*	*5 (7%)*	*0*	*8 (5%)*	*6 (11%)*	*14 (6%)*
Having to work and I can't get to my appointments.	*11 (12%)*	*6 (11%)*	*5 (7%)*	*0*	*16 (10%)*	*6 (11%)*	*22 (10%)*
Having problems with childcare.	*0 (0%)*	*1 (2%)*	*2 (3%)*	*0*	*2 (1%)*	*1 (2%)*	*3 (1%)*
Having to wait a long time at the clinic or doctor's office.	*9 (10%)*	*8 (15%)*	*6 (8%)*	*0*	*15 (9%)*	*8 (14%)*	*23 (10%)*
Takes a long time to schedule an appointment.	*9 (10%)*	*6 (11%)*	*4 (5%)*	*0*	*13 (8%)*	*6 (11%)*	*19 (9%)*
Not knowing where to go to get care.	*5 (5%)*	*2 (4%)*	*3 (4%)*	*0*	*8 (5%)*	*2 (7%)*	*10 (5%)*
Not wanting anyone I may know to see me in the doctor's office.	*4 (4%)*	*4 (7%)*	*5 (7%)*	*1 (50%)*	*9 (5%)*	*5 (9%)*	*14 (6%)*

Other comments made by males out of care:

- *weather i live in the mountains*
- *My meds were delivered, amazingly at my address, not any more!*
- *Simply has not paid any of my Doctor bill so lost all of them bur primary*
- *That's a MAJOR ISSUE IS PRIVACY*
- *I feel with pain almost all the time...and can not walk right...*
- *This is too hard.*

There were no comments made by females out of care.

Comments made my males in care:

- *None: Care Resources has been enormously helpfully from PCP, its pharmacy the staff and its care coordinator, thank you*
- *Rude office workers*
- *I receive a monthly bus pass*
- *Pain in my colon and any Dr. can't find the right issue, whatever I eat doesn't come out only every 3 or 4 week and that is the reason I missed my Dr. appointment because is very painful*
- *No problem just too many appts.*
- *I've been taking the Broward county transit to get to doctors and appointments that I have to be at. My medications are usually delivered*

Comments made by females in care:

- *I used my car*
- *I drive and have my own transportation and I try to schedule appts on dsyd snd times convenient to me.*
- *Broward County Transit doesn't send the bus pass on time*
- *I have a car to get to my appointments*
- *Manage to find a way to get there*

