Fort Lauderdale / Broward County EMA
Broward County HIV Health Services Planning Council
An Advisory Board of the Broward County Board of County Commissioners
200 Oakwood Lane, Suite 100, Hollywood, FL, 33020 - Tel: 954-561-9681 / Fax: 954-561-9685

Committee Meeting Agenda: System of Care Committee
Date/Time: Friday, March 27, 2015, 9:30 a.m. **Location:** Gov't Center Room GC-302
Chair: Dr. Mark Schweizer **Vice Chair:** Donna Sabatino

1. **CALL TO ORDER:** *Welcome, Review meeting ground rules, Statement of Sunshine, Introductions, Moment of Silence, Public Comment*

2. **APPROVALS:** 3/27/15 Agenda and 11/24/14 Meeting Minutes

3. **MEETING ACTIVITIES/NEW BUSINESS**

Goal/Work Plan Objective #:	*Accomplishments*
SOC Meeting Date (Handout A)	ACTION ITEM: Discuss current meeting date and time, and determine if a different date and time would be better for committee members.
Review Data Sources (WP Item 1.2) (Handouts B-1-B-3 & C-1-C-3)	ACTION ITEM: Continue review of FY 2013 needs assessment, new infection data, and *Voices* Study. Determine solutions or recommendations to other committees.
Community Forum (Handout D)	ACTION ITEM: Review identified location, themes, potential keynote speakers, and recommendations from CEC.

4. **GRANTEE REPORT**

5. **PUBLIC COMMENT**

6. **AGENDA ITEMS/TASKS FOR NEXT MEETING:** April 24, 2015 **VENUE:** Room A-337

Goal/Work Plan Objective #:	*Accomplishments*
Client Health Outcomes (WP Item 1.3)	ACTION ITEM: Review client health outcomes by payer, EMA/TGA, and along the HIV Care Continuum.
Funding Sources (WP Item 1.4)	ACTION ITEM: Analyze available funding in Broward County and identify services that are needed but not currently funded, or underfunded.
How Best to Meet the Need (WP Item 2.1)	ACTION ITEM: Develop language for How Best to Meet the Need (HBTMTN).

7. **ANNOUNCEMENTS**

8. **ADJOURNMENT**

PLEASE COMPLETE YOUR MEETING EVALUATIONS

THREE GUIDING PRINCIPLES OF THE BROWARD COUNTY HIV HEALTH SERVICES PLANNING COUNCIL

• Linkage to Care • Retention in Care • Viral Load Suppression •

VISION: To ensure the delivery of high quality comprehensive HIV/AIDS services to low income and uninsured Broward County residents living with HIV, by providing a targeted, coordinated, cost-effective, sustainable, and client-centered system of care

MISSION: We direct and coordinate an effective response to the HIV epidemic in Broward County to ensure high quality, comprehensive care that positively impacts the health of individuals at all stages of illness. In so doing, we: Foster the substantive involvement of the HIV affected communities in assuring consumer satisfaction, identifying priority needs, and planning a responsive system of care
Support local control of planning and service delivery, and build partnerships among service providers, community organizations, and federal, state, and municipal governments
Monitor and report progress within the HIV continuum of care to ensure fiscal responsibility and increase community support and commitment

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Committee Meeting Minutes: System of Care (SOC) Committee
Date/Time: Monday, November 24, 2014, 9:30 a.m. **Location:** Gov't Center Annex Room A337
Chair: Dr. Mark Schweizer **Vice Chair**: Donna Sabatino

ATTENDANCE				
#	**Members**	**Present**	**Absent**	**Guests**
1	Schweizer, M. *(Chair)*	**X**		Runkle, D.
2	Sabatino, D. *(Vice Chair)*	**X**		Myers, L.
3	Cook, R.	**X***		Culpepper, K.
4	Eckardt, P.		**A**	Robertson, P.
5	Eserman, C.	**X***		Shamer, D.
6	Kress, G.	**X**		**Grantee Staff**
7	Katz, H.B.	**X**		Copa, R.
8	Markman, N.	**X**		Jones, L.
9	Rodriguez, J.	**X**		Green, W.E.
10	Ullah, E.		**A**	Morris, R.
				HIVPC Staff
	Quorum = 6	**8**		Sandler, C.
	*attended via phone			Bente, A.

1. CALL TO ORDER

The Vice Chair called the meeting to order at 9:39 a.m. and welcomed all present. Attendees were notified of information regarding the Government in the Sunshine Law and meeting reporting requirements, which includes the recording of minutes. Attendees were advised that the meeting ground rules are present, for reference. In addition, attendees were advised that the acknowledgement of HIV status is not required but is subject to public record if it is disclosed. Chair, guest, Grantee staff and HIV Planning Council (HIVPC) staff self-introductions were made. The following motions were made:

Motion #1: To approve today's meeting agenda.
Proposed by: Markman, N.
Seconded by: Katz, H.B.
Action: Passed Unanimously

Motion #2: To approve the 10/27/14 meeting minutes.
Proposed by: Rodriguez, J.
Seconded by: Kress, G.
Action: Passed Unanimously

2. UNFINISHED BUSINESS

None.

3. MEETING ACTIVITIES/NEW BUSINESS

a) 18 month Work Plan (Handout A):

The Chair discussed the 18-month committee work plan. The Chair discussed work plan items and stated the mini-retreat will take place on December 8, 2014. Staff asked that attendees RSVP as soon as possible. The Chair stated that the committee must always take into consideration the three guiding principles of the HIVPC when reviewing the work plan. The Chair explained that this committee will be reviewing client health data and make recommendations to other committees to address gaps in care. The Chair asked for any comments or questions from the committee. A guest asked why are there only 12 months of activities included, when the

work plans are supposed to be for 18 months. Staff explained that there is a master work plan available with all 18 months of activities included. The work plan presented only includes activities for this upcoming year. The following motion was made to approve the work plan:

Motion #3: To approve the SOC 18-month work plan.
Proposed by: Katz, H.B.
Seconded by: Markman, N.
Action: Passed Unanimously

b) Review Data Sources (WP Item 1.2) (Handouts B-1 to B-3 & C):
The Chair and committee reviewed the needs assessment presentation and findings. The Chair explained the data sources for the presentation and the importance of the needs assessment. The Vice Chair asked for sites where consumer surveys were distributed. Staff and the Grantee explained that surveys were distributed at all CIED and Part A provider sites. Online consumer surveys were also distributed. Staff explained that a consultant evaluated all needs assessment data and presented findings to the PSRA committee in May. Staff explained the data sources, demographics of survey respondents, and findings of note.

The Chair asked staff to explain the service categories currently funded by Part A. Staff explained that Part A funds ten service categories out of a possible 28 that are allowed to be funded. The Chair stated that the committee should look at the engagement of clients in HIV medical care. The Chair stated that a main goal of this committee will be to engage all Broward County residents in HIV care. The Vice Chair stated that some clients may have been confused when asked if there were currently receiving HIV-related primary medical care, as some clients have a primary medical doctor and an HIV specialist. There was committee discussion about retaining clients in care. A guest stated that some PLWHAs will never go to an HIV provider due to shame and stigma. Another guest stated that improving education about shame and stigma among providers will incline PLWHAs to get into care and be retained in care. The Grantee stated that there are many factors that perpetuate shame and stigma. The Grantee stated that there is stigma among Part A providers, which must be addressed.

Staff explained the most frequent reasons given by PLWHA for not receiving medical care. The most frequent reason was recertification and provider issues. Transportation was also included as a barrier to care. A member stated that Part B provides transportation and there are still transportation passes left over from the last fiscal year. The Chair stated that this factor can analyzed by the committee as some clients may not be able to utilize public transportation. Staff explained provider views on common barriers to client entry into care. Denial was noted as a major factor for client retention in care. Staff explained that provider personnel attitudes was a major barrier identified during the focus groups as well as the client surveys. The Chair asked a member if clients are asked what language they prefer to communicate in with their medical provider. A member stated that clients are asked about language preferences and staff tries to make sure that when they go to their first appointment a medical doctor is present who speaks their preferred language. However, there are other variables that may influence which medical provider a client is directed to, such as location. A guest stated that empathy should be looked at from both the client and front desk personnel's point of view. The Chair stated that providers should get to the root of the reason of a client's discomfort. The Chair stated that all providers must engage clients equally in order to provide quality care. The Grantee stated this data can be presented to each provider and corrective action may be issued to providers that have low ratings on friendliness of personnel.

Staff explained reasons given by clients for not having a usual place for HIV medical care. Not affording care was a major barrier to care. A member noted that this survey was completed earlier this year after open enrollment concluded, when clients may have chosen plans with low premiums and high deductibles, hindering retention in care. The Vice Chair stated that a prior needs assessment measured awareness of services and concluded that awareness of services was very low. The Vice Chair stated that awareness is a factor that this

committee must review and analyze. The Chair asked if the committee can review the needs assessment survey questions. The Grantee recommended that the committee have input on questions to be included in needs assessment surveys. The Grantee recommended including items that were not historically analyzed and including items that were identified in prior needs assessment surveys. The Chair stated that further discussion be tabled to the next meeting.

Action Items:

- Send needs assessment survey tools to committee

c) Community Forum (Handout D):
The Chair announced the HIVPC community forum and explained that the forum will provide the community with information about important HIV related issues and concerns. Topics such as available services and biomedical interventions will be presented. A guest stated that educating the community about coordination of HIV care would be an important information session for PLWHAs. The Grantee stated this forum was designed to educate the community about the epidemic, the role of the HIVPC, and elicit consumer feedback. The Grantee recommended that the committee have realistic goals as this event will take place in approximately four months; although this may seem like a lot of time, planning for these large events usually takes much longer. A member stated that the event should target communities where services and events are not usually held. The Grantee recommended the committee first review the goals of the event and the populations that will be served before planning specifics. A guest asked if the committee can reach out to elected officials to be involved in the event. The Grantee stated that would be a good idea. The Grantee recommended having a multi-year build up by starting small and making the event better and bigger in the future. The Chair stated that this event should be interactive among attendees rather than just providing information. The Grantee recommended collaborating with the Community Empowerment Committee (CEC) about event topics and logistics. The Chair asked staff to look for event locations with private spaces for breakout sessions.

4. GRANTEE REPORT

The Grantee stated that the Grantee's Office along with Florida's AIDS Drug Assistance Program (FL ADAP) are analyzing and coming to agreements on Marketplace Plans. The Grantee stated that approximately four to five plans will be approved and released. The Grantee's Office is working diligently to make sure this transition is as seamless as possible for clients.

5. PUBLIC COMMENT

None.

6. AGENDA ITEMS/TASKS FOR NEXT MEETING: Friday, January 23, 2015, 9:30 a.m. VENUE: Gov't Center Annex Room A337

Goal/Work Plan Objective #:	*Accomplishments*
Review Data Sources (WP Item 1.2)	ACTION ITEM: Review identified areas for further research from November meeting. Determine solutions or recommendations to other committees.
	ACTION ITEM: Review the 2014 Needs Assessment, *Voices*, FY2014 Grant Application, and epidemiology data for emerging and priority populations. Identify populations in need of further research.

7. ANNOUNCEMENTS

None.

8. ADJOURNMENT

The meeting adjourned at 11:29 a.m.

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System of Care Attendance - CY2014

Member	10/27/14	11/24/14
Cook, R.	1	1
Eckardt, P	A	A
Eserman, C.	1	1
Katz, H.B.	A	1
Kress, G.	1	1
Markman, N.	1	1
Rodriguez, J.	1	1
Sabatino, D. *Vice Chair*	1	1
Schweizer, Dr. M *Chair*	1	1
Ullah, E.	1	A
Quorum = 6	8	8

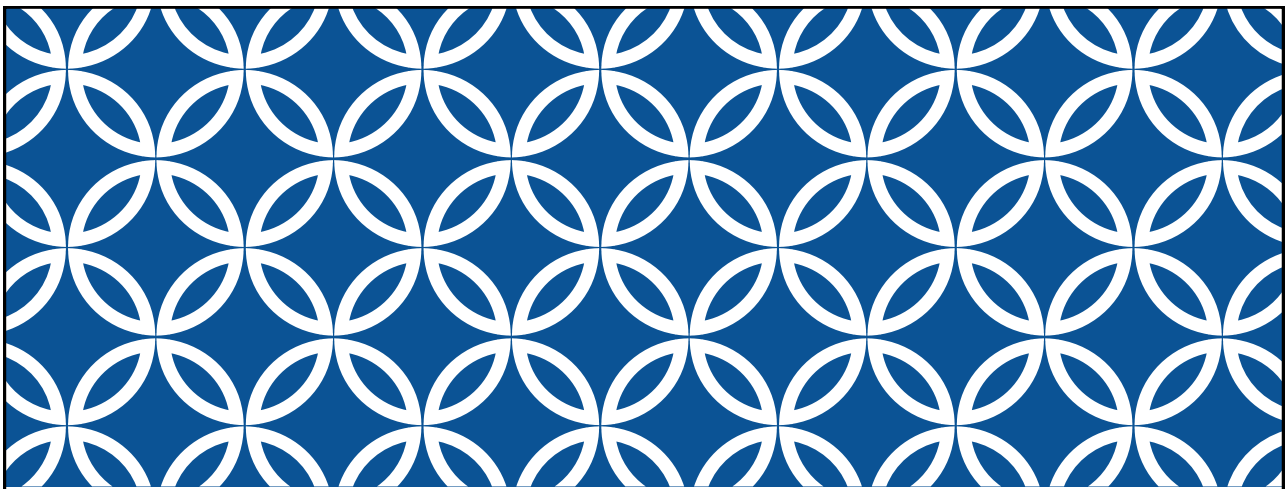
HANDOUT A

Broward County HIV Health Services Planning Council Calendar

Last Updated: 3/23/2015

	Monday	Tuesday	Wednesday	Thursday	Friday
WEEK ONE		CEC, 1:00 p.m.		MCDC, 9:30 a.m.	
WEEK TWO	NAE, 1:00 p.m.	Ad-Hoc Food Services, 12:30 p.m.	Ad-Hoc By-Laws, 9:30 a.m.	Ad-Hoc LPAC, 9:30 a.m.	
WEEK THREE	QMC, 12:30 p.m.	Executive, 9:30 a.m.	PSRA, 12:30 p.m.		
WEEK FOUR				HIVPC, 9:30 a.m.	

HIVPC
Broward County HIV Health Services Planning Council



2013 NEEDS ASSESSMENT FINDINGS

TOPIC AREAS

- Data Sources for the Presentation
- Characteristics of PLWH in the Client Survey
- PLWH Use of Medical Care and Antiretroviral Drugs
- Service Needs and Gaps

DATA SOURCES FOR THE PRESENTATION

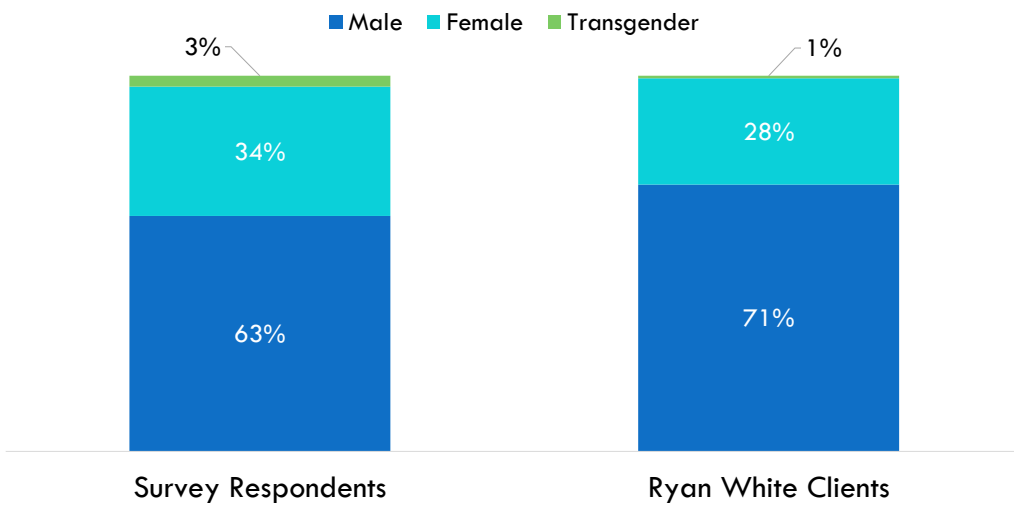
- 2014 PLWH/client survey – 730 responses (some incomplete)
- 2014 provider survey – 10 responses
- 2013 and 2014 Hispanic focus groups – 15 participants
- Ryan White Service Report (RSR) data on Ryan White client demographics – 7,467 clients of Part A and ADAP
- Note: Several challenges were encountered in analyzing the client survey data

CHARACTERISTICS OF PLWH IN THE CLIENT SURVEY

PLWH COMPLETING THE 2014 SURVEY

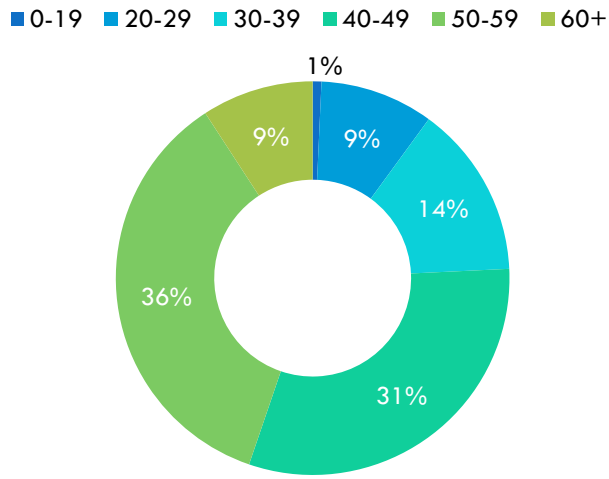
- The 730 PLWH participating in the 2014 client survey come from 34 countries plus Puerto Rico and the U.S. Virgin Islands – more than 80% were born in the U.S. or its territories
- 89% speak most often speak English at home – 6% speak Spanish, 3% Creole, and 2% other languages
- Comparison with all Broward Ryan White clients shows a largely representative sample except for gender
- Survey respondents are more likely to be female than all Ryan White clients
- PLWH participating in the survey are a little younger than all clients

Gender of Survey Respondents and Ryan White Clients



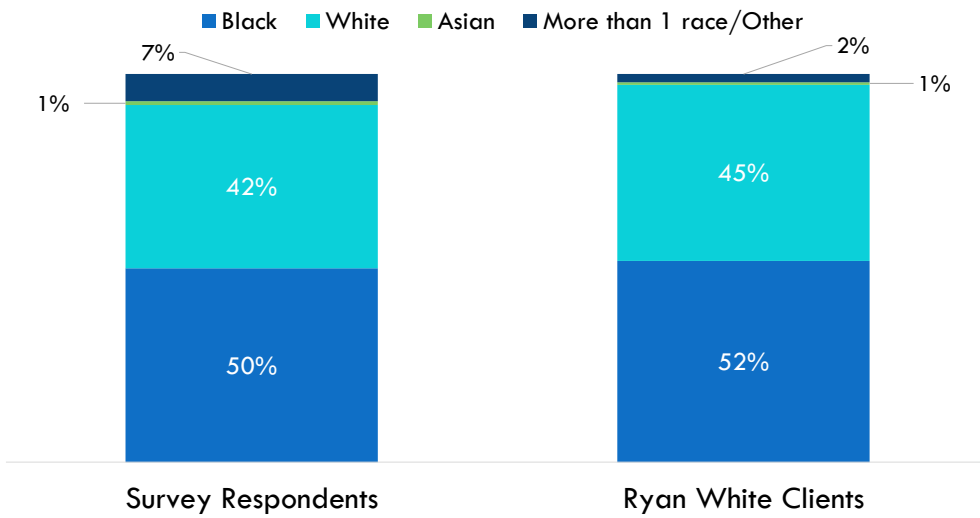
- Both women and transgender people are overrepresented in the PLWH survey
- The overrepresentation of transgender people is helpful because it provides a sufficient number (20) to permit separate analysis of their needs and perspectives

Age of Survey Respondents
N = 697



- 24% of PLWH in the survey are 39 or younger, 67% are 40-59, and less than 9% are 60 or older
- The overall Ryan White client population appears somewhat older – 15% are 59+

