Broward County HIV Health Services Planning Council

BRHPC
HEALTH & HUMAN SERVICE INNOVATIONS

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HIVPC
Broward County HIV Health Services Planning Council

Joint Planning Committee
Meeting Agenda
April 9, 2012 at 1:00 P.M.

Karlene Tomlinson, Part A Co-Chair **Kim Saiswick, Part B Co-Chair**

1. **Call to Order (**Please sign-in)
2. **Moment of Silence**
3. **Welcome and Introductions**
   a. Review Meeting Ground Rules, Sunshine
   b. Review Public Comment (Sign-in at Front of Room)
   c. Committee Member Introductions
   d. Guest Introductions
   e. Excused Absences
   f. Approve Today's Agenda
   g. Approve 02/13/12 and 03/12/12 Meeting Minutes
4. **Public Comment**
5. **Grantee Reports**
   a. Part A
   b. Part B, ADAP
6. **Viral Load Presentation** (20 minutes)
   - Kate Goodin, DOH , Tallahassee
7. **Annual Surveillance and Epidemiology Presentation**
   - Three-year EPI trend
8. **Prevention Update**
9. **Comprehensive Plan Discussion:**
   - Client Survey Input
10. **Old Business/New Business**
11. **Agenda Items for Next Meeting**
12. **Next Meeting Date:** Thursday, 5/14/12 at 1:00 p.m.
13. **Adjournment**

IMPORTANT NOTICE

Please be aware this meeting and all information stated thereof is a matter of public record under FL's Government in the Sunshine Law (FL Statute, Chapter 119.01). Acknowledgement of HIV status is not required, and if disclosed becomes a part of the public record.

Joint Planning Committee
Monday, March 12, 2012
200 Oakwood Lane, Suite 100, Hollywood FL 33020
Meeting Minutes

Attendance							
#	**Members**		**Present**	**Absent**		**Guests**	**Grantee Staff**
1	Tomlinson, K.	Part A Co-Chair		X		Doe, P.	Jones, L. (Part A)
2	Saiswick, K.	Part B Co-Chair	X			Kenny, K.	Strong, K. (Part A)
3	Gammell, B.		X			Markman, N.	Degraffenreidt, S. (Part A)
4	Katz, H. B.		X				
5	Mercer, A.			X			**HIVPC Support Staff**
6	Moragne, T.		X				Desa, G.
7	Shirley, J.			X*			Rosiere, M.
		Quorum = 5	**4**	**3**			Smith, N.
Excused Absence requested; Part A Co-Chair was absent thus EA could not be given							

1. **Call to Order** (Government and Sunshine)
   The Part B Co-Chair called the meeting to order at 1:32 p.m.

2. **Moment of Silence**
   A moment of silence was observed.

3. **Welcome and Introductions**
   The Part B Co-Chair welcomed everyone and introductions were made. Attendees were notified of information regarding Government in the Sunshine Law and meeting reporting requirements, which includes the recording of minutes. In addition, they were advised that the acknowledgement of HIV status is not required but is subject to public record if it is disclosed.

   Approval of 03/12/12 Agenda and 2/13/12 Minutes
   These were tabled due to lack of quorum.
   There were no changes to the current Agenda.

4. **Public Comment**
   There was no public comment.

5. **Grantee Reports**
   A. Part A Grantee Report
   The Grantee introduced Kim Strong, Healthcare Quality Assurance Support Specialist. The Minority AIDS Initiative (MAI) Request for Proposal (RFP) was released on February 27, 2012 and is due on March 30, 2012. The RFP is a Peer Case Management model based on ARTAS model. The Grant Award of approximately $15,390,358.00 was received; an increase of 2.6% or $384,397.00. Members queried whether the increase in Grant funding would change the PSRA process. The Grantee explained that based on the PSRA process allocations may change to utilize additional funds.

   B. Part B Grantee Report
   The Part B Grantee report was provided on expenditures to January 31, 2012: Non Medical Case Management conducted 399 eligibility interviews in January of which 104 were new clients. Medication co-payment served 279 clients in which 7 were new to the program. There were 265 clients served in January for Med Co Pay and 14 clients served in January for mail orders. Cost avoidance for Med Co-Pay program is $35,744.14. Total cost avoidance from April-January is $174,077.00. Bus passes have been purchased for the next year and are being distributed and is working with Part A with regards to eligibility as once Part A bus passes are depleted, all bus passes will be under Part B and clients must be eligible. There are many bus passes to cover clients through the transition period. Case Mangers

are urged to work with clients during this period.

ADAP Update

The ADAP report up to 02/29/12 was provided: Total ADAP "Open" Enrollment: 2,227; Total ADAP Clients Served in Last 30 Days*:1,436; Total ADAP Waitlist Enrollment: 228; Category A: 2; Category B: 45; Category C: 172; Category D: 9; Total ADAP/Medicare Part D Enrollment: 187; Number of Appointments in January: 676; Number of Missed Appointment in January: 258; Percentage of January Appointments Missed: 38%. "Clients Served" are defined as having at least one "pickup" in the period. The category definitions are as follows:

Category A - CD4 < 200 cells/mm3 and/or CD4% < 14%: A diagnosis of AIDS and/or diagnosis of active opportunistic infection and/or diagnosis of HIV-associated nephropathy (HIVAN)

Category B - CD4 cell count between 201-350 cells/ mm3: Persons who are currently on ARV therapy, persons who were previously on ARV therapy but therapy was interrupted and treatment naïve clients

Category C - Treatment naïve clients with CD4 cell count > 350 cells/mm3

Category D - Unknown/Other

Clients are removed from the Wait List by medical category in the order they were placed on it.

This serves as a reminder to people that if they are on the wait list they MUST recertify at 6 months or they will lose their position on the Wait List.

6. Annual Surveillance & Epidemiology Presentation

A representative from the health department was present and the preliminary surveillance and epidemiology report for January – December 2011was reviewed:

The finalized report will be released around April-May 2012 along with the Epidemiology Profile with the data and statistics. The BCHD representative noted the 'No Indicated Risk' (NIR) category is comprised mostly of heterosexual females. As CDC is redefining terms by viral loads the New AIDS vs. New HIV was explained. The new AIDS cases report does not include new HIV cases as the new AIDS cases may not have been previous HIV reported cases and thus are reported as 'new' HIV and AIDS. Monthly report only runs new AIDS cases. For surveillance purposes an AIDS case is one where the CD4 viral load is below 14% or below 200.