Figure 29. Barriers to Access to Care all Respondents

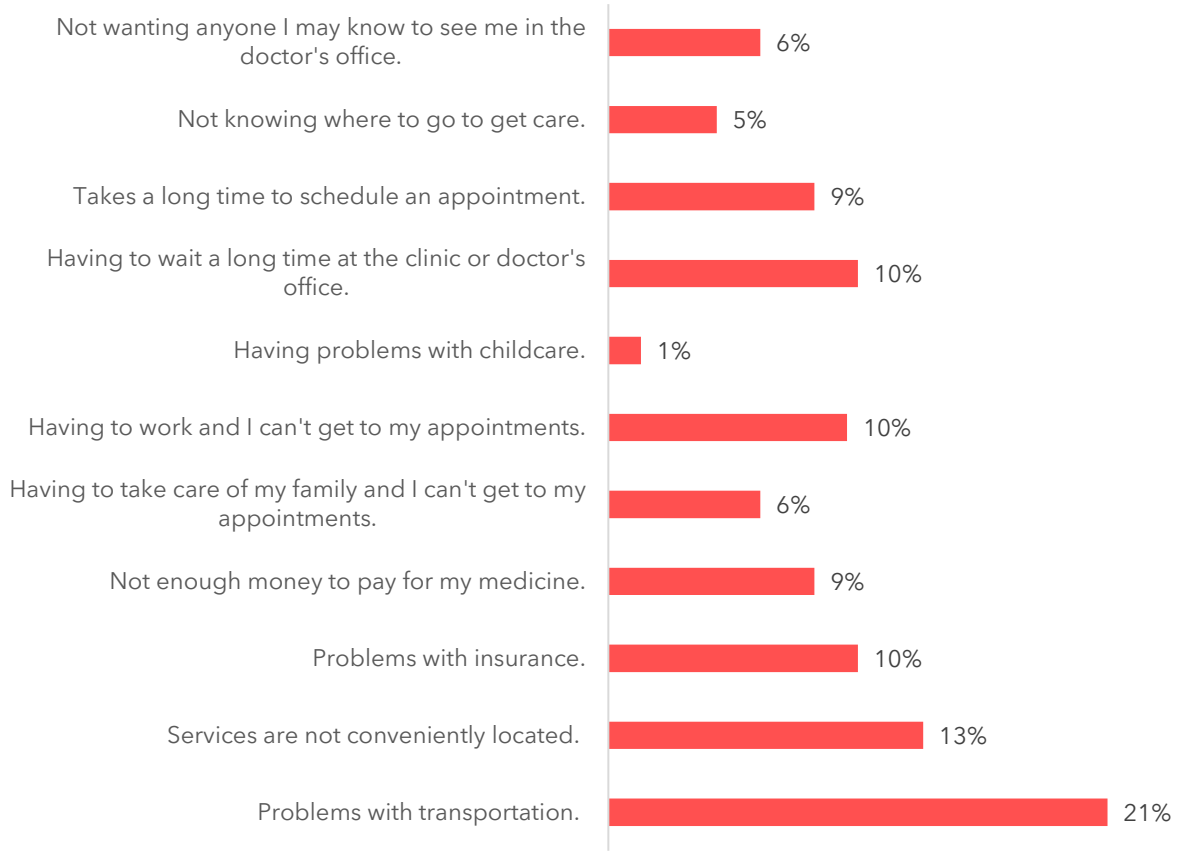


Figure 30. Barriers to Access to Care by Gender

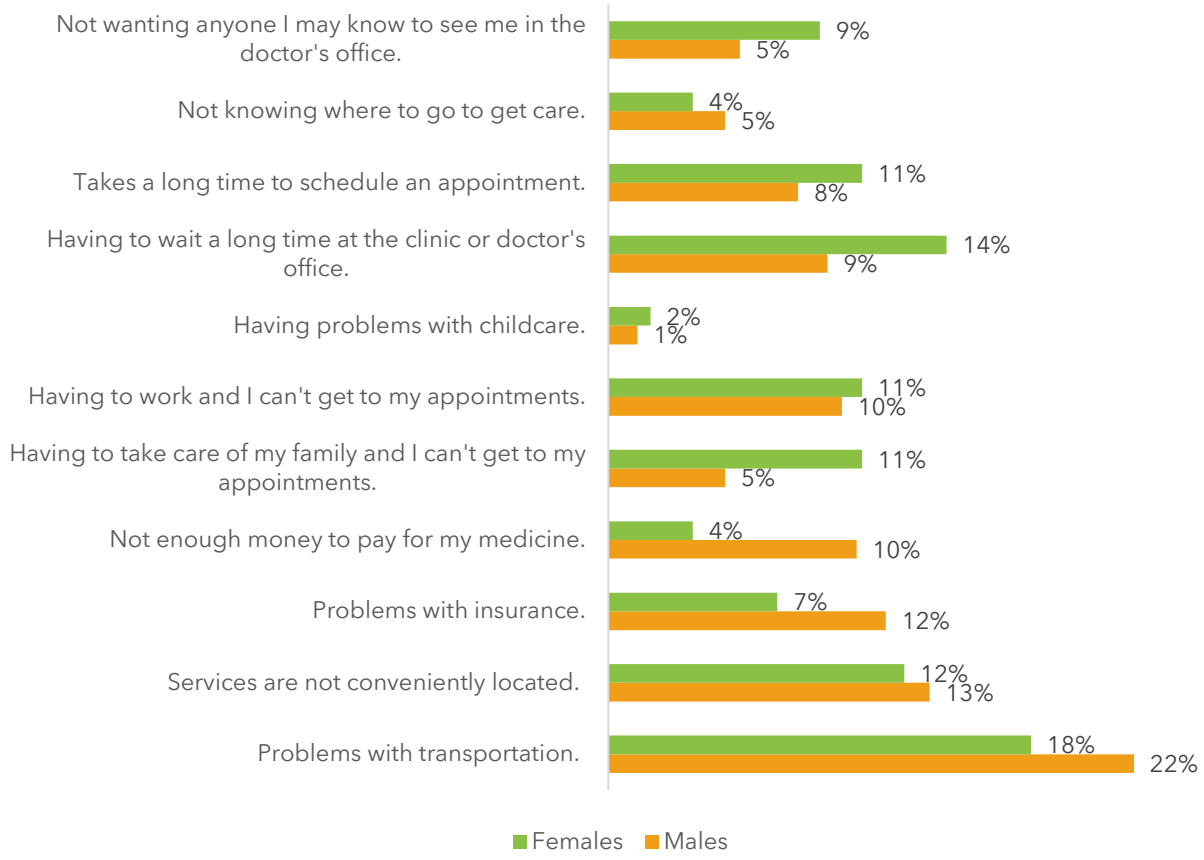
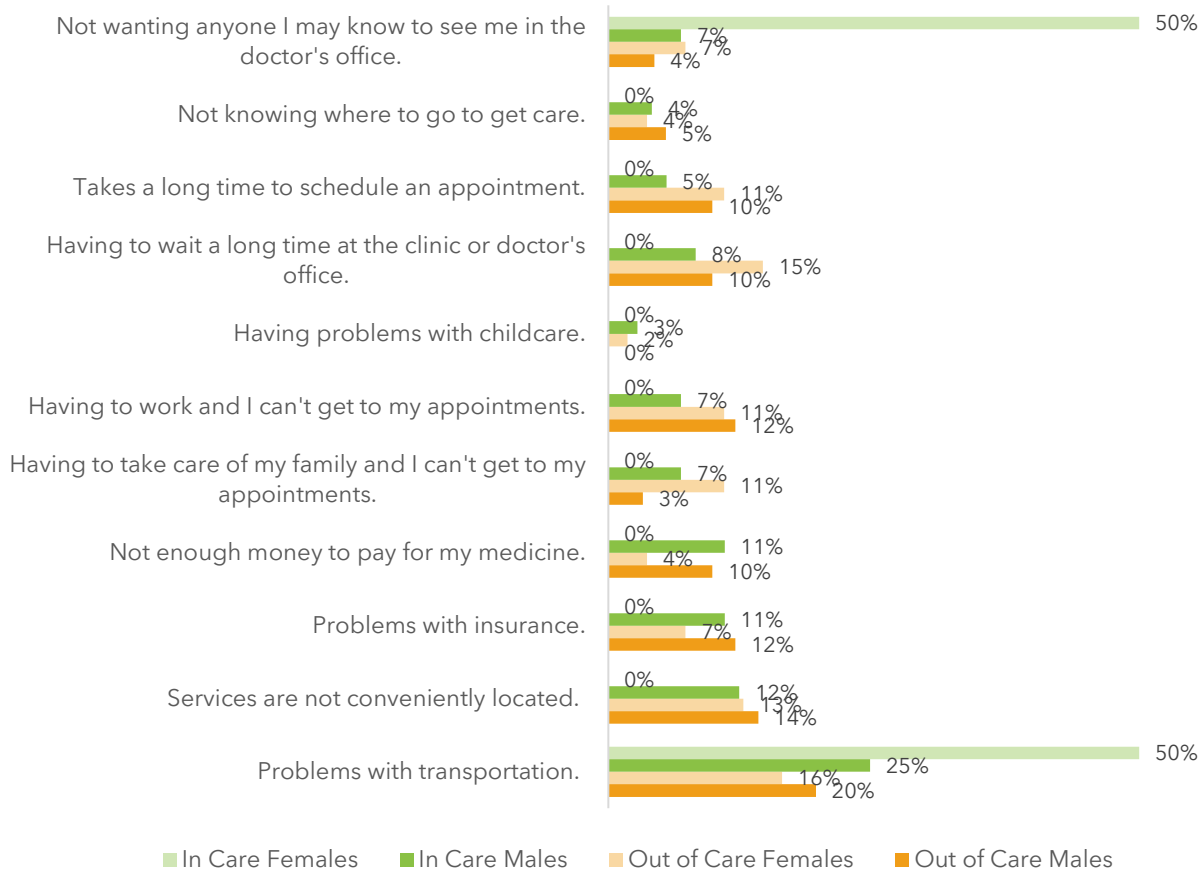


Figure 31. Barriers to Access to Care by Care Status and Gender



The final question of the survey asked respondents if they would like to tell the Ryan White Part A Program Office anything to help improve services to individuals living with HIV in Broward County. The following represents those responses.