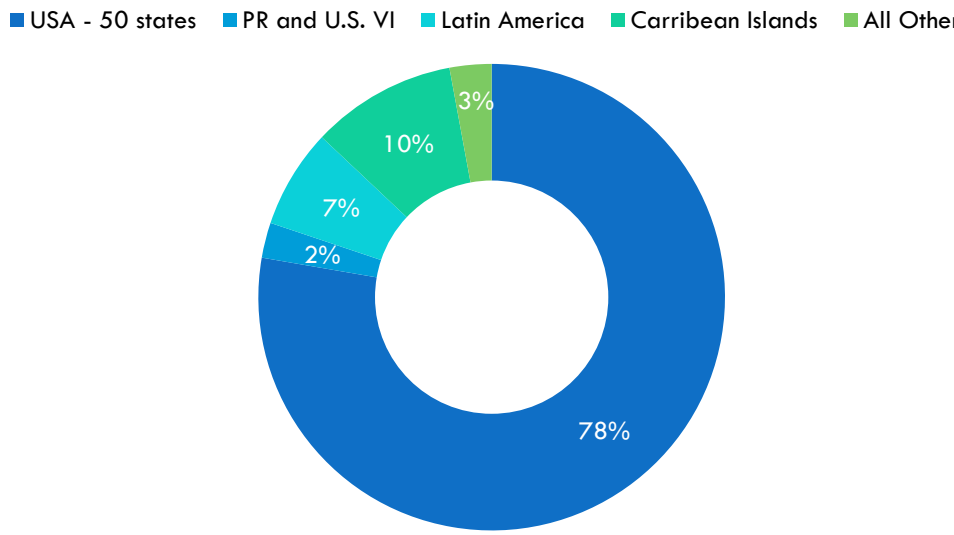
Race of Survey Respondents and Ryan White Clients



- The survey respondents are similar to the Ryan White client population in race
- Asians and mixed/other racial groups are slightly overrepresented
- 17% of PLWH identify as Hispanic/Latino (as do 16% of all Ryan White clients living in Broward County)

HANDOUT B-1

Country or Region of Birth of Survey Respondents
N = 655



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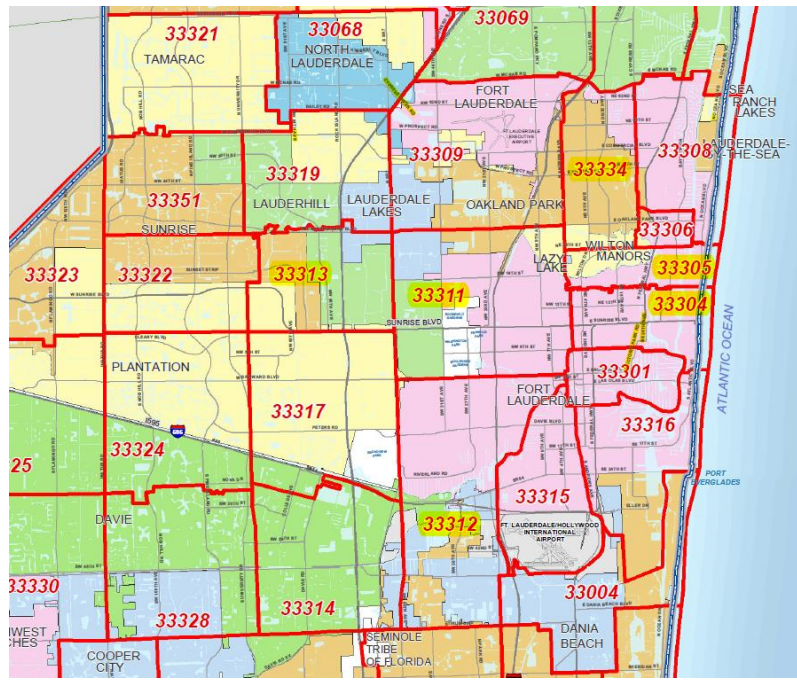
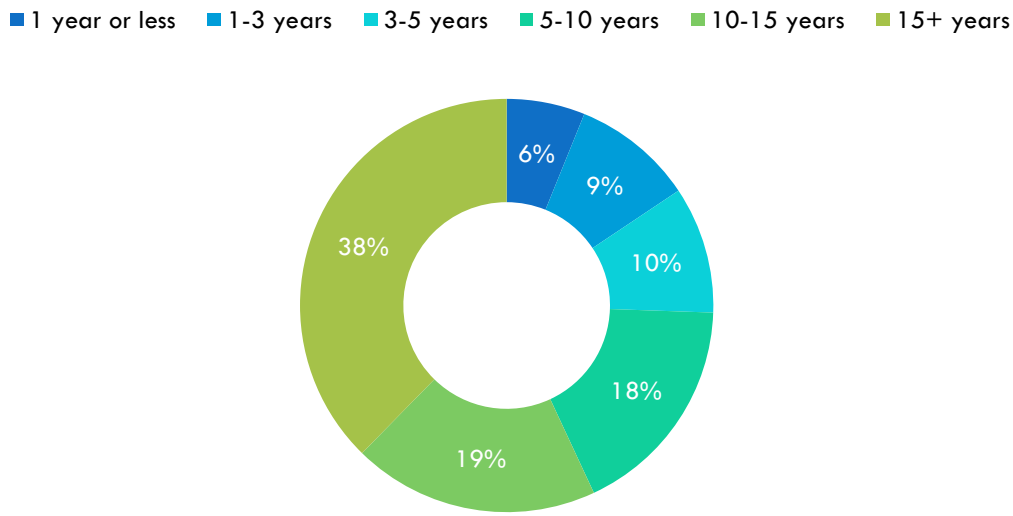
TOP SIX ZIP CODES OF RESIDENCE

1. 33311 – Fort Lauderdale
2. 33304 – Fort Lauderdale
3. 33334 – mostly Oakland Park
4. 33313 – Sunrise & Lauderhill
5. 33312 – Fort Lauderdale
6. 33305 – Fort Lauderdale



How Long PLWH Have Lived with Diagnosed HIV



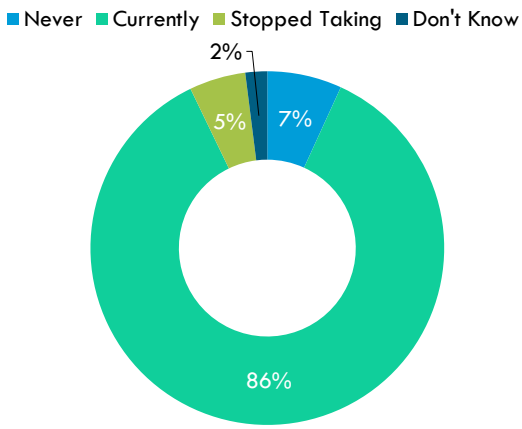
- 25% of the PLWH in the survey were diagnosed with HIV less than 5 years ago
- 37% were diagnosed 5-15 years ago and 38% more than 15 years ago

USE OF MEDICAL CARE AND ANTIRETROVIRAL DRUGS

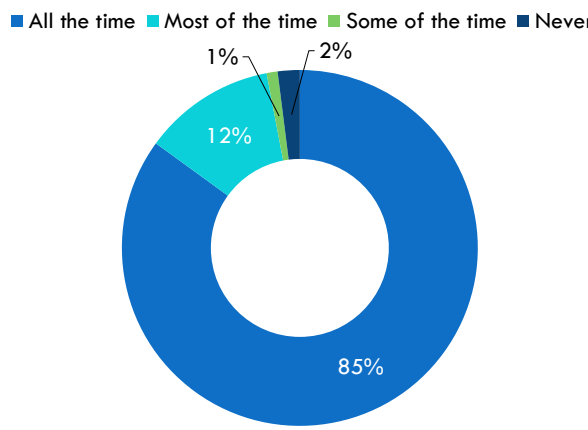
ENGAGEMENT IN MEDICAL CARE

- 76% PLWH responding to the survey said they get their medical care through Ryan White
- 96% said they are Ryan White clients (PLWH were surveyed at CIED locations)
- 91% said they have a place they usually go for their HIV medical care
- 17% reported not receiving HIV-related primary medical care at some point during the last 12 months

Experience with Antiretroviral Drugs N=601

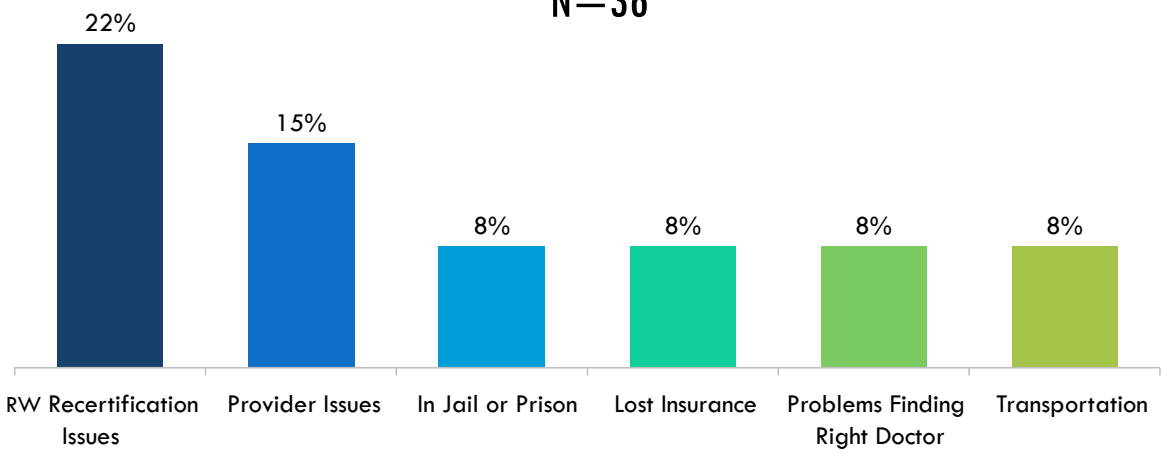


How Often PLWH Take HIV Drugs as Prescribed N=580



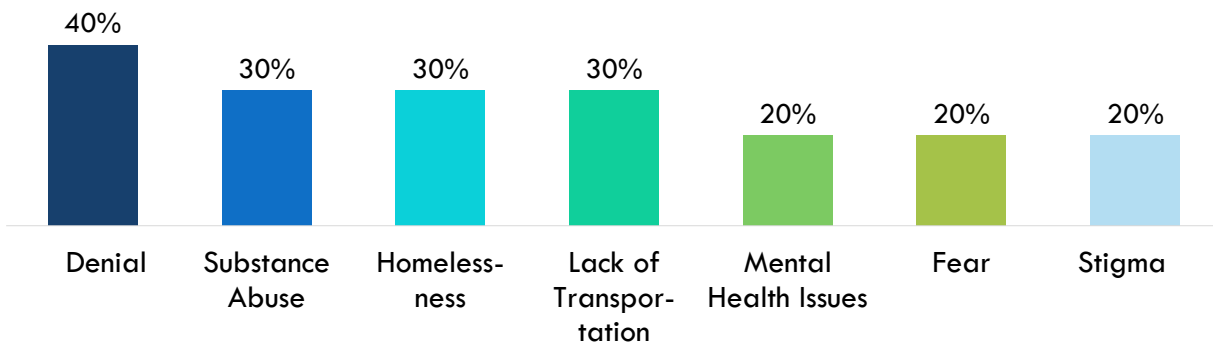
- Transgender respondents are less likely to be currently taking antiretrovirals (67%) and more likely never to have taken them (17%)
- Hispanic respondents are slightly more likely never to have taken ART (9%)
- Homeless PLWH respondents are less likely than other PLWH to always take ART as prescribed (76%), and more likely to have stopped taking ART (15%)

Most Frequent Reasons Given by PLWH for Not Receiving Medical Care
N=36



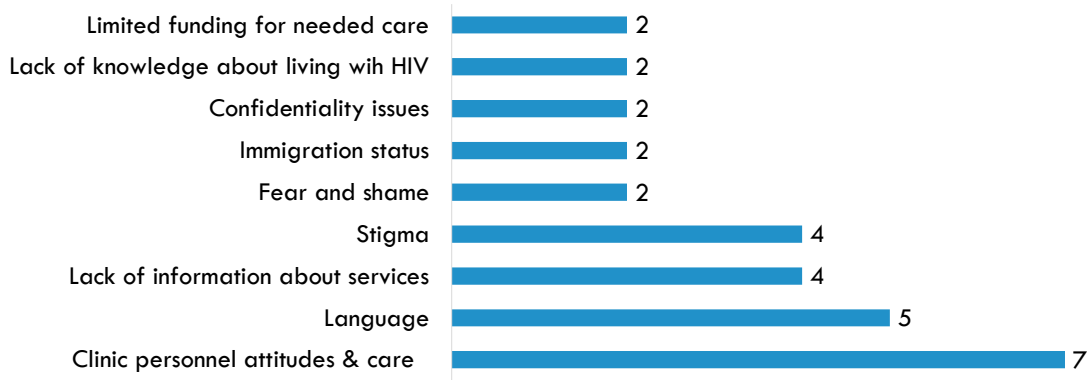
- Reasons for going without HIV-related medical care related to access or navigating the system of care
- Letting Ryan White "eligibility lapse" after 6 months and having challenges with recertification
- 1-2 PLWH reported immigration issues, addiction, being unable to keep appointments due to a job, homelessness, other serious medical problems, moving, not feeling a need for medical care, and laziness

Provider Views on Most Common Barriers to Client Entry into HIV Medical Care
(Factors identified by at least 2 of 10 providers)



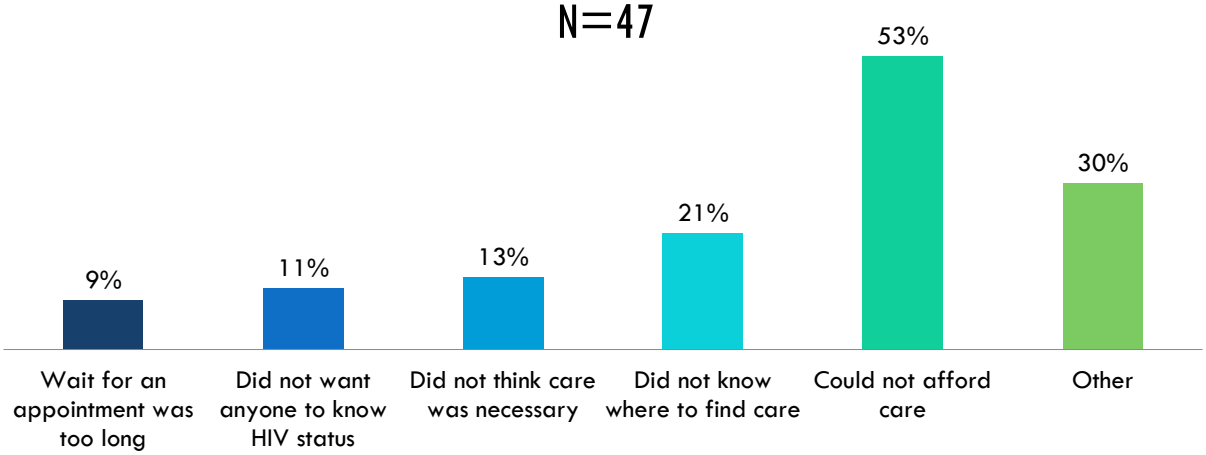
- Providers most often identified co-occurring conditions or other personal or societal factors as preventing or delaying entry into HIV medical care

Barriers to Medical Care for Hispanic PLWH Focus Groups N=15



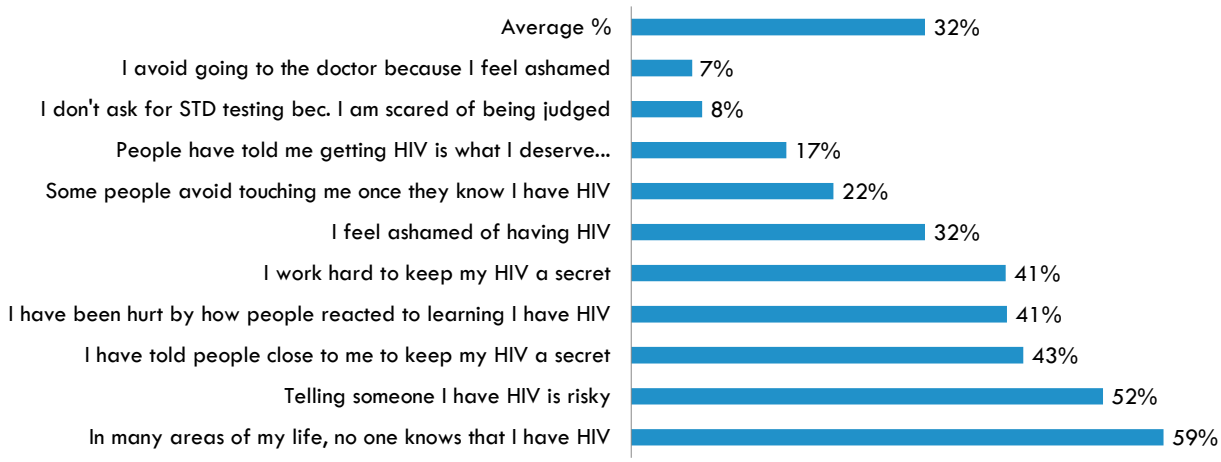
- Participants in the Hispanic focus groups identified multiple personal and system of care-related barriers to medical care
- Most frequently identified were negative experiences with clinic personnel, such as poor communications, lack of empathy, rude front desk personnel, and being treated in a "lesser way" than other patients as well as a lack of bilingual services – which taken together suggest a lack of sufficient culturally appropriate services

Reasons Given by PLWH for Not Having a Usual Place for HIV Medical Care N=47



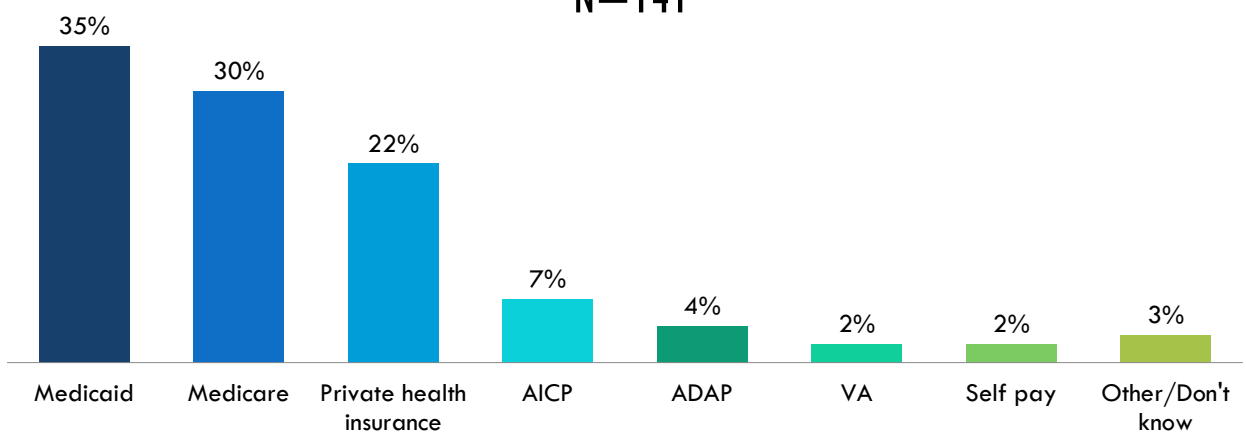
- 47 PLWH who said they do not have a usual place for HIV medical care provided one or several reasons – and a majority said they cannot afford care
- Among the "Other" responses: could not leave work to keep appointments, couldn't find a doctor who speaks my language, and lack of transportation

PLWH Experiences Living with HIV (Percent Who Strongly Agree or Agree with Each Statement)



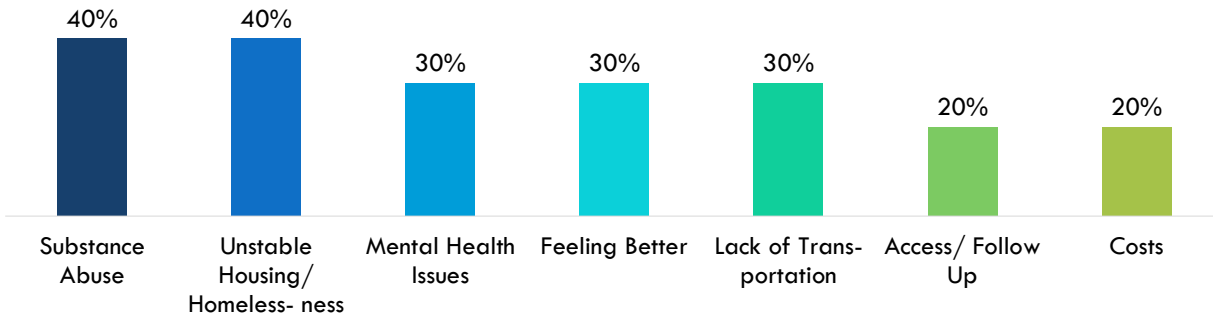
- Stigma and confidentiality remain important issues for PLWH
- A small minority may not get care because they feel ashamed of their status or fear stigma and discrimination