The Healthy People 20/20 and the National AIDS strategy both have an indicator as to the length of time from HIV diagnosis to AIDS diagnosis and BCHD is computing this data which is done within a six month span. This is indicated on the National HIV Surveillance Report card and will be brought to the next meeting.

The PROACT program at BCHD assists with community linkage to services, in to care or to clients who have been lost back to care and helps with linkage, assistance and referrals. This is especially helpful when private doctors do HIV testing the patient/client can be referred to PROACT. The Part A grantee elaborated that the EIIHA component needs to be improved. Rapid linkage into care is required and the system needs to be streamlined and become more functional. There is a gap that needs to be bridged and we need to develop solutions to fill this gap. Last year's report had estimated within a six month period the viral load was 40% and the CD4 count was 45%.

7. Prevention Update

The following report was provided:

Priority Setting Tool for Florida's Prevention Planning Group, to be used with
Four Fold Path Methodology and Advancing HIV Prevention (AHP)Partnership 10
(excludes DOC data)

HIV Cases Reported 2009-2011
Age 13+ by Race and Mode of Exposure*

2009-2011	Heterosexual	MSM	IDU	
	M+F	Males	M+F	
White	111	813	56	
Black	905	389	128	
Hispanic	123	329	33	TOTAL
TOTAL	1139	1531	217	2887

Percent of Cases	Heterosexual M+F	MSM Males	IDU M+F	
White	4%	28%	2%	
Black	31%	13%	4%	
Hispanic	4%	11%	1%	100.0%

Ranking of Data by Percent of Cases

Rank	Population	% of Cases
1	B-Hetero	31.3%
2	W-MSM	28.1%
3	B-MSM	13.5%
4	H-MSM	11.4%
5	B-IDU	4.4%
6	H-Hetero	4.3%
7	W-Hetero	3.8%
8	W-IDU	1.9%
9	H-IDU	1.2%
		100.0%

*Cases with no identified risks (NIRS) have been redistributed into known risks
***MSM=MSM and MSM/IDU cases & Male IDU=IDU and MSM/IDU cases,
Therefore these two groups are NOT mutually exclusive

8. Comprehensive Plan Discussion

At the Joint Executive Retreat areas going well and those where there is need for improvement were identified and from the break out groups, reports and recommendations were made how to go about doing this. The Joint Planning Committee is tasked with developing the Comprehensive Plan work plans on the committee level looking at the part(s) that are a good fit. The committee work plans are based on the required activities for the Planning Council in general and are already broken out by committees, however, there have been since new requirements e.g. EIIHA, Special Populations, Affordable Care Act [ACA] and Healthcare Reform.

From the Joint Executive Retreat, the three break-out groups for the Planning Council retreat were identified:

- Special Populations
- Needs Assessment
- Continuum of Care

Also at the HIVPC retreat it was suggested that the Client Survey be done every two to three years rather than annually as (i) there is no time to 'digest' the report and (ii) similar information is gathered during intake at Centralized Intake and Eligibility (CIED). A guest was concerned that if CIED does the survey, only one bracket of

the population would be captured. It was then reiterated that CIED will not be doing the client survey for the county but that CIED captures valuable data. A member remarked that the survey is not a "convenience sample" and the results are a true picture of the population and can be generalized into what's happening in the county adding that qualitative information can be captured with focus groups to be statistically analyzed from any angle e.g. age group, gender, race/ethnicity, cultural background.. It was agreed that more specific questions e.g. "what was your special population at the time of diagnosis" and "where were you tested" ,"did you know this service was available", "were you eligible" and if so, "what prevented you from using the service (transportation, childcare etc)" will help Part A with the specific categories of special populations and data.

It was noted that the survey does not capture the PSRA process.

The Part A grantee suggested that a profile report from the Ryan White Part A Program office can be developed on a monthly/quarterly basis and proposed that a small workgroup be established to develop a general client profile to generate reports. The Part A grantee suggested that this group could participate in a PE 101(Provide Enterprise) WebEx with Groupware Technologies Inc. Two members along with the CIED manager will participate establishing a timeline, identifying, prioritizing and managing resources.

The committee also reviewed the Ryan White Part A Planning Council Handout - Planning Process Evaluation document. What are the questions to ask and what is the plan for analyzing results? Member noted the resources needed to accomplish such a task from a "group of volunteer citizens". The committee agreed to obtain PSRA Committee's input on not doing a client survey this year, but to use last year's report along with current EPI utilization data. With lack of quorum, this could not be put into motion form but the Part A grantee suggested it be sent as a recommendation to PSRA Committee for data sets, data trends and data parameters at the next meeting with quorum. It was requested from the BCHD representative for a three year EPI trend to give the committee a starting point to send recommendations to Priorities (PSRA) Committee.

9. Old Business/New Business

- Committee Work plan status as it relates to the Comprehensive Plan. Should be permanent Executive Agenda Item.
- PSRA committee chairs will be informed of the direction the committee is headed with regards to (data sets, data trends)
- The Part A grantee reported that the oral health assessment is expected to be completed by April. Some components of the original assessment were postponed due to the late grant award. Broward County ranks second in the nation for dental expenditures.

10. Agenda items for next meeting

- Standing Agenda Items
- Comprehensive Plan Discussion
- Three year trend request from BCHD
- Recommendations to PSRA Committee
- Surveillance data that ties into funding (NGA reflects $1000 reduction in Formula however this is based on HIV cases)
- Set dates for WebEx

11. Next meeting date

Monday, April 9, 2012 at 1:00 p.m. **Venue**: BRHPC

12. Adjournment:

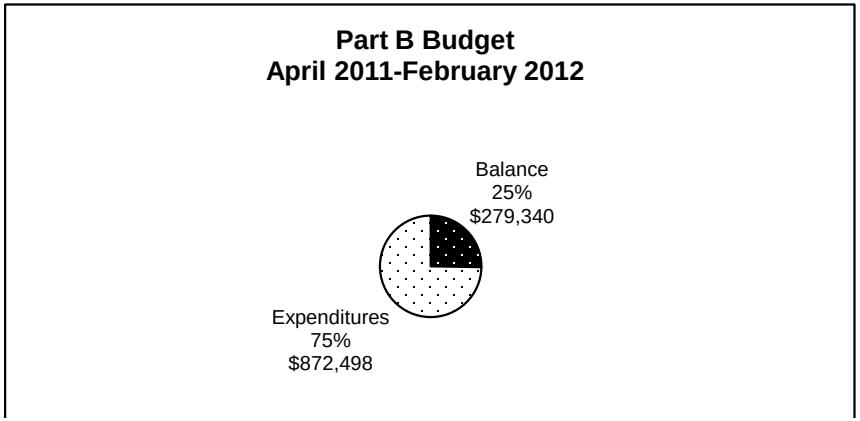
Meeting was adjourned at 2:54 p.m.