Comments made by males:

- *People without resources need help with food and housing in our communities.*
- *I worked for Dept. S.S. as a provider from 1983 to 2010 for AIDS patents my teeth are very important to me my gums can't be saved pull out all my teeth, i dont do drugs why can they save them there not all eaten up lol*
- *Broward County should have a program with grants to allow people who are HIV positive to open businesses. There are so many with potential and allowing them to empower themselves and help others get in their feet would be great for the community*
- *A hotline where you call with a problem and they can direct you where to go get help. I really don't know what Ryan White covers, Who and when can help me. I'm sure I'm not the only one*
- *I can't thank you enough for all the help*

- *No, I have to thank Broward County for having my medication in a very good way that made my blood work numbers got much better even that I'm going through this housing problem!*
- *There are a plethora of issues with services regarding HIV staff. Starting with the unprofessionalism. you can't say that this issue is confidential and required people that are in a housing programs to punch group meetings, exposing their private information or discussing client information amongst each other our wall in the lobby, talking to client your loud and the client has to say their information that is not privacy.*
- *No I'm good with everything thank you very much*
- *Online re enrollment services would be helpful*
- *Clear and vet the people that work for you? Make them go through a course, I have some associates I know that looks up people information to see if they or HIV POSITIVE. SOME OF YOUR EMPLOYEES..SAY/ Send sexual or inappropriate things to client or not limited to AROUND client some times EXPOSing other people's information privacy. Whether there behind the class talking or in a room talking to each omongs each other or to a client(through lobby or window) I had to get very specific because I pay attention and I seen it happen*
- *Have a 1 time a year recertification for Ryan White and ADAP as they do in other states.*
- *Hacer reuniones y grupos para compartir nuestras ideas*
- *Very professional staff, I am very happy to receive assistance from Broward Health*
- *We need more providers with longer hours and weekends so it is easier to be seen*
- *Be kind*
- *Broward County (as well as Ryan White and ADAP) have literally been a lifesaver. Broward County has done a great job supporting and assisting those with HIV and have streamlined a lot of the processes for the better over the past year or so. I honestly don't know where I'd be if it weren't for the available programs and assistance.*
- *The physicians should assess the patients and recommend as necessary tests to analyze why certain labs are the way they are. In addition, not because we have HIV or black means we should be alienated. That is how I feel at Oakland AHF.*
- *Change medication for better results, reduce bloodwork, better insurance cover.*
- *Not have to renew Ryan White every 6 months is stupid*
- *1. Hold ASOs accountable for their often callous, dismissive treatment of those living with HIV, particularly those who so carelessly manage their administration and interactions with Ryan White. 2. Stop ignoring the often unique and critical issues of long term HIV survivors (pre-HAART). This is a population that had their numbers decimated in the 80s and 90s, who willingly acted as guinea pigs for experimental treatments (the physiological effects of which have often seriously and adversely affected their health years later), who are often now left to live in poverty, their quality of life having become irrelevant to care providers. Most ASOs are focused on the newly-diagnosed, a one-size-fits-all approach. Little consideration is given to long-term comorbidities, mental health issues (such as PTSD), or advanced physiological aging (10-15 years or more) due to decades of chronic organ inflammation. None of this is on their radar. 3. There are no consistent support group services for those who are struggling to survive, having lived with HIV for 25 or more years. In the same way not all veterans return from war with PTSD,*

not all long term survivors may have significant issues. Nevertheless, some have neither family nor other sources of support. Isolation is a far too common issue.