How PLWH Pay for Medical Care When it is Not Provided by Ryan White N=141



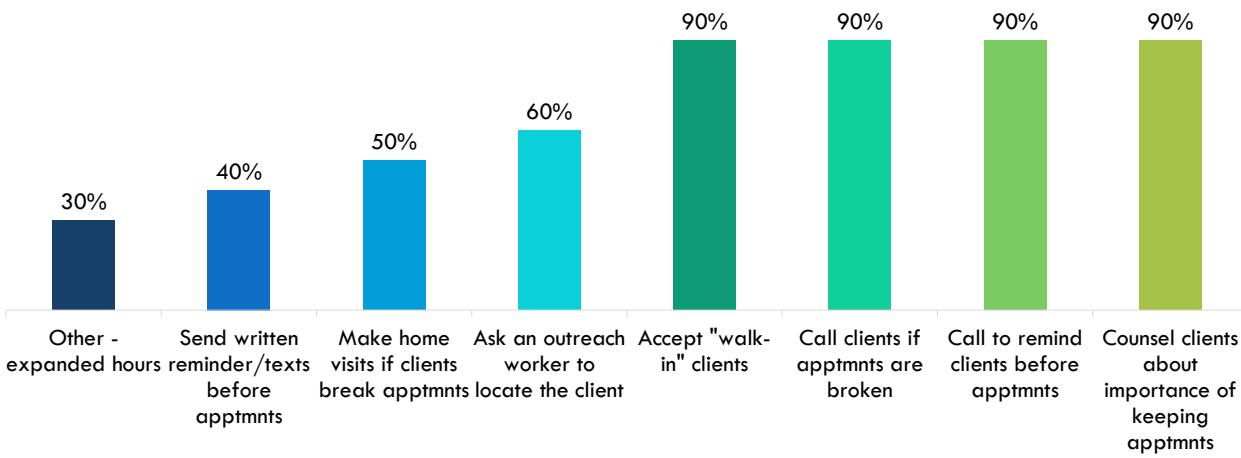
- PLWH who said Ryan White does not pay for their medical care most often reported Medicaid, Medicare, or private insurance
- A small number identified several Ryan White service categories (AICP or ADAP) as funding their care
- A few PLWH identified more than one source (e.g., Medicare & Medicaid)

Provider Views on Most Common Barriers to Client Retention (Factors identified by at least 2 of 10 providers)



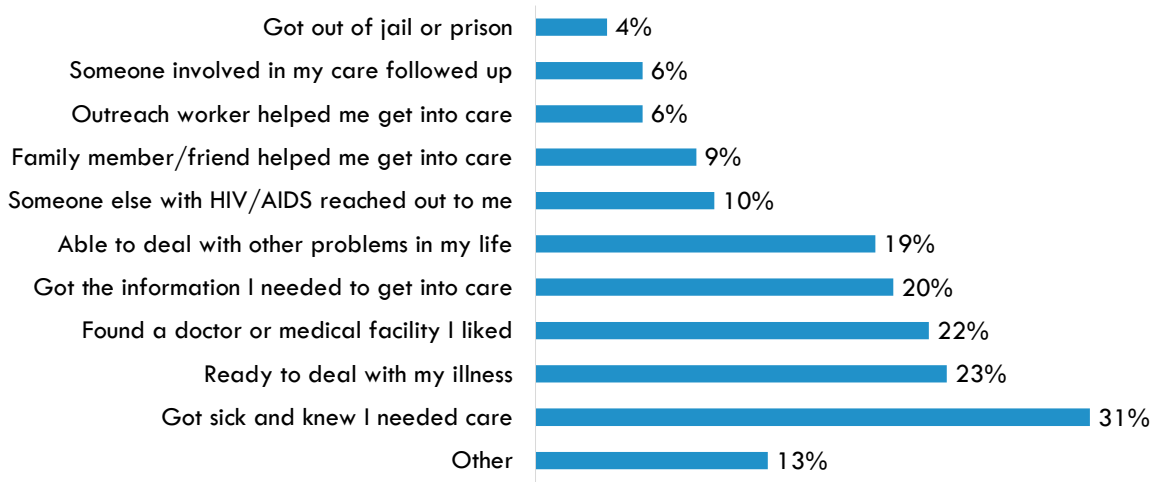
- This was an open-ended question
- Providers most often identified co-occurring conditions as the most common barriers to retention
- Some system of care issues (transportation, access/follow-up, and costs) were also identified

Provider Reported Retention Activities N=10



- Providers reported numerous activities to encourage retention
- Most of the response options involve communications to help PLWH keep their appointments or to reconnect with them after a missed appointment
- The most frequent “other” response was expanding hours to make services more accessible

Main Reasons PLWH Gave For Returning to Care
N=150



- PLWH identified many reasons for returning to care, some involving personal issues, others related to outreach or to finding a source of care that meets their needs

DIFFERENCES BY PLWH SUBPOPULATIONS

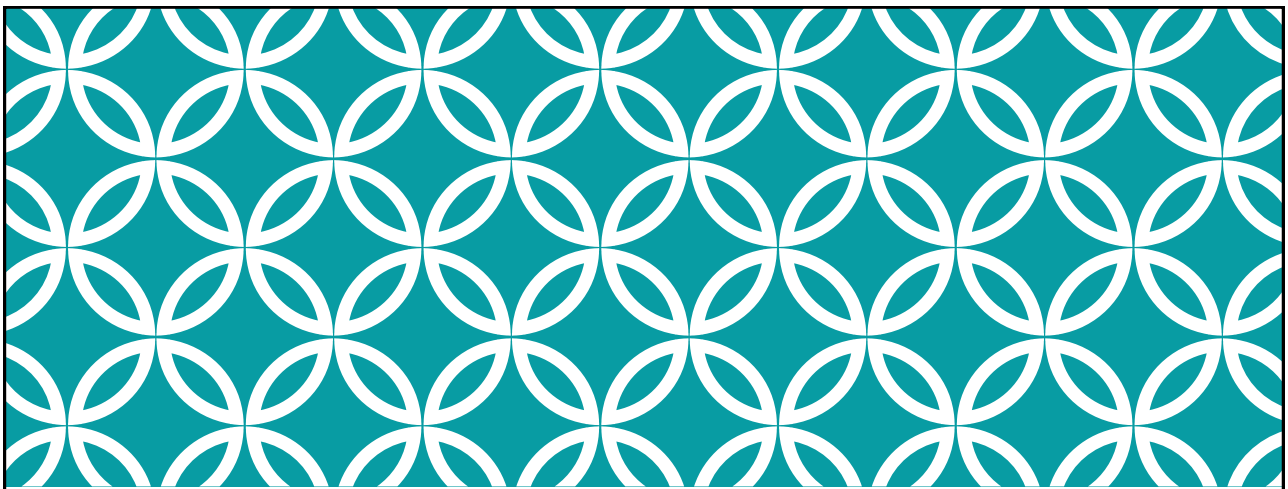
- Cross-tabulations and tests of significance were used to identify differences in characteristics and responses by PLWH subpopulations
- Small differences in access to care and service needs were found by race
- A few differences were found by ethnicity – for Hispanics
- Some differences were found by gender – particularly for transgenders
- Differences appear to be largest based on co-occurring conditions such as homelessness

DIFFERENCES BASED ON HOMELESSNESS

- 118 or 18% of the PLWH surveyed indicated that they were homeless at some point during the past 12 months
  - Almost 1/3 of them are female
- 58% were in stable housing at the time of the survey
- Compared to other PLWH, those who were homeless in the past 12 months:
  - Were diagnosed more recently: More likely to have been diagnosed 3-10 years ago (38% vs. 28%)
  - Are more likely to get their medical care through Ryan White (81% vs. 73%)
  - Are more likely to have traded sex for a place to stay (24% vs. 5%) or drugs (11% vs. 6%)

HOMELESSNESS, CONT.

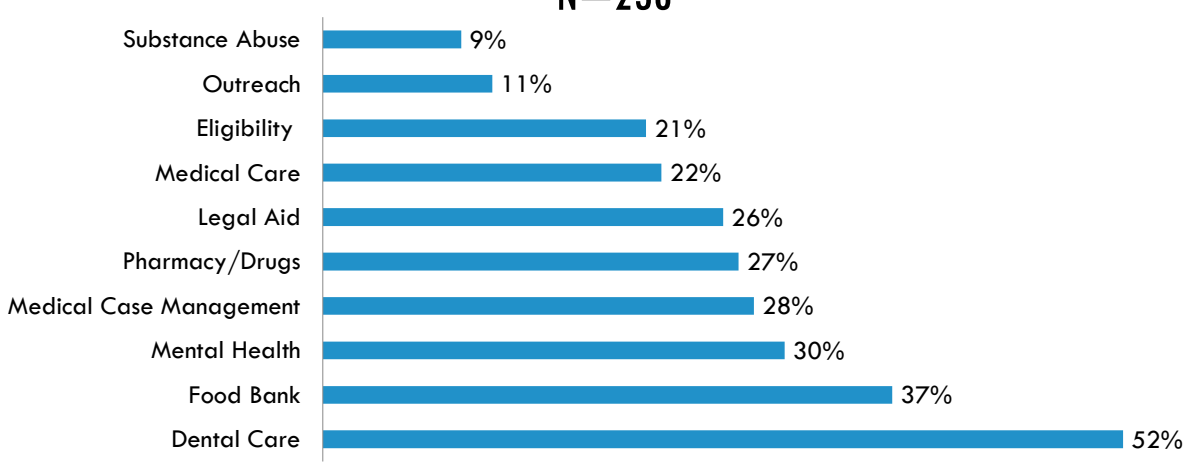
- Being homeless interferes with treatment:
  - 79% are currently on ART, compared to 88% of other PLWH
  - 15% stopped taking ART, compared to 3% of other PLWH
  - 76% of those on ART take their meds all the time, compared to 86% of other PLWH
- Homelessness can interrupt HIV care:
  - While homeless, half (50%) continued seeing their previous doctor, but 15% got care through a shelter clinic or other low-cost clinic
  - 11% got their care only in the emergency room, and 13% did not receive medical care while homeless
- Obtaining stable housing improves care:
  - Two-thirds (69%) of PLWH said their medical care improved because they are in stable housing



SERVICE NEEDS AND GAPS

Services Needed by PLWH but Not Received in the Past 12 Months

N=238



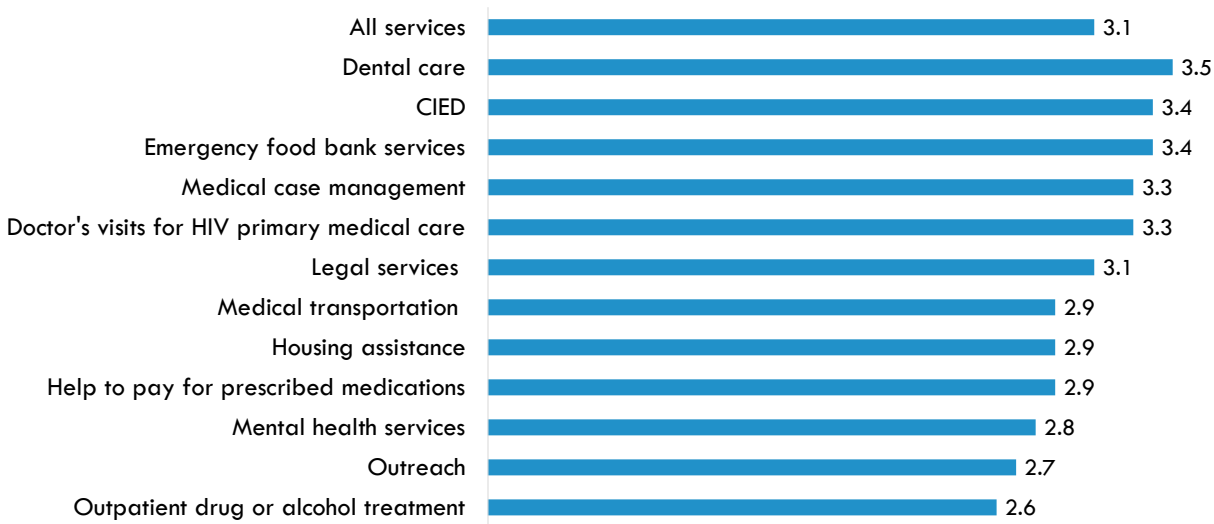
- 238 PLWH reported needing but not receiving 1 or more services in the past year
- Most often identified service gaps were in Dental Care and Food Bank

ACCESS TO CARE: PROVIDER PERSPECTIVES

- 30% said access to assistance in paying insurance premiums, deductibles, and co-pays has gotten worse
  - The wait time for intake is longer, and Ryan White funds could not be used to help with Marketplace plans while plans were being evaluated by the State
- Reported least capacity to serve clients who are substance users, are depressed or anxious, or have severe & persistent mental illness
- When asked about referrals, 30% identified challenges in obtaining timely mental health services for their clients and suggested a need for:
  - Increased use of peers, more clarity from case managers about mental health options and referrals, and more mental health services with fewer limitations and eligibility issues

Ease of Referrals to Services in the Past 12 Months: Weighted Means

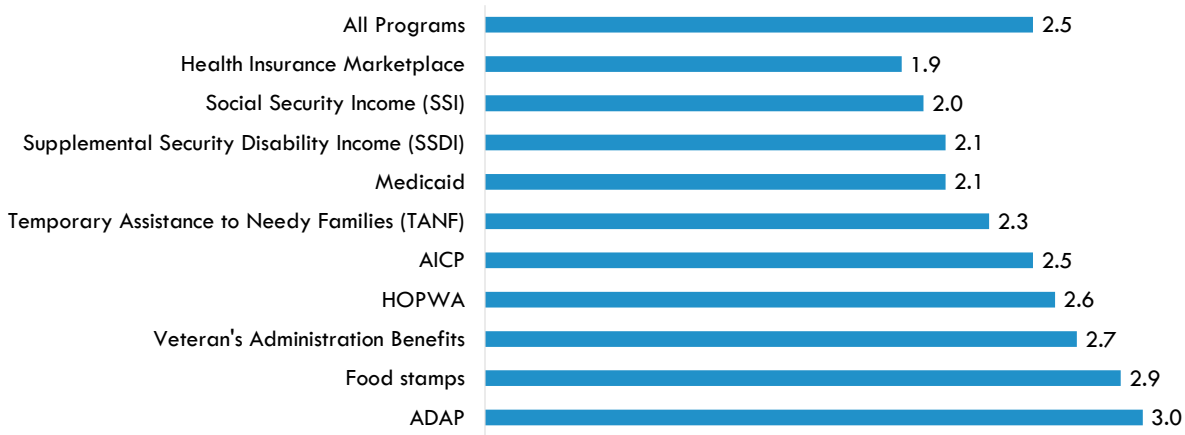
Scale: 4 = very easy, 3 = easy, 2 = hard, 1 = very hard



- Providers reported the greatest difficulties in referring clients for substance abuse, outreach, and mental health

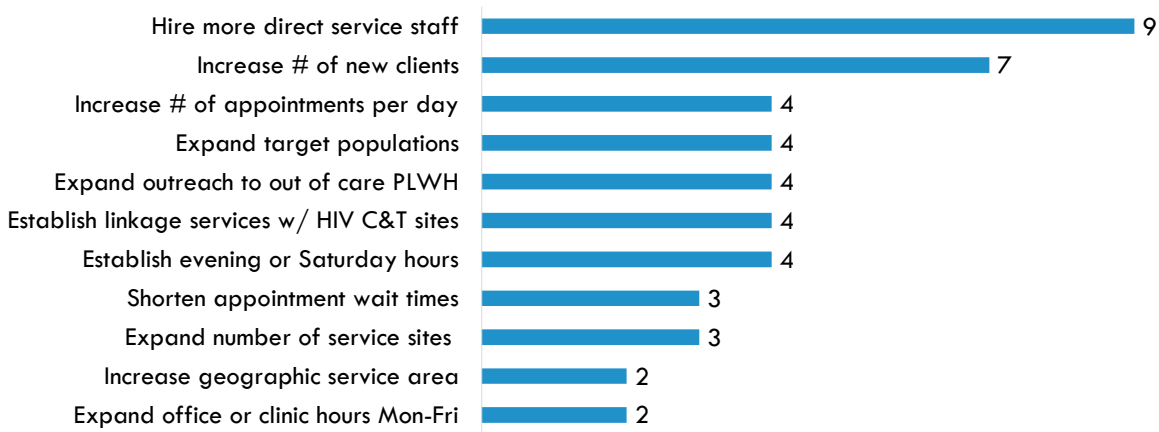
Ease of Client Enrollment into Assistance Programs in the Last 12 Months: Weighted Means

Scale: 4 = very easy, 3 =easy, 2 = hard, 1 = very hard



- Providers reported considerable difficulties in helping clients enroll in health plans and an inability to provide insurance premium and cost-sharing assistance in the absence of State guidance
- Clients often have a long wait after applying for services such as Food Stamps and Medicaid; many Medicaid applications are denied and require Legal Aid assistance for the appeals process

Ways Providers Would Use Additional Funds to Expand Services



When asked about their current capacity to increase the number of PLWH they serve:

- 2 said they could increase the number by 1-5%
- 4 said 6-10%
- 1 said 11-15%
- 3 said 16-20%

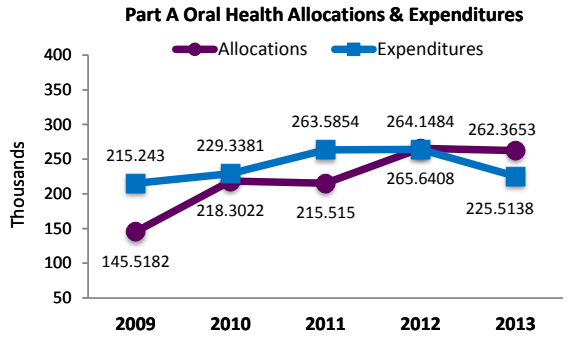
QUESTIONS/DISCUSSION?

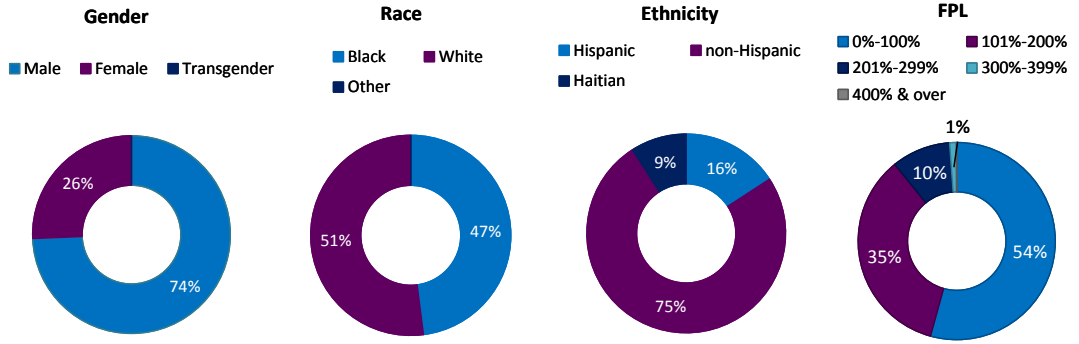
2014 Needs Assessment Findings

Identified Service Gaps ** mentioned by providers and clients*
Dental Care*
Food Bank
Pharmacy
Housing
Case Management*
Transportation*
Mental Health Care*
Substance abuse*
Legal Aid
Identified Capacity Development Needs
Cultural Competency
Confidentiality
Education and client outreach
Identified Structural Barriers
Difficulty for Providers Referring to Services: • Substance Abuse • Outreach • Mental Health • Medical Transportation • Housing Assistance • Help paying for medications
Stigma and Shame
Lack of Transportation

FY 2013/14 Scorecard: Part A Oral Health Care — ELIGIBILITY: </=400% FPL

Fiscal Year	Part A & MAI Service Allocations			Final Part A & MAI Expenditures				EMA Award		Priority Rank
FY	Part A	MAI	Total	Part A	MAI	Total	% change	Total	% Award	
2013	$2,623,653	$0	$2,623,653	$2,255,138	$0	$2,255,138	-15%	$15,366,650	14.7%	3
2012	$2,656,408	$0	$2,656,408	$2,641,484	$0	$2,641,484	0%	$15,423,413	17.1%	3
2011	$2,155,150	$0	$2,155,150	$2,635,854	$0	$2,635,854	15%	$15,006,261	17.6%	4
2010	$2,183,022	$0	$2,183,022	$2,293,381	$0	$2,293,381	7%	$15,395,252	14.9%	3
2009	$1,455,182	$0	$1,455,182	$2,152,430	$0	$2,152,430		$15,189,762	14.2%	4





FY 2013/14 Part A Demographics

Year	Total Clients	% change	# New	% New
2013	**3,182**	16%	905	28.4%
2012	2,751		676	24.6%

Ryan White Part A Providers

Type	Part A	MAI
Number	2	0

Male	Female	Transgender
74.0%	25.5%	0.0%
Black	**White**	**Other**
47.4%	51.4%	0.0%
Hispanic	**non-Hispanic**	**Haitian**
17.4%	82.6%	10.0%

FPL*	#	%
0%-100%	1728	54.3%
101%-200%	1110	34.9%
201%-299%	307	9.6%
300%-399%	35	1.1%
400% & over	2	0.1%

* FPL is current for the end of the FY

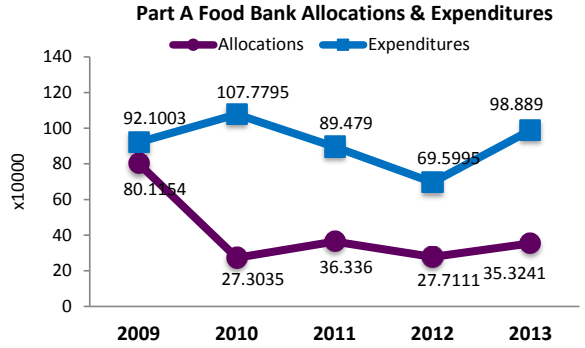
Fort Lauderdale/Broward EMA Oral Health Outcome	2011		2012		2013	
Outcome: Reduction in the number of teeth with untreated caries.	Num/Denom	%	Num/Denom	%	Num/Denon	%
1.1 90% of caries identified in the initial treatment plan will be restored upon completion of the initial treatment plan.	243/249	97.6%	257/262	98.1%	539/548	98.4%
1.2 90% of patients will be free of recurrent caries on restorations placed in the initial treatment plan upon examination at a period of six to twelve months after completion of the initial treatment plan.	47/55	85.5%	32/61	52.5%	142/189	75.1%

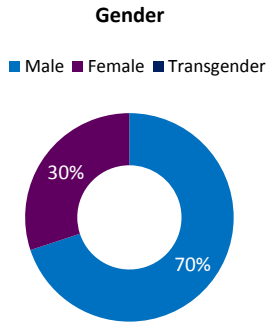
FY 2013/14 Scorecard: Part A Oral Health Care			ELIGIBILITY: <=400% FPL			
National Quality Center (NQC) inCARE Retention Measures for Part A Oral Health Patients	**2012**		**2013**		**Participant National Avg**	**Comments**
#1: Gap Measure	Num/Denom	%	Num/Denom	%	%	
Patients with NO medical visits in last 180 days of measurement year / Patients with >/= 1 medical visit in 1st 6 months of measurement year	91 / 741	12.3%	140 / 723	19.4%	14.5%	Strive for low%. Better than nat'l avg.
#2: Medical Visit Frequency	Num/Denom	%	Num/Denom	%	%	
Patients with >/=1 medical visit in EACH 6 month period of 24-mos period / Patients with >/=1 medical visit in 1st 6 months of 24-mos period	412 / 545	75.6%	365 / 476	76.7%	69.6%	Strive for high%. Better than nat'l avg.
#3: Patients Newly Enrolled in Medical Care	Num/Denom	%	Num/Denom	%	%	
Patients with >/= 1 medical visit in each 4-months of measurement year / Patients newly enrolled w/ provider & >/=1 visit in 1st 4 mos. of year	45 / 89	50.6%	43 / 131	32.8%	55.1%	Strive for high%. Worse than nat'l avg.
#4: Viral Load Suppression	Num/Denom	%	Num/Denom	%	%	
Patients with a viral load <200 at last VL test in measurement year / Patients with at least one medical visit in the measurement year	652 / 834	78.2%	702 / 910	77.1%	77.1%	Strive for high%. Equal to nat'l avg.