Ryan White Part B
Expenditure Report
February 2012

Service Category	Part B 2011-2012 Allocated	Part B 2011-2012 (February Spent / Encumbered)	Part B 2011-2012 Monthly Average Left	Part B 2011-2012 (YTD Spent / Encumbered)	Part B 2011-2012 (% Left)	Part B 2011-2012 (Balance)
Home Delivered Meals	$ 2,479		$ 1,744	$ 735	70%	$ 1,744
Home Health Care Services	$ 13,018		$ 9,829	$ 3,189	76%	$ 9,829
Medication Co Pay	$ 647,309	$ 82,560	$ 192,066	$ 505,152	30%	$ 192,066
Case Management (non-medical)	$ 179,001	$ 11,695	$ 58,629	$ 120,372	33%	$ 58,629
Medical Transportation	$ 149,930	$ 99,938	$ -	$ 149,930	0%	$ -
Administration	$ 110,192	$ 8,177	$ 17,072	$ 93,120	15%	$ 17,072
TOTALS	**$ 1,101,929**	**$ 202,371**	**$ 139,670**	**$ 872,498**	**25%**	**$ 279,340**
					75%	

Non-Medical Case Management conducted 448 eligibility interviews in February of which 101 were new clients.
Medication Co Payment served 307 clients in February in which 7 were new to the program.
298 Clients served in February Med Co Pay
9 Clients served in February Mail Order

Cost Avoidance for Medication Co Payment Program for February is approximately $39,655. Total cost avoidance from April-February is $213,732



Broward County Health Department ADAP Report as of 3/30/12

Total ADAP "Open" Enrollment		**2,312**
Total ADAP Clients Served in Last 30 Days*		**1,525**
Total ADAP Waitlist Enrollment**		**171**
	Category A	8
	Category B	64
	Category C	97
	Category D	9
Total ADAP/Medicare Part D Enrollment		**187**
Number of Appointments in March		**771**
Number of Missed Appointment in March		**272**
Percentage of March Appointments Missed		**35%**

*"Clients Served" defined as having at least one "pickup" in the period.

**** Category Definitions:**

CATEGORY A

Diagnosis of AIDS and/or CD4 < 200 cells/mm3 and/or CD4% < 14%
Diagnosis of active opportunistic infection
Diagnosis of HIV-associated nephropathy (HIVAN)

CATEGORY B

Persons who are currently on ARV therapy
Persons who were previously on ARV therapy but therapy was interrupted
Treatment naïve clients with CD4 cell count between 201-350 cells/ mm3

CATEGORY C

Treatment naïve clients with CD4 cell count > 350 cells/mm3

CATEGORY D

Unknown/Other

Clients are removed from the Wait List **by medical category** in the order they were placed on it. This serves as a reminder to people that if they are on the wait list they MUST recertify at 6 months or they will loose their position on the Wait List.

HIV Community Viral Load in Florida: Methodology, Feasibility, and Implications

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Viral Load in Individuals

- Studies have shown that people with higher viral loads are more likely to infect others
- Also, people who are not aware of their HIV infection generally have higher viral loads
- People who are aware of their HIV status and are on ARVs have lower viral loads

What is Community Viral Load?

- Community viral load is a term that refers to the overall level of HIV virons in a predefined "community" of people
  - Definition of your community can be variable, but it needs to be fixed before starting analysis
    - Geographic: County, EMA, MSA, etc.
    - Social: MSM, IDU, etc.
    - Need to look at where people in your area are likely to become infected
  - Measured as the average number of virons in your community for a given time frame
    - Reported as copies/mL

1. Centers for Disease Control and Prevention. Guidance on Community Viral Load: A Family of Measures, Definitions, and Method for Calculation. August 2011.

How Has Community Viral Load Been Used in Research?

- Studies have shown:
  - High rates of unknown HIV infections as well as low rates of ARV treatment among communities lead to a higher community viral load as compared to other communities
    - This higher community viral load leads to more efficient transmission and higher infection rates
  - Statistically significant correlation between median community viral load and incidence of new HIV infections
    - Found that when the median community viral load was <20,000 copies/mL there was no longer an association with HIV incidence

2. Wood E, Kerr T, Marshall BD, Li K, Zhang R, Hogg RS, Harrigan PR, Montaner JS. Longitudinal community plasma HIV-1 RNA concentrations and incidence of HIV-1 among injecting drug users: prospective cohort study. BMJ. 2009 Apr 30;338:b1649.

3. Das M, Chu PL, Santos GM, Scheer S, Vittinghoff E, McFarland W, Colfax GN. Decreases in community viral load are accompanied by reductions in new HIV infections in San Francisco. PLoS One. 2010 Jun 10;5(6):e11068.

Why Do We Care About Community Viral Load?

- Community viral load can be used as a proxy measure for the likelihood of infection within that community
  - As community viral load decreases, the likelihood of new infections decrease (opposite is true as well)
- Can also be used as a measure of outreach and linkage to care efforts
  - Used for program evaluation and continued targeting of hard to reach populations

4. Montaner JS, Wood E, Kerr T, Lima V, Barrios R, Shannon K, Harrigan R, Hogg R. Expanded highly active antiretroviral therapy coverage among HIV-positive drug users to improve individual and public health outcomes. J Acquir Immune Defic Syndr. 2010 Dec;55 Suppl 1:S5-9.

Which Groups of People Do You Need Data on for This Type of Analysis?