- *Services are great*
- *I need my HIV cured soon*
- *This is why I am missing to schedule some appointments at the clinic in Hollywood cause they don't answer their calls. Right now, I have to go to schedule one for my routine colon cancer which is due. I even got the message from them but cannot find anyone to talk to to schedule an appointment.*
- *I have lived in other states and I have lived in Dade County services there have being better like in California or Dade County for our likes a lot of funding and more problems*
- *Housing reevaluate the affordable housing market*
- *If you feel sick, with a pain or something; you will never think to go to appointments with people that are going only to look at you and do nothing for you...Please, get in my shoes..can not walk and having to take three buses to go and see a doctor that didn't even know who i am...and a clinic where everybody is running...they don't know till it happens to them... 20 years in this...i am tired now.*
- *Yes. Please, be sure that all your case managers really know about all the services that you guys have. Sometimes, you'll need a person to go with you to the appointments, especially if you can not walk normally, like me...or are in pain almost all the time. So many places to go, too much papers to give, a lot to classified, and with the pain and no transportation. This is horrible...all alone is horrible. This is happening to me, no one cares.*

Comments made by females:

- *Broward County is the best*
- *Yes more section 8 vouchers or subsidized housing for person with disability and income restricted.*
- *Housing case management services at Care Resource and Sunserve are limited. They don't help consumers as they should. They always require additional documents.*
- *More housing support. I see a lot of people living on the streets and it is painful to even see old people in wheelchairs and so on.*
- *Housing case management services doesn't help*
- *Yes I need housing Section 8 please can i get help with housing*
- *Enforce the people to take the pill to prevent it*
- *No, everything is great for me. I am bless to get the help I get. Thanks*
- *I understand the rate is high but make more affordable housing for people living with HIV. Not everyone can keep a full time will dealing with mental health issues and occasional issues*
- *Provide and schedule free transportation and make the recertification for transportation at the Care Resources. One stop shop!*
- *Keep on improving Services everyone needs some kind of help Thanks*
- *Late service hour*
- *Sometimes I feel like a number not a person when I visited my doctor and if for any reason I need to see my Dr before my next appointment is impossible, according to my Dr*

because of the many patients that he has to schedule, the relationship that I used to have with my Dr , now is 0 , unfortunately

- *Everything is ok*
- *No! Thank you*
- *Broward County has been doing a great job with its services.*
- *availability of services*
- *AGING WITH HIV WHEN YOU HAVE LIVED LONGER HIV POSITIVE THAN NEGATIVE. HOW MEDICATION FATIGUE IS REALLY TRUE. NEVER KNEW I WOULD BE HIV FATIGUE*
- *Been with my specialty care since 1994. I know what I have to do to stay healthy. Only issue is checking in my doc never know who they should bill*
- *More family housing*

Appendix D: Provider Survey Results

Overview:

A provider survey was distributed to Ryan White Part A providers in January 2020. Thirteen (13) provider organizations were invited to participate and twelve (12) organizations responded. The following represents the organizations and the respective positions that responded for the organization:

- Latinos Salud, Research and Evaluation Coordinator
- NSU, Program Director
- Broward Regional Health Planning Council, Program Manager
- Broward House, CEO
- Broward Community and Family Health Centers, HIV Program Manager
- Care Resource, Director of Dental Care Services
- AHF, Associate Director of Contract Administration
- Poverello Center, Programs/Quality Manager
- SunServe, QA Director
- Legal Aid Service of Broward County, Supervising Attorney/Program Manager
- Broward Health, Program Director
- South Broward Hospital District (Memorial Healthcare System), Director, Physician Practices

How do individuals access your services? Check all that apply.

Table 1. How individuals access services

	Number of Organizations
Our organization seeks clients to provide them with services.	12
Clients can walk in and access services same day	12
Clients can call and schedule themselves for an appointment	12
Our organization seeks clients out to provide them with services	10
A referral from a care coordinator is appreciated	8
A referral from another provider (e.g., a private physician) is appreciated	7
A referral from another provider (e.g., a private physician) is required	2
A referral from a care coordinator is required	0

Does your organization serve a particular population? For example, are your services oriented towards people of a particular race/ethnicity, gender, age, sexual orientation, or towards people with substance abuse/mental health problems or people who are homeless, etc.?

- 11/12 organizations responded no
- 1/12 organizations responded yes (Latino MSM)

How does your organization serve clients who do not speak English? Check all that apply.