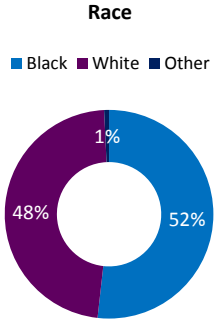
FY 2013/14 Scorecard: Part A Food Services

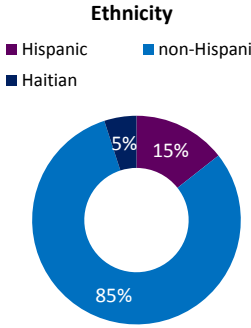
ELIGIBILITY: Food Bank <= 250% FPL, Emergency Provision (Food Vouchers/Box) <= 251%-300% FPL

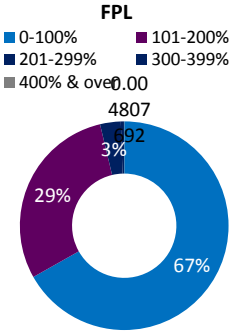
Fiscal Year	Part A & MAI Service Allocations			Final Part A & MAI Expenditures				EMA Award		Priority Rank
FY	Part A	MAI	Total	Part A	MAI	Total	% change	Total	% of Total	
2013	$353,241	$0	$353,241	$988,890	$0	$988,890	42.1%	$15,366,650	6.4%	2
2012	$277,111	$0	$277,111	$695,995	$0	$695,995	-22.2%	$15,423,413	4.5%	1
2011	$363,360	$0	$363,360	$894,790	$0	$894,790	-17.0%	$15,006,261	6.0%	1
2010	$273,035	$0	$273,035	$1,077,795	$0	$1,077,795	17.0%	$15,395,252	7.0%	1
2009	$801,154	$0	$801,154	$921,003	$0	$921,003		$15,189,762	6.1%	1











FY 2013/14 Part A Utilization & Demographics

Year	Total Clients	% change	# New	% New
2013	**2,496**	14.1%	650	26.0%
2012	2,188		577	26.4%

Ryan White Part A & MAI Providers		
Type	Part A	MAI
Number	1	0

Male	Female	Transgender
69.6%	29.9%	0.0%
Black	**White**	**Other**
51.8%	47.5%	0.8%
Hispanic	**non-Hispanic**	**Haitian**
15.1%	84.9%	5.2%

FPL *	#	%
0-100%	1668	66.8%
101-200%	735	29.4%
201-299%	80	3.2%
300-399%	12	0.5%
400% & over	1	0.0%

FY 2013/14 Scorecard: Part A Food Services

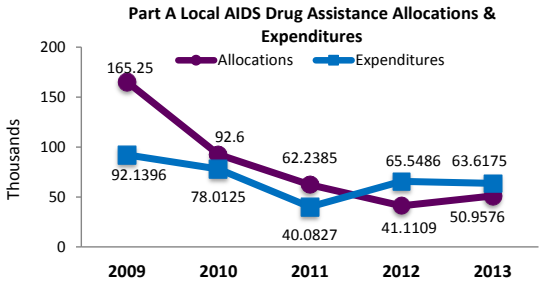
ELIGIBILITY: Food Bank <= 250% FPL, Emergency Provision (Food Vouchers/Box) <= 251%-300% FPL

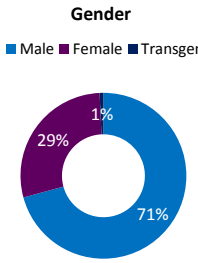
Fort Lauderdale/Broward EMA Food Services Outcomes	2011		2012		2013	
Outcome: Improve and/or maintain a client's adherence to medication when food is required.	Num/Denom	%	Num/Denom	%	Num/Denom	%
1.1 80% of clients report an improved ability to take medications when food is required.	1397/1407	99.3%	1507/1524	98.9%		100.0%
Outcome: Improve client's knowledge of food handling.	Num/Denom	%	Num/Denom	%	Num/Denom	%
2.1 100% of clients will receive food handling information as indicated by client signature.	2053/2059	99.7%	1839/2280	80.7%		100.0%

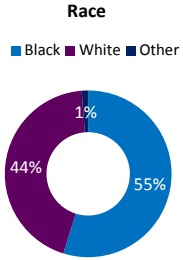
* FPL is current for the end of the FY

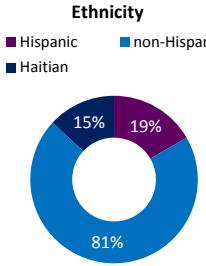
FY 2013/14 Scorecard: Part A Local AIDS Drug Assistance — ELIGIBILITY: <=400% FPL

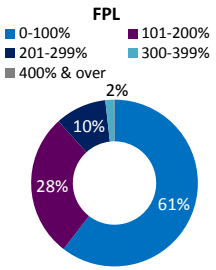
Fiscal Year	Part A & MAI Service Allocations			Final Part A & MAI Expenditures				EMA Award		Priority Rank
FY	Part A	MAI	Total	Part A	MAI	Total	% change	Total	% of Total	
2013	$509,576	$0	$509,576	$636,175	$0	$636,175	-2.9%	$15,366,650	4.1%	2
2012	$411,109	$0	$411,109	$655,486	$0	$655,486	63.5%	$15,423,413	4.2%	2
2011	$622,385	$0	$622,385	$400,827	$0	$400,827	-48.6%	$15,006,261	2.7%	2
2010	$926,000	$0	$926,000	$780,125	$0	$780,125	-15.3%	$15,395,252	5.1%	2
2009	$1,652,500	$40,000	$1,692,500	$921,396	$0	$921,396		$15,189,762	6.1%	2











FY 2013/14 Part A Utilization & Demographics

Year	Total Clients	% change	# New	% New
2013	**3,108**	21.8%	816	26.3%
2012	2,551		679	26.6%

Ryan White Part A & MAI Providers

Type	Part A	MAI
Number	3	0

Male	Female	Transgender
70.8%	28.5%	0.7%
Black	**White**	**Other**
54.8%	43.9%	1.3%
Hispanic	**non-Hispanic**	**Haitian**
19.2%	80.8%	15.1%

FPL *	#	%
0-100%	1879	60.5%
101-200%	864	27.8%
201-299%	310	10.0%
300-399%	51	1.6%
400% & over	4	0.1%

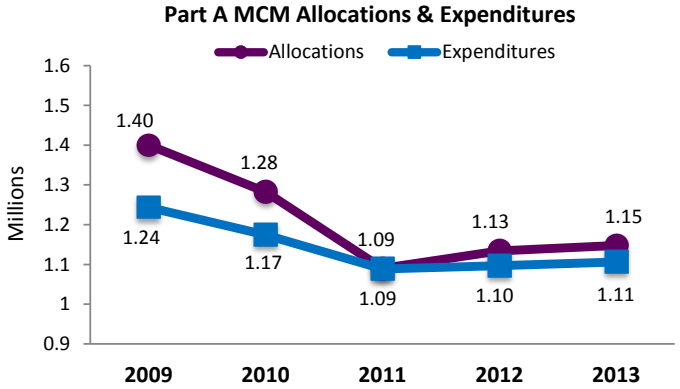
* FPL is current for the end of the FY

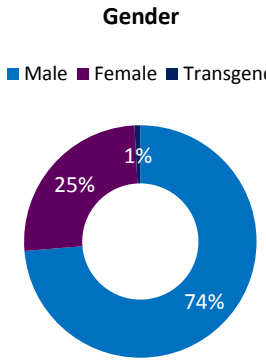
FY 2013/14 Scorecard: Part A Local AIDS Drug Assistance — ELIGIBILITY: <=400% FPL

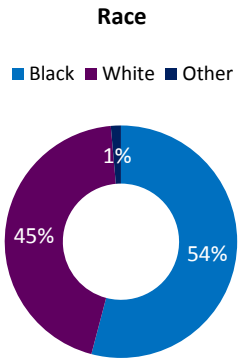
National Quality Center (NQC) inCARE Retention Measures	2012		2013		Participant National Avg	Comments
#1: Gap Measure	Num/Denom	%	Num/Denom	%	%	
Patients with NO medical visits in last 180 days of measurement year / Patients with >/= 1 medical visit in 1st 6 months of measurement year	50 / 802	6.2%	43 / 353	12.2%	14.5%	Strive for low%. Better than nat'l avg.
#2: Medical Visit Frequency	Num/Denom	%	Num/Denom	%	%	
Patients with >/=1 medical visit in EACH 6 month period of 24-mos period / Patients with >/=1 medical visit in 1st 6 months of 24-mos period	622 / 692	89.9%	276 / 318	86.8%	69.6%	Strive for high%. Better than nat'l avg.
#3: Patients Newly Enrolled in Medical Care	Num/Denom	%	Num/Denom	%	%	
Patients with >/= 1 medical visit in each 4-months of measurement year / Patients newly enrolled w/ medical provider & >/=1 visit in 1st 4 mos. of yr	19 / 29	65.5%	4 / 9	44.4%	55.1%	Strive for high%. Worse than nat'l avg.
#4: Viral Load Suppression	Num/Denom	%	Num/Denom	%	%	
Patients with a viral load <200 at last VL test in measurement year / Patients with at least one medical visit in the measurement year	700 / 852	82.2%	336 / 384	87.5%	77.1%	Strive for high%. Better than nat'l avg.

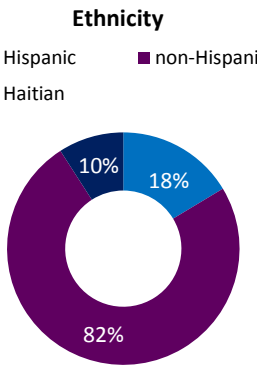
FY 2013/14 Scorecard: Part A Medical Case Management — ELIGIBILITY: <= 400% FPL

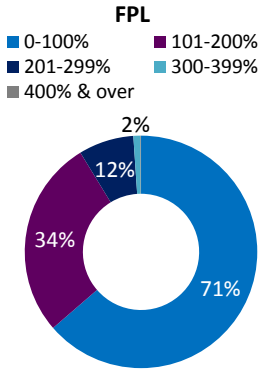
Fiscal Year	Part A Service Allocations	Final Part A Expenditures	Part A % Change	EMA Award		Priority Rank
				Total	% of Total	
2013	$1,147,448	$1,105,992	0.8%	$15,366,650	7.2%	4
2012	$1,134,105	$1,097,100	0.8%	$15,423,413	7.1%	5
2011	$1,090,105	$1,088,560	-7.3%	$15,006,261	7.3%	3
2010	$1,282,612	$1,174,211	-5.6%	$15,395,252	7.6%	4
2009	$1,400,201	$1,243,500		$15,189,762	8.2%	3











FY 2013/14 Part A Utilization & Demographics

Total Clients	# New	% New
3,321	875	26.3%

Ryan White Part A & MAI Providers		
Type	Part A	MAI
Number	7	1

Gender	Male	Female	Transgender
	73.7%	25.5%	0.8%
Race	**Black**	**White**	**Other**
	54.1%	44.5%	1.4%
Ethnicity	**Hispanic**	**non-Hispanic**	**Haitian**
	18.0%	81.9%	10.0%

FPL *	#	%
0-100%	2114	63.7%
101-200%	917	27.6%
201-299%	255	7.7%
300-399%	32	1.0%
400% & over	3	0.1%

* FPL is current for the end of the FY

HAB HRSA HIV Performance Measures	2012		2013	
	Num/Denom	%	Num/Denom	%
Medical Case Management Care Plans	298/2292	13%	402/2335	17%
Medical Case Management Medical Visits	2292/2292	100%	2335/2335	100%

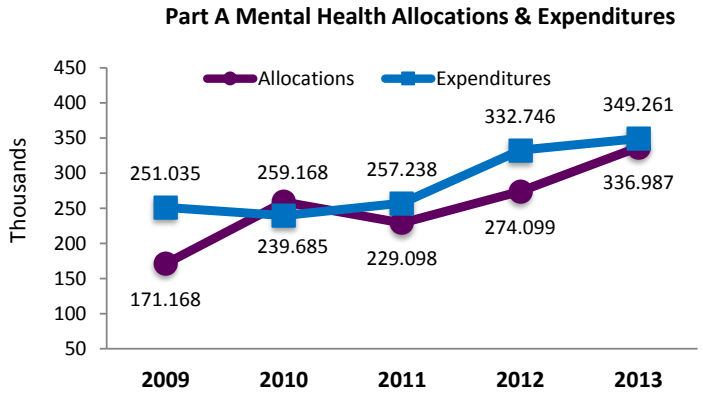
HANDOUT B-3

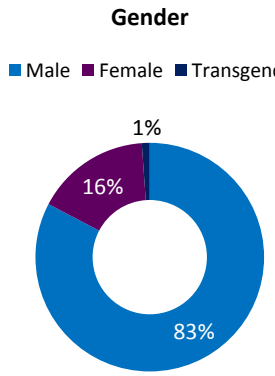
FY 2013/14 Scorecard: Part A Medical Case Management			ELIGIBILITY: <=400% FPL			
Fort Lauderdale/Broward EMA Medical Case Management Outcomes	**2011**		**2012**		**2013**	
Outcome: Improved ability to independently navigate and access needed services.	Num/Denom	%	Num/Denom	%	Num/Denom	%
1.1. 100% of clients receive information regarding available services & corresponding eligibility.	1771/1781	99.4%	1716/1725	99.5%	2006/2011	99.8%
Outcome: Increased access, retention and adherence to Outpatient/ Ambulatory Medical Care.	Num/Denom	%	Num/Denom	%	Num/Denom	%
2.1. 80% of new clients achieve initial POC goals by designated target dates.	1287/2697	47.7%	1475/2573	57.3%	1759/2747	64.0%
2.2. 80% of clients self-report adherence with their prescribing medication regimen.	3118/3253	95.8%	3136/3248	96.6%	3537/3643	97.1%
2.3. 80% of new clients have outpatient medical visits scheduled to occur within 2 weeks of intake.	1542/1781	86.6%	1590/1725	92.2%	1874/2011	93.2%
2.4. 80% of new clients remain enrolled in OAMC at time of discharge or episodic status.	898/1425	63.0%	861/1314	65.5%	1091/1365	79.9%

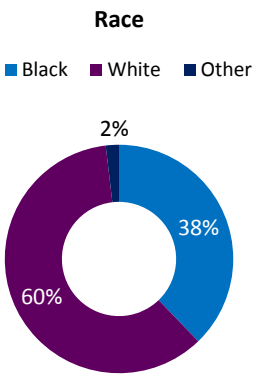
National Quality Center (NQC) inCARE Retention Measures for Part A Medical Case Management Patients	**2012**		**2013**		**Participant National Avg**	**Comments**
#1: Gap Measure	Num/Denom	%	Num/Denom	%	%	
Patients with NO medical visits in last 180 days of measurement year / Patients with >/= 1 medical visit in 1st 6 months of measurement year	109 / 1559	7.0%	169 / 1540	11.0%	14.5%	Strive for low%. Better than nat'l avg.
#2: Medical Visit Frequency	Num/Denom	%	Num/Denom	%	%	
Patients with >/=1 medical visit in EACH 6 month period of 24-mos period / Patients with >/=1 medical visit in 1st 6 months of 24-mos period	770 / 1028	74.9%	855 / 1096	78.0%	69.6%	Strive for high%. Better than nat'l avg.
#3: Patients Newly Enrolled in Medical Care	Num/Denom	%	Num/Denom	%	%	
Patients with >/= 1 medical visit in each 4-months of measurement year / Patients newly enrolled w/ medical provider & >/=1 visit in 1st 4 mos. of year	135 / 205	65.9%	115 / 208	55.3%	55.1%	Strive for high%. Equal to nat'l avg.
#4: Viral Load Suppression	Num/Denom	%	Num/Denom	%	%	
Patients with a viral load <200 at last VL test in measurement year / Patients with at least one medical visit in the measurement year	1,400 / 2,095	66.8%	1601 / 1984	80.7%	77.1%	Strive for high%. Better than nat'l avg.