1. All people known to our data system who are currently receiving care
   - People designated as “in care” are those that have ANY recent laboratory results
   - Broken down into 3 smaller groups based on viral load test results
     - VL=undetectable
     - VL=detectable
     - In care, but no VL
       - A person has recent CD4 labs but no viral load results, then they fall into “In care, no VL”
2. All people known to our data system who are not receiving care
   - Have no recent laboratory results of any kind
3. People who are HIV infected but they have never been reported to the data system
   - Considered “undiagnosed”
   - Have never been tested, were tested anonymously, were never reported by the lab or physician, etc.

Why Do I Need to Know All of These Groups?

- Knowing which group each person falls into is essential to knowing how to interpret the data
- If you are missing data on a group it limits the types of analysis you can do
- Knowing the data by group allows you to track your progress over time
  - Example: If a CVL increases dramatically from 2009 to 2010 does that mean that your prevention and linkage programs are failing?
  - Not necessarily. It could be that you started a large testing initiative and you are identifying a large number of previously undiagnosed cases. These people will typically have higher viral loads when they are first identified and might affect your calculations.

How Do the Groups We Just Talked About Fit Together?

	Population Groups Included				
Population Viral Load	In care with undetectable VL	In care with detectable VL	In care, no VL*	Diagnosed but not in care	Undiagnosed
Community Viral Load	In care with undetectable VL	In care with detectable VL	In care, no VL*	Diagnosed but not in care	
In-Care Viral Load	In care with undetectable VL	In care with detectable VL	In care, no VL*		
Monitored Viral Load	In care with undetectable VL	In care with detectable VL			

*No VL = missing/unknown viral load, for a variety of reasons (e.g., incomplete reporting) but do have some other type of lab result indicating ongoing medical monitoring.
**Not in care= no lab results of any type

1. Centers for Disease Control and Prevention. Guidance on Community Viral Load: A Family of Measures, Definitions, and Method for Calculation. August 2011.

How Do the Differences Affect Us?

	Strengths	Weaknesses	Comments
Population Viral Load	Complete picture of HIV viral load within the area. Those with undiagnosed disease are likely to have a higher viral load and to be a source for ongoing transmission.	Viral load in those with undiagnosed HIV infection is not readily available.	Would require a special study including specimen collection.
Community Viral Load	The most complete population-level measure that is reasonably attainable.	Viral load data is missing for many diagnosed cases.	Need viral load results for >75% of diagnosed individuals.
In-Care Viral Load	Easy to calculate. Readily identifies areas of incomplete reporting and/or people not receiving optimum monitoring.	Can not be used as a measure of the "infectiousness" of the population.	Need viral load results for >75% of diagnosed individuals.
Monitored Viral Load	When compared to the in-care viral load over time, it can provide an indication of improvements to care and/or data capture.	Can not be used as a measure of the "infectiousness" of the population.	

Comprehensiveness

Difficulty

How Do These Measures Relate to Each Other Over Time?

- Population and community viral load are the only measures that are able to indicate how likely your group is to have ongoing HIV transmission
- As the proportion of individuals with HIV who know they are infected increases, the community viral load approaches the population viral load
- As the proportion of individuals who are diagnosed with HIV and are successfully linked to appropriate care, the monitored and in care viral loads will approach the community and population viral loads
- In its most basic interpretation, you would eventually want all people with HIV to be in the in care with known viral load groups (2)

How Do These Measures Relate to Each Other Over Time?

	Population Groups Included				
Population Viral Load	In care with undetectable VL	In care with detectable VL	no VL*	not in care	U n
Community Viral Load	In care with undetectable VL	In care with detectable VL	no VL*	not in care	
In-Care Viral Load	In care with undetectable VL	In care with detectable VL	no VL*		
Monitored Viral Load	In care with undetectable VL	In care with detectable VL			

Now That We Know Which Measures We Are Able to Calculate, How Do We?

Record Selection

- Time frame
  - Calculated for each calendar year
  - Allow for 12 months lag time to allow for reporting delays and to match cases to death records
- Case inclusion criteria
  - All residential cases
  - Alive at the end of the year in question
- Lab selection
  - Only use one result per person
  - Use the most recent viral load result, lab closest to December 31 of the corresponding year

Data Transformation

- How to handle undetectable viral loads
  - Enter a numeric value for those listed as “undetectable” based on the lower limit of detection for those assays
  - Best estimate is half of the lower limit of detection
- How do you account for people who are in-care but missing viral load results?
  - Data imputation
  - Use demographics from those with known viral loads to assign viral loads to those missing results
  - Can not be used for those not in-care because the viral load distributions would be fundamentally different
  - Recommended that you have <25% of people with missing viral loads

Sub-group Analysis

- What if you want to look at sub-groups compared to each other or to the state?
  - Geographic region (city, MSA, zip code, county, etc.)
  - Racial/ethnic groups
  - Gender
  - Risk category
- Data quality checks similar to the overall analysis to ensure that the data for sub-groups is complete.
- Need a large enough sample size in each sub-group to detect a difference between the groups
  - For example, to detect a three-fold difference in the mean viral load you would need at least 78 observations

Florida Data Sources

- eHARS
  - Surveillance data set
  - Detectable and undetectable viral loads for all previously reported cases
  - Electronic and hard copy labs
- ADAP
  - ADAP and waitlist enrollment requires a viral load test every six months
- CAREWare
  - Labs entered for clinical management
  - Incorporates HMS data and several other sources

Florida Limitations

- Not all lab results are uploaded/entered into eHARS
  - Paper labs currently being entered for 2011, estimated completion March 2012
  - Not all lab systems are reporting electronically
- ADAP and other data systems represent special populations
  - Known in-care and therefore should have lower viral loads
  - Meet special eligibility requirements
  - Excludes people with health insurance who may be receiving different care

Next Steps

- Monitor proportion of known cases with VL as more ELRs are incorporated
- Encourage data collaboration to ensure that all data is captured and available centrally
- Explore smaller level analysis
  - For sites that are interested:
    - Assess lab data completeness
    - Address must represent the patient's location (not clinic or lab) and it must be a valid address

Questions?