Table 2. Serving individuals who do not speak English	
	Number of Organizations
By hiring staff who speak languages other than English	12
By translating patient materials into different languages	11
By ensuring translators/interpreters are available when needed	10
By using Broward County's interpreter Language Line to translate	2
No organizations responded that their organization does not serve clients who do not speak English	0
No organizations responded that they did not know how their organization serves/would serve clients who do not speak English	0

Note: Although the Language Line was given as a choice, two organizations responded in the "other" comments that they used the Language Line when needed. These two organizations did not check the response regarding the Language Line.

Please check the languages of any populations you are currently able to serve. Check all that apply.

Table 3. Languages able to serve	
	Number of Organizations
English	12
Spanish	12
French Creole	11
Portuguese	7
Hebrew	1
German	1
Most others through interpretation services (1/12)	1

Please check the languages of any populations whose language needs you are having difficulty meeting. Check all that apply.

Note: 6 of 12 organizations responded to this question.

Table 4. Languages unable to serve	
	Number of Organizations
Deaf or Hard of Hearing	3
Portuguese	3
Arabic	2
Armenian	2
Chinese	2
German	2
Greek	2
Gujarti	2
Hindi	2
Italian	2
Korean	2
Persian	2
Polish	2
Tagalog	2
Urdu	2
Vietnamese	2
Visually impaired	2
French	1
French Creole	1
Hebrew	1
Other (1/6): "As long as the language line has the staff we don't have an issue, with the hearing impaired we do have to make appointment"	

Based on your experiences, please indicate the level to which you agree or disagree with the following statements:

Table 5. Provider challenges					
	Strongly Agree	Agree	Disagree	Strongly Disagree	N/A
We don't have enough community partnerships/linkages to provide our clients with the referrals that they need.	0	1	5	6	0
There is not enough communication between our organization and other organization providers that serve our clients.	0	1	7	4	0
We have insufficient resources to serve clients who do not speak English.	0	2	5	4	1
There is not enough time for adequate communication with our clients.	0	2	6	3	1
We have insufficient staff to deal with our client load.	0	3	6	2	1
We have difficulty filling vacant staff positions.	0	4	4	2	2
We have trouble identifying resources to help our clients pay for the other services they may need.	1	5	3	3	0

Below are listed some common barriers that clients face when accessing services. Based on your experiences, please indicate whether you agree or disagree with the following statements.

Table 6. Barriers faced by clients

	Strongly Agree	Agree	Disagree	Strongly Disagree	N/A
Our clients are reluctant to trust us as providers.	0	1	6	5	0
Remaining engaged in HIV care is not a priority for our clients.	0	3	6	3	0
*Our clients have difficulties accessing care due to physical disabilities.	0	2	7	1	1
Our clients have difficulties remaining engaged in care because they are unsure of how to navigate the system.	0	5	6	1	0
Our clients are reluctant to seek services due to financial barriers (e.g., co-pays, spend down, uncovered services).	1	5	5	0	1
Our clients have difficulties keeping their appointments.	0	9	3	0	0
Our clients are reluctant to seek services due to cultural norms.	2	6	4	0	0
Our clients are reluctant to seek services due to stigma or fear of disclosing their status.	3	5	3	1	0
Our clients are reluctant to seek services because they have undocumented immigration status.	1	8	2	0	1
Our clients have difficulties getting transportation to our organization.	3	6	3	0	0
Our clients have difficulties remaining engaged in care due to substance abuse/addiction issues.	4	6	2	0	0
Our clients have difficulties remaining engaged in care due to mental health issues.	3	9	0	0	0

*One organization did not respond to this question.

Other: One organization included the comment "In answering the questions, we considered "our clients" to be potential clients.

How can we best collaborate to increase communication?

Note: 9/12 organizations responded to this question.