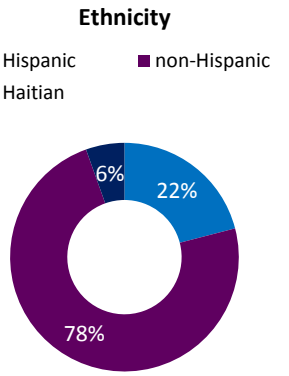
FY 2013/14 Scorecard: Part A & MAI Mental Health — ELIGIBILITY: <= 300% FPL

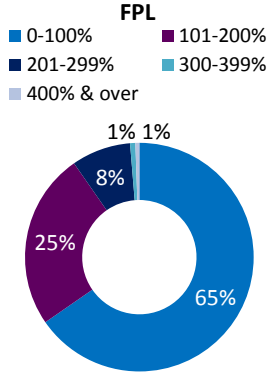
Fiscal Year	Part A & MAI Service Allocations			Final Part A & MAI Expenditures				EMA Award		Priority Rank
FY	Part A	MAI	Total	Part A	MAI	Total	% change	Total	% of Total	
2013	$336,987	$128,418	$465,405	$349,261	$63,477	$412,738	-1%	$15,366,650	2.7%	3
2012	$274,099	$95,368	$369,467	$332,746	$84,003	$416,749	20%	$15,423,413	2.7%	6
2011	$229,098	$95,000	$324,098	$257,238	$88,814	$346,052	8%	$15,006,261	2.3%	7
2010	$259,168	$95,000	$354,168	$239,685	$79,579	$319,264	-16%	$15,395,252	2.1%	5
2009	$171,168	$112,408	$283,576	$251,035	$129,476	$380,511		$15,189,762	2.5%	6











FY 2013/14 Part A/MAI Utilization & Demographics

Year	Total Clients	% change	# New	% New
2013	**537**	6%	177	33.0%
2012	508		157	30.9%

Ryan White Part A & MAI Providers

Type	Part A	MAI
Number	3	1

Male	Female	Transgender
82.7%	16.2%	1.1%
Black	**White**	**Other**
37.8%	60.3%	1.9%
Hispanic	**non-Hispanic**	**Haitian**
22.2%	77.8%	5.8%

FPL *	#	%
0-100%	351	65.4%
101-200%	134	25.0%
201-299%	45	8.4%
300-399%	4	0.7%
400% & over	3	0.6%

* FPL is current for the end of the FY

Fort Lauderdale/Broward EMA Medical Outcome	2012		2013	
Outcome: Improvement in client's symptoms associated with primary diagnosis.	Num/Denom	%	Num/Denom	%
1.1 60% of clients showed improvement in related clinical scale over baseline (quarterly until discharge or at the end of one year).	N/A	N/A	62/75	82.7%
Outcome: Increased retention and adherence to OAMC for clients who have not been in care or have been out of care for a period of 6 months or more.	Num/Denom	%	Num/Denom	%
2.1 85% of clients referred to OAMC kept their initial appiontment.	N/A	N/A	6/7	85.7%
2.2 85% of clients remain enrolled in OAMC at time of discharge.	N/A	N/A	244/255	95.7%

FY 2013/14 Scorecard: Part A & MAI Mental Health — **ELIGIBILITY: <= 300% FPL**

National Quality Center (NQC) inCARE Retention Measures for Part A/MAI Medical Patients	2012		2013		Participant National Avg	Comments
#1: Gap Measure	Num/Denom	%	Num/Denom	%	%	
Patients with NO medical visits in last 180 days of measurement year / Patients with >/= 1 medical visit in 1st 6 months of measurement year	7 / 228	3.1%	14 / 150	9.3%	14.5%	Strive for low%. Better than nat'l
#2: Medical Visit Frequency	Num/Denom	%	Num/Denom	%	%	
Patients with >/=1 medical visit in each 6 month period of 24-mos period / Patients with >/=1 medical visit in 1st 6 months of 24-mos period	122 / 141	86.5%	97 / 111	87.4%	69.6%	Strive for high%. Better than nat'l
#3: Patients Newly Enrolled in Medical Care	Num/Denom	%	Num/Denom	%	%	
Patients with >/= 1 medical visit in each 4-months of measurement year / Patients newly enrolled w/ provider & >/=1 visit in 1st 4 mos. of yr	23 / 28	82.1%	7 / 12	58.3%	55.1%	Strive for high%. Better than nat'l
#4: Viral Load Suppression	Num/Denom	%	Num/Denom	%	%	
Patients with a viral load <200 at last VL test in measurement year / Patients with at least one medical visit in the measurement year	191 / 297	64.3%	152 / 178	85.4%	77.1%	Strive for high%. Better than nat'l

Mental Health Parity and Addiction Equity Act

This new Federal law requires group health insurance plans (with >50 insured employees) that offer coverage for mental illness and substance use disorders to provide those benefits in no more restrictive way than all other medical and surgical procedures covered by the plan. The Mental Health Parity and Addiction Equity Act does not require group health plans to cover mental health (MH) and substance use disorder (SUD) benefits but, when plans do cover these benefits, MH and SUD benefits must be covered at levels that are no lower and with treatment limitations that are no more restrictive than would be the case for the other medical and surgical benefits offered by the plan.

Why is the Federal parity law important?

Eliminates unequal health treatment. This practice has kept individuals with untreated substance use and mental health disorders from receiving critically important treatment services. Providing parity provides insurance coverage for substance use and mental health disorders equally to other chronic health conditions like diabetes, asthma, and hypertension.

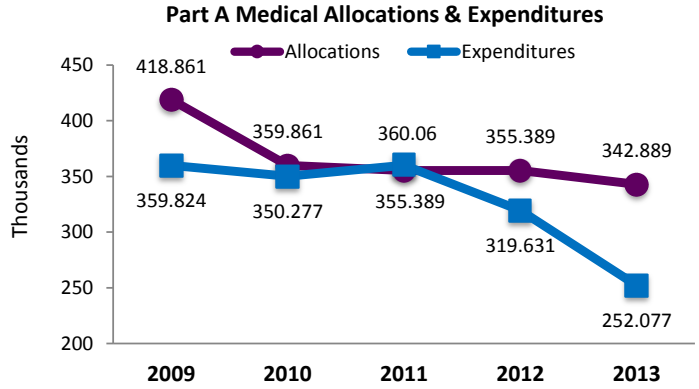
How does the Federal parity law work?

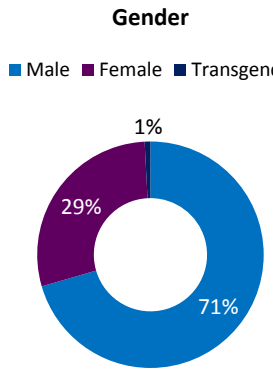
Improves access to much needed mental health and substance use disorder treatment services through more equitable coverage. Millions of Americans with mental health (MH) and/or substance use disorders (SUD) fail to receive the treatment they need to get and stay well. The lack of health insurance coverage for MH and SUD treatment has contributed to a large gap in treatment services. Improving coverage of MH and SUD services will help more people get the care they need.

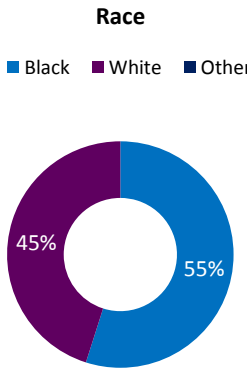
HANDOUT B-3

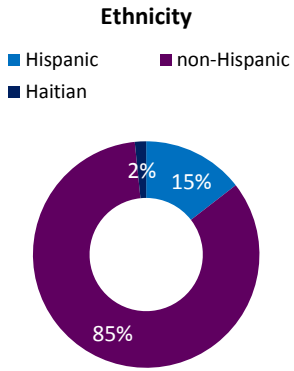
FY 2013/14 Scorecard: Part A and MAI Substance Abuse — ELIGIBILITY: <= 300% FPL

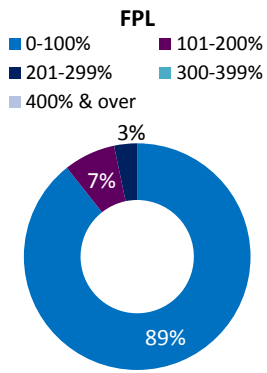
Fiscal Year	Part A & MAI Service Allocations			Final Part A & MAI Expenditures				EMA Award		Priority Rank
FY	Part A	MAI	Total	Part A	MAI	Total	% change	Total	% of Total	
2013	$342,889	$400,000	$742,889	$252,077	$452,255	$704,332	-2%	$15,366,650	4.6%	3
2012	$355,389	$400,624	$756,013	$319,631	$399,986	$719,617	-2%	$15,423,413	4.7%	6
2011	$355,389	$375,000	$730,389	$360,060	$374,931	$734,991	7%	$15,006,261	4.9%	7
2010	$359,861	$375,000	$734,861	$350,277	$334,750	$685,027	4%	$15,395,252	4.4%	5
2009	$418,861	$215,268	$634,129	$359,824	$296,393	$656,217		$15,189,762	4.3%	6











FY 2013/14 Part A/MAI Utilization & Demographics

Total Clients	# New	% New	Gender	Male	Female	Transgender	FPL *	#	%
122	50	41.0%		70.5%	28.7%	0.8%	0-100%	109	89.3%
			Race	Black	White	Other	101-200%	9	7.4%
Ryan White Part A & MAI Providers				54.9%	45.1%	0.0%	201-299%	4	3.3%
Type	Part A	MAI	Ethnicity	Hispanic	non-Hispanic	Haitian	300-399%	0	0.0%
Number	2	1		14.8%	85.2%	1.6%	400% & over	0	0.0%

* FPL is current for the end of the FY

Fort Lauderdale/Broward EMA Medical Outcome	2012		2013	
Outcome: Improvement in client's symptoms associated with primary diagnosis.	Num/Denom	%	Num/Denom	%
1.1 60% of clients showed improvement in related clinical scale over baseline.	N/A	N/A	7/10	70.0%
Outcome: Increased access, retention and adherence to OAMC for clients who have not been in care or have been out of care for a period of 6 months or more.	Num/Denom	%	Num/Denom	%
2.1 60% of clients referred to OAMC kept their initial appiontment.	N/A	N/A	4/4	100.0%
2.2 85% of clients remain enrolled in OAMC at time of discharge.	N/A	N/A	86/92	93.5%
Outcome: Decreased substance abuse.	Num/Denom	%	Num/Denom	%
3.1 60% of all clients will achieve at least 30 days clean/sober at time of discharge.	N/A	N/A	67/92	72.8%

FY 2013/14 Scorecard: Part A and MAI Substance Abuse **ELIGIBILITY: </= 300% FPL**

National Quality Center (NQC) inCARE Retention Measures for Part A/MAI Medical Patients	2012		2013		Participant National Avg	Comments
#1: Gap Measure	Num/Denom	%	Num/Denom	%	%	
Patients with NO medical visits in last 180 days of measurement year / Patients with >/= 1 medical visit in 1st 6 months of measurement year	3 / 34	8.8%	5 / 34	14.7%	14.5%	Strive for low%. Equal to nat'l avg.
#2: Medical Visit Frequency	Num/Denom	%	Num/Denom	%	%	
Patients with >/=1 medical visit in EACH 6 month period of 24-mos period / Patients with >/=1 medical visit in 1st 6 months of 24-mos period	16 / 21	76.2%	16 / 26	61.5%	69.6%	Strive for high%. Worse than nat'l avg.
#3: Patients Newly Enrolled in Medical Care	Num/Denom	%	Num/Denom	%	%	
Patients with >/= 1 medical visit in each 4-months of measurement year / Patients newly enrolled w/ medical provider & >/=1 visit in 1st 4 mos. of yr	4 / 7	57.1%	3 / 7	42.9%	55.1%	Strive for high%. Worse than nat'l avg.
#4: Viral Load Suppression	Num/Denom	%	Num/Denom	%	%	
Patients with a viral load <200 at last VL test in measurement year / Patients with at least one medical visit in the measurement year	41 / 49	83.7%	42 / 58	72.4%	77.1%	Strive for high%. Worse than nat'l avg.

Mental Health Parity and Addiction Equity Act

This new Federal law requires group health insurance plans (with >50 insured employees) that offer coverage for mental illness and substance use disorders to provide those benefits in no more restrictive way than all other medical and surgical procedures covered by the plan. The Mental Health Parity and Addiction Equity Act does not require group health plans to cover mental health (MH) and substance use disorder (SUD) benefits but, when plans do cover these benefits, MH and SUD benefits must be covered at levels that are no lower and with treatment limitations that are no more restrictive than would be the case for the other medical and surgical benefits offered by the plan.

Why is the Federal parity law important?

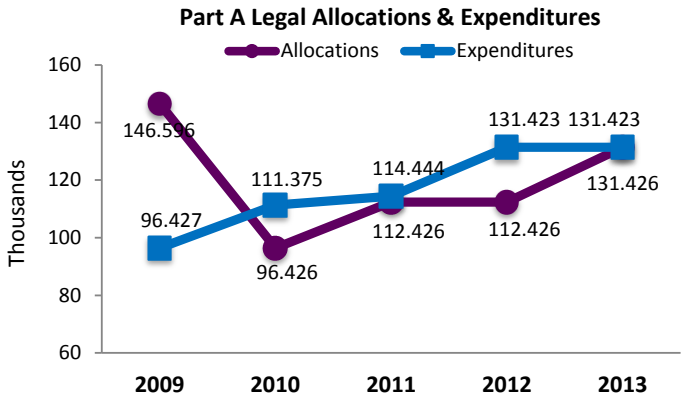
Eliminates unequal health treatment. This practice has kept individuals with untreated substance use and mental health disorders from receiving critically important treatment services. Providing parity provides insurance coverage for substance use and mental health disorders equally to other chronic health conditions like diabetes, asthma, and hypertension.

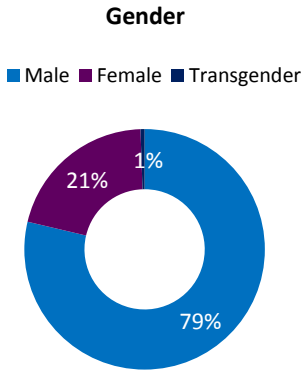
How does the Federal parity law work?

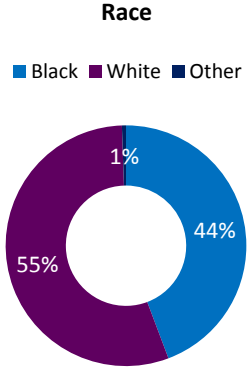
Improves access to much needed mental health and substance use disorder treatment services through more equitable coverage. Millions of Americans with mental health (MH) and/or substance use disorders (SUD) fail to receive the treatment they need to get and stay well. The lack of health insurance coverage for MH and SUD treatment has contributed to a large gap in treatment services. Improving coverage of MH and SUD services will help more people get the care they need.

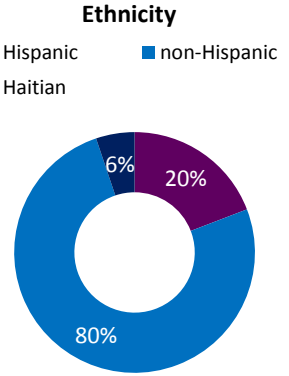
FY 2013/14 Scorecard: Part A Legal Services — ELIGIBILITY: Proof of Income, <= 300% FPL

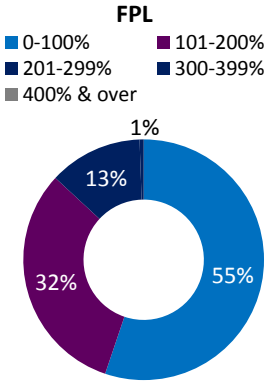
Fiscal Year	Part A & MAI Service Allocations			Final Part A & MAI Expenditures				EMA Award		Priority Rank
FY	Part A	MAI	Total	Part A	MAI	Total	% change	Total	% of Total	
2013	$131,426	$0	$131,426	$131,423	$0	$131,423	0.0%	$15,366,650	0.9%	3
2012	$112,426	$0	$112,426	$131,423	$0	$131,423	14.8%	$15,423,413	0.9%	5
2011	$112,426	$0	$112,426	$114,444	$0	$114,444	2.8%	$15,006,261	0.8%	3
2010	$96,426	$0	$96,426	$111,375	$0	$111,375	15.5%	$15,395,252	0.7%	5
2009	$146,596	$0	$146,596	$96,427	$0	$96,427		$15,189,762	0.6%	3











FY 2013/14 Part A Utilization & Demographics

Total Clients	# New	% New	Gender	Male	Female	Transgender	FPL *	#	%
183	100	54.6%		78.7%	20.8%	0.5%	0-100%	101	55.2%
			Race	Black	White	Other	101-200%	58	31.7%
Ryan White Part A & MAI Providers				44.3%	55.2%	0.5%	201-299%	23	12.6%
Type	Part A	MAI	Ethnicity	Hispanic	non-Hispanic	Haitian	300-399%	1	0.5%
Number	1	0		20.2%	79.8%	5.5%	400% & over	0	0.0%

FY 2013/14 Scorecard: Part A Legal Services — ELIGIBILITY: Proof of Income, <= 300% FPL

Fort Lauderdale/Broward EMA Legal Services Outcomes	2011		2012		2013	
Outcome: Increased access to benefits for which the client is eligible.	Num/Denom	%	Num/Denom	%	Num/Denom	%
1.1 70% of clients whose cases are accepted for representation at SS admin Law Judge hearing will win approval of case benefits and/or medical benefits thus improving their financial stability.	11/11	100.0%	15/15	100.0%	7/8	87.5%
1.2 60% of clients whose cases are accepted for representation at the Social Security Appeals Council will win approval of benefits or will have their case remanded for a hearing before an Administrative Law Judge.					0/1	0.0%

* FPL is current for the end of the FY

2009-2013 Part A and MAI Funding Allocation By Service Category

PART A and MAI	2009	2010	2011	2012	2013
Outpatient /Ambulatory Health	$4,712,039	$6,064,710	$6,154,833	$6,604,282	$5,806,496
AIDS Pharmaceutical Assistance	$1,692,500	$926,000	$622,385	$411,109	$509,376
Oral Health Care	$1,455,182	$2,183,022	$2,155,150	$2,623,653	$2,623,653
Health Insurance Premium	$0	$140,642	$356,229	$0	$0
Mental Health Services	$283,576	$354,168	$324,098	$369,467	$465,405
Medical Case Management	$1,430,154	$1,312,565	$1,120,058	$1,310,749	$1,324,092
Substance Abuse - outpatient	$634,129	$734,861	$730,389	$756,013	$742,889
Case Management (non-Medical)	$800,000	$675,000	$590,957	$590,957	$758,470
Food Bank/Home-Delivered Meals	$801,154	$273,035	$363,360	$277,111	$353,241
Legal Services	$146,596	$96,426	$112,426	$112,426	$131,426
Medical Transportation Services	$159,088	$263,371	$163,261	$0	$0
Outreach Services	$797,079	$221,345	$67,000	$67,000	$58,768*
Total	**$12,911,497**	**$13,245,145**	**$12,760,146**	**$13,122,767**	**$12,715,048**

* Part A funding only

2010-2013 Part A and MAI Utilization By Service Category				
PART A and MAI	**2010**	**2011**	**2012**	**2013**
Outpatient /Ambulatory Health	3,559	3,506	3,790	3,958
AIDS Pharmaceutical Assistance	2,765	2,061	2,551	3,108
Oral Health Care	2,595	2,768	2,751	3,182
Health Insurance Premium	102	137	0	0
Mental Health Services	439	419	508	537
Medical Case Management	3,780	3,551	3,509	3,332
Substance Abuse - outpatient	149	124	126	122
Case Management (non-Medical)	2,978	6,333	6,629	6,953
Food Bank/Home-Delivered Meals	2,114	2,019	2,188	2,496
Legal Services	132	164	214	183
Medical Transportation Services	345	124	0	0
Outreach Services	581	118	182	441
Total Unduplicated	**7,116**	**7,022**	**7,064**	**6,953**

2010-2013 Part A and MAI Client Demographics				
Race	**2010**	**2011**	**2012**	**2013**
Other	214	249	147	137
White	3,169	3,117	3,208	3,177
Black	3,733	3,656	3,712	3,639
Total	**7,116**	**7,022**	**7,064**	**6,953**
Ethnicity	**2010**	**2011**	**2012**	**2013**
Hispanic	997	1,014	1,088	1,140
Haitian	651	696	717	725
Other	6,003	5,829	5,897	5,758
Total	**7,116**	**7,022**	**7,064**	**6,953**
Gender	**2010**	**2011**	**2012**	**2013**
Transgender	23	28	37	48
Female	2,110	2,076	2,065	1,999
Male	4,983	4,918	4,962	4,906
Total	**7,116**	**7,022**	**7,064**	**6,953**
Insurance Status	**2010**	**2011**	**2012**	**2013**
HMO/Private	520	569	473	527
Medicaid/Medicare	2,831	2,677	2,730	2,568
No Insurance	3,765	3,776	3,813	3,742
Total	**7,116**	**7,022**	**7,064**	**6,953**
FPL	**2010**	**2011**	**2012**	**2013**
0-100	4,317	4,087	4,151	4,074
101-200	2,095	2,193	2,202	2,124
201-300	613	649	629	627
301-400	74	79	69	106
400+	17	14	14	22
Total	**7,116**	**7,022**	**7,064**	**6,953**

FY 2013 Total Expenditures By Funder

	Part A & MAI		Part B / ADAP / AICP		Part C		Part D		Part F		HOPWA		Medicaid (PAC Waiver)		Veterans Administration	
	$	#	$	#	$	#	$	#	$	#	$	#	$	#	$	#
Outpatient /Ambulatory	$6,477,426	3958	-	-	$360,380	374	$303,385	1291	-	-	-	-	-	-	-	-
AIDS Drug Asstnc. Prog.	-	-	$20,255,349	4,035	-	-	-	-	-	-	-	-	-	-	-	-
Pharmaceutical Asstnc.	$636,175	3108	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Dental	$2,255,138	3182	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Early Intervention	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Health Insur. Premium	-	-	$270,647	350	-	-	-	-	-	-	-	-	-	-	-	-
Home Health	-	-	-	-	-	-	-	-	-	-	-	-	$188,452	268	-	-
Home/Community Hlth.	-	-	-	-	-	-	-	-	-	-	-	-	$149,329	155	-	-
Hospice Services	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Mental Health	$412,738	537	-	-	$10,676	120	$114,332	1095	-	-	-	-	-	-	-	-
Medical Nutrition	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Medical Case Mgt.	$1,145,974	3332	-	-	$153,100	500	$431,134	1291	-	-	-	-	$672,410	717	-	-
Subst. Abuse - outpat.	$704,332	122	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Non-Medical Case Mgt.	$758,459	6953	$305,526	5,195	-	-	$0	1291	-	-	-	-	-	-	-	-
Child Care	-	-	-	-	-	-	$0	420	-	-	-	-	-	-	-	-
Emerg. Financial Aid	-	-	-	-	-	-	$0	953	-	-	-	-	-	-	-	-
Food Bank/Deliv. Meals	$988,890	2496	$1,190	4	-	-	$0	778	-	-	-	-	$135,800	83	-	-
Education/Risk Redctn.	-	-	-	-	-	-	$0	778	-	-	-	-	$6,420	17	-	-
Housing	-	-	-	-	-	-	-	-	-	-	$8,446,375	1066	$175	2	-	-
Legal	$131,423	183	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Linguistics	-	-	-	-	-	-	$0	340	-	-	-	-	-	-	-	-
Medical Transportation	-	-	$134,328	1,254	-	-	$0	414	-	-	-	-	-	-	-	-
Outreach	$24,702	441	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Psychosocial Support	-	-	-	-	-	-	$94,488	1291	-	-	-	-	-	-	-	-
Referral/Support Care	-	-	-	-	$32,454	841	-	-	-	-	-	-	-	-	-	-
Rehabilitation	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Respite Care	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Subst. Abuse - residntl.	-	-	$82,486	33	-	-	-	-	-	-	-	-	$140	1	-	-
Treatment Adherence	-	-	-	-	$208,642	978	$19,003	951	-	-	-	-	-	-	-	-
Total Unduplicated	**$13,535,256**	**7,417**	-	**5,195**	-	**978**	-	-	-	-	**$8,446,375**	**1,066**	**$1,152,726**	**1,243**	**$758,047**	**375**

HANDOUT C-1

HIV/AIDS Epidemiology Partnership 10

Broward County

Excluding Dept. of Corrections

Created: 12/03/14
Revision: 02/23/15

Florida Department of Health
HIV/AIDS Section
Annual data trends as of 12/31/2014
Living (Prevalence) data as of 06/30/2014

Snapshot of Persons Reported with HIV Disease, 2014, Partnership 10

Total Population, 2014*

1,792,586

*2014 estimate is provisional

HIV Infection and AIDS Cases Reported in 2014*

	Adults (Age 13+)	Pediatrics (Age <13)	TOTAL
HIV Infection Cases	993	-	993
AIDS Cases	402	1	403

*HIV infection cases and AIDS cases by year of report are NOT mutually exclusive and CANNOT be added together.