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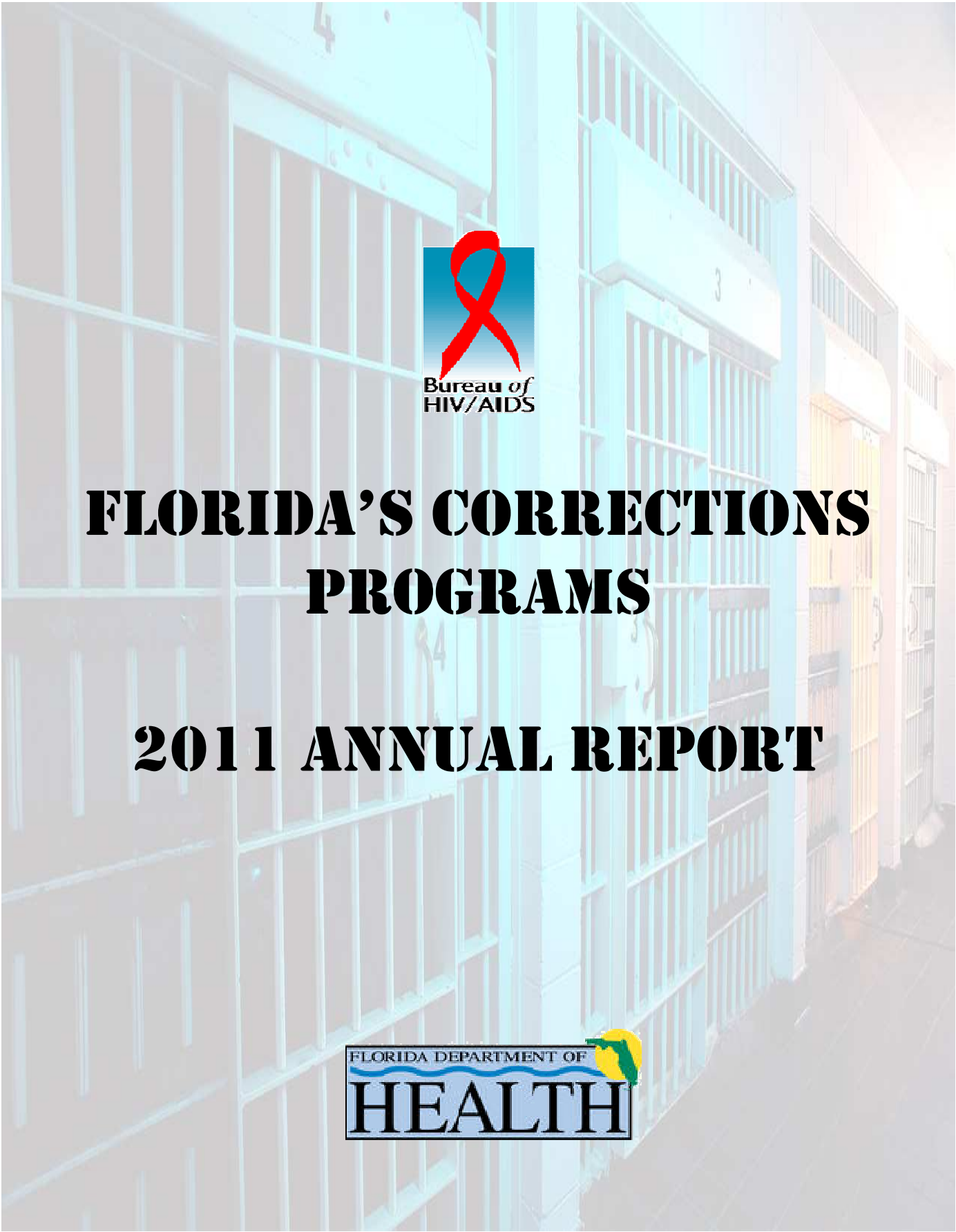


Bureau of HIV/AIDS

FLORIDA'S CORRECTIONS PROGRAMS

2011 ANNUAL REPORT

FLORIDA DEPARTMENT OF HEALTH

Corrections Programs Overview

The Florida Department of Health (DOH), Bureau of HIV/AIDS has been, and continues to be, a leader in the provision of prevention, testing, and linkage services within the correctional system. DOH funds two programs for the incarcerated population preparing to return to the community; the Jail Linkage Program and the Pre-Release Planning Program. The total funding allotted to the corrections programs is approximately $1.6 million.

Jail Linkage Programs

The Jail Linkage Programs (JLP), which span 16 counties in the state, continue to educate and test for HIV as well as screen for hepatitis and sexually transmitted diseases (STD). Increased HIV testing has been made available through the Expanded Testing Initiative (ETI). This grant expanded the African American Testing Initiative and integrated HIV testing for populations disproportionately affected by HIV, primarily African Americans, but also Hispanic men and women, men who have sex with men, transgender populations, and injection drug users regardless of race/ethnicity. The grant allows funds to be used for screening in jails, among other venues. Six of our funded JLP sites receive ETI funding. Through this continuing grant, the jail linkage program is able to offer a greater array of screening services to the inmates.

In 2011, the JLP tested 32,157 inmates for HIV and identified 207 positives for an overall positivity rate of 0.6%. The overall positivity rate for 2010 was also 0.6%, following a slight decline in each of the previous three years from 1.4% in 2007 to 1% in 2009. Of the 24,616 male inmates tested for HIV, 164 were positive, while 43 of the 7,498 female inmates were positive. The overall positivity rate for males was higher than females; 0.67% versus 0.57%. The distribution of HIV tests by gender and county in 2011 is shown in Table 1.