- More trainings and more assistance that helps us to apply knowledge and become more efficient with programmatic outcomes.
- A majority of the collaboration takes place through monthly/quarterly network meetings with a prepared agenda. Discussion regarding accomplishments/challenges/resources are usually addressed at the end of the meeting with minimal time and it may be helpful to build in additional time for full discussion.
- Learning new techniques.
- Our agency has an "all programs" sheet that describes our programs in languages that help providers understand and updates regularly with contact information. It would be beneficial to have a shared drive of sorts or portal that we could share all the services offered and share resources. Internally we have a resource committee and share the resources via an intranet.
- Continue monthly Quality Network meetings and update access to care schedule.
- Develop a system of providers that advise each other on availability of spots for referrals for substance abuse/behavioral health.
- By having more community feedback meetings.
- I believe we have a good collaborative system in place and use the MOUs to facilitate collaboration of services within the consortium.
- Ensure all grantee personnel are on the same page and communicating information in a timely manner.

What are the top five areas that should be addressed to eliminate HIV in our community?

Note: 2/12 organizations did not respond to this question at all. 10/12 provided two areas; 9/12 provided three areas; 8/12 provided four areas; and 7/12 provided five areas.

Table 7. Areas to address to eliminate HIV	
Stigma	Stigma (4) Eradicating the Stigma
Housing/Homelessness	Affordable Long-term Housing Homelessness Increased transitional housing
HIV Testing	Conduct HIV testing Implement routinized HIV testing in healthcare settings
Viral Load	Monitor viral load
Transportation	Transportation barriers
Relationships	Trust/Relationship Building
Special Populations	Disparities Race/Ethnicity Gender
Access to Care	Increase access to care easier access to services access to care rapid engagement into care for those diagnosed
Prevention, Education, and Outreach	Innovative methods for prevention education in high risk areas/among high risk populations

Table 7. Areas to address to eliminate HIV	
	Prevention more innovative prevention campaigns by DOH Community involvement in education include education for middle school/high school students Increasing outreach initiatives involving religious groups to engage in community action to end HIV Erasing the media panic from the 80's Educating those who are incarcerated
Medication	ADAP
PrEP	Getting at risk individuals on PrEP increasing access to PrEP encourage the use of PrEP easier access to PrEP in low income areas-i.e., providing funding to non-clinical CBOs to track client adherence to PrEP by reviewing lab work and referring clients to FQHC's for care when necessary
Behavioral Health	Mental health access substance abuse expanding detox and substance abuse treatment IDU
Systemic Issues	Reducing redundancies in the system More funding Programming that supports agencies in outreach and marketing efforts

What are the strengths and challenges of the current system?

Note: 8/12 organizations responded to this question.

Table 8. Strengths and Challenges of System	
Strengths	Challenges
RW is an amazing system to helping clients. multiple provider locations Client focused and care oriented staff and doctors Coordinated care resources Broward County has agencies able to serve our diverse community with proficiency condom distribution allocation of funding to non-clinical community agencies, with creation of a strong referral system more people in the community are learning about things such as viral suppression (undetectable status) Great community providers and a dedicated grantee staff	The red tape associated with the program is a challenge public transit services offered in the Western portion of the County Challenges with transportation. Challenges with coordinating HIV testing among agencies stigma causes clients to split care between PCP and different community agency and this is not being addressed Trust is a challenge, as more agencies are popping up to treat HIV, clients are going from one agency to the next (playing the healthcare field), there is not a sure way of identifying if the client is new to care or is just for care the site can give then disappears

Do you have enough staff and resources to effectively meet the needs of your clients on your current caseload?

- 7/12 responded yes
- 5/12 responded no

Of those that responded no, the following explanations were given:

- Have a staff position open
- I want to answer yes with a but-and had to put no for a comment. We do effectively meet current caseloads. The funding though does not support the level of care we would like to provide which impacts our ability to maintain staff without salary increase or our administrative supports. We receive the same rate for a unit of service for case management that we received 20 years ago with no increase
- Currently understaffed due to vacancy. Additional funding is also needed to support organizational needs
- Although we do a good job in providing services to our patients, an additional 1-2 staff would help tremendously
- But insufficient funding from outside sources

Do you have enough staff and resources to effectively meet the needs of your clients if your caseload were to increase by:

Table 9. Capacity for increased caseload

	Yes	No	Don't Know
5%	8	3	1
10%	7	3	2
20%	4	5	3

Comment: I think that if we were to work on undoing the scare tactics of the 80's, it will bring more people in for testing and into treatment.