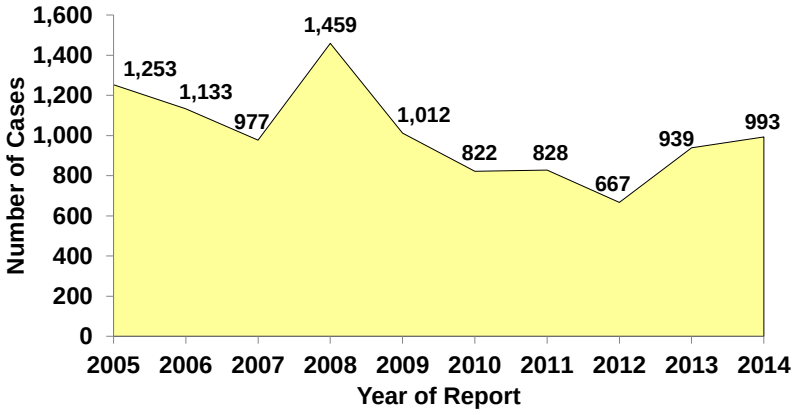
Cumulative HIV/AIDS Cases Reported 1981-2014

	Adults (Age 13+)	Pediatrics (Age<13)	TOTAL
HIV (not AIDS) Cases**	9,329	67	9,396
AIDS Cases	20,732	271	21,003
Total	30,061	338	30,399

**HIV (not AIDS) cases were NOT reportable until 07/1997

Persons Living with HIV Disease through 2013, as of 06/30/2014: 17,248

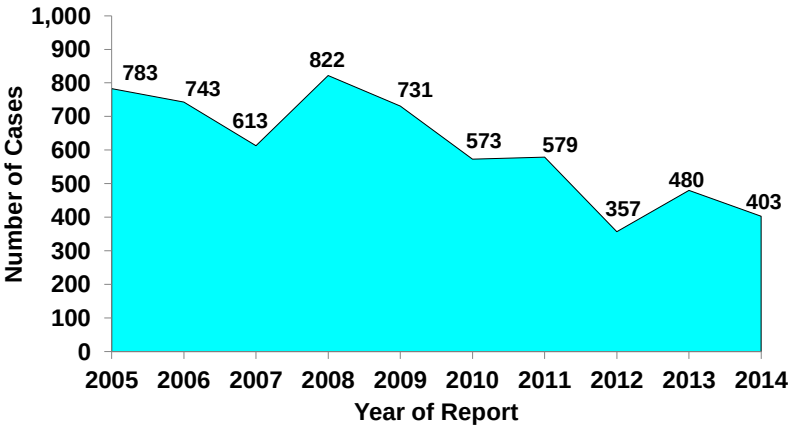
HIV Infection Cases and Rates*
By Year of Report, 2005-2014, Partnership 10



Year	Rate
05	72.2
06	64.9
07	56.1
08	84.3
09	58.5
10	47.1
11	47.8
12	38.3
13	58.5
14	55.4

Note: Enhanced laboratory reporting (ELR) laws in 2006 and the expansion of ELR in 2007 led to an artificial peak in newly reported cases of HIV infection in 2008. This was followed by a general decline in reported cases through 2012. Another surge in the expansion of ELR in 2012 was followed by another increase in newly reported cases of HIV infection in 2013. An additional 6% increase was observed in 2014 compared to the previous year. This is lower than the 12% incline observed by the state during the same time period.
***Source: Population estimates are provided by Florida CHARTS as of 12/19/2014. Rates are expressed as per 100,000 population.**

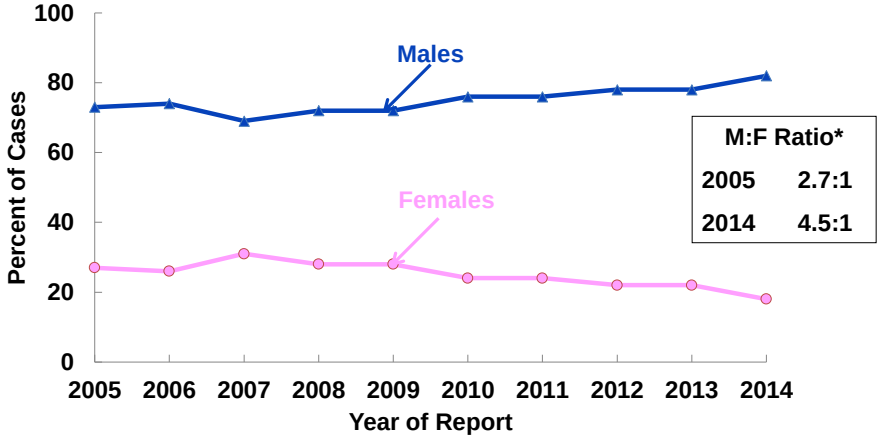
AIDS Cases and Rates*
By Year of Report, 2005-2014, Partnership 10



Year	Rate
05	45.0
06	42.6
07	35.2
08	47.4
09	42.1
10	32.8
11	33.1
12	20.0
13	27.9
14	22.5

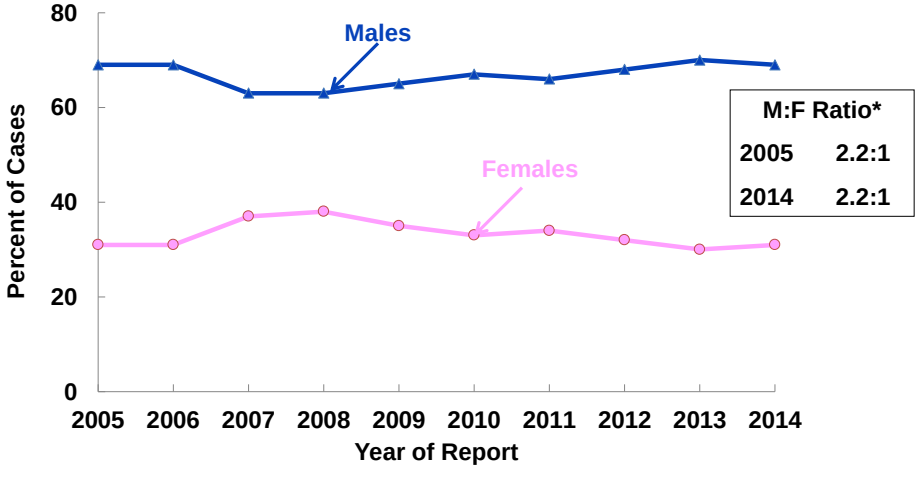
Enhanced laboratory reporting (ELR) laws in 2006 and the expansion of ELR in 2007 led to an artificial peak in newly reported cases of AIDS in 2008. This was followed by a general decline in reported cases through 2012. Another surge in the expansion of ELR in 2012 was followed by another increase in newly reported cases of AIDS in 2013. AIDS cases in 2014 dropped by 16% from the previous year. This is higher than the 15% decline observed by the state during the same time period.
***Source: Population estimates are provided by Florida CHARTS as of 12/19/2014. Rates are expressed as per 100,000 population.**

Adult HIV Infection Cases, by Sex and Year of Report, 2005-2014, Partnership 10



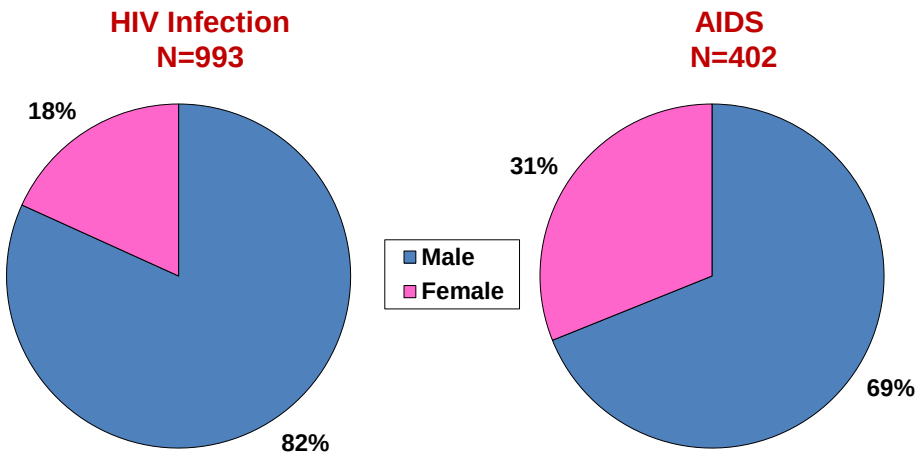
Note: Recent trends in HIV transmission are best described by the HIV case data. The relative increases in male HIV Infection Cases might be attributed to proportional increases in HIV transmission among men who have sex with men (MSM), which may influence future AIDS trends. *The male-to-female ratio is the number of cases among males divided by the number of cases among females.

Adult AIDS Cases, by Sex and Year of Report, 2005-2014, Partnership 10



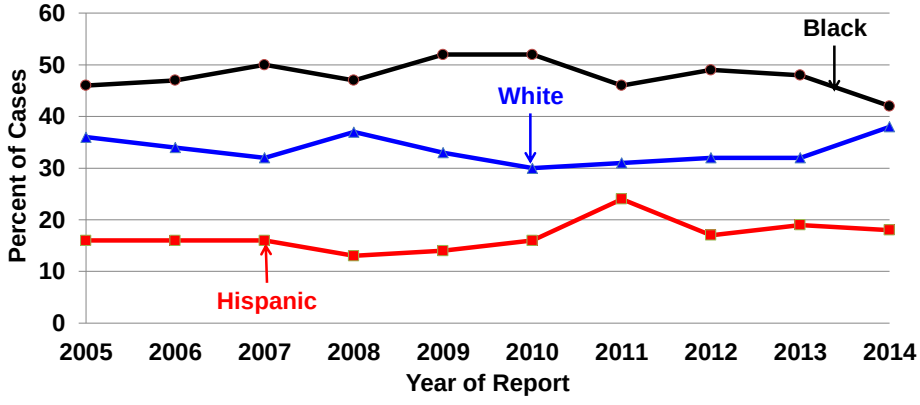
Note: AIDS cases tend to represent HIV transmission that occurred many years ago. The relative increases in males cases reflect the changing face of the AIDS epidemic over time. *The male-to-female ratio is the number of cases among males divided by the number of cases among females.

Adult HIV Infection and AIDS Cases by Sex, Reported in 2014, Partnership 10



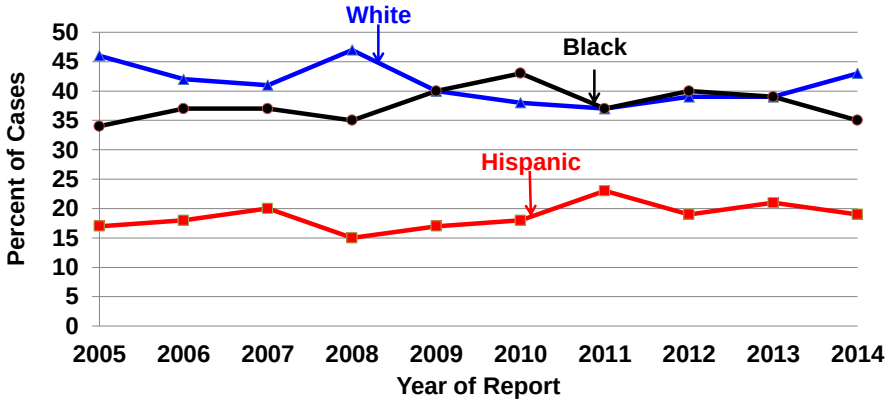
Note: Partnership 10's Adult Population is: 48% Male and 52% Female.

Adult HIV Infection Cases by Race/Ethnicity and Year of Report, 2005-2014, Partnership 10



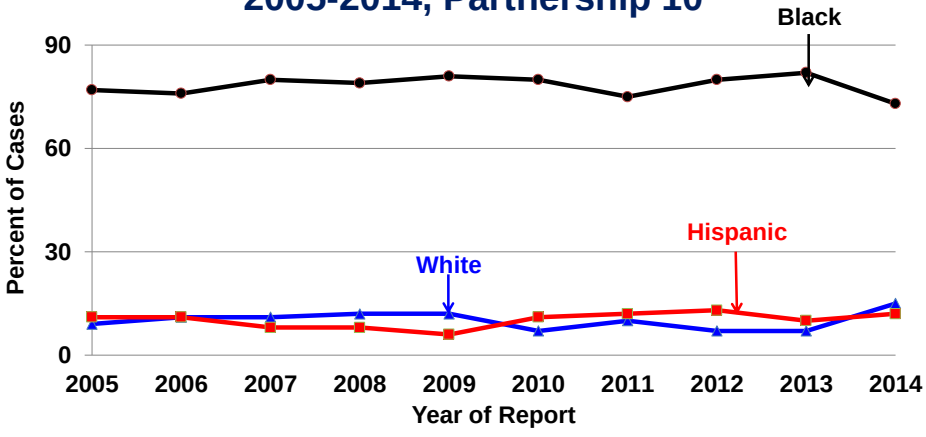
Note: HIV case reporting reflects more recent trends in the epidemic with respect to the distribution of cases by race/ethnicity. For the past ten years, blacks represented 42% or more of the cases each year. From 2005 to 2014, the proportion of HIV infection cases among whites and Hispanics increased by 2 percentage points respectively. In contrast, the proportion of HIV infection cases among blacks decreased by 4 percentage points. Other races represent less than 3% of the cases and are not included.

Adult Male HIV Infection Cases by Race/Ethnicity and Year of Report, 2005-2014, Partnership 10



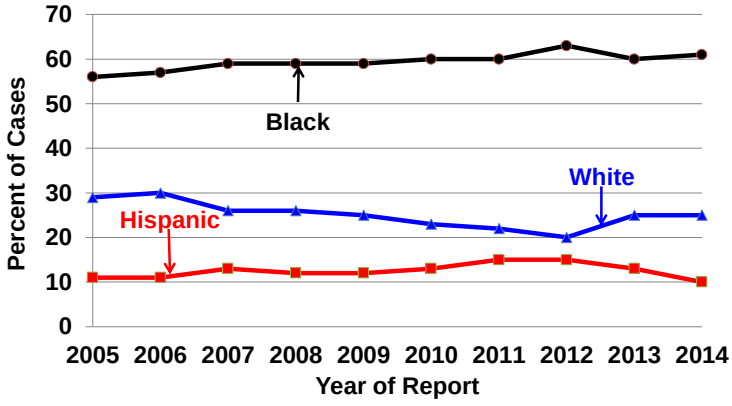
Note: The proportion of adult male HIV infection cases among blacks and whites has shifted up and down over the years, at times, crossing paths. From 2005 to 2014, the proportion of HIV infection cases among black and Hispanic males increased by 1 and 2 percentage points, respectively. In contrast, HIV infection cases among white males decrease by 3 percentage points. Other races represent less than 3% of the cases and are not included.

Adult Female HIV Infection Cases by Race/Ethnicity and Year of Report, 2005-2014, Partnership 10



Note: HIV case disparities are more evident among women than men. For the past ten years, black women represented 75% or more of the cases each year. From 2005 to 2014, the proportion of HIV infection cases among Hispanic and white females increased by 1 and 6 percentage points, respectively. In contrast, the proportion of HIV infection cases among black females decreased by 4 percentage points. Other races represent less than 5% of the cases and are not included.

Adult AIDS Cases by Race/Ethnicity and Year of Report, 2005-2014, Partnership 10



Factors Affecting Disparities

-Late diagnosis of HIV.

-Access to/ acceptance of care.

-Delayed prevention messages.

-Stigma.

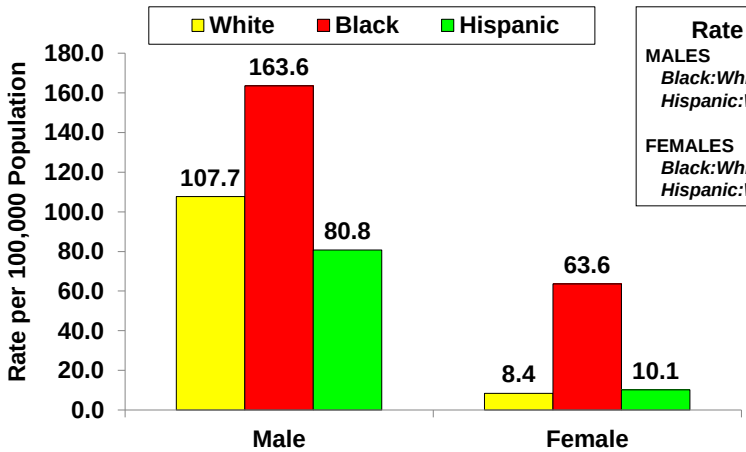
-Non-HIV STD's in the community.

-Prevalence of injection drug use.

-Complex matrix of factors related to socioeconomic status

Note: In 2014, blacks accounted for 61% of adult AIDS cases, but only 25% of the population. From 2005 to 2014, the proportion of AIDS cases among blacks increased by 5 percentage points. In contrast, the proportion of AIDS cases among Hispanics and whites decreased by 1 and 4 percentage points, respectively. Numerous disparities can affect the increases of HIV disease in a given population. Other races represent less than 4% of the cases and are not included.

Adult HIV Infection Case Rates* by Sex and Race/Ethnicity, Reported in 2014, Partnership 10



Rate Ratios:

MALES

Black:White, 1.5:1

Hispanic:White, 0.8:1

FEMALES

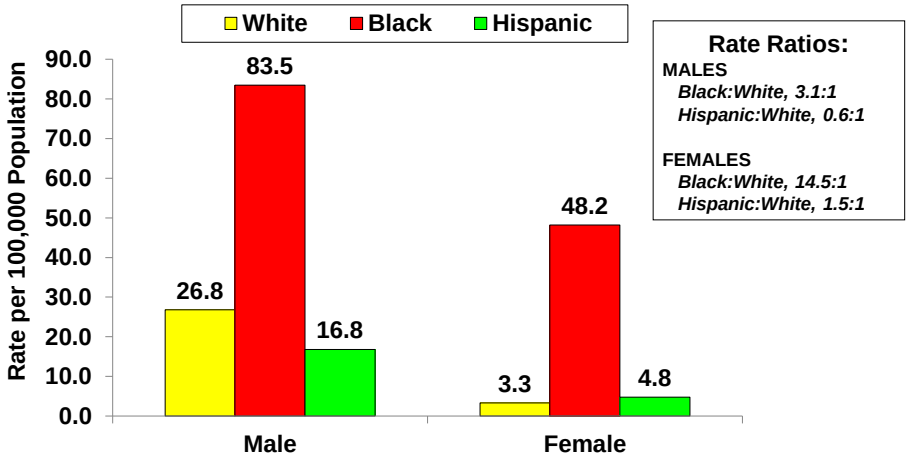
Black:White, 7.5:1

Hispanic:White, 1.2:1

Note: Among black males, the HIV infection case rate is nearly 2 times higher than the rate among white males. Similarly, among black females, the HIV case rate is nearly 8 times higher than the rate among white females. Hispanic females have a HIV case rate that is slightly higher than the rate among white females. In contrast, Hispanic males have a slightly lower HIV case rate compared to the rate among white males.