Table 1. HIV Tests by County and Gender

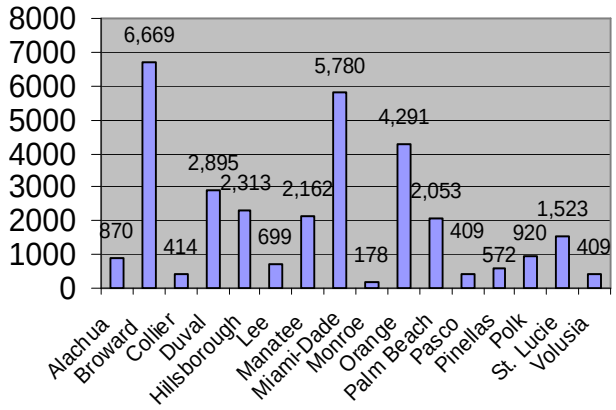
COUNTIES	MALE NEGATIVE	MALE POSITIVE	Male Positivity Rate	FEMALE NEGATIVE	FEMALE POSITIVE	Female Positivity Rate
Alachua*	706	2	0.28%	161	1	0.62%
Broward*	5,455	24	0.44%	1,184	6	0.50%
Collier	334	1	0.30%	79	0	0.00%
Duval	2,068	11	0.53%	812	4	0.49%
Hillsborough	1,994	6	0.30%	311	2	0.64%
Lee	498	1	0.20%	200	0	0.00%
Manatee	1,339	6	0.45%	814	3	0.37%
Miami-Dade*	4,855	78	1.58%	839	8	0.94%
Monroe**	111	0	0.00%	67	0	0.00%
Orange*	2,954	14	0.47%	1,318	5	0.38%
Palm Beach*	1,839	4	0.22%	210	0	0.00%
Pasco	299	1	0.33%	109	0	0.00%
Pinellas	366	4	1.08%	202	0	0.00%
Polk	433	8	1.81%	468	11	2.30%
St. Lucie*	996	3	0.30%	522	2	0.38%
Volusia	205	1	0.49%	202	1	0.49%
TOTAL	**24,452**	**164**	0.67%	**7,498**	**43**	0.57%

*receive ETI funding
**unfunded program

As shown in the table above, female positivity rates were highest in Miami-Dade and Polk counties, with rates of 0.94% and 2.3%, respectively. Male positivity rates were highest in Miami-Dade and Polk counties as well, with rates of 1.6% and 1.8%, respectively.

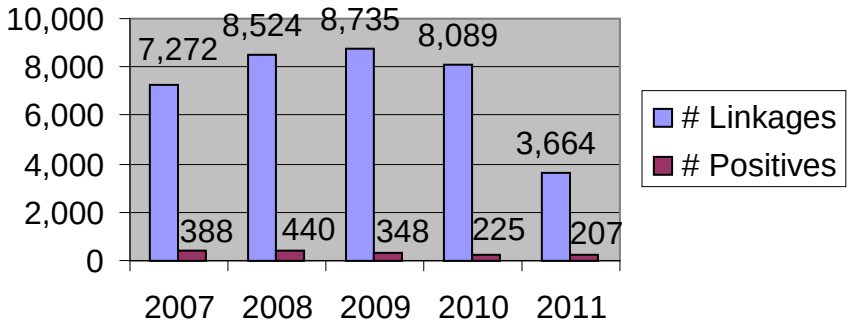
Broward County tested the most inmates in 2011, with a total of 6,669 reported HIV tests, followed by Miami-Dade County with 5,780 tests. The total number of HIV tests conducted by county is shown in Figure 1.

Figure 1. Total HIV Tests by County, 2011



The number of inmates tested and the number of HIV-infected inmates subsequently linked to services have varied in the past few years. The number of jail inmates tested in 2007 was 28,647 and rose to 37,149 in 2008, while the number of linkages was 7,272 and 8,524, respectively. The number tested in 2009 was 35,717 with 8,735 linkages to services, but testing numbers decreased again in 2010 to 34,824 and 32,157 in 2011. The sharp decline in linkages in 2011 can be explained in part by a change in the reporting form to reflect prevention linkages. Technical assistance was provided to clarify counting linkages to care upon release rather than linkages to services provided within the facility. A comparison can be seen in Figure 2 below.

Figure 2. Comparison of Linkages by Year



In 2011, the JLPs provided linkages to 718 HIV-infected inmates preparing to return to their community. Of these inmates, 87% were previously diagnosed with HIV while 13% were newly diagnosed. Staffs made a total of 3,664 linkages for these inmates, equating to over five linkages per client. Miami-Dade JLP reported the largest number of linkages at 1,261, followed by Palm Beach with 571. The linkages were to various social services including, but not limited to, case management, mental health, county health departments, housing, substance abuse treatment, and transportation. Jail linkage staffs continue to strengthen relationships with local community-based organizations and county health department staffs to address barriers to accessing medical care or services. The breakdown of linkages by county and service is shown in Table 2. Case management remained the highest linkage source for 2011 with a total of 1,463 linkages made. As seen in Table 2, 135 linkages were made for those who were released to the Department of Corrections.

Table 2. Linkages by County and Service

COUNTIES	Med-ical	Pre-natal	Case Mgmt	CHD	Subs-tance Abuse	Mental Health	Transpor-tation	Sup-port Group	Housing	DOC	**Total**
Alachua	40	1	27	20	26	33	1	7	0	18	**173**
Broward	63	0	20	2	14	6	12	0	7	4	**128**
Collier	7	0	8	4	1	1	0	0	0	0	**21**
Duval	131	8	3	49	21	32	3	0	5	54	**306**
Hillsborough	171	0	171	15	10	10	7	0	0	25	**409**
Lee	6	0	2	37	3	2	0	4	0	2	**56**
Manatee	36	0	27	27	0	0	12	0	0	9	**111**
Miami-Dade	103	1	986	0	13	12	60	74	12	0	**1261**
Monroe	0	0	0	23	0	0	0	0	0	0	**23**
Orange	14	0	14	19	0	0	0	0	0	0	**47**
Palm Beach	78	0	105	74	0	124	91	23	76	0	**571**
Pasco	82	0	4	23	3	14	0	37	2	0	**165**
Pinellas	62	19	57	17	20	0	0	57	0	23	**255**
Polk	11	31	29	13	1	2	3	2	3	0	**95**
St. Lucie	17	3	10	3	3	0	3	1	1	0	**41**
Volusia	2	0	0	0	0	0	0	0	0	0	**2**
Totals	**823**	**63**	**1,463**	**326**	**115**	**236**	**192**	**205**	**106**	**135**	**3,664**

The jail linkage program, while committed to linking inmates to all needed services, targets linkages for medical care and prenatal care to encourage the continuity of HIV/AIDS care for recently released inmates. Jail linkage staffs conduct follow-ups for these services to ensure clients make it to their appointment following their release from jail. Linkage efforts for these services, as well as partner services, prove to be most successful in preventing transmission of the HIV/AIDS virus. Partner services, provided by the Bureau of STD, are not included in this table. During this year, the jail linkage programs confirmed 75% of medical care linkages, and 98% of prenatal care linkages. Medical care linkages decreased from 84% in 2010, while prenatal care linkages increased from 86% in 2010. This decrease in medical care linkages can be attributed, as described earlier, to a change in reporting. Several programs were counting linkages to medical care within the facilities rather than upon release. Technical assistance was provided to clarify and ensure that all programs were consistent in reporting linkages. Table 3 highlights the efforts made by the jail linkage programs.