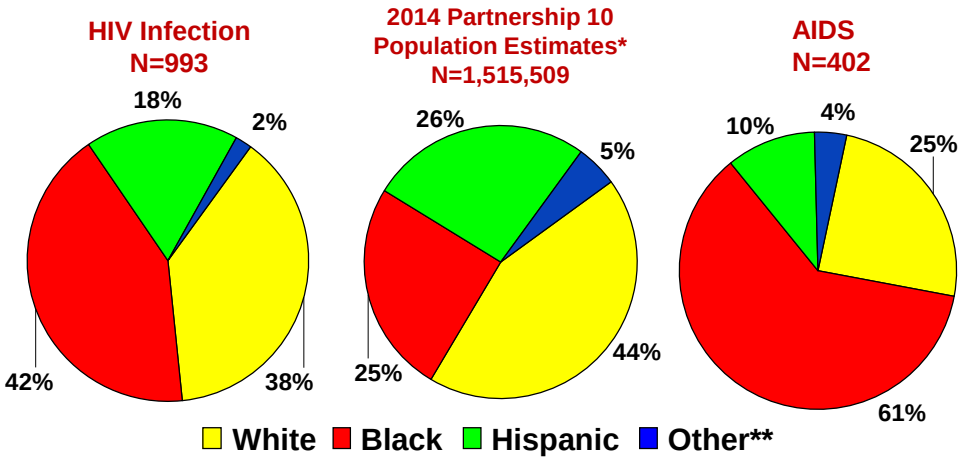
***Source: Population estimates are provided by Florida CHARTS as of 12/19/2014.**

Adult AIDS Case Rates* by Sex and Race/Ethnicity, Reported in 2014, Partnership 10



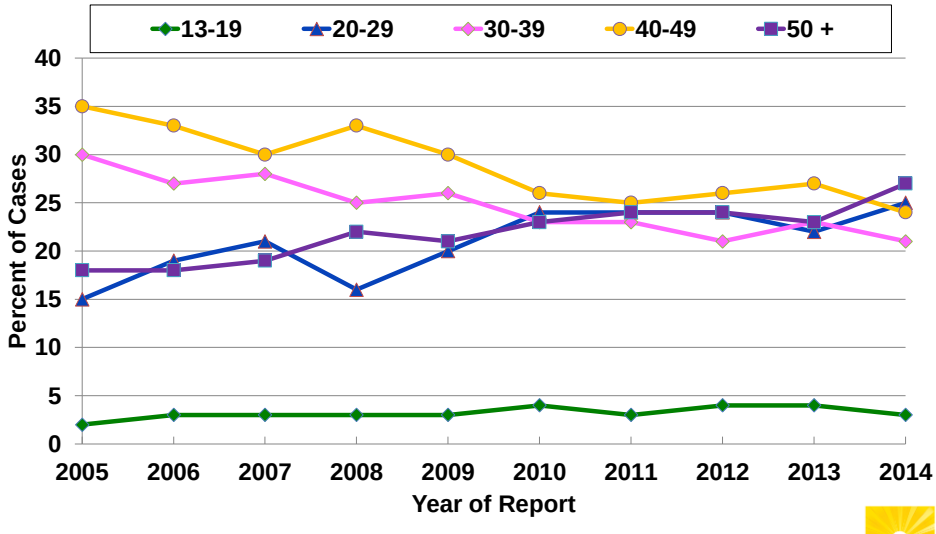
Note: Among black males, the AIDS case rate is 3 times higher than the rate among white males. Among black females, the AIDS case rate is nearly 15-fold greater than the rate among white females. Hispanic males have an AIDS case rate that is lower than the rate among white males. In contrast, the AIDS case rate among Hispanic females is nearly 2 times higher than the rate among white females.
*Source: Population estimates are provided by Florida CHARTS as of 12/19/2014.

Adult HIV and AIDS Cases Reported in 2014 and Population Data, by Race/Ethnicity, Partnership 10



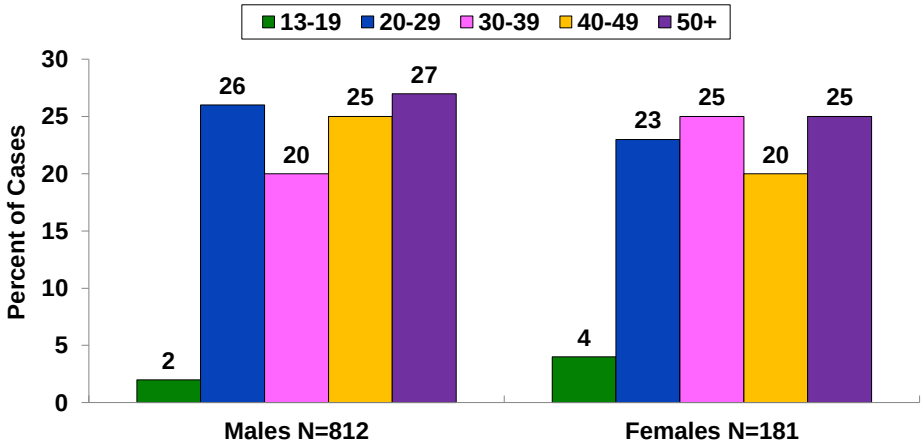
Note: In this snapshot for 2014, blacks are over-represented among the HIV and AIDS cases, accounting for 42% of adult HIV cases and 61% of adult AIDS cases, but only 25% of the adult population. A group is disproportionately impacted to the extent that the percentage of cases exceeds the percentage of the population.
*Source: Population estimates are provided by Florida CHARTS as of 12/19/2014.
**Other includes Asian/Pacific Islanders, Native Alaskans/American Indians and mixed races.

Adult HIV Infection Cases, by Age Group at Diagnosis, and Year of Report, 2005–2014, Partnership 10



Note: From 2005 to 2014, the proportion of adult HIV infection cases among those aged 20-29 and those aged 50+ increased by 10 and 9 percentage points, respectively.

Adult HIV Infection Cases, by Sex and Age Group at Diagnosis, Reported in 2014, Partnership 10

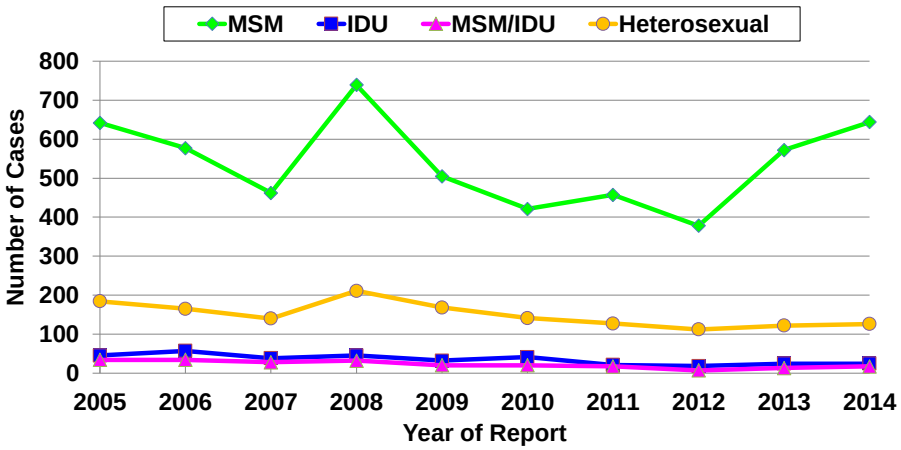


Note: HIV infection cases tend to reflect more recent transmission than AIDS cases, and thus present a more current picture of the epidemic. With regard to the age groups with the highest percent of HIV infection cases, recent estimates show that among males, 27% of HIV infection cases occur among those aged 50 or older, whereas among females, 25% of HIV infection cases occur among those aged 30-39 and those aged 50 or older.

Definitions of Mode of Exposure Categories

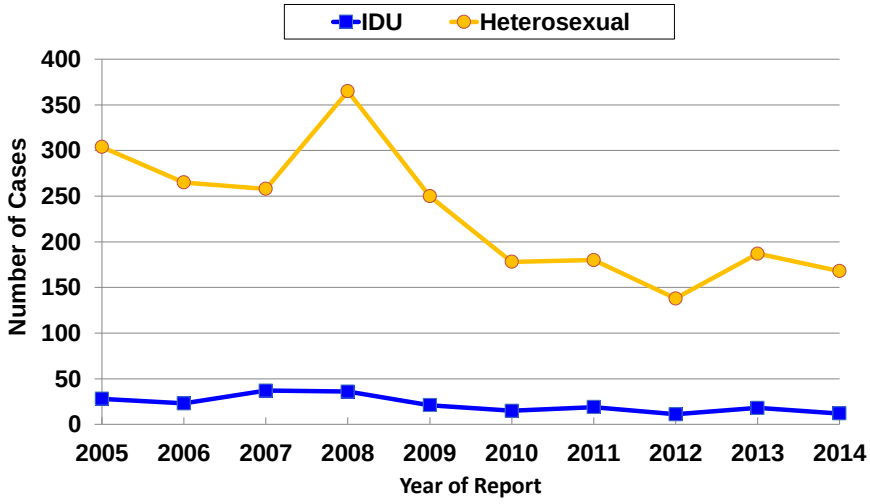
- **MSM =** Men who have sex with men
- **IDU =** Injection Drug User
- **MSM/IDU =** Men who have sex with men & Injection Drug User
- **Heterosexual =** Heterosexual contact with person with HIV/AIDS or known HIV risk
- **OTHER =** includes hemophilia, transfusion, perinatal, other pediatric risks and other confirmed risks.
- **NIR =** Cases reported with No Identified Risk
- **Redistribution of NIRs =** This illustrates the effect of statistically assigning (redistributing) the NIRs to recognized exposure (risk) categories by applying the proportions of historically reclassified NIRs to the unresolved NIRs.

Adult Male HIV Infection Cases, by Mode of Exposure and Year of Report, 2005–2014, Partnership 10



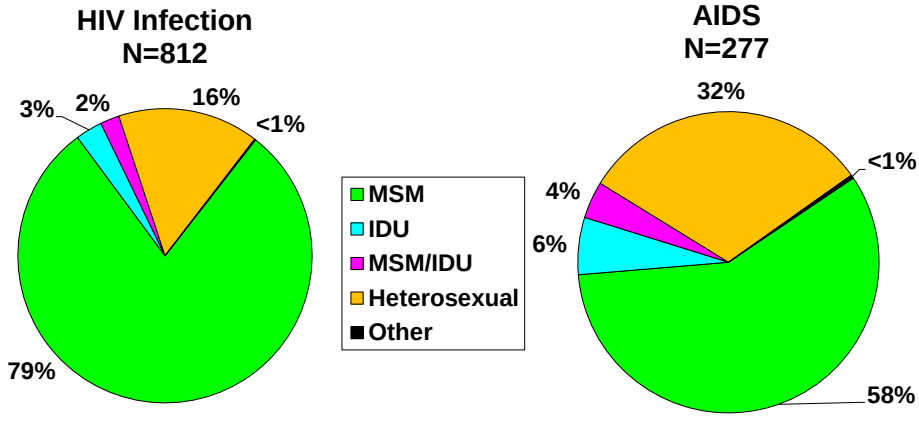
Note: NIRs redistributed. Men who have sex with men (MSM) remains as the primary mode of exposure among male HIV cases in Partnership 10, followed by heterosexual contact.

Adult Female HIV Infection Cases by Exposure Category and Year of Report, 2005-2014, Partnership 10



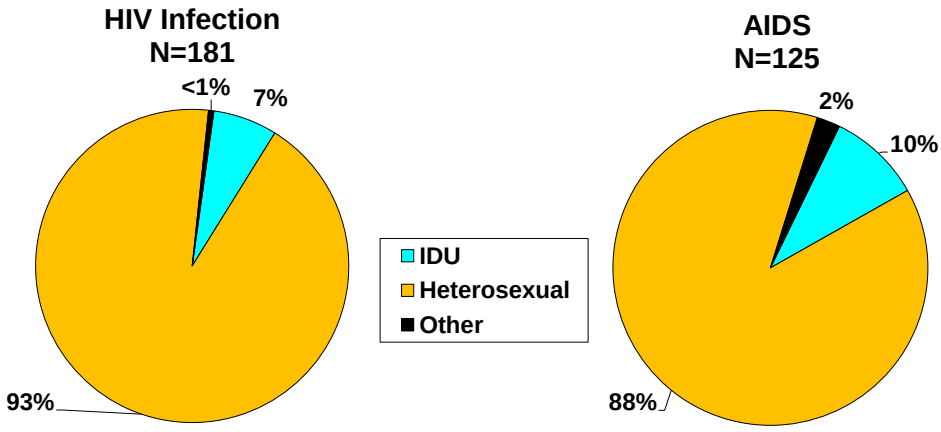
Note: NIRs redistributed. The heterosexual risk continues to be the dominant mode of exposure among females.

Adult Male HIV Infection and AIDS Cases, by Mode of Exposure, Reported in 2014, Partnership 10



Note: NIRs redistributed. Among the male HIV infection and AIDS cases reported for 2014, men who have sex with men (MSM) was the most common risk factor (79% and 58%, respectively) followed by cases with a heterosexual risk (16% for HIV and 32% for AIDS). The recent increase among MSM is indicated by the higher MSM among HIV infection cases compared to AIDS cases, as HIV infection cases tend to represent a more recent picture of the epidemic.

Adult Female HIV Infection and AIDS Cases, by Mode of Exposure, Reported in 2014, Partnership 10



Note: NIRs redistributed. Among the female HIV infection and AIDS cases reported for 2014, heterosexual contact was the highest risk (93% and 88%, respectively).

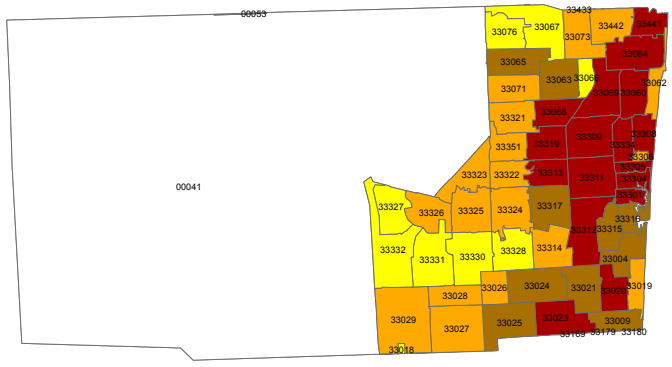
Cases Living with HIV Disease

Adults Living with HIV Disease
By Zip Code, Reported through 2013, Partnership 10

Total Living HIV/AIDS Cases

- 0
- 1 - 50
- 51 - 150
- 151 - 300
- Over 300

N=17,572



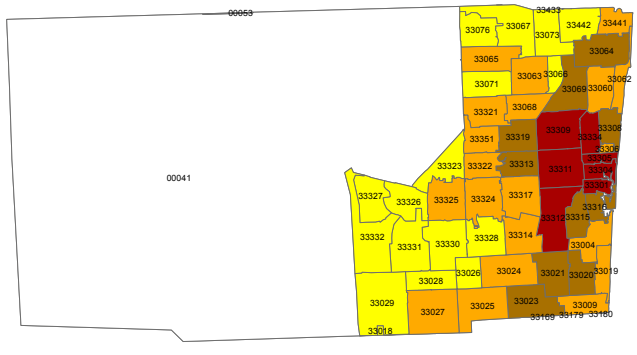
NIRs are not redistributed.
Excludes DOC, homeless, and cases with unknown zips.
Data as of 04/07/2014

Men who have Sex with Men (MSM)*
Living with HIV Disease
By Zip Code, Reported through 2013, Partnership 10

Presumed Living MSM HIV/AIDS Cases

- 0
- 1 - 50
- 51 - 150
- 151 - 300
- Over 300

N=9,152

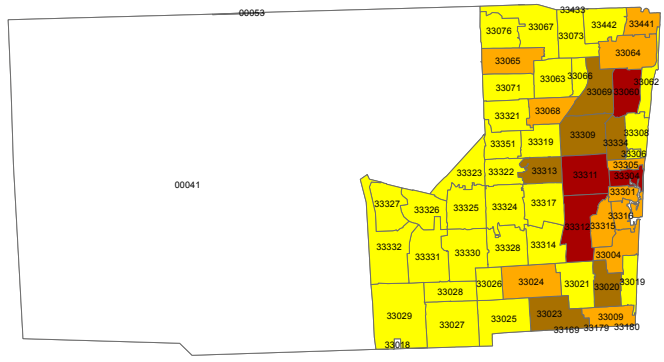


NIRs are not redistributed.
Excludes DOC, homeless, and cases with unknown zips.
***Includes MSM/IDU cases.**
Data as of 04/07/2014

Injection Drug Users (IDUs)*
Living with HIV Disease
By Zip Code, Reported through 2013, Partnership 10

Presumed Living IDU HIV/AIDS Cases

- 0
- 1 - 25
- 26 - 50
- 51 - 75
- Over 75



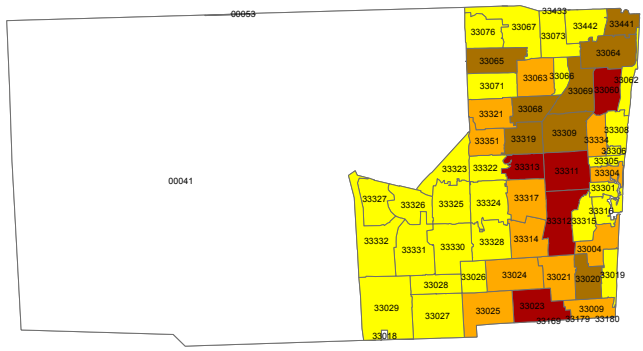
N=1,707

NIRs are not redistributed.
Excludes DOC, homeless, and cases with unknown zips.
***Includes MSM/IDU cases.**
Data as of 04/07/2014

Adult Heterosexuals Living with HIV Disease
By Zip Code, Reported through 2013, Partnership 10

Presumed Living Heterosexual HIV/AIDS Cases

- 0
- 1 - 50
- 51 - 150
- 151 - 300
- Over 300



N=6,948

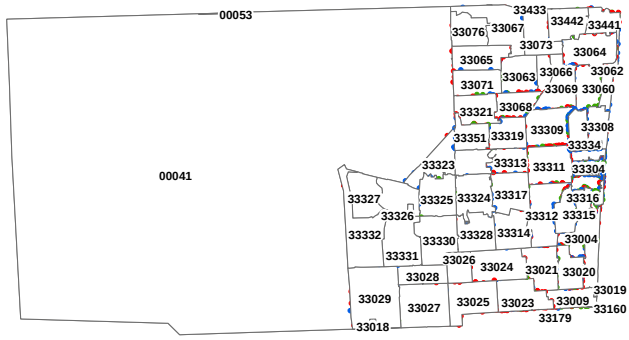
NIRs are not redistributed.
Excludes DOC, homeless, and cases with unknown zips.
Data as of 04/07/2014

Adults Living with HIV Disease By Zip Code and Race/Ethnicity, Reported through 2013, Partnership 10

1 Dot = 3 cases
Dots are randomly placed within zip codes.

- Hispanic
- Black, not-Hispanic
- White, not-Hispanic

N=17,172



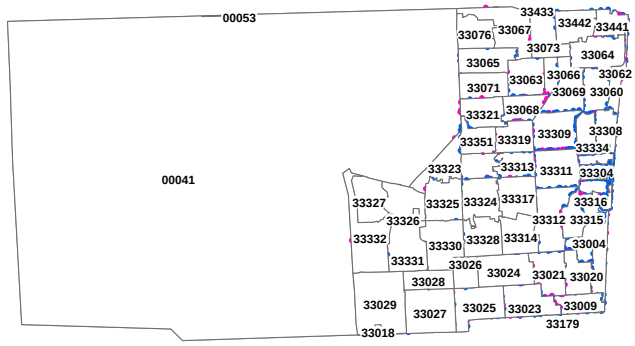
Total includes all races, some which are not on map.
Excludes DOC, homeless, and cases with unknown zips.
Data as of 04/07/2014

Adults Living with HIV Disease By Zip Code and Sex, Reported through 2013, Partnership 10