Table 3. Medical and Prenatal Care Linkages

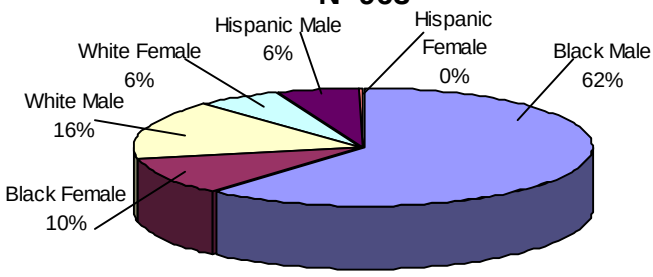
	MEDICAL CARE		PRENATAL CARE	
COUNTIES	Linked	Confirmed	Linked	Confirmed
Alachua	40	40	1	1
Broward	63	63	0	0
Collier	7	7	0	0
Duval	244	142	8	8
Hillsborough	171	171	0	0
Lee	6	6	0	0
Manatee	36	36	0	0
Miami-Dade	103	51	1	1
Monroe	0	0	0	0
Orange	14	0	0	0
Palm Beach	78	68	0	0
Pasco	82	29	0	0
Pinellas	62	62	19	19
Polk	11	10	31	31
St. Lucie	17	15	3	2
Volusia	2	2	0	0
TOTALS	**936**	**702**	**63**	**62**
Percent Confirmed		75%		98%

Pre-Release Planning Program (PRPP)

The PRPP continues to operate under the original intent of the program offering pre-release planning services to all known HIV-infected prisoners in Florida Department of Corrections (DOC) facilities.

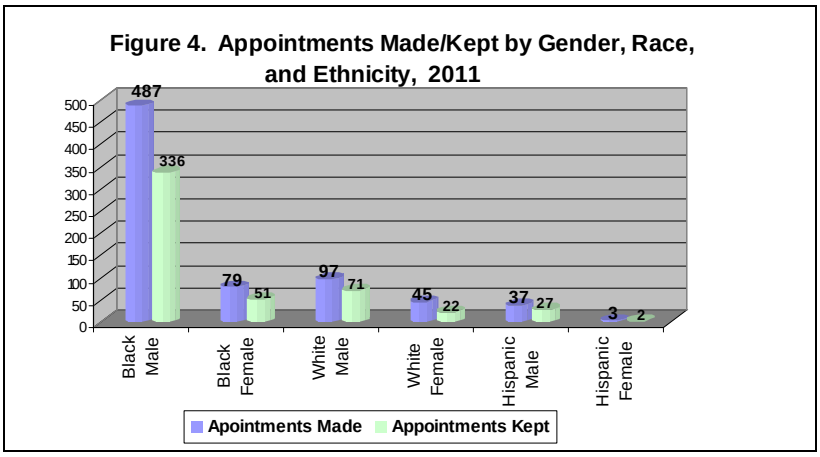
In 2011, the PRPP served 963 HIV-infected inmates. The distribution by race/ethnicity and gender of these inmates is shown in Figure 3. Of the 963 inmates who received services, 748 (78%) had medical and/or social service appointments scheduled by a pre-release planner.

Figure 3. Inmates Served by Gender, Race, and Ethnicity, 2011
N=963



There are several reasons why appointments are not scheduled for every inmate. Some inmates choose to make their own arrangements prior to their release, allowing the planner to focus on other services such as HIV/AIDS education and medical records assistance for the inmate. Other inmates may not require appointments due to detainers that cause them to serve additional time in a county jail upon the end of their sentence. Many immigrants are turned over to Immigration and Customs Enforcement upon their release. In cases where planners are unable to schedule appointments for inmates, medical records are copied by the planner and provided to the inmate upon their release.

Of those inmates with scheduled appointments, 68% kept their initial appointment scheduled by the planner. The breakdown of appointments scheduled and kept by ex-offenders is shown in Figure 4 by race/ethnicity and gender.

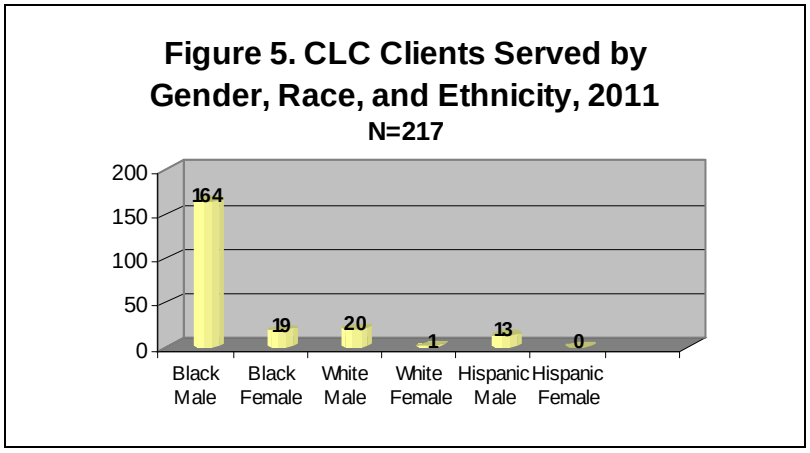


Inmates returning to Broward and Miami-Dade counties receive more intensive linkage services and support to connect to medical care due to the Community Linkage Coordinator (CLC) staff located there. The CLC and pre-release planners work together to ensure inmates returning to one of these two counties are given an appointment to meet with the CLC upon release, in addition to their appointments for medical care and eligibility services. The appointment with the CLC takes place within one week after the inmate's release and is often before the medical and/or eligibility appointments. The CLC prepares the inmate for these other appointments by ensuring eligibility paperwork is completed, appropriate documents are obtained, and the client is able to arrange transportation. Bus passes are provided to clients to assist them in reaching their healthcare appointment and as an incentive to follow-up with the CLC after their scheduled appointments. Follow-up services for these clients are provided by the CLC for up to six months following their release from prison. The breakdown of referrals to the CLC and linkages provided can be seen in Table 4 below.