1 Dot = 3 cases
Dots are randomly placed within zip codes.

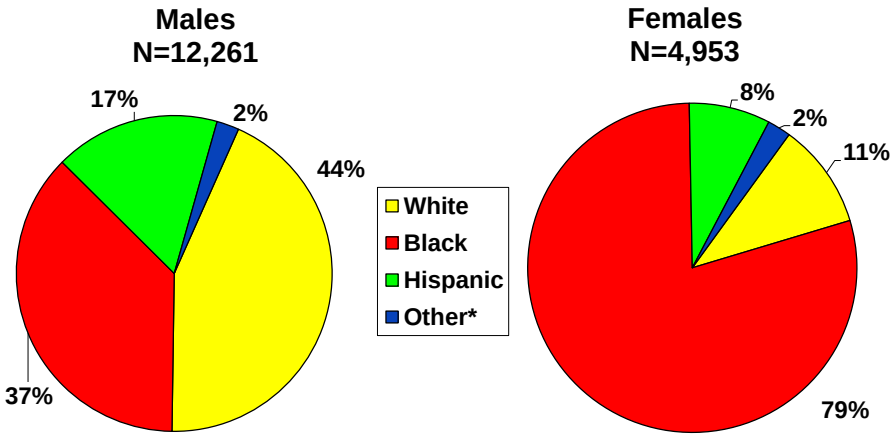
- Male
- Female

N=17,572



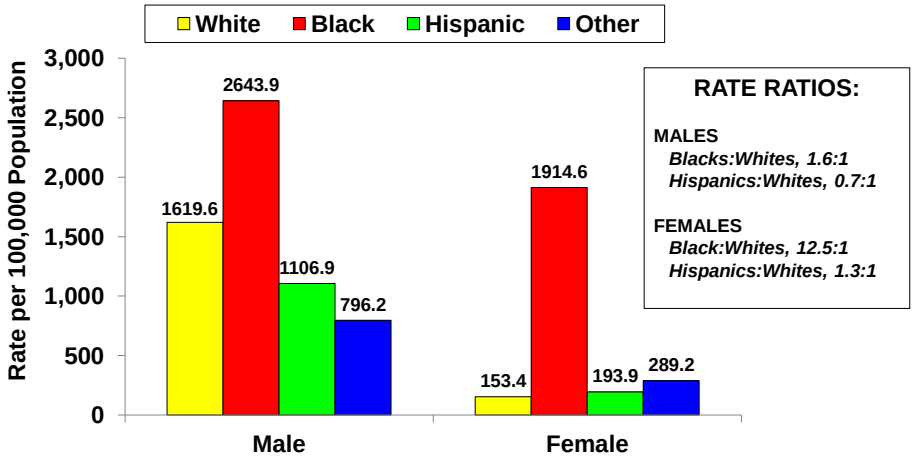
Excludes DOC, homeless, and cases with unknown zips.
Data as of 04/07/2014

Adults Living with HIV Disease, by Sex and Race/Ethnicity Reported through 2013, Partnership 10



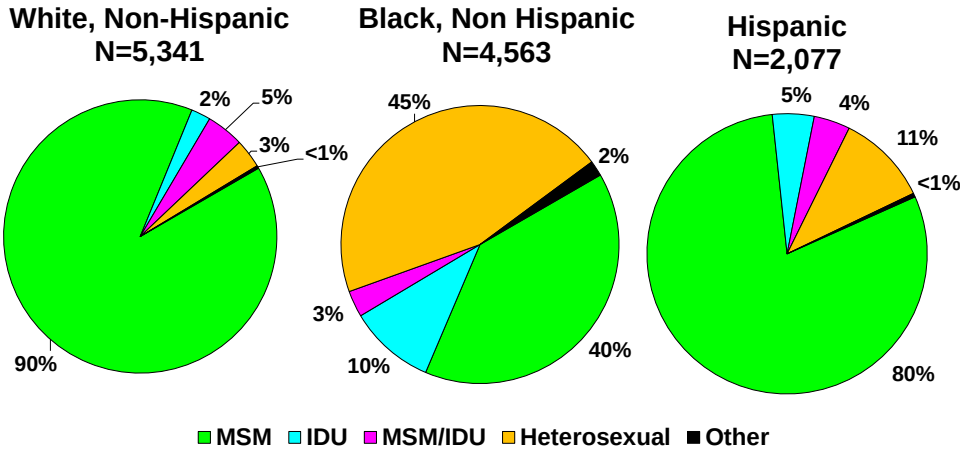
Note: Among adult males living HIV disease, whites represent the race most affected (44%). Among adult females, blacks represent the race most affected (79%).
*Other includes Asian/Pacific Islanders, Native Alaskans/American Indians and Multi-racial individuals.

Case Rates* of Adults Living with HIV Disease, by Sex and Race/Ethnicity, Reported through 2013, Partnership 10



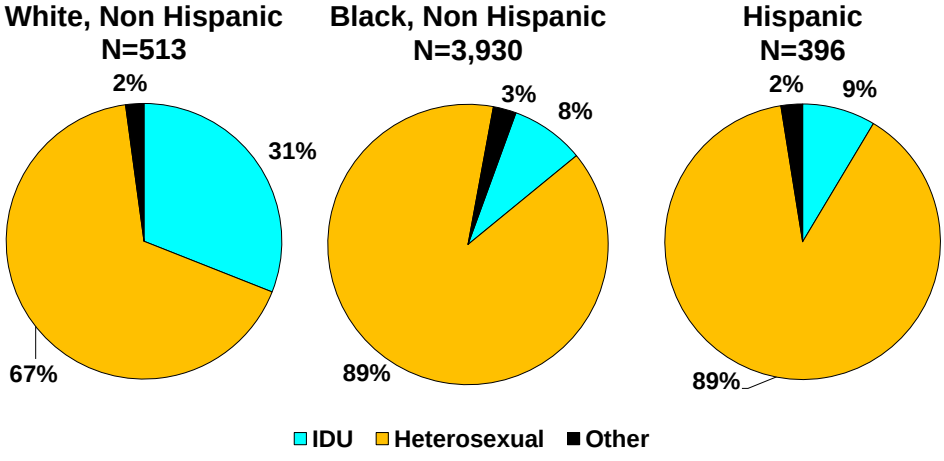
Note: Among black males living with HIV disease reported through 2013, the case rate is nearly 2 times higher than the rate among white males. Among black females living with HIV disease, the case rate is nearly 13 times higher than the rate among white females. The Hispanic male rate is less than the rate among their white counterpart, whereas the Hispanic female rate is slightly higher than the rate among their white counterpart. Data excludes Department of Corrections cases.
*Source: Population estimates are provided by Florida CHARTS.
**Other includes Asian/Pacific Islanders, Native Alaskans/American Indians and Multi-racial individuals.

Adult Males Living with HIV Disease by Race/Ethnicity and Mode of Exposure Reported through 2013, Partnership 10



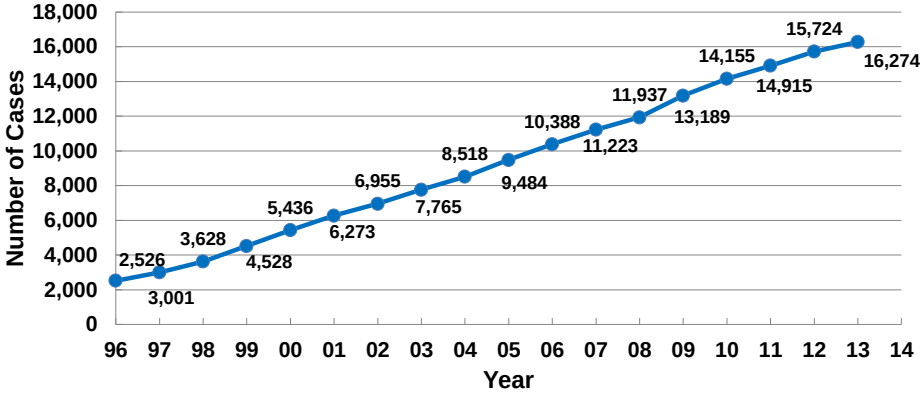
Note: NIRs redistributed. Among males living with HIV disease, the distribution of risk among blacks differs from that among whites and Hispanics. MSM represents the highest risk for all races. White males have the smallest proportion of heterosexual contact cases.

Adult Females Living with HIV Disease by Race/Ethnicity and Mode of Exposure Reported through 2013, Partnership 10



Note: NIRs redistributed. Among females living with HIV disease, the distribution of risk among whites differs from that among blacks and Hispanics. Heterosexual contact is the majority risk for all races. However, whites have the largest proportion of IDU cases.

Annual Prevalence of Adults Living with HIV Disease, 1995-2013, Partnership 10



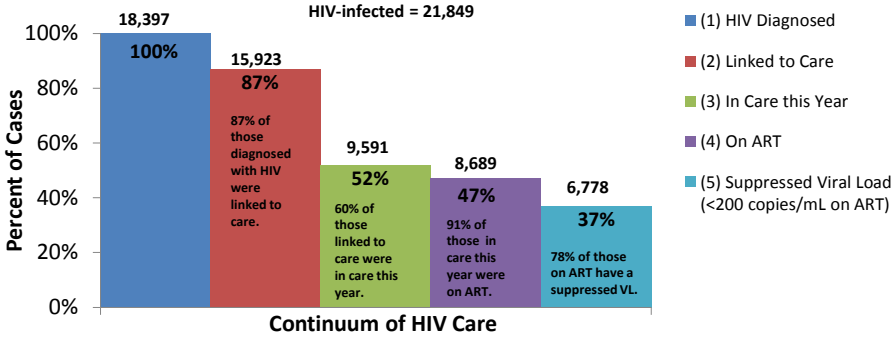
As a result of declining deaths, annual HIV/AIDS diagnoses have exceeded deaths since 1995, and the number of persons reported with HIV/AIDS that are presumed to be alive has been increasing. Since 1995, the number of persons reported living with HIV/AIDS has increased over 580%. In 2013, the prevalence increased by 6% since the previous year.

Partnership 10'sTop-9 Priority Populations in 2013 for Primary and Secondary HIV Prevention Based on Persons Living with HIV Disease

1. **Black Heterosexual men and women**
2. **White Men who have sex with Men**
3. **Black Men who have sex with Men**
4. **Hispanic Men who have sex with Men**
5. **Black Injection Drug User**
6. **Hispanic Heterosexual men and women**
7. **White Heterosexual men and women**
8. **White Injection Drug User**
9. **Hispanic Injection Drug User**

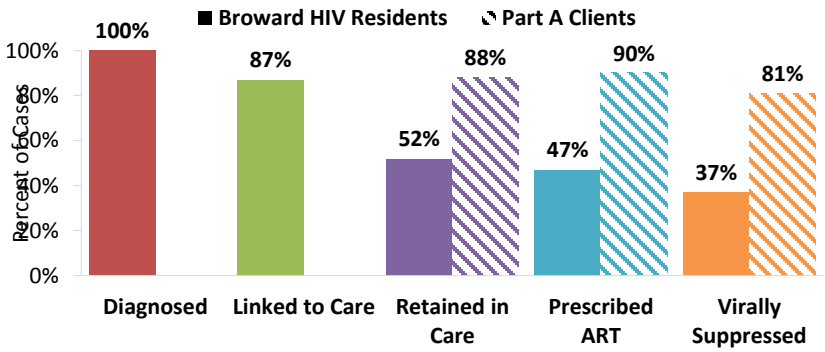
This final ranking is a result of ranking 9 race/risk groups among those newly reported in eHARS with HIV disease in Partnership 1 from the 3 most recent years, plus ranking these same 9 race/risk groups from all persons who were reported and living with HIV disease in eHARS in Partnership 1 through the most recent calendar year. The two ranks were then weighted and combined resulting in the final rank.

Number and Percentage of HIV-Infected Persons Engaged in Selected Stages of The Continuum of HIV Care — Partnership 10, 2013



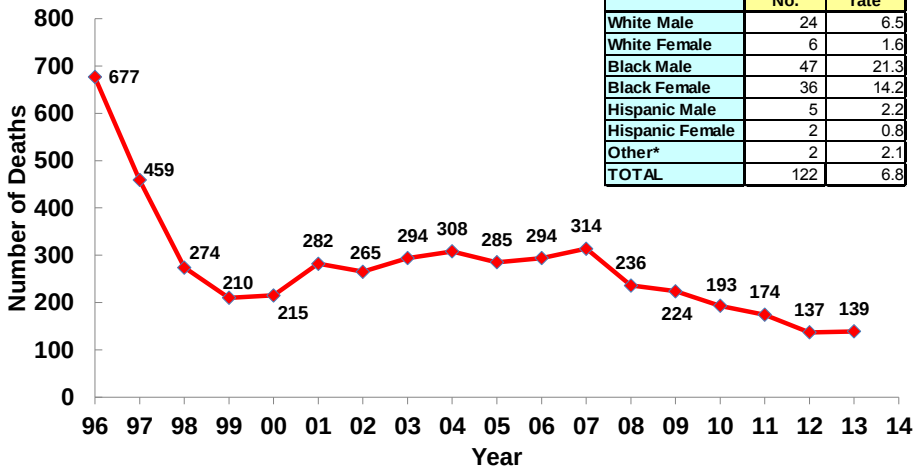
(1) Number of cases known to be alive and living in Florida through 2013, regardless where diagnosed, as of 06/30/2014 (used for unmet need calculations).
(2) Ever in Care = 86% of those cases were linked to care, based on persons living with HIV disease in Florida (regardless of where diagnosed) who ever had a CD4 or Viral load (VL) test in the electronic HIV/AIDS Reporting System (eHARS). (2010 National estimates are 79%*).
(3) 55% of cases were in care this year, based on HRSA unmet need definition, for persons living with HIV in Florida (regardless of where diagnosed) and having at least 1 HIV-related care service involving either a VL or CD4 test or a refill of HIV-related RX. (2010 National estimates for in care are 56%*).
(4) Estimated 90.6% of In care and on ART this year in Florida per 2011 MMP data (2010 National estimates are 80%*).
(5) Estimated 78.0% on ART & the viral load is <200 this year in Florida per 2011 MMP data (2010 National estimates are 70%*).
*Continuum of HIV care among Ryan White HIV/AIDS Program clients, U.S., 2010 (http://hab.hrsa.gov/data/reports/continuumofcare/index.html)
For additional information please refer to the Florida Continuum of Care slide set accessible at http://www.floridahealth.gov/diseases-and-conditions/aids/surveillance/index.html

Broward vs. Part A HIV Care Continuum, 2013



Source: Florida Department of Health & Provide Enterprise

Resident Deaths due to HIV Disease, by Year of Death, 1995-2013, Partnership 10



Race/Ethnicity	2013	
	No.	rate
White Male	24	6.5
White Female	6	1.6
Black Male	47	21.3
Black Female	36	14.2
Hispanic Male	5	2.2
Hispanic Female	2	0.8
Other*	2	2.1
TOTAL	122	6.8

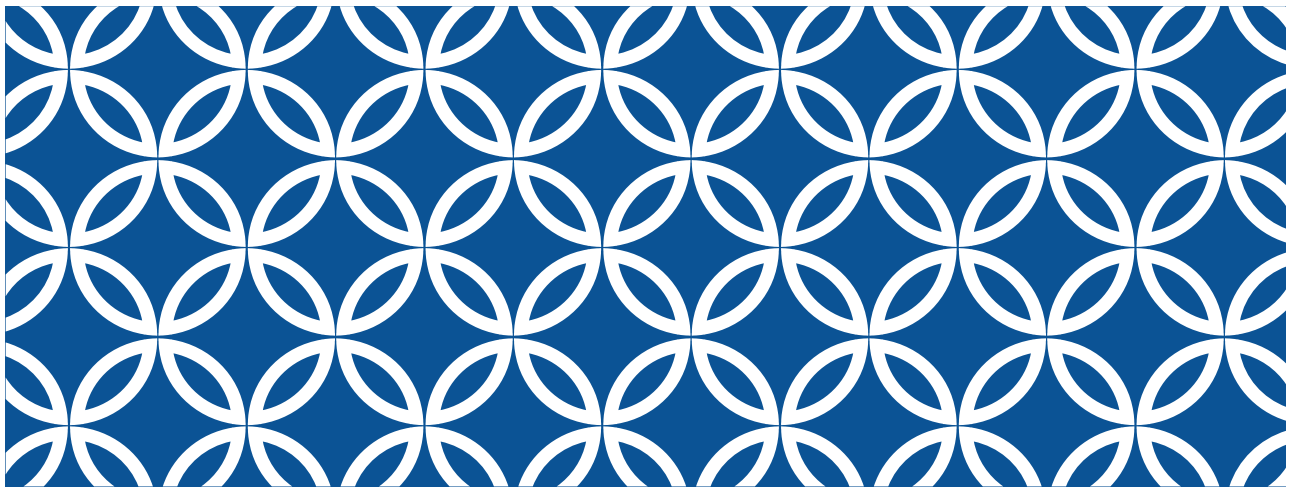
These data represent a 85% decline in HIV resident deaths due to HIV disease from the peak year of 1995 to 2013. This is much higher than the 78% decline observed by the state.

Source: Florida Department of Health, Bureau of Vital Statistics, Death Certificates (as of 05/16/2014).
Population data are provided by Florida CHARTS.
****Other includes Asian/Pacific Islanders, Native Alaskans/American Indians and mixed races.***

Demographics of Part A Clients Not Virally Suppressed,

FY 2013 – FY 2014

	FY 2013	FY 2014	%△ (FY 2013-14)
Race/Ethnicity			
White	607	620	2.1%
Black	986	1,014	2.8%
Hispanic	196	219	**11.7%**
Other	15	11	**-26.7%**
Gender			
Male	1,097	1,123	2.4%
Female	499	506	1.4%
Transgender	15	17	**13.3%**
Total			
	1,611	1,646	2.2%
Male Adult Exposure Category			
MSM	673	712	5.8%
IDU	24	18	**-25.0%**
MSM/IDU	9	8	**-11.1%**
Heterosexual	382	353	-7.6%
Other	35	32	-8.6%
Female Adult Exposure Category			
IDU	10	12	**20.0%**
Heterosexual	454	447	-1.5%
Other	32	42	**31.3%**



VOICES (MSM) STUDY FINDINGS

Voices:
HIV Health and Wellness Assessment Project and Exploratory Study

Broward County Human Services
Ryan White Part A Program Office

An MSM Pilot Study Assessment 2013-2014

Marsha A. Martin, DSW

BACKGROUND

Purpose

The study was a component of the Part A update and yearly review of consumer needs.

Voices looked at several key aspects of the local response:

- MSM of Known HIV Serostatus- HIV Health Care
- MSM of Unknown HIV Serostatus- Healthy Sexuality

Voices utilized focus groups, informant interviews, community participant observation and a community advisory group.

Goal

To provide updated information on the experience of gay and bisexual men and other men who have sex with men (MSM) in Broward County and transgender women.

TOPICS COVERED

Emerging gay community in Broward County

Socio-sexual-cultural context of gay, bisexual and other men who have sex with men (MSM)

Epidemiological profile of MSM in South Florida

Impact of HIV/AIDS on general and sexual health well-being

Mental health, substance use, homelessness

Participation in on-going HIV medical care, supportive and prevention services

HIGHLIGHTS

Stigma, shame and **denial** were identified as the chief issues

Lack of basic education about HIV, where to get an HIV test; what services exist for people with HIV and how to live a healthy life after HIV diagnosis

At-risk transgender women have feelings of **low self-esteem** and **lack of employment opportunities** lead to street work and commercial sex work; many perceive their choices to be very limited and place themselves at risk for HIV infection to 'make it'

A **lackadaisical attitude** and **inevitability** about HIV among some gay, bisexual MSM exist

Cultural competence in HIV care and treatment specifically for gay and bisexual men was identified as a critical need

Drug and alcohol abuse is felt by many to be the leading contributor to HIV transmission among gay, bisexual MSM, and transgender women

RECOMMENDATIONS

Establish a Men's Health and HIV Advisory Workgroup

Expand access to Mental Health and Substance Abuse Services for gay, bisexual men who have sex with men who are living with HIV

Establish an intergovernmental HIV planning integration taskforce to focus on the HIV epidemic in the greater Broward Community

Sponsor an annual Tri-County (Broward, Dade, Palm Beach) Summit on HIV and Gay Men

Fort Lauderdale / Broward County EMA
Broward County HIV Health Services Planning Council
200 Oakwood Lane, Suite 100, Hollywood, FL, 33020
Tel: 954-561-9681 / Fax: 954-561-9685

HANDOUT D

SOC/CEC COMMUNITY FORUM

Proposed Date: June 2015
Proposed Location: Tree Tops Park (Nob Hill Rd & Griffin Rd, Davie)

1. **Collaboration**
   The Community Empowerment Committee (CEC) and the System of Care (SOC) Committee will hold a joint community event to educate greater Broward County about HIV services.

2. **Proposed Topics**
   HIV Biomedical Interventions: The community forum will focus on current HIV biomedical medical interventions. It will explore interventions such as Pre-Exposure Prophylaxis (PrEP) and Post-Exposure Prophylaxis (PEP), both utilized to prevent HIV infection. Community members will be asked to provide feedback about topics they would like more information about, or education that is missing from the community.

   Health Fair: The community forum will work as a health fair, designed to bring awareness about different services available in the community. Items will include services for both HIV-negative and HIV-positive attendees, including testing and Ryan White services. The health fair may also feature a keynote speaker to help draw people to the event, as well as breakout sessions about different health topics.

3. **Potential Keynote Speakers**
   - Florida/Caribbean AETC: Dr. Jeffrey Beal, Dr. Jose Castro, Elizabeth Sherman
   - Equality Florida
   - South Florida Gay News: Norm Kent
   - FLDOH-Broward Prevention Program: Evelyn Ullah, Christopher Bates
   - Latinos Contra el SIDA (LUCES): Sandra Estevez
   - Sistas Organizing to Survive (SOS): Krystle Kirkland-Mobley
   - Sexual Violence & LGBT Health: CDC Speakers

4. **Other Parties to Invite**
   - Ryan White Program (all Parts)
     - Providers: AHF, BRHPC, Broward Health, Broward House, Care Resource, CDTC, Memorial Health
   - FLDOH-Broward Prevention Program
   - HOPWA
   - 211 Broward
   - Broward Children's Center
   - MODCO
   - Pride Center
   - SunServe
   - Latinos Salud