Table 4. CLC Linkages, 2011

2011		Inmates referred from PRP's	Non-compliant w/ CLC	Inmates compliant w/ CLC	Medical appts made	Medical appts kept w/in 90 days	% med appts kept	Linked to case mgmt	Linked to mental health	Linked to substance abuse	Bus passes given
January	Broward	16	3	13	13	13	100%	7	0	0	11
	Miami-Dade	9	2	7	7	5	71%	5	0	0	7
February	Broward	6	2	4	4	3	75%	2	0	0	4
	Miami-Dade	5	0	5	5	5	100%	5	0	0	4
March	Broward	10	4	6	6	6	100%	6	0	0	7
	Miami-Dade	6	0	6	6	5	83%	5	0	0	5
April	Broward	9	1	8	8	6	75%	6	0	0	7
	Miami-Dade	7	1	6	6	5	83%	5	0	0	5
May	Broward	10	3	7	7	7	100%	7	0	0	16
	Miami-Dade	10	2	8	8	7	88%	7	0	0	7
June	Broward	17	3	14	14	12	86%	12	0	0	17
	Miami-Dade	6	1	5	5	4	80%	4	1	0	5
July	Broward	10	2	8	8	6	75%	6	1	0	9
	Miami-Dade	10	3	7	7	7	100%	7	0	0	7
August	Broward	7	1	6	6	6	100%	6	0	0	7
	Miami-Dade	8	0	8	8	8	100%	8	0	1	8
Sept	Broward	13	1	12	12	12	100%	12	0	0	12
	Miami-Dade	8	2	6	6	6	100%	5	0	0	4
Oct	Broward	7	4	3	3	3	100%	3	0	0	3
	Miami-Dade	8	2	6	6	6	100%	6	0	0	6
Nov	Broward	9	1	8	8	8	100%	8	0	0	7
	Miami-Dade	10	1	9	9	9	100%	9	1	1	9
Dec	Broward	7	3	4	4	4	100%	4	0	0	2
	Miami-Dade	9	2	7	7	7	100%	7	2	0	5
Totals		217	44	173	173	160	92%	152	5	2	174

From January through December 2011, the pre-release planners referred 217 inmates to the CLC and 80% of these, or 173, were linked to medical care. The demographic breakdown of the clients served by the CLC is shown in Figure 5.



Clients who worked with the CLC in Broward and Miami-Dade counties experienced a much greater success rate than clients who received referrals to medical care and case management in other counties around the state. In comparison to the overall compliance rate of 68% statewide, the medical care compliance rate for clients who worked with the CLC was 92%. The table below shows the demographic breakdown of compliance rates for clients who worked with the CLC.

Table 5. CLC Appointments Made/Kept by Race, Ethnicity, Gender

Clients Served	Medical Appointments Scheduled	Medical Appointments Kept	Compliance Rate
Black Male	126	120	95%
Black Female	19	17	89%
White Male	14	11	79%
White Female	1	1	100%
Hispanic Male	13	11	85%
Hispanic Female	0	0	0%
Totals	**173**	**160**	**92%**

Interagency Collaborations

The Corrections Infections Workgroup, led by the Bureau of HIV/AIDS and Hepatitis, is comprised of members from the Department of Juvenile Justice, Department of Corrections, Department of Children and Families (Substance Abuse and Mental Health offices), Bureau of Sexually Transmitted Diseases, and Bureau of Tuberculosis and Refugee Health. The workgroup is dedicated to information sharing, program development and education, and advocacy on issues related to HIV/AIDS, STD, TB, and/or hepatitis in correctional settings. The workgroup meets on a quarterly basis and strives to improve infectious disease screening and healthcare for inmates across the state of Florida.

For example, in 2011 through an interagency agreement with the Florida Department of Corrections, the Bureau of STD conducted over 51,000 screening tests. These screenings resulted in chlamydia positivity rates of 5.1% in males and 2.3% in females and syphilis rates of 6.4% positivity (or reactive serology tests) in males and 8.5% in

females. These detection efforts coupled with successful treatment reduced the disease burden and avoided risk of potential spread in the prison population.

The Hepatitis Prevention Program provides direct funding to county health departments (CHDs) for the provision of hepatitis services in 15 counties (Broward, Collier, Miami-Dade, Monroe, Pinellas, Polk, Escambia, Lee, Seminole, Bay, Alachua, Palm Beach, Okeechobee, Orange, and Duval). The 15 funded CHDs provide outreach to local jails and prisons such as hepatitis risk assessments, testing, vaccination, and educational materials. During 2011, 6,184 such outreach activities were conducted among the 15 counties.

Other collaborative efforts put forth by the Bureau of TB & Refugee Health found 12 active TB cases among inmates, one of which was co-infected with HIV.

Summary

The Jail Linkage Programs continue their work in the16 Florida counties as they provide testing and linkage to this vulnerable population. Overall, due in part to a change in reporting, the number of tests and linkages in the corrections program decreased in 2011 from the previous year. The Jail Linkage Program had a success rate of 75% confirmed medical care linkages in 2011.

The PRPP data revealed that 78% of the inmates served were linked to medical care after their release from prison. The CLC in Broward and Miami-Dade counties has resulted in a success rate of 92% medical care linkage compliance in that area. This is a strong indicator of the success of this program and is due to the combined efforts of the pre-release planners and the community linkage coordinator.

In an effort to build on the success the CLC position has demonstrated, an additional CLC will be added in 2012 in Orange County. This position will serve both programs as the jail linkage coordinator and the CLC for prison releasees returning to the Orange County area.

The corrections programs continue to address the needs of HIV-infected incarcerated populations in promoting continuity of medical care for ex-offenders and education to encourage risk reduction strategies upon their release.

Part B Core Eligibility hours available on going
Core Eligibility appointments **Monday nights** 5, 6, & 7 p.m
Call 954-713-3196 for an appointment. (Includes ADAP enrollment)
BCHD Ft. Lauderdale Health Center
2421 SW 6th Ave.
Fort Lauderdale, Florida 33315

Effective March 19, 2012 – May 17, 2012
Part B Core Eligibility hours extended temporarily by appointment only as follows:
Core Eligibility appointments only (no ADAP enrollments)
Tues, Wed, Thurs nights 5-6 p.m. Last appointment is 5:00 p.m.
BCHD Operations Bldg.
2421A SW 6th Ave.
Fort Lauderdale, Florida 33315
Call 954-467-4700-5661 for an appointment.